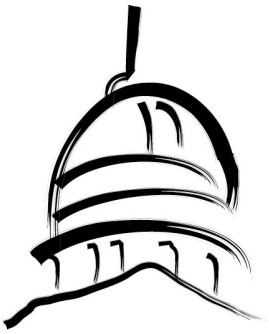
Services for Persons with Mental Illness



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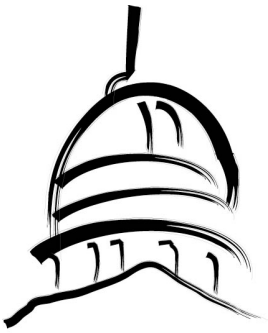

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Services for Persons with Mental Illness

Introduction

The National Institute of Mental Health estimates that 22% of American adults have a diagnosable mental disorder. Four of the ten leading causes of disability in the United States and other developed countries are mental disorders -- major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder. Many individuals have more than one mental disorder.

This paper describes public mental health services available to people in Wisconsin. The first section of this paper briefly describes common types of mental disorders and the factors that are believed to cause these disorders. The second section describes the provision of community-based services to persons with mental disorders and the programs that provide these services. The final section describes the institutional services that provide care and treatment for persons with mental disorders. This paper does not discuss the services provided in Wisconsin for sexually violent persons committed under Chapter 980 of the statutes.

The Nature of Mental Illness

Wisconsin statutes define mental illness as a "mental disease to such extent that a person so afflicted requires care and treatment for his or her own welfare, or the welfare of others, or of the community." Chronic mental illness is defined as "a mental illness which is severe in degree and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, which may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support and which may be of lifelong duration." This definition includes schizophrenia, as well as psychotic and other severely disabling psychiatric diagnostic categories, but does not include infirmities of aging or a primary diagnosis of mental retardation or of alcohol or drug dependence. These definitions are used to determine eligibility for services provided under Chapter 51 of the statutes.

Under federal law, adults with serious mental illness are people 18 years of age or older who currently have, or at any time during the past year had, a diagnosable mental behavior or emotional disorder of sufficient criteria specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), published by the American Psychiatric Association, that has resulted in functional impairments, which substantially interferes with or limits one or more major life activities. People with serious mental illness include individuals who have a twelve-month DSM-IV diagnosis and one or more of the following:

- Non-affective psychosis or mania, major depression or panic disorder with evidence of severity indicated either by hospitalization or use of major psychotropic medications;

- A planned or attempted suicide at some

time during the last 12 months;

- The lack of a legitimate productive role;

- A serious role impairment in their main productive role; and

- A serious interpersonal impairment, as defined through the client's self-report of isolation and loss of capacity to interact with others.

The clinical definition of a mental disorder, as defined in the DSM-IV, is "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event."

Mental Disorders Affecting Adults. The Department of Health and Family Services (DHFS) estimates that approximately 5.7% of the non-institutionalized adult population in Wisconsin have a severe mental illness. There are many types of mental disorders. Anxiety disorders, major depression, bipolar disorder, and schizophrenia are among the most common mental disorders affecting adults.

Anxiety disorders are chronic disorders that are characterized by overwhelming anxiety and fear. Anxiety disorders include panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, social phobia, specific phobias, and generalized anxiety disorder. The common theme among these disorders is "excessive, irrational fear and dread." Depending on the anxiety disorder, men or women may be more often affected.

There are five forms of depression, the most common of which is major or unipolar depression. An estimated 5% of American adults between the ages of 18 and 54 have major depression. The symptoms of major depression include: (a) feelings of sadness or irritability; (b) loss of interest in sex and activities that were once enjoyed; (c) changes in weight or appetite; (d) changes in sleeping patterns; (e) feeling guilty, hopeless, or worthless; (f) inability to concentrate, remember things, or make decisions; (g) fatigue or loss of energy; (h) restlessness or decreased activity noticed by others; and (i) thoughts of suicide or death. A diagnosis of major depression can be made if an individual has five or more symptoms for more than two weeks or has considerable impairment in normal functioning. Individuals between 24 and 44 years of age are most likely to have depression. Annually, nearly twice as many women (6.5%) as men (3.3%) have major depressive disorder.

Bipolar disorder, or manic depression, is a mental illness that is characterized by severe mood swings and behavioral changes. It is estimated that 1% of the adult population has bipolar disorder. Bipolar disorder has two phases – manic and depressive. Symptoms of the manic phase include: (a) a mood that seems excessively good, euphoric, or expansive; (b) expressions of unwarranted optimism and lack of judgment; (c) excessive plans or participation in numerous activities that have a good chance for painful results; (d) rapid, uncontrollable ideas and speech pattern; (e) decreased need for sleep; (f) distractibility; and (g) sudden irritability, rage, or paranoia. Without treatment, the manic phase could last up to three months. The individual may experience a period of normal mood and behavior before the depressive stage begins with the "normal" period lasting between hours and months, depending on the individual. The symptoms of the depressive stage are the same as those listed previously for major depression. Men and women are equally likely to be affected by this disease.

Schizophrenia involves dysfunction in one or more major areas of functioning, such as interpersonal relations, self-care, or work or education, with the dysfunction lasting at least six months and including at least two of the following

symptoms: (a) delusions; (b) hallucinations; (c) disorganized speech; (d) grossly disorganized or catatonic behavior; or (e) restrictions in the range and intensity of emotional expression, in the fluency and productivity of thought and speech, and in the initiation of goal-directed behavior. In a given year, approximately 1% of the national adult population, has schizophrenia. Symptoms first appear between the ages of 15 and 25 and men usually experience symptoms earlier than women.

Mental Disorders Affecting Children. Many mental disorders that affect adults can also affect children. For example, many adults with bipolar disorder first experience symptoms while in their teens - major depression occurs in up to 6% of children and an estimated 8% to 10% of children are affected by anxiety disorders. However, there are certain mental disorders that tend to be associated most often with children, including attention-deficit/hyperactivity disorder, attachment disorder, and conduct disorder.

Attention-deficit/hyperactivity disorder (ADHD) occurs in up to 5% of children, with boys being almost three times as likely to have ADHD as girls. There are three types of ADHD: (a) inattentive; (b) hyperactive-impulsive; and (c) combined attention-deficit/hyperactive disorder. Children with inattentive ADHD have short attention spans, are easily distracted, do not pay attention to details, make lots of mistakes, fail to finish tasks, are forgetful, don't seem to listen, and cannot stay organized. Children with the hyperactive-impulsive type of ADHD fidget and squirm, are unable to stay seated or play quietly, run or climb too much, talk too much, blurt out answers before questions are completed, have trouble taking turns, and interrupt others. The third type, combined attention-deficit/hyperactive disorder, is the most common type and the symptoms are a combination of both the inattentive and hyperactive-impulsive types. For a diagnosis of ADHD, symptoms must begin before the age of seven, last six months, and be evident in at least two different settings, such as school and home.

Attachment disorder may affect children who were unable to establish secure and permanent relationships early in their life. Children who, from birth to 18 months of age, were ill, experienced forced separations, emotional, sexual or physical abuse or neglect, or were at least two years old when an adoptive/foster placement occurred are more likely to experience attachment disorder. There are many symptoms of an attachment disorder, including, but not limited to: (a) being superficially engaging or charming; (b) avoiding eye contact with parents; (c) being indiscriminately affectionate with strangers; (d) being destructive to themselves, others, and material things; (e) being cruel to animals and other people; (f) being unable to connect cause and effect, action and consequence; (g) demonstrating a lack of conscience; (h) lying obviously; (i) failing to form deep relationships; (j) having learning disabilities or disorders; and (k) having trouble recognizing and expressing feelings.

