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Services for Persons with Mental Illness

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Introduction

This paper provides information on public mental health services available to Wisconsin residents. The first section describes common types of mental disorders and the factors believed to cause these disorders. The second section describes community-based services to persons with mental disorders and the programs that provide these services. The final section describes institutional services for persons with mental disorders. This excludes services provided for persons committed as sexually violent persons (described in a separate Legislative Fiscal Bureau informational paper entitled "Civil Commitment of Sexually Violent Persons") and services provided to incarcerated individuals.

Mental Illness

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.

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."

These definitions are used to determine eligibility for services provided under Chapter 51 of the statutes. The definition includes schizophrenia, as well as psychotic and other severely disabling psychiatric diagnostic categories, but does not include infirmities of aging, developmental disabilities, or alcohol or drug dependence.

Federal law defines adults with serious mental illness as people over 18 years of age who have (or had at any time during the previous year) a diagnosable mental behavior or emotional disorder specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), published by the American Psychiatric Association. The disorder must result in functional impairments that substantially interfere with or limit one or more major life activity.

Mental Disorders Affecting Adults. NIMH estimates that between 4% and 7% of Wisconsin adults who are not homeless or institutionalized have a severe mental illness. Anxiety disorders, major depression, bipolar disorder, and schizophrenia are among the most common mental disorders affecting adults. This section describes these conditions.

Anxiety Disorders. Characterized by overwhelming anxiety and fear, these disorders include panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, social and other specific phobias, and generalized anxiety disorder. In any given year, approximately 18% of adults in the United States have an anxiety disorder. People with these disorders experience excessive or irra-

tional fear and dread. Depending on the type of anxiety disorder, men or women may be affected more often.

Depression. Major, or unipolar, depression is the most common type of mood disorder, affecting an estimated 6.7% of American adults. The various symptoms of major depression can range from feelings of sadness or irritability to changes in sleeping patterns. A diagnosis of major depression includes 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. Depression occurs most often in individuals between 24 and 45 years of age. Annually, nearly twice as many women as men exhibit major depressive disorder.

Bipolar Disorder. This mood disorder is characterized by severe mood swings between mania and major depression. An estimated 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 extreme happiness, distractibility, rapid and uncontrollable ideas or speech, decreased need for sleep, poor judgment, and 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, ranging from several hours to several months, before the depressive stage begins. The symptoms of the depressive stage are the same as those for major depression. Men and women are equally likely to be affected by this disease.

Schizophrenia. This disorder involves dysfunction lasting at least six months in a major area of functioning (such as interpersonal relations, self-care, or work or education). The dysfunction must include at least two of the following symptoms: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, restrictions in the range and intensity of emotional expression, or lack 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 the late teens or early twenties; for women, symptoms usually appear in the twenties or thirties.

Mental Disorders Affecting Children. The prevalence of mental disorder among children and adolescents is not as well documented as that for adults. An estimated 20% of children in the United States have mental disorders with at least mild functional impairment. While many mental disorders that affect adults also affect children, certain mental disorders mainly affect children.

Attention-Deficit/Hyperactivity Disorder (ADHD). ADHD occurs in 5% to 10% of American children, with boys nearly three times as likely to be affected as girls. There are three types of ADHD: inattentive, hyperactive-impulsive, and combined attention-deficit/hyperactive disorder. Children with inattentive ADHD have short attention spans, are easily distracted and forgetful, do not pay attention to details, make many mistakes, fail to finish tasks, and cannot stay organized. Children with hyperactive-impulsive ADHD fidget and squirm, cannot stay seated or play quietly, run or climb too much, talk too much, have trouble taking turns, and interrupt others.

The most common type of ADHD is combined attention-deficit/hyperactive disorder, a combination of the symptoms of both inattentive and hyperactive-impulsive ADHD. A diagnosis of ADHD includes symptoms beginning before the age of seven that last for six months and that are evident in at least two different settings (such as school and home).

Attachment Disorder. This disorder may affect children who did not establish secure and permanent relationships early in life. Children from birth to 18 months who were ill, experienced forced separations, emotional, sexual, or physical abuse or neglect, or were at least two years old when an

adoptive or foster care placement occurred are more likely to experience attachment disorder. Symptoms include being superficially engaging or charming, avoiding eye contact with parents, or failing to form deep relationships

Conduct Disorder. An estimated 10% of children in the United States exhibit conduct disorder, or disruptive behavior. These children repeatedly violate the personal or property rights of others and the basic expectations of society. The symptoms of conduct disorder include aggressive or destructive behavior, lying, theft, skipping school, and other serious violations of rules. For a diagnosis of conduct disorder, these symptoms must persist for six months or longer.

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 the development of mental illness, including 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 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. 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 individuals over 18 years of age with any past history of mental disorder had more that twice the risk of having an alcohol disorder, and had more than four times the risk of having another substance abuse disorder.

History of the Provision of Mental Health Services in Wisconsin

During the last 50 years, mental health service provision has shifted from inpatient, institutional care to community-based care. This shift reflects many changes, including an increased understanding of the causes and treatment of mental illness and a change from viewing individuals with mental illness as "passive service users" to proactive consumers who can direct their own care and live within the community. During this time, the view of all mental disorders as lifelong and progressive also changed. With appropriate supports, persons with mental disorders can maintain school performance, jobs, friendships, and family networks. As people with mental disorders value independence and productivity, mental health services must respond to individual needs and environments.

