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Services for Persons with Mental Illness

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State and local agencies provide a wide range of treatment and rehabilitation services for persons with developmental disabilities, mental disorders, alcoholism, and other drug abuse problems. This paper provides information on publicly-supported mental health services available to Wisconsin residents, including: (a) community-based mental health services funded by the state's medical assistance (MA) program; (b) institutional services available to persons with mental illness; and (c) non-MA funded community-based mental health services.

Provision of Public Services

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." Statutes further define chronic mental illness 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 conditions related to 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 fourth edition of 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.

Over the past 50 years, mental health service provision has shifted from inpatient, institutional care to community-based care. This shift reflects an improved 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.

In July, 2010, the Department of Health Services (DHS) released the state's 10-year health plan for the period 2010 through 2020, "Healthiest Wisconsin 2020: Everyone Living Better, Longer." The plan's main goals are to improve health across the life span, and eliminate health disparities. The plan includes the following mental health goals: (a) reducing smoking and obesity among people with mental health disorders; (b) reducing disparities in suicide and mental health disorders for disproportionately affected populations; and (c) reducing the rate of depression, anxiety and emotional problems among children with special health care needs.

The Department of Health Services. The Department of Health Services administers state and federal funding for the provision of the mental health services described in this paper. The DHS Division of Mental Health and Substance Abuse Services (DMHSAS) oversees most of the state's

community mental health services. Chapter 51 of the statutes directs DHS to perform the following activities, within available state and federal funding:

- Promote coalitions among the state, counties, service providers, service consumers, families, and advocates for persons with mental illness 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 that use individualized service plans establish measurable goals for the individual, base the plan on the individual's attributes, and modify the plan as necessary.

Council on Mental Health. As a condition of receiving funding under the federal mental health block grant (MHBG), all states must have a mental health planning council. The Wisconsin Council on Mental Health is an advocacy and advisory council attached to DHS for administrative purposes. State statutes require the Council to have between 21 and 25 members appointed by the Governor for three-year terms. Federal law requires the Council to include the following: (a) representatives of the state agencies charged with mental health, education, vocational rehabilitation, criminal justice, housing, social services, and medical assistance; (b) public and private mental health service providers; and (c) adults or family members of adults with serious mental illnesses who are receiving or have received services (this last group must make up at least half of the Council's membership).

By statute, the Council is required to advise DHS, the Legislature, and the Governor on mental health policy issues, including the use of state and federal resources, the provision of mental health services, the needs of underserved groups, and the prevention of mental health problems. In addition, the Council is required to do the following: (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.

County Services. 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 who need immediate emergency services receive them. Statutes specify that counties are responsible for the program needs only within the limits of available state and federal funding, and county matching funds. Each county establishes its own program and budget for these services. Counties may limit service levels and establish waiting lists to ensure that expenditures do not exceed available resources. For these reasons, the type and amount of available services varies among counties.

Counties must provide services in the least restrictive environment 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.

Medical Assistance Community-Based Services

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 (aside from those who participate in the BadgerCare Plus Core Plan, which covers a more limited range of services) 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 alcohol and other drug abuse (AODA) care when the treatment is prescribed by a physician and provided within a hospital institution for mental disease (IMD). The program also covers inpatient services provided in non-specialty hospitals that have DHS-certified inpatient psychiatric or AODA programs.

In order for an MA recipient to receive inpatient mental health services, 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.

States may not receive federal MA cost-sharing for IMD services provided to MA recipients who are between the ages of 22 and 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 general purpose revenue (GPR) supplement of $9 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 $10,628,000 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 $825 or 15 hours of outpatient services in a calendar year.

The MA program also covers 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 a $500/15 hour limitation.

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, 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 services cannot 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, but are not limited to, community support programs (CSP), crisis intervention, case management, and comprehensive community services.

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 and certified by DHS.