An estimated 10% of children and adolescents have conduct, or disruptive behavior, disorder. These children repeatedly violate the personal or property rights of others and the basic expectations of society. The symptoms of conduct disorder include: (a) aggressive behavior that harms or threatens to harm other people or animals; (b) destructive behavior that damages or destroys property; (c) lying or theft; and (d) skipping school or other serious violations of rules. These symptoms must persist for six months or longer for a diagnosis of conduct disorder.

The cause of mental illnesses is not definitively known. However, researchers have indicated that a number of factors play a role in causing or helping to facilitate the development of many mental illnesses, including biological, cognitive, genetic, and situational. For example, individuals with relatives with depression are two to three times more likely to experience depression than an individual without a relative with depression. In addition, life events may trigger a depressive

episode. Finally, the existence of certain medical illnesses, such as a stroke, heart disease, or cancer, appears to increase the occurrence of mental disorders.

Many individuals are affected by more than one mental disorder. For example, approximately 50% of the children with ADHD also have oppositional or conduct disorder; adults with bipolar disorder may also experience anxiety disorders. Additionally, approximately 15% of all adults who have a mental disorder in a given year also experience a substance abuse disorder.

History of the Provision of Mental Health Services in Wisconsin

During the last 50 years, there has been a shift in the provision of mental health services from inpatient, institutional care to community-based care. This shift reflected many changes, including an increased understanding of the cause and treatment of mental illnesses and a philosophy change from viewing individuals with mental illness as "passive service users" to proactive consumers who can direct their own care and live and work within the community. During this time, it was realized that mental disorders are not necessarily lifelong and progressive. With appropriate supports, persons with mental disorders or severe emotional disturbance can maintain school performance, jobs, friendships, and family networks. Further, it is recognized that mental health services must be flexible and responsive to highly individual needs and environments; and people with mental disorders value independence and productivity.

Blue Ribbon Commission on Mental Health. In May, 1996, under an Executive Order, Governor Thompson appointed a Blue Ribbon Commission on Mental Health. The Commission was directed to recommend: (a) model mental health delivery systems that are effective in an environment that emphasized managed care, client outcomes, and performance contracting; (b) ways federal, state, and county governments can cooperate to gain fiscal efficiencies and greater service capacity; (c) a service system targeted at prevention, early intervention, treatment, recovery, and positive consumer outcomes; and (d) ways to reduce stigma in the state's mental health policies and programs.

In its April, 1997, report, the Commission recommended changes to the mental health system that focus on consumer outcomes, the concept of recovery, prevention, and early intervention services, reducing stigma associated with mental disorders, the DHFS role in the mental health system, and financing and organizational structures of the mental health system. Specifically, the Commission recommended pooling federal, state, and county funding for human services through a managed care approach to services.

The Blue Ribbon Commission adopted the concept of recovery, defined as the successful integration of a mental disorder into a consumer's life, as the key tenet of the redesigned mental health system. In a recovery-oriented system, mental health consumers participate in services that enable them to recover and decrease their dependence on the mental health system, rather than become long-term users of the system.

The Commission identified five target populations, based on the level of a person's service needs, for which to plan mental health services. The first three populations include: (a) persons who need ongoing, low-intensity, comprehensive services; (b) persons who need ongoing, high-intensity, comprehensive services; and (c) persons who need short-term, situational services. These populations were identified to be in need of treatment and recovery services. The Commission identified four broad categories of treatment and recovery services: (1) core mental health services (assessment, crisis intervention, case management); (2) self-help, peer support, and

natural supports; (3) community supportive services; and (4) in-residence services. The pattern of expected services to be offered will be influenced both by the age of the consumer and the intensity of service needs.

The other populations include persons who are at risk of developing a mental disorder at some point in their lives and persons at an acceptable level of mental health. These populations were identified by the Commission to be in need of prevention and early intervention services. Through prevention and early intervention, many of the conditions of mental illness can be reduced in absolute number, delayed in onset, or lessened in severity if specific risk factors are reduced, certain protective factors enhanced, and early warning signs treated promptly.

The Commission recommended that the redesigned mental health system emphasize flexibility and creativity with the objective to empower consumers, families, and mental health professionals to be creative as they seek to achieve mutually agreed upon outcomes. To meet these goals, the Commission recommended that all consumers: (a) participate in comprehensive assessments; (b) receive highly individualized services based on that assessment and the consumer's chosen way of life; (c) have a plan of services designed to achieve positive consumer outcomes, including self-sufficiency; (d) are served with dignity, respect, and receive the least restrictive interventions necessary to achieve consumer outcomes; and (e) receive services that meet applicable standards of care.

The Commission's report outlined a recovery-oriented mental health system that promotes self-determination and quality of life, rather than dependence, for persons of all ages with mental disorders and emphasizes prevention and early intervention of targeted mental disorders.

The Provision of Mental Health Services

The Department of Health and Family Services. The DHFS Bureau of Community Mental Health in the Division of Supportive Living is the primary state contact for community mental health services in Wisconsin. DHFS has a number of statutory requirements that the Bureau implements on behalf of the state. Under s. 51.03 of the statutes, DHFS may, within the limits of available state and federal funds, do the following:

- Promote the creation of coalitions among the state, counties, providers of mental health services, consumers of the services and their families, and advocates for persons with mental illness to develop, coordinate, and provide a full range of resources to advance prevention, early intervention, treatment, recovery, safe and affordable housing, opportunities for education, employment and recreation, family and peer support, self-help, and the safety and well-being of communities;

- In cooperation with counties, providers of mental health services, consumers of these services, interested community members and advocates for persons with mental illness, develop and implement a comprehensive strategy to reduce stigma of and discrimination against persons with mental illness;

- Develop and implement a comprehensive strategy to involve counties, providers of mental health services, consumers of these services and their families, interested community members and advocates for persons with mental illness as equal participants in service system planning and delivery;

- Promote responsible stewardship of human and fiscal resources in the provision of mental health services;

• Develop and implement methods to identify and measure outcomes for consumers of mental health services;

• Promote access to appropriate mental health services regardless of a person's geographic location, age, degree of mental illness, or availability of personal financial resources;

• Promote consumer decision making to enable persons with mental illness to be more self-sufficient; and

• Promote use by providers of mental health services of individualized service planning, under which the providers develop written individualized service plans that promote treatment and recovery, together with service consumers, families of service consumers who are children, and advocates chosen by consumers.

Finally, DHFS is required to ensure that providers of mental health services who use individualized service plans: (a) establish meaningful and measurable goals for the consumer; (b) base the plan on a comprehensive assessment of the consumer's strengths, abilities, needs, and preferences; (c) keep the plan current; and (d) modify the plan as necessary.

DHFS also administers state and federal funding for mental health services to counties or agencies for the provision of these services, which are described elsewhere in the paper.

Counties. In Wisconsin, counties are assigned primary responsibility for the well-being, treatment, and care of persons with mental disabilities (persons with mental illness, developmental disabilities, and alcoholic and other drug dependent persons) who reside in the county and for ensuring that persons in need of emergency services who are in the county receive immediate emergency services.

Under standards established by rule, each county establishes its own program and budget for these services. The statutes specify that counties are responsible for the program needs of persons with mental illness only within the limits of available state and federal funds and county funds required to match these funds. Thus, counties limit service levels and establish waiting lists to ensure that expenditures for services do not exceed available resources. For this reason, the type and amount of community-based services that are available to persons with mental illness varies among counties in the state.