Blue Ribbon Commission on Mental Health. In May, 1996, Governor Tommy Thompson appointed a Blue Ribbon Commission on Mental Health. The Commission studied reforms to improve performance, coordination and outcomes of the mental health service delivery system. The Commission's April, 1997, report recommended changes focused on consumer outcomes, recovery, prevention, early intervention, reduction of stigma, and financing and organizational structures of the mental health system. Specifically, the Commission suggested pooling federal, state, and county funds for human services through a managed care approach to services.

The Commission proposed that the redesigned mental health system emphasize flexibility and creativity to empower consumers, families, and

mental health professionals to achieve outcomes. To meet these goals, the Commission recommended that all persons receive health services that are individualized, comprehensive, and provided with dignity and respect.

Healthiest Wisconsin 2010. The Wisconsin Turning Point Initiative developed *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*. Required under s. 250.07 of the statutes, this document is the state's public health plan for 2000 through 2010, and includes goals for the provision of mental health services. These goals include improving screening and reducing discrimination, increasing cultural competence, and improving access to evidence-based treatment.

The plan sets out specific targets for each of these goals, none of which had been achieved as of the 2005 progress report. However, the progress report shows DHS accomplishments in other areas of improving mental health service provision. The Turning Point Initiative is in the early stages of drafting *Healthiest Wisconsin 2020*, the state public health plan for the coming decade.

The Provision of Mental Health Services

The Department of Health Services (DHS). The DHS Division of Mental Health and Substance Abuse Services (DMHSAS) is the state authority for community mental health services, implementing a number of responsibilities under s. 51.03 of the statutes. DHS may, within the limits of available state and federal funds, do the following:

- Promote coalitions among the state, counties, service providers, service consumers and their families, and advocates for persons with mental illness. These coalitions should provide a range of resources to advance prevention, early intervention, treatment, recovery, and other positive outcomes;

- Reduce stigma and discrimination against persons with mental illness;

- Involve all stakeholders as equal participants in service planning and delivery;

- Promote responsible use of human and fiscal resources for mental health service provision;

- Identify and measure outcomes for consumers of mental health services;

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

- Enable persons with mental illness to become more self-sufficient through consumer decision making; and

- Promote the use of individualized and collaborative service planning by providers of mental health services to promote treatment and recovery.

DHS ensures that providers of mental health services using individualized service plans do the following: establish measurable goals for the consumer; base the plan on an assessment of the consumer's attributes; and modify the plan as necessary. Finally, DHS 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.

Council on Mental Health. As a condition of the federal mental health block grant (MHBG), all states must have a council on mental health. The Wisconsin Council on Mental Health is an advocacy and advisory council attached to DHS for administrative purposes. The Council is statutorily required to advise DHS, the Legislature, and the Governor on mental health policy issues. These issues include the use of state and federal resources, the provision of programs for persons who are mentally ill or who have other mental health

problems, the needs of groups who are not adequately served, and the prevention of mental health problems.

In addition, the Council is required to: (a) provide recommendations to DHS on the expenditure of MHBG funds; (b) help develop the MHBG plan and evaluate the implementation of the plan; (c) monitor all DHS mental health plans and programs; and (d) promote a delivery system for community mental health services that is sensitive to consumer needs. DHS must submit all plans affecting persons with mental illness to the council for review.

Counties. Each county is responsible for the treatment and care of persons with mental illness who reside in the county. Counties must also ensure that persons in need of immediate emergency services receive these services.

Under standards established by rule, each county establishes its own program and budget for these services. Statutes specify that each county is responsible for the program needs only within the limits of available state and federal funding, and county matching funds. Counties limit service levels and may establish waiting lists to ensure that expenditures do not exceed available resources. For this reason, the type and amount of available services varies among counties.

Counties must provide services in the least restrictive environment that is appropriate for an individual's needs. These services can range from community-based care to inpatient and psychotherapy services. Counties must, within the limits of available funds, offer the following services: (a) collaborative and cooperative services for prevention; (b) diagnostic and evaluation services; (c) inpatient and outpatient care, 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.

Funding of Mental Health Services in Wisconsin

There are four primary funding sources for mental health services in Wisconsin: (a) medical assistance (MA); (b) the federal community mental health services block grant (MHBG); (c) state/federal community aids and county funds; and (d) private insurance and individual copayments. These funding sources (with the exception of private insurance) are discussed in this paper

Medical Assistance. Wisconsin's medical assistance (MA) program has two comprehensive coverage plans: the standard plan, and the more limited benchmark plan. Currently, virtually all MA recipients receive MA "card services" under the standard plan. Therefore, the treatment services described below are those covered by the MA standard plan.

Inpatient Care. Wisconsin's MA program covers inpatient hospital mental health and AODA care when the treatment is prescribed by a physician and provided within a hospital institution for mental disease (IMD). An IMD is defined by federal law as a hospital, nursing home, or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care for individuals with mental diseases, including medical care, nursing care and related services.

In order for an MA recipient to receive services in an IMD, an independent team of health care professionals, including a physician, must certify that ambulatory care resources do not meet the individual's treatment needs, proper treatment of the psychiatric condition requires services provided on an inpatient basis under the direction of a physician, and the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will be needed in reduced amount or will no longer be needed. State law also requires that an individual

plan of care designed to achieve the recipient's discharge from inpatient status at the earliest possible time be developed and implemented within 14 days of the recipient's inpatient admission, and reviewed every 30 days thereafter.

Federal law prohibits states from covering IMD services under their MA programs for individuals between the ages of 22 to 65, but Wisconsin provides state funding for counties to support a portion of the costs of the care for this population. The state provides a supplement of $9 of general purpose revenue (GPR) per person per day to support the care of individuals who receive specialized mental health services in an institutional setting under the nursing home reimbursement formula. In addition, DHS distributes $10,583,800 GPR each fiscal year to assist counties in supporting residents of IMDs and individuals relocated from IMDs to community-based treatment programs. A portion of these funds are available annually to support relocation services for individuals who have a mental illness, are otherwise eligible for MA, and are in need of active treatment but whose needs can be met in the community.

