Informational Paper 51

# Services for Persons with Mental Illness

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## Introduction

The National Institute of Mental Health (NIMH) estimates that 26.2% 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. Some individuals may have more than one mental disorder.

This paper describes public mental health services available to people in Wisconsin. The first section 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, except services provided for persons committed as sexually violent persons, which are described in a separate Legislative Fiscal Bureau informational paper entitled "Civil Commitment of Sexually Violent Persons," and services provided to incarcerated individuals.

## 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**. NIMH estimates that approximately 6% of adults in the United States 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 disorders that are characterized by overwhelming anxiety and fear. They include panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, social phobia, specific phobias, and generalized anxiety disorder. In any given year, approximately 18.1% of adults in the United States have an 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.

Depression is a mood disorder, of which the most common is major or unipolar depression. An estimated 6.7% of American adults have major depression. The symptoms of major depression include: (a) feelings of sadness or irritability; (b) loss of interest in 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 one or more episodes of depression, characterized by at least two weeks of depressed mood (sadness, hopelessness, or feeling discouraged) or loss of interest in nearly all activities accompanied by at least four other symptoms of depression. Individuals between 24 and 45 years of age are most likely to have depression. Annually, nearly twice as many women as men have major depressive disorder.

Bipolar disorder is another mood disorder, characterized by severe mood changes that shift between mania and major depression. It is estimated that 2.6% of adults in the United States have bipolar disorder. Bipolar disorder has two phases – manic and depressive. Symptoms of the manic phase include: (a) extreme happiness, optimism, or self-confidence; (b) distractibility; (c) rapid, uncontrollable ideas and speech pattern; (d) decreased need for sleep; (e) poor judgment; 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 1.1% of adults in the United States have schizophrenia. In men, symptoms usually first appear in their late teens or early twenties, but for women symptoms appear in their twenties or thirties.

**Mental Disorders Affecting Children**. The annual prevalence of mental disorder in children and adolescents is not as well documented as that for adults. About 20% of children in the United States are estimated to have mental disorders with at least mild functional impairment. While many mental disorders that affect adults can also affect children, 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 (AD-HD) occurs in 5 to 10% of American children. Boys are 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 in the United States 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.

**Causes of Mental Illness**. The causes of mental illnesses are 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 factors. For example, an individual with relatives with depression is 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.

**Co-Occurring Mental Illness and Substance Abuse Disorders.** Attention at the national and state level is beginning to focus on the prevalence of co-occurring substance abuse and mental disorders. Approximately 15% of all adults who have a mental disorder in a given year also experience a substance abuse disorder. Some studies have found that, in the general population of individuals 18 years or age and older, any past history of mental disorder was associated with more that twice the risk of having an alcohol disorder. In addition, the studies found that those with a mental disorder were more than four times at risk of having another 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 individualized needs and environments and people with mental disorders value independence and productivity.

**Blue Ribbon Commission on Mental Health.** In May, 1996, 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 included: (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. The commission recommended that these

people receive treatment and recovery services, including: (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 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. The Commission recommended that these groups receive prevention and early intervention services. By providing these services, 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 persons that receive health services: (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.

**Healthiest Wisconsin 2010.** The Wisconsin Turning Point Initiative, comprised of approximately 40 individuals involved in the different areas of public health, developed Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public. This document is required under s.250.07 of the statutes, and is the state's public health plan for 2000 through 2010. The plan includes goals for the provision of mental health services in Wisconsin by 2010. These include: (a) incorporating questions relating to mental health problems in the screening and referral process for state-administered health plans; (b) reducing discrimination against individuals with mental illness; (c) providing mental health services in a culturally competent manner; and (d) increasing the number of people with a mental health need who have access to evidence-based treatment.

## The Provision of Mental Health Services

**The Department of Health and Family Services (DHFS).** The DHFS Bureau of Mental Health and Substance Abuse Services in the Division of Disabilities and Elder Services is the state mental health authority 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 of individualized service planning by providers of mental health services, 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 this paper.

**Counties.** In Wisconsin, each county is assigned the 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 each county is 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 mental health services in Wisconsin: (a) the federal community mental health services block grant (CMHSBG); (b) community aids and county funds; (c) medical assistance (MA); and (d) private insurance and individual copayments. The first three funding sources are discussed in this paper.