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 at least 65 years of age who 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; (c) alcohol or drug dependent; (d) physically or sensory disabled; (e) under age 21 and severely emotionally disturbed; (f) HIV positive; (g) children enrolled in the Birth-to-3 program; (h) children with asthma; (i) individuals infected with tuberculosis; (j) women age 45 through 64; and (k) 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, or the community options program.

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 psychosocial 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 of 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 converted its prescription drug benefit into a 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 2009-10, Wisconsin's clawback payment for all fee-for-service prescription drugs (not just those prescribed for the treatment of mental illness) totaled $126.3 million.

Institutional Services

State Mental Health Institutes. DHS operates two psychiatric hospitals. These facilities, the, 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 12 different inpatient treatment units, including forensic psychiatry, adult, and geropsychiatric programs. These treatment units include three adult units and nine forensic units that, in total, have the capacity to serve 234 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 nine units that serve different adult and youth populations, including four forensic units, four adult units, and one child and adolescent unit. 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. Patients receive a variety of services, including psychiatry, psychology, nursing, education, social, nutritional, and chaplaincy.

Due to low utilization of beds at MMHI and WMHI, DHS started consolidating units in December, 2009. Initially, three child and adolescent units were consolidated into one unit at WMHI, while one treatment unit for adolescent males remained at MMHI. In March, 2010, DHS began a second round of consolidation by transferring the remaining adolescent males from MMHI to WMHI. Consequently, all children and adolescents now receive services at the Youth Services Unit at WMHI.

In addition, DHS began consolidating adult units at the MHIs in September, 2010. One unit at MMHI and another at WMHI ceased accepting admissions over this time period and two units at WMHI were consolidated into a single unit.

WMHI offers occupational, physical, musical, pre-vocational, recreational, speech, and language therapy. In addition, WMHI also offers outpatient day school programs for children with mental health and behavioral disorders.

Table 1 provides information on the average number of patients, by type, at the institutes in 2009-10, and the percentage of the total each patient population represents. Total patient capacity for the MMHI and WMHI facilities during fiscal year 2009-10 was 263 and 207 patients, respectively.

Table 1: Average Daily Populations (ADP) at the Mental Health Institutes (by Type) -- 2009-2010

	Mendota		Winnebago	
	ADP	Percent	ADP	Percent
Child / Adolescent	7.2	2.8%	18.0	10.0%
Forensic	173.3	66.7	101.6	56.3
Adult	50.3	19.4	37.2	20.6
MJTC	29.0	11.2	0.0	0.0
Substance Abuse	0.0	0.0	23.7	13.1
Totals	259.7	100.0%	180.5	100.0%

Annually, DHS establishes the rates for 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 2 shows the daily rates DHS established for each patient population group at MMHI and WMHI that were in effect as of January 1, 2011.

Table 2: Mental Health Institutes Inpatient Daily Rates as of January 1, 2011

	Mendota	Winnebago
Adult Psychiatric Services	$969	$969
Geropsychiatric	1020	---
Child / Adolescent	---	940
Forensic-Maximum Security	969	---
Other Security	969	969
TLC / STEP / Gemini / Anchorage	---	969
Emergency Detention*	200	200
Day School		$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. 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. In addition, any emergency detention of an individual at a state facility must be approved by the local county department of community programs in the county in which the individual was taken into custody before the individual can be admitted to the facility.

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 3 identifies funding from each of these sources for the mental health institutes in 2009-10.

Table 3: Mental Health Institutes Operating Revenue, by Source Fiscal Year 2009-10

	Mendota		Winnebago	
	Amount	% of Total	Amount	% of Total
State GPR	$38,622,000	57.2%	$30,075,700	56.6%
Medical Assistance	4,646,700	6.9	9,772,400	18.4
Counties	12,689,200	18.8	8,145,200	15.3
Private Insurance	6,571,100	9.7	1,690,200	3.2
Medicare	4,537,300	6.7	2,573,600	4.8
Other Gov. Agencies	294,800	0.4	119,800	.2
Miscellaneous	147,100	0.2	749,100	1.4
Total	$67,508,200	100.0%	$53,126,000	100.0%

Non-MA Community-Based Services

DHS also administers several mental health service programs that are not part of the MA program (although some MA funding may support portions of these programs). These include programs funded by the community mental health services block grant, the community aids program, the coordinated services team initiative, and the community support programs.