Outpatient Psychotherapy. Outpatient psychotherapy services are covered by the state's MA program if a physician prescribes the services and a certified psychotherapy provider conducts a diagnostic examination of the recipient. A provider must obtain prior authorization from the state MA program to receive MA payment for services once the individual receives either $500 or 15 hours of outpatient services in a calendar year.

The MA program also covers alcohol and other drug abuse (AODA) outpatient treatment services, provided the recipient first receives a complete medical evaluation, including diagnosis, summary of present medical findings, medical history and explicit recommendations by the physician for participation in the AODA treatment program. Outpatient treatment services for AODA are subject to the same $500/15 hour limitation as the outpatient psychotherapy services described above.

Day Treatment. "Day treatment" refers to a nonresidential program in a medically supervised setting that provides case management, medical care, psychotherapy or other therapies, and follow-up services to alleviate problems related to mental illness or emotional disorders. To be covered by the state MA program, a physician must prescribe the services, the MA recipient must receive an initial evaluation, and a treatment plan must be developed and periodically monitored. All day treatment services for AODA treatment must be authorized in advance by DHS, and in no event can the services exceed five hours per day.

The MA program also covers day treatment and day hospital services for the acutely and chronically mentally ill who have a need for day treatment and are determined to have the ability to benefit from those services. Day treatment services for these individuals beyond 90 hours per calendar year must be authorized in advance by DHS, and the MA program will not reimburse services in excess of five hours per day or 120 hours per month.

County-Funded Services. In addition to the inpatient, outpatient, and day treatment services described above, 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. In total, these county-funded services generated approximately $68 million in federal MA matching funds in 2007-08, funds which in turn were paid to the counties to help support these programs.

Community support program services include assessments, treatment, case management, and psychological rehabilitation services, such as employment-related services, social and recreational skill training, and assistance with activities of daily living and other support services. These services

are designed to enable a recipient to better manage the symptoms of their illness, increase the likelihood of independent and effective functioning in the community, and reduce the incidence and duration of institutional treatment otherwise brought about by mental illness. MA recipients may access CSP services when a physician prescribes the services, and the services are provided by providers that meet the conditions for community support programs administered by counties. This program is described in more detail later in this paper.

Crisis intervention services are services provided by a mental health crisis intervention program operated by, or under contract with, a county.

Case management services help recipients and their families access, coordinate, and monitor necessary medical, social, educational, vocational, and other services covered by MA and other programs. People who are over age 64, are diagnosed with Alzheimer's disease or other dementia, or are members of one or more of the following target populations are eligible for case management services under MA: (a) developmentally disabled; (b) chronically mentally ill, age 21 or older; (d) alcoholic or drug dependent; (e) physically or sensory disabled; (f) under age 21 and severely emotionally disturbed; (g) HIV positive; (h) children enrolled in the Birth-to-Three program; (i) children with asthma; (j) individuals infected with tuberculosis; (k) women age 45 through 64; and (l) families with children at risk of serious physical, mental, or emotional dysfunction, including lead poisoning, risk of maltreatment, involvement with the juvenile justice system, or where the primary caregiver has a mental illness, developmental disability, or substance abuse disorder.

Case management providers are required to perform a written comprehensive assessment of a person's abilities, deficits and needs. Following the assessment, providers develop a case plan to address the needs of the client, and provide ongoing monitoring and service coordination.

Case management services must be provided by qualified private, nonprofit agencies or qualified public agencies. A uniform, contracted hourly rate determines payment for case management services. The MA program pays the federal share of this rate and case management agencies must provide the state MA match by using funding provided through other programs, such as the local tax levy, community aids, community options program, family support program or Alzheimer's caregiver support funds.

Beginning in 2004-05, comprehensive community services (CCS) 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.

CCS can include medical and rehabilitative services and supportive activities intended to provide a maximum reduction of the effects of the individual's mental health or substance abuse condition, restoration to the best possible level of functioning, and facilitation the individual's recovery. MA recipients must obtain a physician's prescription to receive CCS. These services must be consistent with needs identified through a comprehensive assessment 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. Prior to February 1, 2008, the state MA program included drug costs as a component of the capitation rate received by health maintenance organizations to serve MA recipients. Beginning February 1, 2008, the state consolidated its prescription drug benefit into a totally fee-for-service model.

The implementation of the Medicare Part D prescription drug benefit on January 1, 2006 generates prescription drug cost savings for the state's MA program, 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. To partially compensate the federal government for the prescription drug costs now covered by Medicare Part D, states make a "clawback" payment to CMS. In 2007-08, DHS estimates that Wisconsin's clawback payment for all fee-for-service prescription drugs (not just those prescribed for the treatment of mental illness) totaled $139.7 million.

Community Mental Health Services Block Grant (MHBG). The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) allocates the community mental health services block grant (MHBG) to states to provide comprehensive community mental health services to adults and children with serious mental illness and to monitor the implementation of a comprehensive community based mental health system. States may use up to 5% of the allocation to fund administrative costs. States may not use block grant funding to provide inpatient services or to make cash payments to intended service recipients.

Wisconsin received $7,358,600 in FFY 2007-08, and $7,415,200 in FFY 2008-09. The state's 2009-2011 MHBG plan focuses on several issue areas, including community based service provision, rural and homeless populations, and management and data systems. Table 1 shows planned expenditures for the MHBG for FFY 2008-09. More information on most of these services is provided under the "Other Grant Programs" section of this paper.