**Community Mental Health Services Block Grant.** The CMHSBG is authorized by Part B of Title XIX of the Public Health Services Act and administered by the Center for Mental Health Services in the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). States may use these funds to provide comprehensive community mental health services to adults with serious mental illnesses and to children with serious emotional disturbances and to monitor the progress in implementing a comprehensive community based mental health system. Federal guidelines allow states to use 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.

Wisconsin received $6,814,200 in federal fiscal year (FFY) 2005-06 and $6,711,200 in FFY 2006-07 under the CMHSBG. The FFY 2005-06 Wisconsin state mental health plan identifies six priority program areas for the use of these funds: (1) wraparound programs for children with serious emotional disorders (SED); (2) consumer and family self-help and peer support services; (3) prevention and early intervention; (4) recovery and other training for consumers and providers; (5) protection and advocacy services; and (6) program development for the behavioral mental health managed care demonstration projects.

Of the $6,711,200 the state received from the CMHGBG in FFY 2006-07, DHFS budgeted: (a) $2,513,400 to partially support community aids; (b) $1,306,700 for integrated service projects for children throughout the state; (c) $519,800 for the coordinated services team initiative; (d) $1,964,500 for a variety of grant programs distributed to counties and agencies; and (e) $406,800 to support DHFS operations costs. These programs are described in greater detail elsewhere in this paper.

*Council on Mental Health.* As a condition of receiving the CMHSBG block grant, each state is required to establish and maintain a council on mental health. In Wisconsin, 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 CMHSBG funds; (b) participate in the development of the CMHSBG 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 counties may expend for any of these eligible services, and categorical allocations, which counties must expend for specific services and programs. For 2006, the estimated basic county allocation totals $242,151,800 (all funds), representing 93% of all funds allocated to counties in that year ($260,680,600). 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") they expended to support services to individuals with mental disorders. In 2005, counties reported spending approximately $344 million on mental health services to approximately 93,000 individuals. Counties report this information, along with information on county spending for other client groups and services, through the human services reporting system (HSRS).

*Community Aids Services Supported by the CMHSBG.* Counties' calendar year (CY) 2006 community aids allocations included $2,513,400 of CMHSBG funds. DHFS required counties to use these funds for the following purposes: (a) to provide comprehensive community mental health services to adults with serious mental illness and to children with a serious emotional disturbance; (b) to evaluate programs and services; and (c) to conduct planning, administration, and educational activities related to providing services. There are eight priority program areas where counties could use these funds: (1) supported housing for people with serious mental illness; (2) integrated service projects (ISPs) for children with serious emotional disturbances; (3) jail diversion programs; (4) community support programs; (5) crisis intervention services; (6) family and consumer peer support services; (7) programs for people with co-occurring mental illness and substance abuse problems; and (8) community mental health data-set development. Counties are required to submit a plan to DHFS annually identifying how the county plans to use its allocation in one or more of these priority areas.

**Medical Assistance.** Wisconsin's medical assistance (MA) program provides outpatient and day treatment mental health services to MA recipients who are prescribed these services, and only if certain other conditions are met. Health maintenance organizations (HMOs) that serve MA recipients are required to provide to their MA enrollees all of the services that are available to MA recipients that are not enrolled in HMOs (individuals who receive services on a "fee-for-service" basis), including mental health services. HMOs do not report their costs of providing mental health services to MA recipients. The payment information included in this section only reflects the cost of MA-funded services provided to MA recipients who are not enrolled in HMOs.

*Outpatient Psychotherapy.* Outpatient psychotherapy services are available to any MA recipient if the service is prescribed by a physician and a certified psychotherapy provider conducts a

diagnostic examination on the recipient. A provider must obtain prior authorization from the state MA program to receive MA payment for services once the individual receives either: (a) $500 in services; or (b) 15 hours of outpatient services in a calendar year. MA payments for outpatient psychotherapy services totaled approximately $20.5 million (all funds) in 2005-06. Approximately 16,000 recipients received these services in an outpatient hospital setting and approximately 53,000 recipients received these services in a non-hospital setting, such as clinics or therapists' offices.

*Day Treatment*. "Day treatment" refers to a nonresidential program in a medically supervised setting that provides case management, medical care, psychotherapy and other therapies, and follow-up services to alleviate problems related to mental illness or emotional disorders. In order to receive these services, an MA recipient is evaluated through the use of a functional assessment scale to determine the medical necessity for day treatment and the recipient's ability to benefit from these services. Next, a treatment plan is developed with the recipient, which is based on the initial evaluation, which includes measurable, individual goals and objectives, treatments, and the expected outcomes of treatment. A supervising psychiatrist must approve the plan and continue to review the plan at least once every 60 days.