The mental health services available in Wisconsin range from community-based care to inpatient and psychotherapy services. Counties are directed to provide services to individuals in the least restrictive environment that is appropriate for their needs. Counties are required within the limits of available state and federal funds and of required county matching funds, to provide for the needs of persons with mental disabilities, including mental illness, developmental disabilities, and substance abuse by offering the following services: (a) collaborative and cooperative services with public health and other groups for programs of prevention; (b) comprehensive diagnostic and evaluation services; (c) inpatient and outpatient care and treatment, residential facilities, partial hospitalization, emergency care, and supportive transitional services; (d) related research and staff in-service training; and (e) continuous planning, development, and evaluation of programs and services for all population groups.

Funding of Mental Health Services in Wisconsin

There are four primary funding sources for public mental health services in Wisconsin: (a) the federal community mental health block grant (CMHBG); (b) state and local funding; (c) medical assistance (MA); and (d) private insurance and

individual copayments. The first three funding sources are discussed in this paper.

Community Mental Health Block Grant. In federal fiscal year 2001-02, Wisconsin received $6,868,600 in CMHBG funds. States may use these funds to provide comprehensive community mental health services to adults with a serious mental illness and to children with a serious emotional disturbance and to monitor the progress in implementing a comprehensive community based mental health system. The federal fiscal year 2002-03 Wisconsin state mental health plan identifies eight priority program areas: (1) community support programs; (2) supported housing (including services for individuals who are homeless); (3) jail diversion; (4) crisis intervention; (5) family and consumer peer support and self-help; (6) services for children and adolescents with severe emotional disturbances; (7) programs for persons with mental illness and substance abuse problems; and (8) community mental health data-set development.

Of $6,699,300 FED available in state fiscal year 2002-03 from the CMHBG, $2,513,400 is allocated to counties through community aids, $1,330,500 is distributed to integrated service projects for children throughout the state, $296,000 is allocated for the coordinated services team initiative, $2,137,400 is allocated for a variety of grant programs distributed to counties and agencies, and $422,000 is budgeted to support DHFS operations costs. These programs are described in greater detail later in this paper.

Under federal law, the state is required to establish and maintain a council on mental health in order to receive CMHBG funds. The Council on Mental Health is an institutional advocacy and advisory council for individuals with mental illness and is attached to DHFS for administrative purposes. The Council is statutorily required to advise DHFS, the Legislature, and the Governor on the use of state and federal resources and on the provision and administration of programs for persons who are mentally ill or who have other mental health problems, for groups who are not adequately served by the mental health system, for the prevention of mental health problems, and for other mental health-related purposes. In addition, the Council is required to: (a) provide recommendations to DHFS on the expenditure of CMHBG funds; (b) participate in the development of the CMHBG plan and monitor and evaluate the implementation of the plan; (c) review and monitor all DHFS plans and programs affecting persons with mental illness; (d) annually submit a report on recommended policy changes in the area of mental health to the Governor and Legislature; and (e) promote the development and administration of a delivery system for community mental health services that is sensitive to the needs of consumers of the services. DHFS is required to submit all its plans affecting persons with mental illness to the council for its review.

Community Aids. Under the state's community aids program, DHFS distributes state and federal funds to counties for community-based social, mental health, developmental disabilities, and substance abuse services. DHFS allocates community aids funding to counties on a calendar year basis and in a single amount that includes federal and state revenue sources. Counties receive both a basic county allocation, which may be expended for any of these eligible services, and categorical allocations, which are funds that are earmarked for specific services and programs. For 2003, the estimated basic county allocation totals $242,174,000 (all funds), representing 93% of all funds allocated to counties in that year ($261,720,500). From the remaining portion, counties receive funding earmarked for selected programs and specific services, including mental health services.

Services Supported by the Basic County Allocation. Counties may use funding they receive under the community aids basic county allocation for a wide range of services for specified populations, including persons with mental disorders.

Annually, counties report the funding, including community aids, required county matching funds, and local funds contributed that are in excess of the required matching funds ("overmatch funds") used to support services to individuals with mental disorders. In 2001, counties reported spending approximately $319.8 million on mental health services provided to approximately 94,700 individuals.

Categorical Allocations. There are five categorical allocations in community aids, including the community mental health block grant. For 2002-03, an estimated $2.5 million will be distributed from the CMHBG to counties to provide comprehensive community mental health services to adults with serious mental illness and to children with a serious emotional disturbance, evaluate programs and services, and conduct planning, administration, and educational activities related to providing services. Services provided with funds from the block grant include: (a) respite care; (b) adult family home care; (c) community prevention services; (d) crisis intervention; and (e) counseling and therapy. Federal guidelines allow up to 5% of the block grant to pay for administrative costs. Block grant funding may not be used to provide inpatient services or to make cash payments to intended recipients of health services.

Medical Assistance. Wisconsin's MA program provides outpatient and day treatment mental health services if prescribed by a physician and certain other conditions are met. Health maintenance organizations (HMOs) serving MA recipients are required to provide all of the same services available to recipients receiving services on a fee-for-service basis, including mental health services. Information is not available on expenditures for mental health services provided to MA recipients enrolled in HMOs. The payment information included below only reflects services provided to individuals on a fee-for-service basis, meaning the provider directly bills the MA program, rather than providing the service through an HMO.

Outpatient Psychotherapy. Outpatient psychotherapy services are available to any MA recipient if prescribed by a physician and a diagnostic examination is performed by a certified psychotherapy provider. Prior authorization is required for outpatient services provided in excess of $500 or after 15 hours of services are provided to a recipient in a calendar year. MA payments for outpatient services totaled approximately $43.9 million (all funds) in 2001-02 for services provided to approximately 40,000 MA recipients.

Day Treatment. Day treatment services are reimbursed for up to five hours per day or 120 hours per month and require prior authorization after 90 hours are provided in a calendar year. Day treatment services are only covered for MA recipients with serious and persistent mental illness or acute mental illness with a need for day treatment and an ability to benefit from the service, as measured by a functional assessment scale provided by DHFS. Payments for day treatment services totaled approximately $10.8 million in 2001-02 for services provided to approximately 2,000 MA recipients.

County-Funded Services. In addition to outpatient psychotherapy and day treatment services, MA covers several mental health services targeted to individuals with severe, serious, and persistent or acute mental illness, but for which local governments pay the state's share of the MA payment. By claiming federal MA-matching funds for these services, local governments, particularly counties, are able to supplement local funding for services provided to MA-eligible individuals. These services include community support program (CSP), crisis intervention, and case management services.

Community support program services include assessments, treatment, case management, and psychological rehabilitation services, including employment-related services, social and

recreational skill training, and assistance with activities of daily living and other support services. These services are available when prescribed by a physician and provided by providers that meet the conditions for community support programs administered by counties. In 2001-02, federal funds claimed for CSP services totaled approximately $18.6 million for services provided to approximately 4,800 recipients.

Crisis intervention services are services provided by a mental health crisis intervention program operated by, or under contract with, a county. In 2001-02, federal funds claimed for crisis intervention services totaled approximately $5.5 million for services provided to approximately 5,400 recipients.

Federal claims totaled approximately $3.8 million in 2001-02 for case management services provided to approximately 5,400 MA recipients with serious and persistent mental illness.

Prescription Drugs. In addition to therapy services, treatment for individuals with severe mental illness can frequently involve the use of medication. In 2001-02, MA paid an estimated $69.1 million (all funds) on behalf of approximately 35,900 MA recipients for drugs considered anti-psychotic medications.

Additionally, MA paid an estimated $48.9 million in 2001-02 for drugs considered anti-anxiety and anti-depressant medications. However, while these medications are usually considered mental health treatment drugs, these medications can be prescribed to any MA recipient who receives services on a fee-for-service basis for a variety of medical reasons. For example, individuals receiving chemotherapy for treatment of cancer can be prescribed anti-anxiety medications to address some of the side effects associated with that treatment. MA payment for drugs used by individuals enrolled in HMOs are included in the capitation payments made to those organizations and are not included in this data. MA payments for drugs are offset by rebate revenue received from companies that manufacture drugs purchased under MA. On average, this revenue represents approximately 20% of payments for prescription drugs.

