Services for Persons with Mental Illness

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Chapter 51 of the Wisconsin state statutes establishes the state's policy for the treatment and rehabilitation of persons with mental illnesses. According to the policy statement contained in the introduction to Chapter 51, it is the state's intention, within the limits of available funds, to establish a unified system for the provision of mental health services that assures all people in need of care access to the least restrictive treatment appropriate to their needs, and movement through all treatment components to assure continuity of care.

This paper first outlines the state and county framework for the provision of publicly-supported mental health services available to Wisconsin residents, and then provides more detailed information on those services and some of the key legal procedures related to mental illness. That information is organized in sections, as follows: (a) mental health services funded by the state's medical assistance program; (b) other programs that provide funding and support for county mental health services; (c) the procedures for emergency detention and for the civil and forensic commitment of persons suffering from severe and persistent mental illness; and (d) the mental health institutions operated by the Department of Health Services.

County and State Framework for the Provision of Publicly-Supported Mental Health Services

Publicly-funded mental health services are provided through a variety of state and county programs. In general, counties are responsible for establishing and administering a mental health system to serve their residents, while the state distributes state and federal funding in support of county services, provides oversight and policy guidance for counties, and operates the state's mental health institutes. This section describes these respective duties for mental health service delivery.

County Functions

General Framework. Every county is responsible for the well-being, treatment, and care of persons with mental illness who reside in the county. In practice, since mental health care is a covered benefit under private health insurance plans, county services are typically provided for persons without private insurance, are supportive services not covered by private insurance, or are related to involuntary commitments. In addition, county programs frequently provide or coordinate mental health care provided for persons eligible for the state's medical assistance program.

Chapter 51 requires every county board to establish a county agency (or participate in a multi-county agency) for the provision of community-based mental health services, although counties are responsible for program needs only within the limits of available state and federal funding, and county funds. Each county establishes its own program and budget for these services, and may limit service types 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.

There are currently 67 agencies serving the state's 72 counties, including 64 single-county agencies, and three multi-county agencies (Forest/Oneida/Vilas, Grant/Iowa, and Langlade/Lincoln/Marathon).

Milwaukee County Mental Health Framework. While Chapter 51 gives county boards the

ultimate responsibility for the mental health services in Wisconsin, this responsibility rests with a separate body in Milwaukee County. Act 203, enacted during the 2013 legislative session, transferred control of mental health functions and programs in Milwaukee County from the county board to a newly-established Milwaukee County Mental Health Board (MCMHB). Initially, the Board's members were appointed by the Governor from candidates suggested by the county board and the county executive. On January 1, 2015, the MCMHB became a county entity, with appointment of members made by the county executive after the initial terms expire. The Milwaukee County Board is prohibited from forming policies regarding mental health or mental health institutions, program, or services. Finally, Act 203 specifies that the county's tax levy portion of the annual mental health budget must be between $53 million and $65 million unless a majority of the MCMHB, a majority of the county board, and the county executive agree to a different amount.

Basic County Requirements. County programs must provide mental health care in the least restrictive environment appropriate for an individual's needs, and must, within the limits of available funds, offer the following services:

- Collaborative and cooperative services for prevention;

- Diagnostic and evaluation services;

- Inpatient and outpatient care, residential facilities, partial hospitalization, emergency care, and supportive transitional services;

- Related research and staff in-service training; and

- Continuous planning, development, and evaluation of programs and services.

In addition to these duties, every county must establish an emergency mental health services program to serve persons in crisis situations within the county, regardless of their county of residence. At a minimum, emergency programs must offer 24-hour crisis telephone service and 24-hour in-person service on an on-call basis. Telephone service must be staffed by mental health professionals or paraprofessionals or by trained mental health volunteers, backed up by mental health professionals. In order to receive reimbursement under the state's medical assistance program (for services provided to persons who are eligible under that program), an emergency mental health services program must have additional features, such as a mobile crisis team for on-site in person response, walk-in services, and short-term voluntary or involuntary hospital care when less restrictive alternatives are not sufficient to stabilize an individual experiencing a mental health crisis.

Total County Expenditures. The Appendix provides total county expenditures for services for persons with mental illness for calendar years 2009 through 2013. 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.