The MA program reimburses providers for the following services if they are specifically identified in the recipient's treatment plan as necessary to meet measurable goals: (a) psychiatric services, including assessments, psychotherapy, and medication management; (b) other individual or group counseling services, supportive psychotherapy, and symptom management; (c) skill development in communications or problem solving, such as stress management and assertiveness training; (d) skill development related to activities of daily living, such as personal hygiene, cooking, budgeting, health and nutrition; (e) pre-employment services to assist the recipient in gaining and using skills necessary for employment; (f) occupational, physical, social recreational, and speech therapies; (g) face-to-face crises intervention services; and (h) substance abuse treatment and educational services. A provider must obtain prior authorization from the MA program before the provider renders services for day treatment services that an individual receives that exceed 90 hours in a calendar year, for all day treatment services provided to a nursing home resident, and to all individuals who are concurrently receiving psychotherapy, occupational therapy, or substance abuse services.

In 2005-06, MA payments for day treatment services totaled approximately $1.1 million (all funds). Approximately 700 individuals received these services.

*County-Funded Services.* In addition to outpatient psychotherapy and day treatment services, Wisconsin's MA program 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. These services include community support program (CSP), crisis intervention, case management, and comprehensive community 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 to MA recipients when they are prescribed by a physician and provided by providers that meet the conditions for community support programs administered by counties. In 2005-06, the state MA program claimed approximately $25.7 million in federal MA matching funds for CSP services counties provided to approximately 5,200 MA recipients. .

Crisis intervention services are services provided by a mental health crisis intervention

program operated by, or under contract with, a county. In 2005-06, the state MA program claimed approximately $15.2 million in federal MA matching funds for crisis intervention services provided to approximately 8,800 MA recipients

In 2005-06, the state MA program claimed approximately $4.1 million in federal MA matching funds for case management services counties provided to approximately 5,300 MA recipients with serious and persistent mental illness.

Beginning in 2004-05, a new benefit, comprehensive community services, became available for persons with mental health or substance abuse conditions, as a county-funded service. Counties must elect to provide the service and provide the state's share of the costs of the benefit. Recipients must have impairment in major areas of community living as evidenced by the need for ongoing and comprehensive services of either high-intensity or low-intensity nature. Services can include medical and rehabilitative services and supportive activities intended to provide for a maximum reduction of the effects of the individual's mental health or substance abuse condition and restoration to the best possible level of functioning and to facilitate the individual's recovery. MA recipients must obtain a physicians' prescription to receive comprehensive community services. These services must be consistent with needs identified through a comprehensive assessment, which is completed by a recovery team made up of the individual, a licensed mental health professional, the individual's family, and others as appropriate.

*Prescription Drugs.* In addition to therapy services, treatment for individuals with severe mental illness can frequently include the use of medication. In 2005-06, MA paid approximately $43.8 million (all funds) for psychotic medications prescribed to approximately 19,500 MA recipients.

Additionally, the MA program paid an estimated $15.8 million (all funds) in 2005-06 for anti-anxiety and anti-depressant medications. However, not all MA recipients who use these drugs have a severe mental illness. These medications can be prescribed to any MA recipient 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.

The state MA program includes drug costs as a component of the capitation rate health maintenance organizations receive to serve MA recipients. The information on MA-funded drug expenditures included in this section reflect only drug costs paid on a fee-for-service basis. Fee-for-service drug costs decreased significantly beginning with the implementation of Medicare Part D on January 1, 2006, as all recipients eligible for both Medicare and MA ( "dual eligibles") began receiving drug coverage under Medicare Part D. Previously, this group of MA recipients made up a substantial portion of fee-for-service drug expenditures.

## Programs for Children with Serious Emotional Disturbances

Children with serious 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: (a) self care; (b) community; (c) social relationships; (d) family; or (e) 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 and about one-half will, at one point, need public services.

**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 18 counties in Wisconsin with ISP programs. In 2005-06, DHFS distributed $1,440,000 ([$133,300 general purpose revenue (GPR) and $1,306,700 federal (FED) from the CMHSBG]) for grants to these counties for their ISP programs. Table 1 lists these counties and their annual grant award for 2006.