Table 1: Summary of Expenditure Plan for Mental Health Block Grant Funds, FFY 2008-09

Program	Planned Expenditure
Community Aids Allocation	$2,513,400
Children's Initiatives (Integrated Services Projects and Coordinated Services Teams)	1,826,500
Family / Consumer Self-Help & Peer Support	991,600
Transformation Activities	790,300
Systems Change	374,600
Training and Technical Assistance	182,000
Wisconsin Protection & Advocacy	75,000
State MH Authority Staff-Planning and Technical Assistance	361,000
Administration / State Operations	300,800
Total	$7,415,200

Community Aids. Under the state's community aids program, DHS distributes state and federal funds to counties for community-based social, mental health, developmental disability, and substance abuse services. Counties receive both a basic county allocation (BCA), which they may expend for any of these eligible services, and categorical allocations, which are funds earmarked for specific services and programs. The Legislative Fiscal Bureau Informational Paper entitled "Community and Children and Family Aids" provides additional information on the community aids program.

Basic County Allocation. DHS is directed to distribute up to $176,068,400 (all funds) annually under the community aids BCA. Counties use the BCA, in combination with funding from other sources (such as other state and federal programs and revenue from the county levy), to support their human services programs, including the services provided to individuals with mental illness. While counties annually report to DHS the total amount they expend on services they provide to individuals with mental illness, they do not report this information by funding source. Consequently, it is not known how much of the community aids BCA counties expend to support services to persons with mental illness.

Community Aids MHBG Allocation. DHS is required to allocate up to $2,513,400 annually from the MHBG to fund a categorical allocation under community aids. In 2008, DHS required counties to use these funds to provide comprehensive

community mental health services to adults and children, evaluate programs and services, and conduct planning, administration, and educational activities related to service provision. Counties submit annual plans to DHS for the use of the allocation in one or more of these priority areas:

- supported housing;
- comprehensive services for children with severe emotional disturbances;
- jail diversion programs;
- community support programs (CSP);
- mobile crisis intervention services;
- family and consumer peer support services;
- programs for people with co-occurring mental illness and substance abuse problems; or
- development of a community mental health data-set.

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 child must exhibit the following characteristics. First, the condition must have persisted for six months and be expected to persist for a year or longer.

Second, the condition must be listed in the DSM-IV diagnostic categories 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.

Third, the condition must include functional symptoms and impairments. The individual must exhibit the symptoms of defective or lost contact with reality (often with hallucinations or delusions), or danger to self, others, or property. The individual must exhibit functional impairment in two of the following capacities: self care, community, social relationships, family, or school or work.

Finally, the individual must receive services from two or more of the following service systems: mental health, social services, child protective services, juvenile justice, special education, or substance abuse.

In Wisconsin, DHS estimates that there are approximately 110,000 children with a substantial functional impairment. Of those children, approximately 70,000 children between the ages of nine and 15 exhibit extreme functional impairment and about one-half will need public services at some point.

Integrated Service Projects for Children who exhibit SED. Integrated service projects (ISPs) provide integrated services, or "wraparound services." These services focus on the strengths and needs of the child and family, and "wrap" services around them for treatment and support 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. Priority is given to children with severe disabilities who risk placement outside of the home, who are in institutions and do not receive integrated community-based services, or who could 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 2008-09, DHS will distribute $1,440,000 ($133,300 general purpose revenue (GPR) and $1,306,700 federal (FED) from the MHBG) for grants to these counties for their ISP programs. Table 2 lists these counties, each of which received $80,000.

In addition to the counties listed in Table 2, two

Table 2: Counties Receiving Integrated Service Project (ISP) Funding, FFY 2008-09

Ashland	Kenosha	Rock
Chippewa	La Crosse	Sheboygan
Dunn	Portage	Washburn
Eau Claire	Marinette	Washington
Fond du Lac	Marquette	Waukesha
Door	Racine	Waushara

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 funded with medical assistance (MA) and county funds.

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

Wraparound Milwaukee offers 80 different services to families through a network of service providers. The most frequently utilized community services include in-home family therapy, foster care services, in-home therapy, and crisis stabilization. The Milwaukee County Department of Health and Human Services, Division of Behavioral Health administers the Wraparound Milwaukee program.

Coordinated Service Team Initiative. The coordinated service team (CST) initiative, created in 2002, combines mental health, substance abuse, and child welfare funding to award grants to support county programs. These projects implement systems change by coordinating services for children and families involved in multiple systems, including mental health, child welfare, substance abuse, juvenile or adult justice, special education, W-2, domestic violence, and developmental disabilities. Projects use a wraparound approach 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.

DHS currently allocates funding to 22 counties and two tribes, chosen through a competitive request for proposal (RFP) process. These counties receive these grants for five years. DHS allocates funding to the counties on a federal fiscal year basis. Table 3 shows the active county CST grants in FY 2008-2009.

Table 3: Active Coordinated Service Team (CST) Grants, FY 2008-09

County / Tribe	Amount
Adams	$49,900
Ashland	49,000
Brown	50,000
Buffalo	50,000
Burnett	49,000
Crawford	49,900
Dodge	50,000
Douglas	49,900
Eau Claire	33,000
Juneau	50,000
La Crosse	33,000
Lafayette	49,900
Menominee	49,000
Monroe	49,000
Pierce	49,900
Polk	49,900
Price	49,000
Richland	49,900
Sheboygan	33,000
St. Croix	49,900
Vernon	49,800
Washburn	33,000
Lac Courte Oreilles	49,000
Red Cliff	49,000
Total	$1,124,000

Counties may use this funding for systems change activities, to promote consumer involvement, and to provide direct services. No more than 10% of a county's allocation can be used for direct services, as the services must be provided by established county programs. The CST grant allocation

allows the county to implement the CST approach to serving those families.