Programs for Children with Severe Emotional Disturbances

Children with severe emotional disturbances (SED) are defined in Wisconsin as individuals under the age of 21 who require acute treatment and may lead to institutional care. In addition, the disability must be evidenced by the following:

1. The disability must have persisted for six months and be expected to persist for a year or longer;

2. A mental or emotional disturbance listed in the DSM-IV diagnostic categories appropriate for children and adolescents and disorders usually first evident in infancy, childhood, and adolescence. These could include schizophrenia and other psychotic disorders, anxiety disorders, attention deficit and disruptive behavior disorders, and feeding and eating disorders;

3. Functional symptoms and impairments. The individual must have either symptoms or functional impairment, as described below:

Symptoms. The individual must exhibit one of the following:

- A serious mental illness that is characterized by defective or lost contact with reality, often with hallucinations or delusions; or

- Danger to self, others, or property as a result of an emotional disturbance.

Functional Impairment. The individual must

exhibit functional impairment in two of the following capacities (compared with expected developmental level):

- Self Care;
- Community;
- Social Relationships;
- Family; or
- School or work.

4. The individual is receiving services from two or more of the following service systems: (a) mental health; (b) social services; (c) child protective services; (d) juvenile justice; (e) special education; or (f) substance abuse.

In Wisconsin, DHFS estimates that there are approximately 62,000 children between the ages of nine and 15 with SED. Of these children, about one-half will, at one point, need public services. Not all of these services will be specialized, as many of these children will be served through the mental health and social services system administered by the counties.

Integrated Service Projects for Children with SED. Integrated service projects (ISPs) provide integrated services, also referred to as "wraparound services," which focus on the strengths and needs of the child and family and "wrapping" services around them to treat and support families in the community. The program serves children under 18 years old who: (a) have a serious emotional disturbance; (b) have minimal coping skills to meet the ordinary demands of family life, school, and the community; and (c) are involved in two or more service systems, including mental health, child welfare, or juvenile justice. Priority is given to children with severe disabilities who are at risk of placement outside of the home, who are in institutions and are not receiving integrated community-based services, or who would be able to return to community placement or their home from an institutional placement if such services were provided.

There are currently 27 counties in Wisconsin that have ISP programs; 19 of these programs receive grants from DHFS, two counties operate with county-administered funds, and six are currently developing their programs.

In 2002-03, DHFS distributed $1,463,800 [$133,300 general purpose revenue (GPR) and $1,330,500 FED] for grants to counties for their ISP programs. The federal funding is available under CMHBG. Table 1 lists these counties, their annual grant award, and the number of children enrolled in each program in 2002. In 2001, 402 children were enrolled in the program. Additionally, 837 family members received support and services through these ISPs in 2001. Of the children enrolled, 37% were diagnosed with ADHD, 13% with oppositional defiant disorder, 10% with conduct disorder, and 10% with bipolar disorder. Appendix I identifies the counties with ISP programs that receive grant funding from DHFS.

In addition to the programs listed in Table 1,

Table 1: Integrated Service Projects Calendar Year 2002 Awards

Counties	GPR	FED	Total Award	Enrollees
Ashland	$7,200	$72,800	$80,000	5
Chippewa	7,200	72,800	80,000	11
Door	7,200	72,800	80,000	14
Dunn	7,300	72,700	80,000	14
Eau Claire	7,300	72,700	80,000	11
Fond du Lac	7,300	72,700	80,000	11
Kenosha	7,300	72,700	80,000	57
La Crosse	7,300	72,700	80,000	20
Marinette	7,300	72,700	80,000	22
Marquette	7,300	72,700	80,000	10
Portage	7,300	72,700	80,000	11
Racine	7,300	72,700	80,000	23
Rock	7,300	72,700	80,000	21
Sheboygan	7,300	72,700	80,000	10
Washburn	7,300	72,700	80,000	8
Washington	7,300	72,700	80,000	9
Waukesha	7,300	72,700	80,000	6
Waupaca	2,200	21,600	23,800	19
Waushara	7,300	72,700	80,000	12
Total	$133,300	$1,330,500	$1,463,800	294

eight other counties in Wisconsin operate ISP programs for children with SED. The Children Come First Program in Dane County and Wraparound Milwaukee in Milwaukee County are managed care programs that are funded with MA and county funds. Forest, Oneida, Vilas, Marathon, Langlade, and Lincoln Counties are collectively called the Northwoods Alliance for Children and Families and are funded with a federal grant.

Children Come First of Dane County. Children with SED who are eligible for either MA or BadgerCare, live in Dane County, are at imminent risk of an out-of-home placement (including to a psychiatric hospital), and are not residents of a nursing home or a psychiatric hospital are eligible for services through the Children Come First program. Under the program, Dane County contracts with Community Partnerships, Inc., a limited service health organization, to provide services for eligible children.

Services are supported with combined MA and county funds. In 2001, the program served 275 youth.

Wraparound Milwaukee. Wraparound Milwaukee served 869 children and families in 2001, of which 368 children were newly enrolled in the program in 2001. Of the children served, 65% were diagnosed with conduct disorder, 49% with oppositional defiant disorder, and 46% with ADHD. Eight lead agencies provided care coordination services in 2001: (a) Alternatives in Psychological Consultation; (b) Center for Child and Family Services; (c) Children's Service Society; (d) Family Services of Milwaukee; (e) La Causa, Inc.; (f) St. Aemilian – Lakeside; (g) St. Charles Youth and Family Services; and (h) Willowglen Community Care Center. The network of service providers had 230 agencies offering 80 different services to families served through Wraparound Milwaukee. The most frequently utilized community services include residential treatment and foster care services, in-home therapy, day treatment, crisis stabilization, and mentoring.

The Wraparound Milwaukee program is operated by the Milwaukee County's Behavioral Health Division. Wraparound Milwaukee is supported by combining funding from Milwaukee County, the DHFS Bureau of Milwaukee Child Welfare, and MA.

Northwoods Alliance for Children and Families. Forest, Oneida, Vilas, Marathon, Langlade, and Lincoln Counties are collectively called the Northwoods Alliance for Children and Families. The Alliance is supported by a six-year federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Mental Health Services (CMHS). The goal of the Alliance is to create and sustain a regional, integrated system of care that will successfully meet the complex needs of SED children/youth and their families. In 2001, a total of 106 children were served by the Alliance, with the most served (44) in Marathon County. Referrals come from four systems – child welfare, mental health, education, and juvenile justice. At the time of enrollment, 38% of the children were diagnosed with ADHD, 25% with disruptive behavior disorder, and 22% with depression or anxiety. The program is supported with a combination of federal funds, county funds, and MA matching funds.

Coordinated Service Team Initiative. The coordinated service team initiative combines mental health, substance abuse, and child welfare funding to award grants to support pilot programs in Calumet, Green Lake, Iron, Jefferson, and Waupaca Counties. These pilot projects will implement a systems change by coordinating the mental health, child welfare, and substance abuse systems for children and families so that these systems consistently use a strength-based, family centered, coordinated service approach (wraparound) to achieve better outcomes for children and families. The pilot projects use a team approach across agencies, involving parents in all aspects of the process, build on natural supports, respect individual differences and preferences, and require collaborative funding.

