Services for Persons with Mental Illness

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Services for Persons with Mental Illness

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

Chapter 51 of the statutes contains several definitions that are used to determine an individual's eligibility for mental health services. Mental illness is generally defined 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." The statutes further define serious and persistent mental illness as "a mental illness that is severe in degree and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, which may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support and which may be of lifelong duration." This definition includes schizophrenia, as well as psychotic and other severely disabling psychiatric diagnostic categories, but does not include conditions related to aging, developmental disabilities, or alcohol or drug dependence.

For purposes of involuntary commitment, mental illness is defined as a substantial disorder of thought, mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, but does not include alcoholism.

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, the provision of mental health services 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.

The Department of Health Services. The Department of Health Services (DHS) 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 authorizes 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 is required to ensure 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).

Statutes require the Council 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 must 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.

Total County Expenditures. Appendix I provides total county expenditures for services for persons with mental illness for calendar years 2007 through 2011. These expenditures are reported to the DHS human services revenue report (HSRR). The HSRR data tracks expenditures made at the county level from all state, federal and county revenue sources, and are reported by target group population. This data is intended to provide a broad picture of funding from all sources allocated on the county level. In recent years, DHS did not receive data from all counties -- Menominee and Monroe Counties did not report expenditures in 2010 and 2011, and St. Croix County did not report expenditures in 2011.

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 mental health and alcohol and other drug abuse (AODA) care in three institutional settings. Individuals of any age can receive MA eligible mental health and AODA services in an acute and primary care hospital or in a psychiatric unit of an acute and primary care hospital.

Nursing homes also provide mental health services to their residents. The state provides a 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. Most of the supplemental payments are eligible for federal MA matching funds because they can be certified as rehabilitative services.

The MA program covers mental health and AODA services in an institution for mental disease (IMD) for individuals younger than 22 and older than 65. 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. 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.

In order for an MA recipient to receive IMD 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 IMD 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.

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, beyond which prior authorization is required.

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, for which local governments pay the non-federal share of the MA payment. These services include, but are not limited to, community support programs (CSP), crisis intervention, case management, comprehensive community services, and community recovery services (CRS).

Community support program services include assessments, treatment, case management, and psychosocial 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. MA recipients receiving CSP services are not eligible for outpatient psychotherapy services or mental health day treatment services under the program. CSP services are 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.

Effective January 2010, DHS received approval to offer community recovery services (CRS) to individuals with severe and persistent mental illness. The services covered under the CRS benefit include community living supportive services, supported employment, and peer supports. These services are only available in counties that choose to provide them and provide the state's share of the costs. To be eligible for CRS, individuals must meet all of the following criteria: (a) be eligible for elderly, blind, or disabled MA or the BadgerCare Plus standard plan; (b) have countable income at or below 150% of the federal poverty level; (c) reside at home or in the

community; (d) meet CRS functional eligibility requirements; and (e) have a DHS approved service plan.

Under the Patient Protection and Affordable Care Act (ACA), the services provided in the Department's CRS benefit would have needed to be extended statewide. DHS subsequently submitted a state plan amendment in November, 2011, to establish a benchmark plan that would maintain the program's character as a geographically-targeted benefit.

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 2011-12, Wisconsin's clawback payment for all fee-for-service prescription drugs (not just those prescribed for the treatment of mental illness) totaled $159.6 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 two adult civil units and 10 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 seven units that serve different adult and youth populations, including four forensic units, two adult civil units, and one child and adolescent unit. 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 trans-

ferring 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 2011-12, and the percentage of the total each patient population represents. Total patient capacity for the MMHI and WMHI facilities during fiscal year 2011-12 was 263 and 169 patients, respectively.