Community Mental Health Services Block Grant (MHBG). The Substance Abuse and Mental Health Services Administration, in the U.S. Department of Health and Human Services, distributes the community mental health services block grant (MHBG) for community mental health services provided through a comprehensive, community-based mental health care system.

The state's expenditure plan for the 2010-11 MHBG allocation of $7,463,800 is summarized in Table 4. The largest components of this plan are an allocation through the community aids program ($2.5 million), and the coordinated services team initiative ($1.8 million). The remaining $3.1 million supports various projects and grants, as detailed below. States may use up to 5% of the grant for administrative costs, but may not use the grant to fund inpatient services or cash payments to service recipients.

Table 4: Expenditure Plan for Mental Health Block Grant Funds, FFY 2010-11

Program	Planned Expenditure
Community Aids Allocation	$2,513,400
Coordinated Services Teams	1,826,500
Consumer and Family Support	991,600
Transformation Activities	864,600
Systems Change	292,300
Training and Technical Assistance	182,000
Protection & Advocacy	75,000
State Operation and Program Development	718,400
Total	$7,463,800

Consumer and Family Support Grants ($991,600). In 2010-11, DHS plans to 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. The following organizations received these grants for calendar year 2010, funded with the 2009-10 allocation: the National Association of the Mentally Ill ($240,800), Wisconsin Family Ties ($265,900), the Grassroots Empowerment Project ($211,900), and Stable Life, Inc. ($273,000). These organizations provide a range of vocational training, education, and consumer and family support services.

Transformation Activities ($864,600). These grants fund a wide range of activities focused on evidence-based best practices, and access to services.

Some of the specific projects or activities include regional or shared service pilot projects, child psychiatric consultation, tribal best practices for the treatment of co-occurring disorders, and evidence-based supported employment.

System Change Grants ($292,300). 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 using savings generated from incorporating recovery, prevention, and early intervention strategies, and consumer and family involvement in the services. In 2010-11, DHS will allocate funding for stipends for participation ($25,000), a recovery coordinator ($73,000), early intervention and suicide prevention ($120,000), anti-stigma activities ($20,000), and infant mental health consultation ($54,300).

Training ($182,000). MHBG funding supports training for mental health treatment professionals on standards, best practices, recovery principles, and emergency crisis services. In 2010-11, DHS will expend these funds on the following activities:

- Statewide teleconferences and an annual training conference ($97,000);
- Children's and crisis intervention training ($32,000);
- Training for positive behavior supports in schools ($23,000);
- Initiative to promote integrated treatment for the elderly ($20,000);
- Provider training for smoking cessation promotion ($5,000); and
- Geriatric psychiatry training ($5,000).

Protection and Advocacy ($75,000). DHS distributes this grant 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 for advocacy for individuals with mental illness, training activities, and development of training materials.

Staff and Administrative Costs ($718,400). DHS will use MHBG grant funds for staffing costs in the Bureau of Prevention, Treatment and Recovery in DMHSAS related to mental health program development, Mental Health Council costs, and other administrative costs.

Community Aids. Under the 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 designated for specific services and programs. The Legislative Fiscal Bureau informational paper entitled "Community Aids/Children and Family Aids" provides additional information on this program.

Basic County Allocation. In calendar year 2011, DHS will distribute $174,403,300 under the community aids BCA. Counties use the BCA, in combination with funding from other sources, to support their human services programs, including the services they provide for individuals with mental illness. In 2009, counties reported spending approximately $75.4 million of the BCA on services for persons with mental illness.

Community Aids MHBG Allocation. DHS will allocate $2,513,400 in MHBG funding in 2011 as a categorical community aids allocation. While counties may use the BCA for a range of services, MHBG community aids funding must support services that meet the block grant requirements.