**Table 1: Integrated Service Projects Calendar Year 2006 Awards**

| Counties | GPR | FED | Total Award |
|---|---|---|---|
| Ashland | $7,500 | $72,500 | $80,000 |
| Chippewa | 7,400 | 72,600 | 80,000 |
| Door | 7,400 | 72,600 | 80,000 |
| Dunn | 7,400 | 72,600 | 80,000 |
| Eau Claire | 7,400 | 72,600 | 80,000 |
| Fond du Lac | 7,400 | 72,600 | 80,000 |
| Kenosha | 7,400 | 72,600 | 80,000 |
| La Crosse | 7,400 | 72,600 | 80,000 |
| Marinette | 7,400 | 72,600 | 80,000 |
| Marquette | 7,400 | 72,600 | 80,000 |
| Portage | 7,400 | 72,600 | 80,000 |
| Racine | 7,400 | 72,600 | 80,000 |
| Rock | 7,400 | 72,600 | 80,000 |
| Sheboygan | 7,400 | 72,600 | 80,000 |
| Washburn | 7,400 | 72,600 | 80,000 |
| Washington | 7,400 | 72,600 | 80,000 |
| Waukesha | 7,400 | 72,600 | 80,000 |
| Waushara | 7,400 | 72,600 | 80,000 |
| Total | $133,300 | $1,306,700 | $1,440,000 |

In addition to the programs listed in Table 1, two other Wisconsin counties operate 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.

*Children Come First of Dane County.* Children in Dane County with SED who are eligible for either MA or BadgerCare, 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 2005, the program served 266 children.

*Wraparound Milwaukee.* Wraparound Milwaukee served 1,029 children and families in 2005. Of these children, 58% were diagnosed with conduct disorder or oppositional defiant disorder, 40% with depression, 39% with ADHD, 35% with alcohol and other drug abuse related disorders, 30% with learning disabilities, 12% with adjustment disorder, and 9% with developmental disorders. Nine lead agencies provided care coordination services in 2006: (a) AJA Enterprises; (b) Alternatives in Psychological Consultation; (c) Aurora Family Services; (d) Children's Service Society; (e) La Causa, Inc.; (f) My Home Your Home; (g) St. Aemilian – Lakeside; (h) St. Charles Youth and Family Services; and (i) 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 in-home family therapy, foster care services, in-home therapy, and crisis stabilization.

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

**Coordinated Service Team Initiative.** The coordinated service team (CST) initiative combines mental health, substance abuse, and child welfare funding to award grants to support programs in 22 counties. These projects are implementing a systems change by coordinating services for children and families who are involved in multiple systems, which may include mental health, child welfare, substance abuse, juvenile or adult justice, special education, W-2, domestic violence, and developmental disabilities. Projects use a strength-based, family centered, coordinated service approach (wraparound) to improve outcomes for children and families. The CST projects use a team approach across agencies, involve parents in all aspects of the process, build on natural supports, respect individual differences and preferences, and require collaborative funding.

This initiative began in December, 2002. DHFS currently allocates funding to 22 counties, which were chosen through a competitive request for proposal (RFP) process. These counties will receive grants for between three to five years, depending on available funding. DHFS allocates funding to the counties on a federal fiscal year (FFY) basis. In FFY 2005-06, $1,328,400 (all funds) was budgeted for the initiative, including: (a) $673,600 GPR; (b) $519,800 FED from CMHSBG; (c) $35,000 FED from the substance abuse prevention and treatment (SAPT) block grant; (d) and $100,000 FED from funds the state receives under Title IV-B of the Social Security Act, which is funding to support child welfare activities.

In FFY 2005-06, $1,128,100 was allocated to the pilot counties for CST activities, $155,300 was allocated to counties for training, and $45,000 was budgeted for DHFS administrative costs. Table 2 identifies the funding allocated to counties in FFY 2005-06.