Table 2: Coordinated Service Team Grants 2002

County	Amount
Calumet	$60,000
Green Lake	41,252
Iron	48,500
Jefferson	47,000
Waupaca	62,660
Total	$259,412

This initiative began in December, 2002. A total of $381,000 FED is allocated for the initiative. $259,400 was allocated to counties, $66,000 is budgeted for project administration costs, and $55,600 is budgeted for training and consultation with the pilot counties. Of this, $296,000 is from CMHBG. Table 2 identifies the counties that were awarded grants to begin pilot programs.

Beginning in September, 2003, DHFS expects to award $200,000 in additional grants to Bayfield, Manitowoc, Marquette, and Sauk Counties.

Community Support Program

Community support programs, or CSPs, are coordinated care and treatment programs that provide a range of treatment, rehabilitation, and support services through an identified treatment program and staff to ensure ongoing therapeutic involvement, individualized treatment, rehabilitation, and support services in the community for persons with serious and persistent mental illness. There are 75 certified CSPs in 60 counties and 28 case management programs in Wisconsin, as shown in Appendix II. A case management program is not MA certified and thus, the county cannot claim MA-matching funds for services.

As specified in s. 51.421 of the statutes, in order to provide the least restrictive and most appropriate care and treatment for persons with serious and persistent mental illness, every county department must provide community support services, if the funds are provided and within the limits of available funds under community aids. Each CSP has a coordinated case management system and provides or ensures access to services for persons with a serious and persistent mental illness who reside within the community. The services provided or coordinated through a CSP include assessment, diagnosis, identification of persons in need of services, case management, crisis intervention, psychiatric treatment, activities of daily living, and psychosocial rehabilitation. These services are provided on an individual basis, according to the treatment and psychosocial rehabilitation needs of the individual.

An individual is eligible for services in a CSP if the individual has a serious and persistent mental illness which, by history or prognosis, requires repeated acute treatment or prolonged periods of institutional care and exhibits persistent disability or impairment in major areas of community living as evidenced by:

- A condition of serious and persistent mental illness;

- A diagnosis of schizophrenia, affective disorders, delusional disorder, or other psychotic disorders or documentation in the client record that shows that there have been consistent and extensive efforts to treat the client and these efforts have persisted for more than a year, except in unusual circumstances such as a serious and sudden onset of dysfunction, causing the client's condition to move beyond basic outpatient clinical standards of practice;

- The individual exhibits persistent dangerousness to self or others;

- A significant risk of either continuing in a pattern of institutionalization or living in a

severely dysfunctional way if CSP services are not provided; and

• Impairment in one or more of the following functional areas: (a) vocational, educational, or homemaker functioning; (b) social interpersonal or community functioning; or (c) self care or independent living.

Each individual in a CSP is assigned a case manager who is responsible for maintaining a clinical treatment relationship with the client on a continuing basis, whether the individual is in the hospital, in the community, or involved with other agencies. The case manager works with the client, other CSP staff, and agencies to coordinate the assessment and diagnosis of the individual, develop and implement a treatment plan for the individual, and directly provide care or coordinate treatment and services.

Before January, 2002, certified CSPs were solely funded with local and MA matching funds. In 2001, counties reported spending $49.1 million for community support mental health programs, including $1.34 million of CMHBG funds. This funding supported services for 8,134 individuals. 2001 Wisconsin Act 16, the 2001-03 biennial budget act, provided $500,000 GPR in 2001-02 and $1,000,000 GPR in 2002-03 to provide state funding for CSPs. This funding is allocated on a calendar-year basis and programs first received funds in January, 2002. DHFS allocated the funds to 21 counties with certified CSP programs to serve individuals who are MA-eligible and meet the eligibility requirements for CSP, but are on a waiting list for services. The programs and the amount of funding are shown in Appendix III.

If there is a shortage of funds, counties place eligible persons on a waiting list for services, though some of these individuals receive less intensive services.

Behavioral Health Managed Care Demonstration Projects

In January, 2001, DHFS began operating four mental health/substance abuse demonstration pilot programs that provide services to persons with mental illness and/or alcohol or other drug dependency on a fee-for-service basis. The four mental health/substance abuse demonstration projects are in Milwaukee, Dane, Kenosha, and Forest/Vilas/Oneida Counties. The projects are intended to implement the Governor's Blue Ribbon Commission's recommendations by changing mental health service delivery in these counties from a maintenance system (maintaining an individual with a mental illness in a humane environment) to an individualized system, focused on the individual consumer's goals and life.

The demonstration projects will also provide the county with flexibility in funding. The projects are working towards an MA-capitation system to fund services for those individuals who voluntarily enroll in the new system. Under this change, the participating counties agree to provide community aids and county funds at current levels for mental health services. Under this managed care approach, the money follows the mental health service consumer.

The demonstration projects receive grants supported with federal CMHBG funds. With this funding, each project has: (a) hired a consumer affairs coordinator; (b) developed a consumer self-help program; (c) developed a recovery training package; (d) in collaboration with DHFS, developed a functional screen to target the group of people that will be enrolled into the managed care program and developed consumer outcome tools; and (e) established a system to collect individual client expenditure data.

Table 3 shows each demonstration project's grant awards for 2001-02 and 2002-03.

Table 3: Behavioral Health Managed Care Demonstration Project Grant for 2001-02 and 2002-03

County	2001-02	2002-03
Dane	$156,250	$133,725
Forest / Oneida / Vilas	156,250	118,725
Kenosha	156,250	113,775
Milwaukee	156,250	133,725
Total	$625,000	$499,950

Services for Homeless Individuals

DHFS estimates that between 3,500 and 5,000 people in Wisconsin are homeless and have a serious mental illness. DHFS allocates federal funds the state receives for projects for assistance in transition from homelessness (PATH) to public, nonprofit agencies to provide mental health services to persons who are in need of such services and who are also homeless. These funds, combined with state GPR matching funds, are distributed to 11 counties that were identified as having the greatest number of the state's homeless population. In 2002, DHFS distributed $45,000 GPR and $371,400 FED to serve homeless individuals. These allocations are shown in Table 4. There is a 25% match requirement on the PATH funds. The state GPR funding provides a portion of this match requirement and counties provide the remaining funds.

DHFS allocated this funding to support outreach, screening and diagnostic treatment, habilitation and rehabilitation, community mental health services, substance abuse treatment services, staff training, case management, supportive and supervisory services in residential setting, referrals for health services, housing, and other allowable services.

Table 4: PATH Grants -- Calendar Year 2002

County	Federal Funds	State Funds	Total Award
Brown	$22,298	$2,702	$25,000
Dane	53,515	6,485	60,000
Douglas	17,838	2,162	20,000
Eau Claire	17,838	2,162	20,000
Fond du Lac	13,379	1,621	15,000
Kenosha	22,298	2,702	25,000
La Crosse	13,379	1,621	15,000
Milwaukee	155,729	18,870	174,599
Outagamie	13,379	1,621	15,000
Racine	22,298	2,702	25,000
Rock	19,421	2,352	21,773
Total	$371,372	$45,000	$416,372

DHFS allocated $6,300 FED in CMHBG funds in 2002 to the Wisconsin Partnership for Housing to conduct a needs assessment for housing services for persons who are mentally ill and homeless. The results of the assessment will allow DHFS to better distribute PATH funding for this population.

Shelter Plus Care Program. The shelter plus care program provides permanent housing for persons with a serious and persistent mental illness. Funding from the federal Housing and Urban Development (HUD) agency provides the rental subsidy for apartments and PATH funds provide the required match of equal or greater funding for treatment services. Through a request for proposal (RFP) process, DHFS awarded $37,500 FED in PATH funds to both Rock and Kenosha Counties to support this program. In addition, HUD is providing $100,000 FED per year for five years to pay for an apartment for nine people in each county. The 25% match requirement for the PATH funds is fully supported by the counties. Milwaukee, Dane, and Racine Counties receive funding directly from HUD to support their shelter plus care programs.