Counties submit annual plans to DHS for the use of the MHBG allocation in one or more of the following priority areas: (a) community support programs; (b) supported housing; (c) jail diversion programs; (d) crisis intervention services; (e) family and consumer peer support and self-help; (f) programs for people with co-occurring mental illness and substance abuse problems; (g) development of community mental health data-sets; or (h) comprehensive community services.

Coordinated Services Team Initiative. DHS administers the coordinated services team (CST) initiative, allowing counties to coordinate services for children involved in two or more systems of care. These systems of care include services for mental health, substance abuse, child welfare, juvenile justice, special education, or developmental disabilities. The program originally consisted of two components with minor differences in program policy -- coordinated services teams and integrated services projects. 2009 Wisconsin Act 334 combined these two components under the CST initiative, and made multiple changes to the program under s. 46.56 of the statutes.

The CST initiative is supported by several funding sources: state GPR, mental health block grant, substance abuse block grant, medical assistance hospital diversion funds, and funding from the Department of Children and Families. DHS will distribute approximately $2.9 million (all funds) to 40 counties and 5 tribes for the CST initiative in 2010-11. The contract amounts average approximately $60,000, not counting a contract for statewide training and technical assistance of $220,000 for Waupaca County. Table 5 lists the allocations to counties that participated in the CST initiative in 2010-11.

In addition to the counties listed in Table 5, Milwaukee and Dane counties operate programs for children with severe emotional disturbances (the target population of the former integrated services projects). Wraparound Milwaukee in Milwaukee County and Children Come First Program in Dane County are managed care programs supported by MA and county funding. The Milwaukee County Department of Health and Human Services, Division of Behavioral Health administers the Wraparound Milwaukee program, and Dane County contracts with Community Partnerships, Inc., a limited service health organization, to provide services for eligible children.

Table 5: CST Initiative Funding by County and Tribe, Fiscal Year 2010-11

Ashland	$49,000	La Crosse	$79,926	Washburn	$79,926
Ashland	79,926	Marinette	79,926	Washington	79,926
Brown	49,458	Marquette	79,926	Waukesha	79,926
Buffalo	50,000	Menominee	49,000	Waushara	79,926
Burnett	49,000	Monroe	49,000	Wood	48,469
Chippewa	79,926	Oconto	48,469		
Clark	48,469	Ozaukee	50,000	Bad River	48,469
Columbia*	50,097	Price	49,000	Lac Courte Oreilles	49,000
Dodge	50,000	Portage	79,926	Lac Du Flambeau	48,469
Door	79,926	Racine	79,926	Red Cliff	49,000
Dunn	79,926	Rock	79,926	St. Croix	50,097
Eau Claire	79,926	Sawyer	48,469		
Fond du Lac	79,926	Shawano	30,194	Waupaca**	219,997
Green	48,469	Shawano	19,903		
Juneau	49,458	Sheboygan	79,923	Total	$2,887,962
Kenosha	79,926	Trempealeau	50,097		
Kewaunee	48,469	Vernon	49,244		

* *Columbia County has discontinued its CST, and funding will be allocated to another county yet to be determined.*

** *The allocation to Waupaca County is for statewide CST training and technical assistance.*

Community Support Programs. Community support programs (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. Some counties have more than one CSP, and some counties operate joint CSPs with other counties. All counties also have case management programs.

Counties use local tax levy, community aids funding, and federal MA matching funds to support CSPs. In 2009, counties reported spending a total of $67.8 million all funds for CSPs, including $1.2 million of MHBG funds, to provide services for 7,537 individuals. If a county has insufficient funds to provide services to all individuals who qualify for the program, it may establish waiting lists for services or provide less intensive services to these individuals. DHS allocated $974,750 GPR to 23 counties in calendar year 2009 for services to individuals on county CSP waitlists, as shown in Table 6.