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, 2009, there were 78 certified CSPs in 63 counties, as shown in Appendix I. All counties also have case management programs, but the county cannot claim MA-matching funds for the services they provide because the programs are not MA-certified.

As specified in s. 51.421 of the statutes, to provide the least restrictive and appropriate care for persons with serious mental illness, every county must provide community support program services (if funds are provided and within the limits of available funds under community aids). Each CSP has a coordinated case management system and ensures access to services for persons with a 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 qualifies for services in a CSP if he or she has a serious and persistent mental illness that 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 diagnosis of schizophrenia, affective disorder, delusional disorder, or other psychotic disorders or documentation in the client record that shows that there have been extensive efforts of over a year to treat the client, except in unusual circumstances such as the sudden onset of dysfunction;

- The individual presents a persistent danger 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: vocational, educational, homemaking, social interpersonal, community functioning, self-care or independent living.

Each individual 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, implement a treatment plan for the individual, and directly provide care or coordinate treatment and services.

Certified CSPs are funded with local tax levy, which supports the nonfederal share of the MA funds, and $1,000,000 GPR annually, which CSPs may use to fund services for individuals who are on waitlists. In 2007, counties reported spending $57.6 million for community support mental health programs, including $1.32 million of MHBG funds. This funding supported services for 7,652 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. The $1,000,000 GPR appropriation helps fund these services. As shown in Appendix II, DHS allocated CSP waitlist funding to 23 counties in calendar year 2007.

Other Grant Programs

In addition to the programs previously described, DHS allocates federal MHBG funding for a variety of activities. These grants are described below, based on information provided by DHS. Table 1 earlier in this paper also summarizes the expenditure plan for these funds for federal fiscal year 2008-09.

Consumer and Family Support Grants. In FY 2008-09 DHS will allocate $991,600 FED for consumer and family support grants 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 received these grants in FY 2007-08: the National Association of the Mentally Ill ($210,000 FED), Wisconsin Family Ties ($210,000 FED), and the Grassroots Empowerment Project ($454,000 FED). These organizations provide a range of vocational training, education, and consumer and family support services.

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 2008-09, DHS plans to expend $374,600 for system change grants.

Protection and Advocacy. DHS distributes $75,000 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 illness. The group uses this funding to advocate for individuals with mental illness, training activities, and development of training materials.

Training. DHS distributes $182,000 FED annually for training for mental health treatment professionals on mental health standards, best practice, recovery principles, and emergency crisis services. In 2008-09, DHS plans to expend these funds on the following activities:

- $97,000 on statewide teleconferences and an integrated annual training conference;
- $32,000 on ISP/CST training, crisis network and conference;
- $25,000 on consumer and family stipends to encourage participation in policy and planning meetings;
- $23,000 on training in schools for positive behavior supports; and
- $5,000 on geropsychiatry training and elderly consumer participation.

Transformation Activities. DHS plans to expend $790,300 on transformation activities in FFY 2008-09. The federal Center for Mental Health Services has provided new direction to states to focus an increasing share of MHBG funding on efforts to transform their state's mental health systems and to work with other state systems that fund mental health services to improve their delivery of mental health services. These grants fund a wide range of activities focused on evidence-based best practices and access to services.

Staff and Administrative Costs. DHS plans to expend $361,000 from the MHBG in FFY 2008-09 to fund 5.90 full time equivalent positions in the

Division of Mental Health and Substance Abuse Services for planning and technical assistance, and $300,800 to fund administrative costs.

Total County Expenditures. Appendix III summarizes total county expenditures for services provided to persons with mental illness for calendar years 2000 through 2007. These expenditures are reported to the DHS human services reporting system (HSRS). HSRS includes expenditures made at the county level from all state, federal and county revenue sources, and are reported by target group population (including persons with mental illness, developmental disabilities, and substance abuse issues).

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 primarily engages in the diagnosis, treatment or care of persons with mental illness, including medical attention, nursing care and related services. Thirteen hospitals and one nursing home currently operate as IMDs in Wisconsin. 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, IMD residents between the ages of 22 and 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 psychiatric rehabilitative mental health services in an institutional setting.

In calendar year 2008, $10,583,700 GPR was 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 DHS Division of Mental Health and Substance Abuse Services (DMHSAS) operates four mental health facilities that provide inpatient mental health services to individuals in the state. The two mental health institutions, Mendota Mental Health Institute (MMHI) in Madison and Winnebago Mental Health Institute (WMHI) near Oshkosh, 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. In addition to providing psychiatric services, both facilities are licensed and accredited hospitals that provide training and research opportunities.

MMHI offers 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 11 units that serve different adult and youth populations, including four forensic units, four adult units, and three child and adolescent units. The Transitional Living Community (TLC) program (formerly Activities Within a Regulated Environment, or AWARE) assists adults who are dually diagnosed with mental illness and developmental 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. In addition, both facilities offer outpatient day school programs for children with mental health and behavioral disturbances.

Table 3 provides information on the average number of patients, by type, at the institutes in 2007-08, and the percentage of the total each patient population represents. Total patient capacity for the MMHI and WMHI facilities during fiscal year 2007-08 was 293 and 242 patients, respectively.