Other Grant Programs

In addition to the programs already described, DHFS allocates funding for a variety of different consumer support and education opportunities and system change activities. These grants are described below.

Consumer and Family Support Grants. DHFS allocates $874,000 FED annually for consumer and family support grants to increase support for mental health family support projects, employment projects operated by consumers of mental health services, mental health crisis intervention and drop-in projects, and public mental health information activities. Three organizations receive these grants: the National Association of the Mentally Ill, Wisconsin Family Ties, and the Grassroots Empowerment Project.

The National Association of the Mentally Ill receives $210,000 FED annually on a calendar-year basis to support consumer and family projects, including consumer education, information referral resources, advocacy, a toll-free help line available in English and Spanish, and a bi-monthly newsletter for consumers and families. All of these activities are designed to increase public understanding and support of mental health and related issues.

Wisconsin Family Ties also receives $210,000 FED annually on a calendar-year basis. Wisconsin Family Ties focuses on children with SED and their families to help them access ISP services, provides advocacy services for these children, distributes a statewide newsletter, and provides training to county workers and family members to better advocate for individuals who have mental disorders.

Grassroots Empowerment Project is a consumer run organization and receives $454,000 FED annually on a calendar-year basis to fund local consumer organizations for individuals with mental illness. The agency funds seven clubhouse projects around the state, which provide a number of opportunities and supports, including vocational training and job opportunities, for individuals with mental illness.

Prevention, Early Intervention, and Recovery Grants. Under s. 51.03 (1g) of the statutes, "prevention" is defined as actions to reduce the instance, delay the onset, or lessen the severity of a mental disorder, before the disorder may progress to mental illness, by reducing risk factors by enhancing protection against and promptly treating early warning signs of a mental disorder. "Early intervention" is defined as actions to hinder or alter a person's mental disorder in order to reduce the duration of early symptoms or to reduce the duration or severity of mental illness that may result. "Recovery" is defined as the process of a person's growth and improvement, despite a history of mental illness in attitudes, feelings, values, goals, skills, and behavior and is measured by a decrease in dysfunctional symptoms and an increase in maintaining the person's highest level of health, wellness, stability, self-determination, and self-sufficiency.

DHFS allocates $95,000 FED annually to SOAR case management to provide training for the behavioral health demonstration sites on recovery, risk, and choice. They use recovery training materials that were developed by four consumer, family, and provider focus groups. SOAR is located in Madison and is a consumer run, case management organization.

An annual grant of $95,000 FED was initially awarded to the Mental Health Association (MHA) in Milwaukee in September, 2000. The grant is a three-year grant, which was renewed annually. The RFP for the grant stated that the expected outcome is "to implement statewide prevention and early intervention activities or services for mental health." MHA provides technical assistance to the behavioral health managed care

demonstration projects and to local communities within those counties, has developed a MHA resource center and website, has helped to develop the Wisconsin Prevention Network, the anti-stigma initiative, and has provided presentations and materials for the media and for the Bureau of Community Mental Health conferences.

Additionally, from this grant, MHA has allocated $5,000 grants to six agencies to serve specified populations: (a) Interfaith Community Volunteers and Heart to Heart, which targets isolated, low-income, rural older adults; (b) Mental Health Association of Sheboygan County, which targets rural farming families; (c) Our Space, which targets older urban, low-income Native Americans; (d) Parent Education Project, which targets children with disabilities in both urban and rural communities; (e) Waukesha County Human Services Department, which targets older adults with a support system and multiple risk factors, primarily in a rural setting; and (f) Waukesha County Health and Human Services Department and Wisconsin Family Ties, which targets youth in foster or kinship care, primarily in an urban setting.

System Change Grants. Under s. 46.52 of the statutes, system change grants support the initial phasing in of recovery-oriented system changes, prevention and early intervention strategies, and consumer and family involvement for individuals with mental illness. At least 10% of the funds distributed for these grants must be for children with mental illness. Counties are required to continue providing the community-based services that are developed under the system change grant after the three-year grant expires by use of savings made available to the county from incorporating recovery, prevention, and early intervention strategies, and consumer and family involvement in the services.

In 2001-02, $1,077,000 FED and in 2002-03, $306,800 FED was budgeted for system change grants. Some of this grant money was combined with funding for the behavioral health managed care demonstration projects in grants to the projects.

The Mental Health Association received a three-year, annually-renewable systems change grant of $245,100 FED from DHFS in October, 2002, for project management services. The Association works with the demonstration sites to ensure that the projects are delivering recovery services and to provide technical assistance to the projects. The Association will collect outcome data from 300 consumers to evaluate the performance of the projects.

The Wisconsin Council on Children and Families received $131,000 FED beginning in October 1, 2001, ending September 30, 2002, to provide training to counties who are implementing the consolidated service team projects. More information on these projects is found under the programs for children with SED section in this paper.

Protection and Advocacy. DHFS distributes $65,000 FED annually to the Wisconsin Coalition for Advocacy, as a supplemental award to federal funds that the Coalition receives independently. The Wisconsin Coalition on Advocacy is the designated protection and advocacy agency in Wisconsin. This funding is used for advocacy efforts for individuals with mental illness, training, and developing training materials.

Training. DHFS distributes $163,600 FED annually for training for mental health treatment professionals on new mental health treatment approaches in working with special populations, including seriously mentally ill individuals and children with SED, and on the use of new mental health treatment medications.

The Wisconsin Council on Children and Families receives $45,000 annually to support the annual Children Come First conference, a family-based conference, and a crisis conference. In

addition, this funding supports statewide training and technical assistance to counties.

DHFS distributes $87,000 FED annually to the University of Wisconsin, Department of Psychiatry, for bi-weekly teleconferences for direct service providers on a variety of topics, including medications, substance abuse, mental health and the elderly, vocational rehabilitation, and consumer dental care needs.

The Grassroots Empowerment Project received $16,600 FED in calendar year 2002 to reimburse consumers who participate in and attend state conferences, groups, council meetings, and other events.

DHFS allocates $5,000 FED annually to the Bay Area Agency on Aging, which sponsors the aging and substance abuse coalition for the elderly that includes long-term support programs, the aging network, and the substance abuse services system. The agency provides training to case management and nursing staff.

In addition, $10,000 FED is allocated to the Wisconsin Partnership for Housing Development for a study on the number of homeless individuals with mental illness. This grant was described previously in this paper.

Inpatient Services

Institutions for Mental Diseases (IMDs). Under federal law, an institution for mental diseases is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. In addition to the two state mental health institutes, there are 11 hospitals in the state that operate as IMDs. Seven of these hospitals are owned by counties, the rest are privately-owned and operated. For fiscal year 2001, these hospitals reported total net revenue of approximately $164 million, of which, approximately 72% was received from public programs, including Medicare, MA, and county funding. Table 5 identifies net patient revenue, as reported by IMD hospitals for each hospital's 2001 fiscal year.

Table 5: Net Patient Revenue for Fiscal Year 2001 ($ in Thousands)

Source	Net Patient Revenue	Percent
County / Other Public Programs	$77,177.9	47.0%
Commercial Insurance / Other	46,630.8	28.4
MA	22,060.4	13.4
Medicare	18,185.1	11.1
Total	$164,054.2	100.0%

State Mental Health Institutes

The DHFS Division of Care and Treatment Facilities (DCTF) operates two mental health institutes that provide psychiatric services to adults, adolescents, and children who are either civilly committed or are forensic patients committed as a result of a criminal proceeding. The Mendota Mental Health Institute (MMHI), located in the City of Madison, opened in 1860, while the Winnebago Mental Health Institute (WMHI), located near the City of Oshkosh, began operating in 1873. Both facilities are licensed and accredited hospitals that provide training and research opportunities, in addition to psychiatric services.