Table 1: Average Daily Populations (ADP) at the Mental Health Institutes (by Type) -- 2011-2012

	Mendota		Winnebago	
	ADP	Percent	ADP	Percent
Child/Adolescent	0.0	0.0%	22.2	13.0%
Forensic	193.0	77.0	118.1	69.4
Adult	28.8	11.5	29.8	17.5
MJTC	28.8	11.5	0.0	0.0
Totals	250.6	100.0%	170.1	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 October 1, 2012.

Table 2: Mental Health Institutes Inpatient Daily Rates as of October 1, 2012

	Mendota	Winnebago
Adult Psychiatric Services	$999	$999
Geropsychiatric	1,052	---
Child/Adolescent	---	999
Forensic-All Security Levels	999	999
Emergency Detention Add-On*	200	200
Non-typical Services Add-On	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 state general purpose revenue (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 2011-12.

Table 3: Mental Health Institutes Operating Revenue, by Source
Fiscal Year 2011-12

	Mendota		Winnebago	
	Amount	% of Total	Amount	% of Total
State GPR	$44,163,800	68.3%	$29,248,300	59.6%
Medical Assistance	541,500	0.8	3,640,600	7.4
Counties	11,126,300	17.2	11,672,900	23.8
Private Insurance	5,248,100	8.1	2,414,100	4.9
Medicare	3,099,300	4.8	1,408,700	2.8
Other Gov. Agencies	264,900	0.4	74,900	0.2
Miscellaneous	242,500	0.4	634,900	1.3
Total	$64,686,400	100.0%	$49,094,400	100.0%

Non-MA Community-Based Services

DHS also administers multiple non-MA mental health service programs, although some MA funding may support portions of these programs. These include activities 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. The Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services distributes the community mental health services block grant (MHBG) for services provided through a comprehensive, community-based mental health care system. The primary targets for the MHBG grant funds must be adults with a serious mental illness, or children with a severe emotional disturbance, and services must be provided through appropriate, qualified community programs. 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. Also, several requirements in state statute specify uses of MHBG funds.

The state's expenditure plan for the FFY 2012-13 MHBG allocation of $8,015,900 is summarized in Table 4 (Wisconsin's final allocation amount may differ from this amount pending changes to the federal budget). The largest components of this plan are an allocation through the community aids program ($2.5 million), and children's initiatives ($1.8 million), with the remainder supporting various projects and grants ($3.7 million).

Community Aids ($2,513,400). Counties receive community aids funds from the state to support a wide range of human services, including mental health services. MHBG funds are combined with state and other federal funds in this program. See the following section for more details.

Table 4: Expenditure Plan for Mental Health Block Grant Funds, FFY 2012-13

Program	Planned Expenditure
Community Aids Allocation	$2,513,400
Children's Initiatives	1,826,500
Transformation Activities	1,202,000
Consumer and Family Support	1,191,600
State Operations	689,400
Recovery, Early Intervention, Prevention	198,000
Training and Technical Assistance	182,000
Systems Change	138,000
Protection & Advocacy	75,000
Total	$8,015,900

Children's Initiatives ($1,826,500). Part of the funding for coordinated services teams comes from the MHBG. This program is also described in more detail below.

Transformation Activities ($1,202,000). These grants fund a wide range of activities focused on evidence-based best practices, and access to services. Some of the specific projects include supported employment programs, peer specialist certification, child psychiatric consultation, promoting tribal best practices for the treatment of co-occurring disorders, and addressing issues of homelessness and mental health.

Consumer and Family Support Grants ($1,191,600). DHS allocates MHBG funds 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 2012, funded with the 2011-12 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.

State Operations ($689,400). DHS will use MHBG grant funds for staff costs in the Bureau of Prevention, Treatment and Recovery in DMHSAS related to mental health program development, Mental Health Council, and other administrative functions.

Recovery, Early Intervention and Prevention ($198,000). This allocation supports self-directed care, peer specialist expansion, and suicide prevention efforts with a focus on reducing disparities among cultural subgroups and veterans.