Table 3: Average Daily Populations (ADP) at the Mental Health Institutes (by Type) -- 2007-08

	Mendota		Winnebago	
	ADP	Percent	ADP	Percent
Child / Adolescent	23.7	8.3%	31.9	14.2%
Forensic	173.5	61.0	112.3	50.0
Adult	58.7	20.6	47.9	21.4
MJTC	28.8	10.1	0.0	0.0
Substance Abuse	0.0	0.0	32.2	14.4
Totals	284.7	100.0%	224.3	100.0%

Annually, DHS establishes the rates charged to provide services to the different populations served by the institutes. These rates are based on the actual cost of providing services and the availability of third party revenues, such as Medicare and Medicaid. Table 4 shows the daily rates DHS established for each patient population group at MMHI and WMHI that were in effect as of January 1, 2009.

Table 4: Mental Health Institutes Inpatient Daily Rates as of January 1, 2009

	Mendota	Winnebago
Adult Psychiatric Services	$811	$807
Geropsychiatric	851	---
Child / Adolescent	830	783
Forensic-Maximum Security	811	---
Other Security	742	807
TLC / STEP / Gemini / Anchorage	---	807
Emergency Detention*	200	200
Day School	$30 / hour	$30 / hour

*For first three days of service

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 is quite lengthy and detailed. The following discussion is intended to provide a general overview of the commitment process.

Civil commitments may be either voluntary or involuntary, and, in general, the county of the patient's residence must approve these admissions. 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 occur within 14 to 21 days of the individual's detention. If a patient is admitted to a facility, the facility must 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, alcohol or other drug dependent, developmentally disabled, 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 DHS. 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 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 DHS 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.

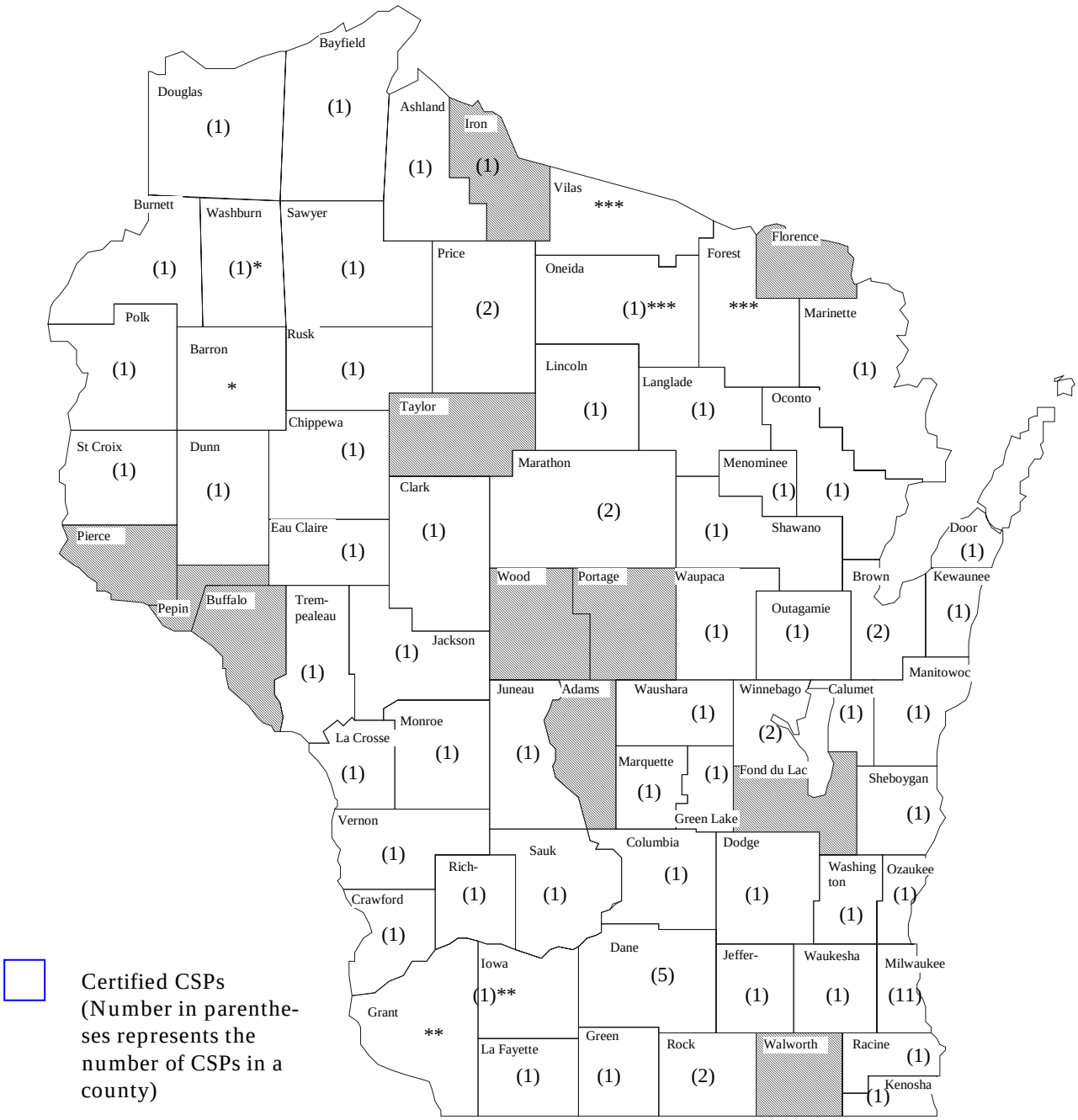
Counties are responsible for supporting the care costs of civil commitments, while the state is responsible for supporting the care costs of forensic patients. Operations at the mental health institutes are funded by a combination of GPR and program revenues. The program revenues consist of the fees counties pay when a county resident is civilly committed at one of the institutes, MA payments for children and elderly patients, Medicare payments, insurance payments from private payers, and transfers from other agencies such as the Department of Corrections. Table 5 identifies funding from each of these sources for the mental health institutes in 2007-08.