Counties may use this funding: (a) for systems change activities; (b) to promote and enable consumer involvement; and (c) to provide direct services. No more than 10% of a county's allocation can be used for direct services. Instead, the services must be provided by the programs already

**Table 2: Coordinated Service Team Grants FFY 2005-06**

| County | Amount |
|---|---|
| Adams | $49,900 |
| Bayfield | 54,000 |
| Calumet | 63,500 |
| Crawford | 49,900 |
| Douglas | 49,900 |
| Eau Claire | 33,000 |
| Green Lake | 58,500 |
| Iron | 53,500 |
| Jefferson | 53,500 |
| La Crosse | 58,000 |
| Lafayette | 49,900 |
| Manitowoc | 63,500 |
| Marquette | 53,500 |
| Pierce | 49,900 |
| Polk | 49,900 |
| Portage | 58,500 |
| Richland | 49,900 |
| Sauk | 53,500 |
| Sheboygan | 33,000 |
| St. Croix | 49,900 |
| Washburn | 33,000 |
| Waupaca | 60,000 |
| Total | $1,128,200 |

established in the county and the CST grant allocation allows the county to implement the CST approach to serving those families.

In addition to the counties that received grants in FFY 2005-06, DHFS expects to provide grants to Dodge, Monroe, Juneau, Price, Burnett, and Menominee Counties and Red Cliff and La Courte Oreilles Tribes in FFY 2006-07.

## Community Support Program

Community support programs, or CSPs, provide treatment, rehabilitation, and support services for persons with serious and persistent mental illness. As of January 1, 2007, there were 78 certified CSPs in 62 counties and at least 18 case management programs in Wisconsin, as shown in Appendix I. 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 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 he or she 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 maintains 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.

Certified CSPs are funded with local and MA matching funds, and $1.0 million GPR annually. As shown in Appendix II, DHFS allocates the GPR funding to 23 counties with certified CSP programs on a calendar year basis. In 2005, counties reported spending $56.7 million for community support mental health programs, including $1.27 million of CMHSBG funds. This funding supported services for 9,156 individuals.

If a county has insufficient funds to provide services to all individuals who qualify for the program, it may place eligible individuals on waiting lists for services or provide less intensive services to these individuals.

## Behavioral Health Managed Care Demonstration Projects

In January, 2001, DHFS began funding 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. Dane and La Crosse Counties continue to receive this funding for the development of Supplemental Security Income managed care systems. 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 provide the county with flexibility in funding. The projects are working towards an MA-capitation system to fund services for those individuals enrolled 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 CMHSBG funds. With this funding, Dane County has begun work on a plan for sustainability of a Consumer Information Center that is run by mental health consumers. Additionally, the county is creating a written toolkit of processes used to develop, improve, and sustain activities of the consumer-run information center. La Crosse County is developing a county policy regarding consumer involvement and input on hiring interviews for all clinical staff. The county is also using the funds to employ a consumer affairs coordinator and to develop a three-year plan and funding commitment for sustainability of their consumer council, consumer administration, clinicians, support staff, and consumers. Finally, La Crosse County is developing and implementing an outreach, orientation, and mentoring program for new consumers interested in participating in workgroups, committees, focus groups, and interviews.

Each project received a final grant of $100,000

FED in FFY 2005-06, as they are expected to be self-sustaining after the 2006 contract year. The federal funds were available under the federal CMHSBG.

## Other Grant Programs

In addition to the programs previously described, DHFS allocates federal CMHSBG funding for a variety of 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 Alliance on Mental Illness 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 intended 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 serves children with SED and their families to help them access 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-operated 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 programs around the state, that 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 from the CMHSBG to the National Alliance on Mental Illness (NAMI) to provide recovery training for the behavioral health demonstration sites on recovery, risk, and choice.

DHFS provides an annual grant of $95,000 FED from the CMHSBG to the Mental Health Association (MHA) of Milwaukee for prevention and early intervention services that include children’s suicide prevention and primary care provider training on mental health issues.

**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. Counties must use at least 10% of the funds for services to children with mental illness. Counties must 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 FFY 2005-06, $275,900 is budgeted for system change grants. Some of these funds were combined with funding for the behavioral health managed care demonstration projects and allocated as grants to the projects.

The Mental Health Association received $96,745 for the first half of 2006 to assist counties with their quality improvement efforts. DHFS is currently conducting an RFP to select a new vendor whose contract will begin January 1, 2007. The proposed funding for the new vendor is an annual grant of $199,945.

The Mental Health Association also received a grant in 2005-06 of $25,500 FED for trauma training for consumers.

Wisconsin Family Ties was awarded $28,000 in 2006 for children's programs. Racine County received $25,000 and Waukesha County received $23,000 in 2006 for implementing innovative practices to provide mainstream mental health services for persons who are homeless.