Table 6: CSP Waitlist Contract Amount, and Individuals Served, Calendar Year 2009

County	CSP Waitlist Contract Amount (GPR)	Number of People Served
Ashland	$15,457	77
Brown	86,767	35
Chippewa	56,048	56
Columbia	31,792	57
Dane	114,557	3,442
Eau Claire	11,117	173
Forest-Oneida-Vilas	59,947	12
Green	11,941	59
Jefferson	59,947	131
Kenosha	40,233	188
La Crosse	59,947	119
Manitowoc	33,775	61
Milwaukee	91,539	1,016
Monroe	21,929	28
Rock	59,947	288
St. Croix	46,994	96
Sheboygan	32,869	116
Vernon	5,244	61
Washington	48,119	97
Waukesha	62,900	192
Waushara	23,681	33
Total	$974,750	6,337

Requirements for CSPs are specified in s. 51.421 of the statutes, and DHS Chapters 63 and 65 of the Administrative Code. CSP services 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 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. The person must exhibit persistent disability or impairment in major areas of community living as evidenced by the following:

- Diagnosis of schizophrenia, affective disorder, delusional disorder, or other psychotic disorders or documentation of consistent extensive efforts of over a year to treat the client, except in unusual circumstances such as the sudden onset of dysfunction;

- Presentation of persistent danger to self or others;

- 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.

Total County Expenditures. Appendix II provides total county expenditures for services for persons with mental illness for calendar years 2005 through 2009. 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.

Additional Resources

Additional information on these and other mental health issues can be found through the following resources:

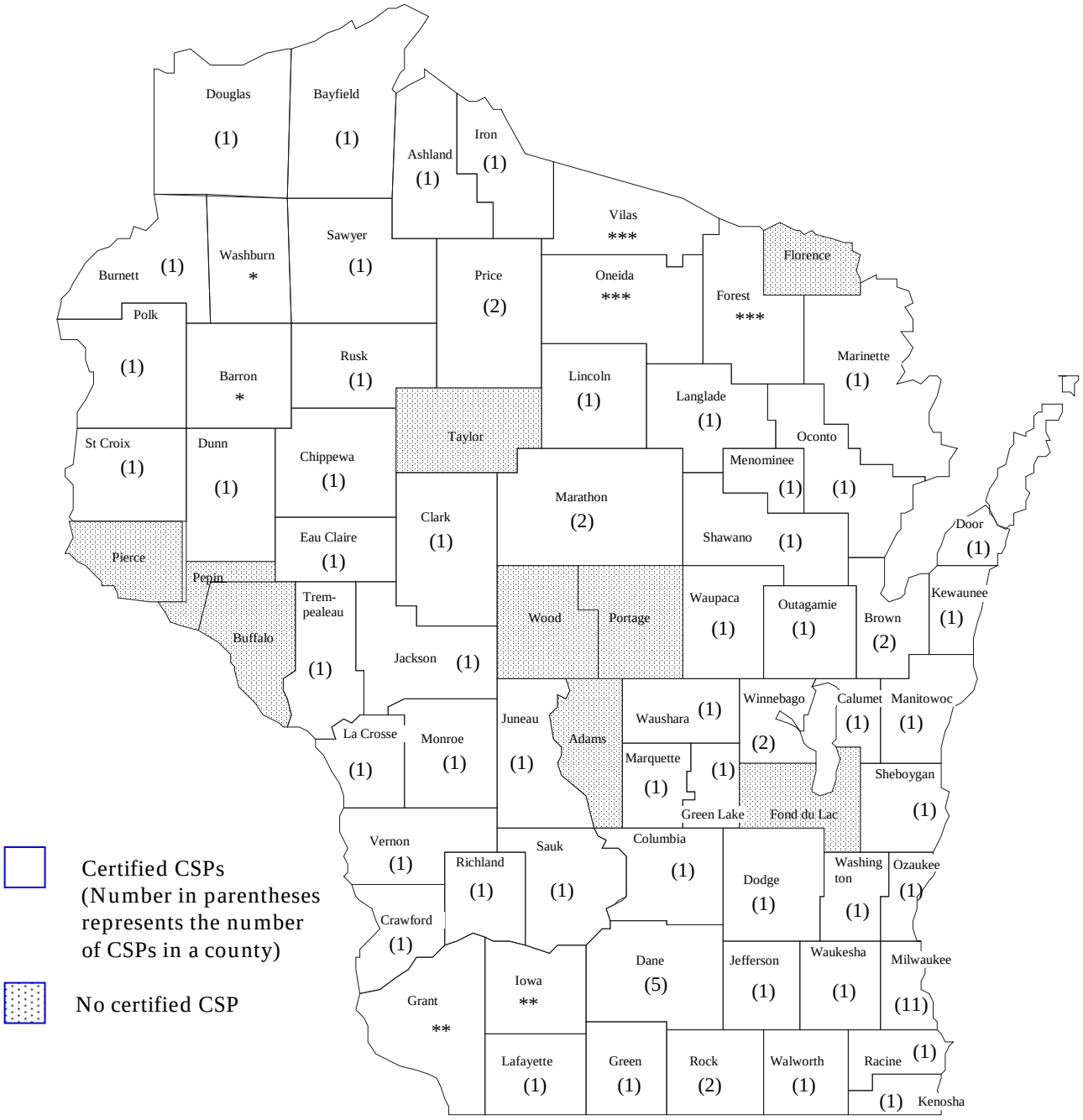
Wisconsin Department of Health Services:
www.dhs.wisconsin.gov/MentalHealth