The Department of Health Services

Basic Departmental Functions and Duties. The state programs for mental health services are administered primarily by the Department of Health Services (DHS). The Department's Division of Mental Health and Substance Abuse Services oversees and provides guidance to county mental health service programs, distributes state and federal funds for mental health programs, and operates the state's mental health institutions.

Chapter 51 authorizes DHS to perform the following activities, related to mental health poli-

cy guidance:

- 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 use individualized service plans, establish measurable goals for the individual, base the plan on the individual's attributes, and modify the plan as necessary.

Wisconsin Council on Mental Health. As a condition of receiving funding under the federal community 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).

The Council provides advice to 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.

Office of Children's Mental Health. The 2013-15 biennial budget act (Act 20) created the Office of Children's Mental Health to make recommendations to the Governor and Legislature regarding children's mental health issues. In addition, the Office is charged with improving integration across state agencies that provide mental health services to children and monitoring the performance of state programs that provide these services. Although the Office is housed within DHS, it reports directly to the Governor and the Director is an unclassified position, appointed by, and serving at the pleasure of, the Governor.

Mental Health Services Funded Under the Medical Assistance Program

Wisconsin's medical assistance (MA) program provides coverage for a variety of mental health care services. Under the MA program, certified providers are reimbursed for services offered to eligible beneficiaries at rates established for each procedure or service. The costs of the provider reimbursement is shared between the federal government and the state (or local government, in some instances) according a formula that is based on each state's per capita personal income. Currently for Wisconsin, the federal share for MA benefit costs is approximately 58%, and the nonfederal share is approximately 42%.

Some medical services offered to MA recipients for mental health conditions, such as physician services, psychotherapy, and prescription drugs, are available for all MA beneficiaries and the nonfederal share is paid by the state. Other services, however, are provided at the option of counties, and, in most cases, the county pays the non-federal share. These county option services include targeted case management and more intensive, community-based support services provided under a variety program models.

Inpatient care for mental health services is also a covered benefit under the MA program under certain circumstances, but is subject to different payment rules, depending upon the situation. This section describes some of the principal mental health services covered under the MA program.

Outpatient Psychotherapy

Outpatient psychotherapy services are intended to offer a person with mental illness the strategies needed to reduce the severity and distress of persistent symptoms. Services may be offered to the afflicted individual as well as to his or her family.

Coverage of psychotherapy under the MA program is subject to certain conditions. An assessment and diagnosis of an MA recipient's condition must be conducted by a certified psychotherapist (psychiatrist, psychologist, or certain other professionals). The diagnosis must involve a "strength-based" assessment, meaning that the therapist must identify the recipient's social and psychological strengths that could assist in treatment, as well as barriers to improvement. The assessment must also document the person's symptoms and his or her overall psychological and social functioning, and, if indicated, establish a diagnosis.

Following the assessment, the therapist must provide psychotherapy services for patients and their families in accordance with a recovery and treatment plan, which identifies the objectives of the treatment and, as treatment progresses, provides documentation of any signs of improved functioning and progress toward meeting the treatment goals. Any medication that has been prescribed for the treatment must also be documented in the plan.

Outpatient psychotherapy may be provided in an outpatient clinic, hospital, nursing home, school, the office of the provider, or, for persons under the age of 21, in the person's home.

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.

Prescription Drugs

In addition to therapy services, treatment for individuals with mental illness can frequently include the use of medication. The MA program covers medication used to treat mental illness that is determined to be medically necessary and if

prescribed by a physician or other professional with prescribing authority.

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. The MA program covers day treatment for both adults and children, although the applicable prerequisites and prior authorization requirements differ.

Adult day treatment services are covered only for recipients who are diagnosed as chronically or acutely mentally ill. To be covered, the adult MA recipient must receive an initial evaluation to determine the medical necessity of the treatment and the recipient's ability to benefit from the treatment. A physician's prescription is not required.

Day treatment for children is provided if the need for services is identified as the result of a HealthCheck examination (the state's federally-required early and periodic screening, diagnosis and intervention and treatment program), and if prescribed by a physician. In addition, the child must meet or substantially meet the criteria to be designated as severely emotionally disturbed.

A day treatment provider must develop a treatment plan that includes individual goals, the treatment modalities, and the expected outcome of treatment.