**Protection and Advocacy.** DHFS distributes $65,000 FED annually to Disability Rights Wisconsin (DRW), as a supplemental award to federal funds that the group receives independently. DRW is the designated protection and advocacy agency in Wisconsin for people with mental illnesses. The group uses this funding to advocate for individuals with mental illness, training, and developing training materials.

**Training.** DHFS distributes $172,800 FED annually for training for mental health treatment professionals on mental health standards, best practice, recovery principles, and emergency crisis services.

The Wisconsin Council on Children and Families receives $45,000 FED 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 receives $20,000 FED annually to reimburse consumers who participate in and attend state conferences, groups, council meetings, and other events.

DHFS allocates $5,000 FED annually to the Green 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, $15,800 FED is provided to UW-Steven's Point ($5,800 for the provision of geropsychiatry training, and $10,000 for administration of the annual mental health and substance abuse training conference.

**Other Grants**. Kenosha, Brown, and Marathon Counties each received $59,000 FED in 2006 to

implement quality improvement systems and evidence-based practices in their CCS and/or CSP programs. These grants are designated to integrate evidence-based practices with Wisconsin's major mental health programs and establish permanent quality improvement systems so counties can continually review the quality and effectiveness of their programs. The quality improvement grants are awarded annually but are shifted to other counties after one to two year periods to continually disseminate quality improvement programs across the state. DHFS expects to provide $59,000 to the three counties again in 2007 for their second and final year.

## Inpatient Services

**Institutions for Mental Diseases.** Federal law defines an institution for mental diseases (IMD) as 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. There are 13 hospitals and one nursing home in Wisconsin that operate as IMDs. The nursing home and six of the hospitals are county-owned and operated, and two of the hospitals are state-owned and operated.

Under federal law, residents of IMDs who are 22 years of age or older but have not reached the age of 65 are ineligible for MA-supported inpatient psychiatric services, except that an MA-eligible person under the age of 22 who has been receiving inpatient psychiatric services under the direction of a physician and provided by an accredited psychiatric hospital or facility, remains eligible for MA until that person is unconditionally released or reaches the age of 22. However, the state provides a GPR supplement of $9 per person per day to support the care of individuals who receive specialized mental health services in an institutional setting. In calendar year 2006, $8,961,300 GPR is also budgeted to assist counties in supporting residents of IMDs and individuals relocated from an IMD, or a MA-certified nursing facility, to a community placement. These funds can also be used for services that assist in the recovery process of the individual and are not billable under MA. Counties are required to supply a match of 9.89% of the cost of community service in order to receive these relocation funds.

## State Mental Health Institutes

The DHFS Division of Disability and Elder Services operates two mental health institutes that provide psychiatric services to adults, adolescents, and children who are either civilly-committed or who 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.

MMHI offers a total of 14 different inpatient treatment units, including forensic psychiatry, child, adolescent, adult, and geropsychiatric programs. These treatment units include two child units, three adult units and eight forensic units that, in total, have the capacity to serve 264 patients. MMHI also operates the Program of Assertive Community Treatment (PACT), a community support program for individuals with serious mental illness. In addition to the units described above, MMHI operates two units at the Mendota Juvenile Treatment Center (MJTC) that have the capacity to serve 29 adolescent males from Wisconsin's juvenile correctional facilities whose behavioral and treatment needs exceed the resources at the correctional facilities.

WMHI includes 12 units targeted to different adult and youth populations, including four

forensic units, four adult units, and four child and adolescent units. The Activities Within a Regulated Environment (AWARE) program assists adults who are dually diagnosed with mental illness and developmental disabilities, while Service for Multiply-Impaired Children (SMIC) treats youth with severe emotional or behavioral problems, in addition to cognitive disabilities. 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. Patients receive a variety of services, including psychiatry, psychology, nursing, education, social, nutritional, and chaplaincy.

Both facilities offer occupational, physical, musical, pre-vocational, recreational, speech, and language therapy.

Table 3 provides information on the average number of patients, by type, at the institutes in fiscal year 2005-06, and the percentage of the total each patient population represents.

**Table 3: Average Daily Populations (ADP) at the Mental Health Institutes (by Type) -- 2005-06**

| | Mendota | | Winnebago | |
|---|---|---|---|---|
| | ADP | Percent | ADP | Percent |
| Child / Adolescent | 19.5 | 7.1% | 47.6 | 18.8% |
| Forensic | 167.2 | 61.2 | 123.6 | 48.9 |
| Adult | 57.6 | 21.1 | 49.0 | 19.3 |
| MJTC | 29.0 | 10.6 | 0.0 | 0.0 |
| Substance Abuse | 0.0 | 0.0 | 32.8 | 13.0 |
| Totals | 273.3 | 100.0% | 253.0 | 100.0% |

Annually, DHFS establishes rates it charges to provide services to the different populations served by the institutes. Table 4 shows the daily rates DHFS established for each patient population group at MMHI and WMHI effective October 1, 2006.