Table 5: Mental Health Institutes Operating Revenue, by Source
Fiscal Year 2007-08

	Mendota		Winnebago	
	Amount	% of Total	Amount	% of Total
GPR	$37,882,200	57.6%	$27,523,600	55.1%
Medical Assistance	6,762,600	10.3	10,382,000	20.8
Counties	12,399,100	18.9	9,413,000	18.8
Private Insurance	1,661,100	2.0	51,362,500	2.7
Medicare	2,976,800	4.5	1,301,200	2.6
Other Gov. Agencies	3,992,300	6.1		
Miscellaneous	39,500	0.1		
Total	$65,713,600	100.0%	$49,982,300	100.0%

APPENDIX I

Wisconsin Mental Health
Certified Community Support Programs (CSPs)
As of January 1, 2009



Certified CSPs
(Number in parentheses represents the number of CSPs in a county)

* 1 certified between Washburn and Barron Counties.
** 1 certified between Grant and Iowa Counties.
*** 1 certified between Vilas, Oneida, and Forest Counties.

APPENDIX II

2007 Community Support Program Waitlist General Program Revenue (GPR) Funding Amounts and Number of People Served

County	2007 CSP Wait List Contract Amount	2007 Number of People Served
Ashland	$15,858	71
Brown	89,015	84
Chippewa	57,500	58
Columbia	32,616	53
Dane	117,524	512
Eau Claire	11,405	150
Forest-Oneida-Vilas	61,500	33
Green	12,250	59
Jefferson	61,500	86
Kenosha	41,275	162
La Crosse	61,500	74
Manitowoc	34,650	57
Milwaukee	93,910	1321
Monroe	22,497	26
Rock	61,500	267
Sheboygan	33,720	109
St. Croix	48,211	84
Vernon	5,380	57
Washington	49,365	95
Waukesha	64,529	165
Waushara	24,295	33
Total	$1,000,000	3,556

APPENDIX III

County Expenditures for Services Provided to Individuals with Mental Illness Calendar Years 2000 through 2007 (All Funds Collected and Spent at the County Level)

County	2000	2001	2002	2003	2004	2005	2006	2007
Adams	$864,737	$803,058	$977,841	$969,750	$991,596	$1,038,939	$770,987	$797,272
Ashland	920,478	730,506	1,179,158	1,079,287	1,175,541	709,265	897,233	881,221
Barron	1,587,507	2,268,867	2,189,418	2,227,071	2,381,929	2,409,063	2,335,827	2,523,639
Bayfield	498,026	504,147	692,811	647,954	857,762	733,129	701,159	1,059,122
Brown	9,614,382	11,330,068	10,231,607	11,496,969	11,872,329	14,027,573	12,605,957	13,903,769
Buffalo	190,908	310,369	224,685	184,529	216,952	201,945	290,856	327,434
Burnett	786,616	737,197	742,755	737,805	801,079	756,434	776,130	667,007
Calumet	1,297,560	1,342,097	1,492,882	1,796,895	2,040,206	2,080,191	2,336,312	2,450,200
Chippewa	2,004,436	2,123,708	2,213,178	2,170,068	2,440,073	2,713,211	2,821,036	2,767,916
Clark	2,047,833	2,275,713	2,210,583	2,420,701	2,494,361	2,480,966	2,466,359	2,747,414
Columbia	1,235,080	1,447,988	1,834,931	1,701,155	1,445,568	1,987,051	2,294,111	2,438,148
Crawford	750,412	874,306	926,868	965,304	1,221,491	1,157,395	1,083,672	1,108,725
Dane	24,357,775	26,084,206	25,721,640	26,770,898	26,879,068	26,714,254	28,122,866	28,765,867
Dodge	3,715,266	3,526,699	3,866,393	3,949,816	4,239,913	4,481,627	5,044,414	5,143,576
Door	1,153,143	1,185,495	1,311,579	1,334,537	1,370,488	1,528,885	1,905,244	1,588,366
Douglas	2,675,830	2,775,406	2,996,259	2,996,203	2,930,248	2,950,258	2,904,016	3,101,112
Dunn	1,567,000	1,543,646	1,706,957	1,742,032	2,097,280	1,956,578	2,038,454	2,212,110
Eau Claire	5,684,409	5,922,273	6,293,663	9,487,625	7,463,359	7,705,293	7,976,972	7,780,523
Florence	51,764	107,126	70,335	93,141	64,036	90,722	134,099	135,916
Fond du Lac	3,364,323	3,577,449	4,017,655	4,459,179	4,839,865	5,095,224	5,546,983	5,644,394
Forest-Oneida-Vilas	3,580,397	3,964,087	3,784,108	3,924,323	3,776,499	3,659,313	3,939,133	4,289,763
Grant-Iowa	2,399,357	2,323,873	2,268,681	2,619,640	2,166,877	2,290,845	2,397,184	2,013,985
Green	1,834,432	1,689,987	1,761,370	1,860,964	2,129,990	2,031,892	2,129,745	2,243,295
Green Lake	938,820	1,052,330	863,468	954,949	882,814	967,802	1,092,182	1,238,661
Iron	110,180	195,748	238,856	342,736	254,014	367,904	463,055	418,853
Jackson	647,673	921,692	1,030,088	978,926	1,090,597	1,272,834	1,317,719	1,396,366
Jefferson	3,318,058	3,834,314	4,145,391	4,601,434	4,978,652	4,639,111	4,550,141	5,074,251
Juneau	1,683,487	1,549,936	1,810,374	1,660,061	1,949,691	2,280,568	2,221,171	2,104,275
Kenosha	4,302,229	5,342,741	5,354,579	4,811,474	5,687,158	6,192,608	6,186,508	6,945,095
Kewaunee	670,061	627,369	515,168	407,232	609,486	523,527	539,637	573,910
La Crosse	4,607,299	4,372,496	5,036,018	6,207,110	6,306,247	6,315,237	7,709,226	8,019,349
Lafayette	808,766	610,400	746,632	770,334	727,227	810,486	822,381	1,016,452
Langlade-Lincoln-Marathon	12,887,649	12,658,951	12,546,324	13,034,269	14,120,412	13,431,940	13,535,235	13,682,800
Manitowoc	2,967,185	3,387,042	2,281,497	2,669,741	3,518,558	3,800,545	3,825,860	4,199,045
Marinette	2,515,534	2,624,244	2,773,115	3,381,774	3,038,666	2,779,055	3,144,344	3,396,300
Marquette	668,465	689,196	778,930	729,316	933,643	829,738	902,848	1,032,995
Menominee	584,003	595,224	619,272	501,905	606,722	683,992	553,467	716,495
Milwaukee	110,042,764	110,108,675	104,376,233	108,437,506	116,594,004	125,336,103	121,002,717	119,720,847
Monroe	2,352,099	3,011,278	3,104,246	2,324,960	2,033,414	1,773,607	2,118,451	1,914,455