Training ($182,000). MHBG funding supports training for mental health treatment professionals on standards, best practices, recovery principles, and emergency crisis services. Funded activities will include training for children and adult services, promotion of evidence-based clinical treatment, and training for certified peer specialists. Funding that had been allocated to the statewide annual conference has been reallocated, as the conference is now self-sustaining.

System Change Grants ($138,000). 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. These funds will support consumer involvement in system planning, anti-stigma efforts, technical assistance to expand transition programs for children into adult services, and promotion of specialty certification in infant and early childhood services. 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.

Protection and Advocacy ($75,000). DHS provides 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.

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 a basic county allocation (BCA), which they may use for any eligible service, and categorical allocations designated for specific services and programs. The Legislative Fiscal Bureau informational paper titled "Community Aids/Children and Family Aids" provides additional information on this program.

Basic County Allocation. In calendar year 2013, DHS will distribute $171.7 million 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 calendar year 2011, counties reported spending approximately $97.3 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) services for children and adolescents; (g) programs for people with co-occurring mental illness and substance abuse problems; (h) development of community mental health datasets; or (i) 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 such as 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.

CSTs provide "wraparound" services to eligible children and their families to coordinate the child's care over multiple areas. The CST itself is a group that includes family members, service providers, and others that work to develop and carry out a coordinated services plan for each participating child. The plan covers multiple areas, including the child's current level of functioning, short-term and long-term goals, and plans to deal with crisis situations that may arise.

The CST initiative is supported by several funding sources: state GPR, federal MHBG, federal substance abuse block grant, medical assistance hospital diversion funds, and funding from the Department of Children and Families. DHS will distribute approximately $2.8 million (all funds) to 38 counties and five tribes for the CST initiative in 2012-13. The contract amounts average approximately $61,000, not counting a contract for statewide training and technical assistance of $220,000 for Waupaca County. Table 5 lists the allocations to counties and tribes that participated in the CST initiative in 2012-13.

Table 5: CST Initiative Funding by County and Tribe, 2012-13

Ashland	$78,800	Marinette	$78,800	Waukesha	$78,800
Barron	50,100	Marquette	78,800	Waushara	78,800
Buffalo	50,000	Menominee*	49,000	Wood County	48,500
Chippewa	78,800	Monroe*	49,000		
Clark	48,500	Oconto	48,500	Bad River Tribe	48,500
Columbia	50,000	Ozaukee	50,000	La Courte Oreilles*	49,000
Door	78,800	Portage	78,800	Lac du Flambeau	48,500
Dunn	78,800	Price*	49,000	Red Cliff*	49,000
Eau Claire	78,800	Racine	78,800	St. Croix Chippewa	50,100
Fond du Lac	78,800	Rock	78,800		
Grant	49,000	Sawyer	48,500	Waupaca**	220,000
Green	48,500	Shawano	50,100		
Iowa	49,500	Sheboygan	78,800	Total***	$2,818,300
Kenosha	78,800	Trempealeau	50,100		
Kewaunee	48,500	Vernon	49,200		
Juneau*	49,000	Washburn	78,800		
LaCrosse	78,800	Washington	78,800		

*Counties and Tribal funding will be re-allocated in a 2013 request for proposal.
**The allocation to Waupaca County is for statewide CST training and technical assistance.
*** Total does not equal sum of county allocations due to rounding.

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

Community Support Programs. Community support programs (CSPs) provide treatment, rehabilitation, and support services for persons with serious and persistent mental illness. In 2012, there were 75 certified CSPs in 62 counties, as shown in Appendix II. Some counties have more than one CSP, and some counties operate joint CSPs with other counties. All counties also have case management programs. Counties reported serving approximately 5,800 individuals in CSPs in 2011.

Counties use local tax levy, community aids funding, and federal MA matching funds to support CSPs. 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 $921,700 GPR to 21 counties in calendar year 2011 for services to individuals on county CSP waitlists, as shown in Table 6. DHS does not track local expenditures on CSPs alone, but counties reported spending a combined $71.1 million all funds in calendar year 2011 for services provided under the CSP, CCS, and CRS programs.