Although the two institutes provide the same types of services, each maintains distinctive programs. For instance, MMHI provides mental health services to male adolescents who are

transferred from the Department of Corrections' juvenile institutions at the Mendota Juvenile Treatment Center (MJTC). WMHI's Gemini unit provides substance abuse programs for mentally ill and chemically dependent adults, and the Anchorage unit provides specialized services for chemically dependent adolescents between the ages of 14 and 18. Table 6 provides information on the average number of patients, by type, at the institutes in fiscal year 2001-02, and the percentage of the total each patient population represents.

Table 6: Average Daily Populations at the Mental Health Institutes -- State Fiscal Year 2001-02

	Mendota		Winnebago	
	ADP	Percent	ADP	Percent
Child / Adolescent	31.1	11.9%	54.4	19.6%
Forensic	156.8	59.8	137.8	49.7
Adult	41.9	16.0	51.5	18.6
MJTC	32.5	12.4	0.0	0.0
Substance Abuse	0.0	0.0	33.4	12.1
Totals	262.3	100.0%	277.1	100.0%

MMHI offers a total of 15 different treatment units, including forensic psychiatry, home and community treatment, and geropsychiatric programs. WMHI includes 13 units targeted to different adult and youth populations. For instance, Activities Within a Regulated Environment (AWARE) assists individuals with combined mental illness and developmental disabilities, while Service for Multiply Impaired Children (SMIC) specializes in the treatment of adolescents with severe emotional or behavioral problems, in addition to cognitive disabilities. Patients receive a variety of services, including psychiatry, psychology, nursing, education, social, nutritional, and chaplaincy. In addition, both facilities offer occupational, physical, musical, pre-vocational, recreational, speech and language therapy.

Patients at the institutes are admitted as either civil commitments or criminal commitments. Civil commitments may be either voluntary or involuntary commitments and, in general, these admissions must be approved by the county of the patient's residence. A voluntary admission occurs when an adult applies for admission to an inpatient treatment facility and receives approval from the director of the facility. In order to be admitted to an inpatient facility, an evaluation must confirm that the applicant is mentally ill, developmentally disabled, or is alcohol or drug dependent and would benefit from inpatient care, treatment, or therapy. Minors may generally be admitted under the same criteria, with the consent of a parent or legal guardian.

Involuntary civil commitments are sought in cases where a patient is considered to be mentally ill and dangerous to either themselves or others. In order to start the involuntary commitment process, a petition for examination must be submitted alleging that the individual is: (a) mentally ill, drug dependent, developmentally disabled, and is a good candidate for treatment; and (b) dangerous to themselves or others, based on one of five statutory standards. The court reviews each petition to determine if an order of detention should be issued. A hearing to review the allegations is then held within 72 hours to 21 days, depending on the status of the individual. If a patient is admitted to a facility, the facility is required to provide a copy of the patient's and resident's rights to the individual at the time of entry.

Criminal commitments are made when a licensed physician or psychologist of a correctional facility reports in writing to the officer in charge of the institution that a prisoner is mentally ill, drug dependent, developmentally disabled, or is an alcoholic and is in need of psychiatric or psychological treatment. If the prisoner voluntarily consents to a transfer to a state institute for

treatment, a transfer application may be submitted to the Department of Corrections and DHFS. If a voluntary application is not made, the Department of Corrections may file a petition for an involuntary commitment. In either case, the state institutes must obtain approval from the county in which the jail is located before admitting an individual who is being transferred from a county jail.

Table 7: Mental Health Institutes -- Average Daily Population, Staffed Beds and Occupancy -- State Fiscal Years 1997-98 thru 2001-02

	1997-98	1998-99	1999-00	2000-01	2001-02
Mendota					
Average Daily Population	258	263	269	281	263
Total Capacity	300	293	293	299	299
Percentage Filled	86.0%	89.8%	91.8%	94.0%	88.0%
Winnebago					
Average Daily Population	259	267	274	279	277
Total Capacity	330	313	313	299	298
Percentage Filled	78.5%	85.3%	87.5%	93.3%	93.0%

During the past several years, the average daily population at the state mental health institutes has increased slightly. At the same time, the capacity of WMHI was significantly reduced. Table 7 provides a summary of the average daily population and capacity rates for each institute for the past five years.

Annually, DHFS staff establish rates the Department charges to provide services to the different populations served by the institutes. For the period between October 1, 2002, through September 30, 2003, the rates for adult residents ranged from $552 per day at WMHI to $620 per day at the MMHI. Table 8 shows the rates DHFS established for each patient population group during that period.

Table 8: Mental Health Institutes Inpatient Rates -- October 1, 2002 thru September 30, 2003

	Mendota	Winnebago
Adult Psychiatric Services	$620	$552
Geropsychiatric	650	
Child / Adolescent	634	535
Forensic-Maximum Security	620	
Other Security	567	552
Aware / STEP / Gemini / Anchorage		552
Emergency Detention*	100	100

*For first three days of service

The institutes are funded by a combination of general purpose revenue (GPR) and program revenue (PR). Program revenues are comprised of charges to counties for civil commitments, MA payments for children and elderly patients, Medicare payments, and insurance payments from private payers. Table 9 identifies the amount, by source, of program revenues for the mental health institutes in 2001-02. In 2002-03, MMHI is budgeted $47.2 million (all funds), and WMHI is budgeted $40.7 million.

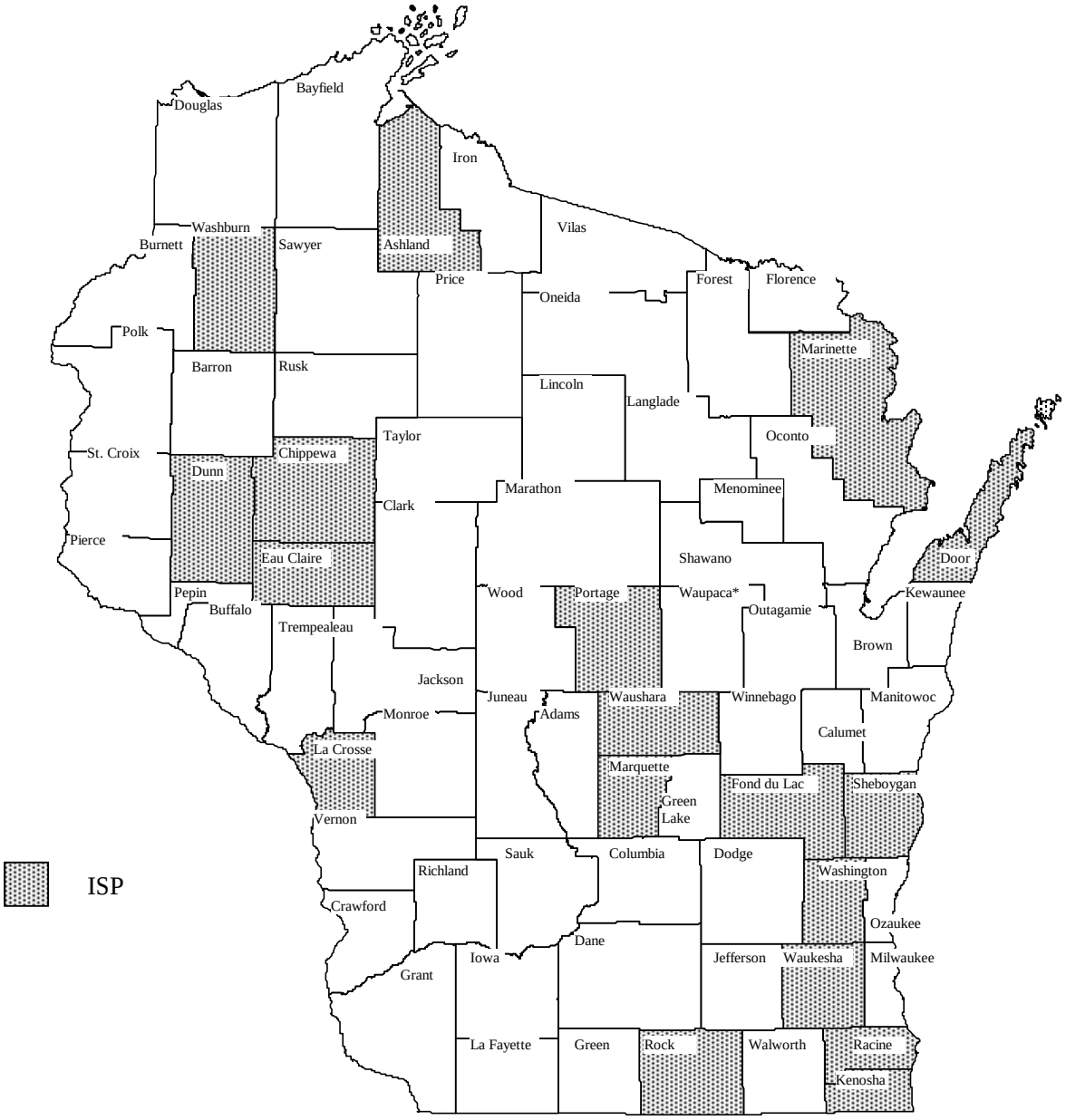
Table 9: Mental Health Institutes Program Revenues, by Source (Fiscal Year 2001-02)