APPENDIX III (continued)

County Expenditures for Services Provided to Individuals with Mental Illness Calendar Years 2000 through 2007 (All Funds Collected and Spent at the County Level)

County	2000	2001	2002	2003	2004	2005	2006	2007
Oconto	$1,549,715	$1,840,964	$935,080	$826,510	$1,234,897	$1,147,756	$1,421,606	$1,270,546
Outagamie	8,223,413	8,823,128	8,724,284	10,590,361	8,943,878	9,202,329	8,766,126	10,750,594
Ozaukee	2,902,674	3,171,902	3,209,717	2,937,285	2,706,690	2,538,526	2,559,412	3,036,832
Pepin	141,830	119,987	78,401	142,673	156,575	236,051	261,273	242,079
Pierce	769,573	821,093	1,064,321	1,197,964	1,742,844	1,410,155	931,804	1,316,552
Polk	879,638	1,288,971	1,797,758	1,851,534	2,403,993	2,805,049	2,674,554	3,109,795
Portage	2,264,702	2,548,858	2,458,410	2,652,496	2,742,733	2,740,690	3,321,215	3,098,357
Price	761,115	916,452	1,019,974	1,082,570	1,119,378	713,620	791,449	1,006,044
Racine	6,401,109	6,548,637	6,827,240	6,885,287	6,965,701	6,728,333	8,354,715	8,206,170
Richland	1,177,834	1,572,037	1,536,021	1,396,452	1,241,935	1,695,591	1,815,447	2,293,556
Rock	6,407,483	7,170,831	7,547,209	8,344,995	8,884,280	9,565,123	10,772,512	12,847,991
Rusk	438,078	591,089	558,613	1,003,430	680,643	770,398	760,240	796,841
Sauk	3,352,710	3,147,787	3,681,971	3,086,535	3,385,826	3,980,169	4,096,310	4,963,641
Sawyer	510,343	675,714	773,011	728,914	878,378	1,002,310	1,147,291	1,225,892
Shawano	1,127,561	1,044,846	1,366,533	1,263,311	1,427,481	1,491,030	1,760,348	1,700,674
Sheboygan	6,488,535	7,368,789	6,480,361	6,070,138	6,067,249	7,092,793	6,347,766	7,300,011
St. Croix	2,063,704	2,510,370	2,708,484	3,144,592	2,963,960	4,655,517	4,675,517	6,192,613
Taylor	676,871	546,838	473,726	482,766	606,724	792,754	828,798	548,456
Trempealeau	310,738	978,205	1,041,028	962,578	1,773,811	1,620,474	1,716,307	1,602,821
Vernon	831,756	1,066,408	1,248,614	1,240,243	1,296,675	1,456,603	1,366,013	1,422,285
Walworth	3,991,761	4,183,074	4,371,588	4,511,325	3,596,002	3,755,369	4,342,728	4,931,852
Washburn	565,483	722,913	768,878	620,479	954,018	1,136,705	1,149,937	1,204,365
Washington	5,618,649	5,626,539	5,617,115	5,975,894	5,512,682	6,041,338	6,174,375	6,802,357
Waukesha	10,044,505	12,191,060	12,466,667	13,593,872	14,113,204	15,536,915	16,217,447	17,397,774
Waupaca	2,187,257	2,459,382	2,549,450	2,363,588	2,982,151	2,952,403	3,638,919	3,552,148
Waushara	1,085,520	1,066,266	964,291	1,068,146	1,352,463	1,625,126	1,734,195	2,108,476
Winnebago	5,815,078	7,092,606	5,656,680	5,966,797	6,707,266	8,324,592	9,780,551	11,012,544
Wood	4,318,631	4,681,784	4,316,161	2,926,030	2,753,894	6,797,082	7,927,429	7,657,035
Total	$302,192,209	$319,806,437	$315,177,134	$330,366,338	$344,423,146	$368,619,911	$376,837,975	$393,639,224