Requirements for CSPs are specified in s. 51.421 of the statutes, and DHS Chapters 63 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.

Table 6: CSP Waitlist Contract Amount and Individuals Served, Calendar Year 2011

County	CSP Waitlist Contract Amount (GPR)	Number of People Served*
Ashland	$14,617	76
Brown	82,046	103
Chippewa	52,999	45
Columbia	30,063	67
Dane	108,323	564
Eau Claire	10,512	173
Forest-Oneida-Vilas	56,686	43
Green	11,291	67
Jefferson	56,686	153
Kenosha	38,044	177
La Crosse	56,686	128
Manitowoc	31,938	53
Milwaukee	86,558	1,315
Monroe	20,736	30
Rock	56,686	122
St Croix	44,437	104
Sheboygan	31,080	107
Vernon	4,959	14
Washington	45,501	94
Waukesha	59,478	185
Waushara	22,393	36
Total	$921,719	3,656

*Includes individuals served through a certified CSP, not just through waitlist services.

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 dis-

orders or documentation of consistent extensive treatment efforts, 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.

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

Services for Individuals with Mental Illness, County Expenditures*
Calendar Years 2007 through 2011

County	2007	2008	2009	2010	2011
Statewide Total	**$393,639,224**	**$416,504,553**	**$428,614,385**	**$443,292,623**	**$430,152,269**
Adams	$797,272	$1,000,171	$1,285,557	$1,560,767	$1,702,525
Ashland	881,221	1,029,265	1,048,767	1,171,579	1,510,667
Barron	2,523,639	2,966,780	3,260,014	3,104,835	2,791,161
Bayfield	1,059,122	834,494	1,001,352	1,036,845	1,468,568
Brown	13,903,769	14,326,058	16,247,424	16,531,281	16,126,168
Buffalo	327,434	387,513	378,614	439,105	787,954
Burnett	667,007	560,313	613,777	975,561	1,153,502
Calumet	2,450,200	2,719,421	3,145,416	3,078,825	3,030,071
Chippewa	2,767,916	2,642,137	2,124,047	2,935,296	2,801,605
Clark	2,747,414	3,450,835	3,437,159	2,891,577	2,943,213
Columbia	2,438,148	2,349,493	2,402,817	3,154,196	2,046,891
Crawford	1,108,725	1,490,616	1,371,723	1,303,903	1,227,677
Dane	28,765,867	31,438,883	30,059,879	31,803,862	33,456,129
Dodge	5,143,576	5,521,130	6,007,896	6,625,294	6,149,900
Door	1,588,366	1,082,967	1,298,510	1,821,266	1,938,796
Douglas	3,101,112	3,205,971	2,863,650	1,631,631	2,894,162
Dunn	2,212,110	2,264,826	1,941,834	2,014,631	2,201,822
Eau Claire	7,780,523	8,231,786	6,750,927	6,010,450	6,011,714
Florence	135,916	258,866	172,363	207,055	78,497
Fond du Lac	5,644,394	6,056,877	6,716,909	6,746,572	7,066,504
Forest/Oneida/Vilas	4,289,763	4,066,571	3,925,577	4,379,496	4,354,297
Grant/Iowa	2,013,985	2,358,456	2,605,185	2,241,721	2,569,701
Green	2,243,295	2,252,285	2,143,432	2,185,952	2,273,049
Green Lake	1,238,661	1,172,527	1,400,775	1,116,641	1,289,815
Iron	418,853	595,814	910,140	1,186,699	573,919
Jackson	1,396,366	1,275,863	1,761,124	1,551,511	1,456,634
Jefferson	5,074,251	5,957,515	5,563,107	6,789,305	7,032,315
Juneau	2,104,275	2,248,766	2,589,717	2,307,395	2,468,900
Kenosha	6,945,095	10,203,529	9,904,245	10,298,995	9,771,063
Kewaunee	573,910	597,034	670,486	904,627	904,747
La Crosse	8,019,349	7,352,430	8,105,943	8,409,717	8,262,554
Lafayette	1,016,452	937,726	1,385,309	1,110,204	1,119,559
Langlade/Lincoln/ Marathon	13,682,800	16,392,327	16,082,349	15,957,276	17,492,693
Manitowoc	4,199,045	5,011,924	4,659,956	4,333,341	6,274,301
Marinette	3,396,300	3,228,915	3,462,424	3,417,404	3,542,626