Wisconsin Council on Mental Health:
www.mhc.state.wi.us

National Institute of Mental Health:
www.nimh.nih.gov

APPENDIX I

Community Support Programs (CSPs)
As of July 1, 2010



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

APPENDIX II

Services for Individuals with Mental Illness, County Expenditures
Calendar Years 2005 through 2009

County	2005	2006	2007	2008	2009
Statewide Total	**$368,619,911**	**$376,837,975**	**$393,639,224**	**$416,504,553**	**$428,614,385**
Adams	$1,038,939	$770,987	$797,272	$1,000,171	$1,285,557
Ashland	709,265	897,233	881,221	1,029,265	1,048,767
Barron	2,409,063	2,335,827	2,523,639	2,966,780	3,260,014
Bayfield	733,129	701,159	1,059,122	834,494	1,001,352
Brown	14,027,573	12,605,957	13,903,769	14,326,058	16,247,424
Buffalo	201,945	290,856	327,434	387,513	378,614
Burnett	756,434	776,130	667,007	560,313	613,777
Calumet	2,080,191	2,336,312	2,450,200	2,719,421	3,145,416
Chippewa	2,713,211	2,821,036	2,767,916	2,642,137	2,124,047
Clark	2,480,966	2,466,359	2,747,414	3,450,835	3,437,159
Columbia	1,987,051	2,294,111	2,438,148	2,349,493	2,402,817
Crawford	1,157,395	1,083,672	1,108,725	1,490,616	1,371,723
Dane	26,714,254	28,122,866	28,765,867	31,438,883	30,059,879
Dodge	4,481,627	5,044,414	5,143,576	5,521,130	6,007,896
Door	1,528,885	1,905,244	1,588,366	1,082,967	1,298,510
Douglas	2,950,258	2,904,016	3,101,112	3,205,971	2,863,650
Dunn	1,956,578	2,038,454	2,212,110	2,264,826	1,941,834
Eau Claire	7,705,293	7,976,972	7,780,523	8,231,786	6,750,927
Florence	90,722	134,099	135,916	258,866	172,363
Fond du Lac	5,095,224	5,546,983	5,644,394	6,056,877	6,716,909
Forest / Oneida / Vilas	3,659,313	3,939,133	4,289,763	4,066,571	3,925,577
Grant / Iowa	2,290,845	2,397,184	2,013,985	2,358,456	2,605,185
Green	2,031,892	2,129,745	2,243,295	2,252,285	2,143,432
Green Lake	967,802	1,092,182	1,238,661	1,172,527	1,400,775
Iron	367,904	463,055	418,853	595,814	910,140
Jackson	1,272,834	1,317,719	1,396,366	1,275,863	1,761,124
Jefferson	4,639,111	4,550,141	5,074,251	5,957,515	5,563,107
Juneau	2,280,568	2,221,171	2,104,275	2,248,766	2,589,717
Kenosha	6,192,608	6,186,508	6,945,095	10,203,529	9,904,245
Kewaunee	523,527	539,637	573,910	597,034	670,486
La Crosse	6,315,237	7,709,226	8,019,349	7,352,430	8,105,943
Lafayette	810,486	822,381	1,016,452	937,726	1,385,309
Langlade / Lincoln / Marathon	13,431,940	13,535,235	13,682,800	16,392,327	16,082,349
Manitowoc	3,800,545	3,825,860	4,199,045	5,011,924	4,659,956
Marinette	2,779,055	3,144,344	3,396,300	3,228,915	3,462,424