Patients at the institutes are admitted as either civil commitments or as forensic patients committed as a result of a criminal proceeding. The legal process governing these commitments is set forth in statute and are quite lengthy and detailed. The following discussion is intended to provide a general overview of the commitment process.

**Table 4: Mental Health Institutes Inpatient Daily Rates -- Effective October 1, 2006**

| | Mendota | Winnebago |
|---|---|---|
| Adult Psychiatric Services | $677 | $664 |
| Geropsychiatric | 710 | --- |
| Child / Adolescent | 692 | 644 |
| Forensic-Maximum Security | 677 | --- |
| Other Security | 619 | 664 |
| Aware / STEP / Gemini / Anchorage | --- | 664 |
| Emergency Detention* | 150 | 150 |

*For first three days of service

Civil commitments may be either voluntary or involuntary, 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, a proper subject for treatment, and dangerous to either themselves or others. In order to start the involuntary commitment process, an emergency detention by a law enforcement officer must be made or a petition for examination must be submitted alleging that the individual is: (a) mentally ill, drug dependent, or developmentally disabled; 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. An initial

hearing to review the allegations is then held within 72 hours. If probable cause is found, a hearing must be held within 14 to 21 days of the individual's detention. 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 of individuals 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.

Forensic patients are those patients referred from the criminal court system. Forensic services provided by the mental health institutes include assessment of competency to stand trial, treatment to competency, and treatment upon a finding of not guilty by reason of mental disease or defect. Individuals found not guilty by reason of mental disease or defect are committed to DHFS for the same period of time that they would have been incarcerated had they been found guilty. These individuals can initially be placed directly in the community on conditional release or be committed to either MMHI or WMHI.

Counties are responsible for supporting the care costs of civil commitments, while the state is responsible for supporting the care costs of forensic patients.

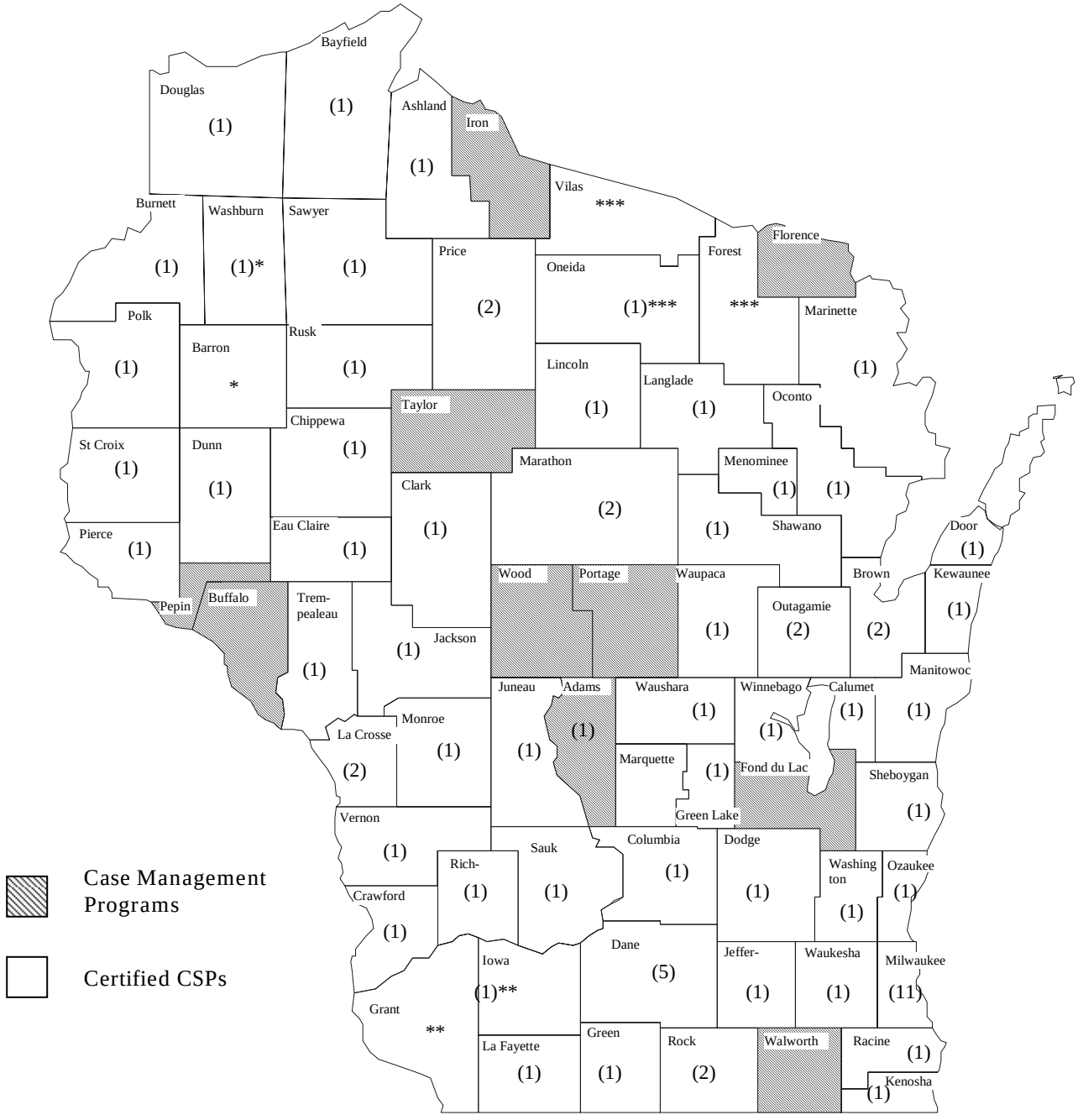
Operations at the mental health institutes are funded by a combination of GPR and program revenues. The program revenues consist of the fees counties pay when a county resident is civilly committed at one of the institutes, MA payments for children and elderly patients, Medicare payments, and insurance payments from private payers. Table 5 identifies funding from each of these sources for the mental health institutes in 2005-06.