APPENDIX I (continued)

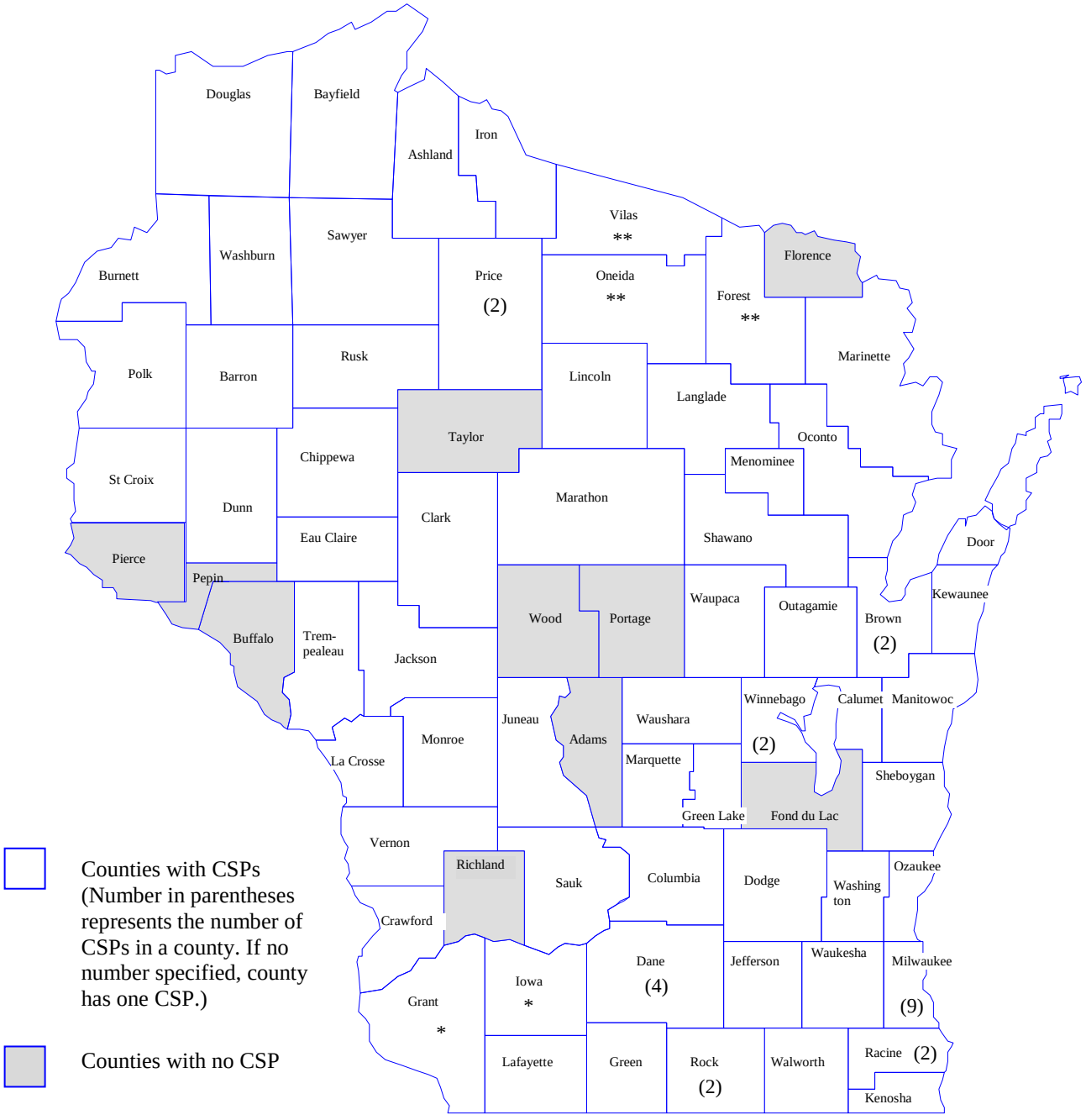
Services for Individuals with Mental Illness, County Expenditures*
Calendar Years 2007 through 2011