APPENDIX II (continued)

Services for Individuals with Mental Illness, County Expenditures
Calendar Years 2005 through 2009

County	2005	2006	2007	2008	2009
Marquette	$829,738	$902,848	$1,032,995	$1,126,862	$1,120,707
Menominee	683,992	553,467	716,495	1,026,927	1,081,536
Milwaukee	125,336,103	121,002,717	119,720,847	124,740,340	127,322,100
Monroe	1,773,607	2,118,451	1,914,455	2,123,650	2,393,100
Oconto	1,147,756	1,421,606	1,270,546	1,324,923	1,329,655
Outagamie	9,202,329	8,766,126	10,750,594	10,326,700	10,010,349
Ozaukee	2,538,526	2,559,412	3,036,832	3,133,060	2,702,921
Pepin	236,051	261,273	242,079	344,080	391,674
Pierce	1,410,155	931,804	1,316,552	1,418,232	1,320,251
Polk	2,805,049	2,674,554	3,109,795	3,196,723	3,337,180
Portage	2,740,690	3,321,215	3,098,357	2,747,774	2,956,119
Price	713,620	791,449	1,006,044	780,931	692,943
Racine	6,728,333	8,354,715	8,206,170	8,023,904	9,491,915
Richland	1,695,591	1,815,447	2,293,556	2,059,354	2,087,809
Rock	9,565,123	10,772,512	12,847,991	12,927,108	13,812,601
Rusk	770,398	760,240	796,841	824,882	713,246
Sauk	3,980,169	4,096,310	4,963,641	4,604,613	5,154,893
Sawyer	1,002,310	1,147,291	1,225,892	1,278,351	1,358,536
Shawano	1,491,030	1,760,348	1,700,674	1,613,907	1,651,750
Sheboygan	7,092,793	6,347,766	7,300,011	9,220,202	8,042,524
St. Croix	4,655,517	4,675,517	6,192,613	6,420,216	5,249,620
Taylor	792,754	828,798	548,456	704,486	644,715
Trempealeau	1,620,474	1,716,307	1,602,821	1,808,919	1,876,321
Vernon	1,456,603	1,366,013	1,422,285	1,878,889	1,814,042
Walworth	3,755,369	4,342,728	4,931,852	5,186,393	5,276,026
Washburn	1,136,705	1,149,937	1,204,365	1,095,596	945,695
Washington	6,041,338	6,174,375	6,802,357	7,025,678	13,742,972
Waukesha	15,536,915	16,217,447	17,397,774	19,112,603	21,065,494
Waupaca	2,952,403	3,638,919	3,552,148	3,613,031	2,927,338
Waushara	1,625,126	1,734,195	2,108,476	2,539,282	2,730,095
Winnebago	8,324,592	9,780,551	11,012,544	10,865,373	10,620,874
Wood	6,797,082	7,927,429	7,657,035	7,941,480	7,450,980