**Table 5: Mental Health Institutes Operating Revenues, by Source**
**Fiscal Year 2005-06**

| | Winnebago | | Mendota | |
|---|---|---|---|---|
| Program Revenues | Amount | % of Total | Amount | % of Total |
| GPR | $24,314,400 | 49.4% | $31,199,700 | 62.3% |
| Medical Assistance | 14,952,800 | 30.4 | 5,838,400 | 11.7 |
| Counties | 7,034,100 | 14.3 | 8,369,000 | 16.7 |
| Private / Commercial | 1,698,300 | 3.4 | 1,327,700 | 2.6 |
| Medicare | 1,216,700 | 2.5 | 3,351,300 | 6.7 |
| Total | $49,216,300 | 100.0% | $50,086,100 | 100.0% |

## APPENDIX I

### Wisconsin Mental Health
### Certified Community Support Programs (CSPs)
### As of January 1, 2007




Counties with both CSPs and case management programs are: Chippewa, Dodge, Door, Milwaukee, Outagamie, Sheboygan, and Washington Counties.

* 1 certified between Washburn and Barron Counties.

** 1 certified between Grant and Iowa Counties.

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

## APPENDIX II

### Allocation of State Funding for Community Support Programs Calendar Year 2006

| County | Estimated Number of Individuals Served | Amount |
|---|---|---|
| Ashland | 11 | $15,858 |
| Brown | 42 | 89,015 |
| Chippewa | 47 | 57,500 |
| Columbia | 12 | 32,616 |
| Dane | 31 | 117,524 |
| Eau Claire | 23 | 11,405 |
| Forest / Vilas / Oneida | 32 | 61,500 |
| Green | 9 | 12,250 |
| Jefferson | 47 | 61,500 |
| Kenosha | 39 | 41,275 |
| La Crosse | 46 | 61,500 |
| Manitowoc | 27 | 34,650 |
| Milwaukee | 38 | 93,910 |
| Monroe | 15 | 22,497 |
| Rock | 34 | 61,500 |
| St. Croix | 29 | 48,211 |
| Sheboygan | 35 | 33,720 |
| Vernon | 8 | 5,380 |
| Washington | 24 | 49,365 |
| Waukesha | 30 | 64,529 |
| Waushara | 19 | 24,295 |
| Total | 600 | $1,000,000 |