County	2007	2008	2009	2010	2011
Marquette	$1,032,995	$1,126,862	$1,120,707	$975,327	$1,095,424
Menominee	716,495	1,026,927	1,081,536	**	**
Milwaukee	119,720,847	124,740,340	127,322,100	132,031,274	129,942,247
Monroe	1,914,455	2,123,650	2,393,100	**	**
Oconto	1,270,546	1,324,923	1,329,655	1,283,719	1,374,366
Outagamie	10,750,594	10,326,700	10,010,349	10,102,475	11,118,053
Ozaukee	3,036,832	3,133,060	2,702,921	3,045,165	2,745,112
Pepin	242,079	344,080	391,674	416,606	339,885
Pierce	1,316,552	1,418,232	1,320,251	1,061,040	1,239,591
Polk	3,109,795	3,196,723	3,337,180	4,015,789	4,177,079
Portage	3,098,357	2,747,774	2,956,119	3,169,851	3,230,019
Price	1,006,044	780,931	692,943	1,064,690	885,134
Racine	8,206,170	8,023,904	9,491,915	10,046,303	9,000,827
Richland	2,293,556	2,059,354	2,087,809	2,074,808	2,292,045
Rock	12,847,991	12,927,108	13,812,601	15,531,563	17,209,117
Rusk	796,841	824,882	713,246	992,469	890,710
Sauk	4,963,641	4,604,613	5,154,893	5,926,651	5,956,018
Sawyer	1,225,892	1,278,351	1,358,536	1,417,935	1,448,423
Shawano	1,700,674	1,613,907	1,651,750	1,654,849	1,132,869
Sheboygan	7,300,011	9,220,202	8,042,524	8,268,673	7,199,610
St. Croix	6,192,613	6,420,216	5,249,620	5,882,087	**
Taylor	548,456	704,486	644,715	795,531	772,180
Trempealeau	1,602,821	1,808,919	1,876,321	2,096,755	1,806,639
Vernon	1,422,285	1,878,889	1,814,042	1,815,215	2,074,578
Walworth	4,931,852	5,186,393	5,276,026	6,313,641	2,529,560
Washburn	1,204,365	1,095,596	945,695	948,657	918,854
Washington	6,802,357	7,025,678	13,742,972	16,439,190	9,135,878
Waukesha	17,397,774	19,112,603	21,065,494	19,442,642	19,920,412
Waupaca	3,552,148	3,613,031	2,927,338	3,789,651	3,864,209
Waushara	2,108,476	2,539,282	2,730,095	2,468,819	2,761,959
Winnebago	11,012,544	10,865,373	10,620,874	10,316,504	10,312,003
Wood	7,657,035	7,941,480	7,450,980	8,669,929	8,005,769

* Data obtained from county Human Services Revenue Reports (HSRR) collected by DHS
**No data reported (Menominee and Monroe Counties for 2010 and 2011, and St. Croix County for 2011).

APPENDIX II

Community Support Programs (CSPs)
Calendar Year 2012



Counties with CSPs (Number in parentheses represents the number of CSPs in a county. If no number specified, county has one CSP.)

Counties with no CSP

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