	Winnebago		Mendota	
Program Revenues*	Amount	Percent of Total	Amount	Percent of Total
Medical Assistance	$18,950,300	62.5%	$13,197,000	52.7%
County 51 Boards	8,627,800	28.5	7,586,300	30.3
Private / Commercial	1,795,700	5.9	1,410,100	5.6
Medicare	939,600	3.1	2,849,000	11.4
Total	$30,313,400	100.0%	$25,042,100	100.0%

*Excludes $156,600 not attributed to a specific institute.

APPENDIX I

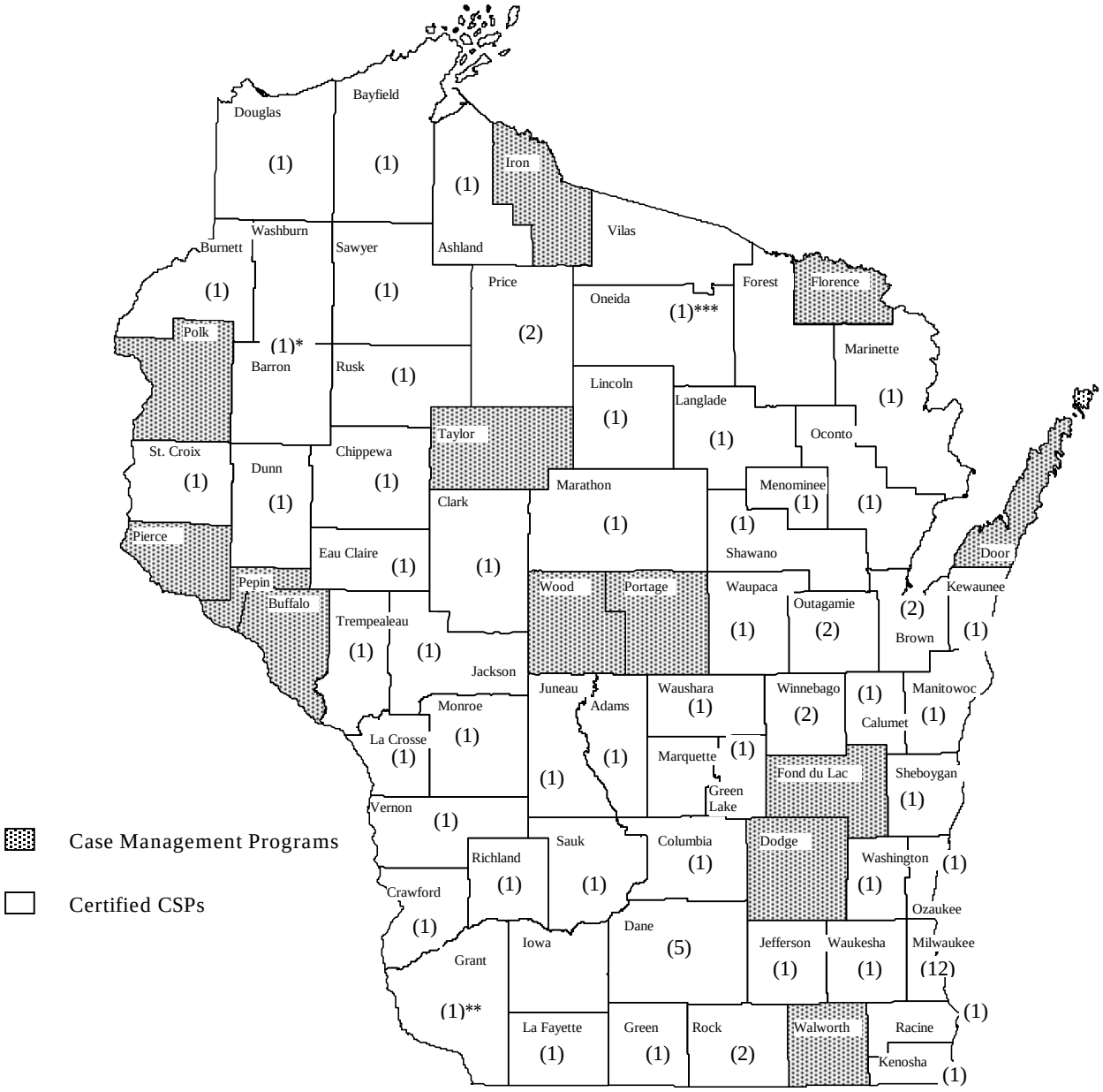
Wisconsin Integrated Service (ISP) Programs for Children with Severe Emotional Disturbances 2002



*Funding ended September 30, 2002
Note: Programs identified receive an ISP grant from DHFS.

APPENDIX II

Wisconsin Mental Health
Certified Community Support Programs (CSPs)



Case Management Programs

Certified CSPs

Counties with both CSPs and case management programs are: Barron, Chippewa, Clark, Dane, Jackson, Marathon, Milwaukee (3), Racine, Sheboygan, Washington, and Winnebago (2) Counties.

* 1 certified between Washburn and Barron Counties.

** 1 certified between Grant and Iowa Counties.

*** 1 certified between Vilas, Oneida and Forest Counties.

APPENDIX III

Allocation of 2001 Act 16 Funding for CSP Waitlists

County	Estimated Number of Consumers Served	Amount
Ashland	6	$15,858
Brown	40	89,015
Chippewa	26	57,500
Columbia	6	32,616
Dane	53	117,953
Eau Claire	11	11,405
Green	4	12,250
Jefferson	34	61,500
Kenosha	25	41,275
La Crosse	30	61,500
Manitowoc	17	34,650
Milwaukee	42	93,910
Monroe	7	22,497
Forest / Vilas / Oneida	26	61,500
Rock	22	61,500
St. Croix	13	48,211
Sheboygan	17	33,720
Vernon	4	5,380
Washington	10	49,365
Waukesha	29	64,529
Waushara	10	24,295
Total	432	$1,000,429