For adults, the MA program limits reimbursement to five hours per day and 120 hours per month. Prior authorization is required for any day treatment in excess of 90 hours per calendar year or 90 hours in total for recipients who are diagnosed as acutely mentally ill. Prior authorization is also required for day treatment offered to an adult who is concurrently receiving psychotherapy or is a hospital inpatient.

For children, the program covers up to five hours of treatment per day and 25 hours per week. Prior authorization is required for all children's day treatment services.

Crisis Care

Care provided to a person experiencing a mental health crisis is a service covered under the MA program if the county's emergency mental health program meets the program's requirements for certification. To meet the certification standards, a program must have 24-hour crisis telephone service, a mobile crisis team to provide on-site service, walk-in services, and short-term voluntary and involuntary hospital care when less restrictive services are not sufficient to stabilize an individual. The program also must satisfy various personnel and training requirements and have written policies related to the procedures followed during a crisis situation.

A person is considered to be in a mental health crisis when his or her mental illness results in a high level of stress or anxiety for the person, for others providing care to the person, or to the public. The objective of the crisis program is to respond to the person's immediate need for care and to refer the person to other community mental health services to provide ongoing treatment and support. In some cases, the person may be referred for short-term voluntary or involuntary hospital care when less restrictive alternatives are not sufficient for stabilization.

Case Management

Case management services are used in the MA program for certain targeted populations who are receiving care from multiple providers. Among the recipients of case management services are persons who have serious and persistent mental illness and children who are determined to be severely emotionally disturbed. The case man-

ager assists the recipient or the recipient's family to gain access to, coordinate, and monitor necessary medical, social, educational, and vocational services.

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

Inpatient Care

In general, MA program coverage for inpatient care for mental health conditions that is provided in a general hospital is treated the same as inpatient care for other health conditions. That is, the care must be prescribed by a physician and must be deemed medically necessary. Typically, mental health care provided in a general hospital is for persons who need short-term stabilization or who are hospitalized for physical care needs.

In cases where a person requires mental health hospitalization for a longer period of time, the hospitalization typically occurs in an institute for mental disease (IMD). However, federal law restricts Medicaid coverage of IMD hospitalization to the elderly (age 65 and over) and children or adolescents (age 20 and younger or age 21 in limited circumstances). For the purposes of this restriction, an IMD is defined as a hospital, nursing home, or other institution with more than 16 beds that is primarily engaged in diagnosis, treatment, or care of persons with mental diseases. The state's two mental health institutes (described in a later section of this paper) are IMDs, but there are also several other private or county-operated IMDs in the state. If a person is hospitalized in a state mental health institute as the result of an involuntary civil commitment (also described in a later section), then his or her county of residence is responsible for any costs of the hospitalization not covered by insurance. If the person is over age 64 or under age 21, and is an MA recipient, then the county must pay the non-federal share of the MA program costs of hospitalization.

DHS distributes state funding to counties to help support a portion of the costs of the care for these MA recipients in an IMD or to assist in providing services for those individuals in the community, instead of in an IMD. In the 2013-15 biennium, the annual amount of state general purpose funding available for these payments is $9,565,200.

MA-eligible nursing home residents may also require mental health care. For patients who receive specialized mental health services in a nursing home, the state provides a supplement of $9 per person per day to support the care of individuals under the MA nursing home reimbursement formula. Most of the supplemental payments are eligible for federal MA matching funds because they can be certified as rehabilitative services.

Psychosocial Rehabilitation and Support Programs for Persons with Chronic or Acute Mental Illness

In addition to services described above, Wisconsin's MA program covers several county-operated mental health services targeted to individuals with severe and persistent mental illness, and who require more than outpatient care. These services are sometimes broadly considered "psychosocial rehabilitation" services since they focus on providing social, educational, or occupational supports that are in addition to mental health care that is provided in an office or hospital setting. The programs that fall under this category of services include: (a) comprehensive community services; (b) community support programs; and (c) community recovery services. These three programs are described in greater detail below.

Comprehensive Community Services (CCS) CCS is a county-option program that provides community-based psychosocial rehabilitation

services for MA-eligible persons of any age to assist a person with mental illness to function in the community with highest possible degree of independence. One of the goals of the program is to reduce the need for institutionalized care for persons who have had episodes requiring hospitalization.

In order to qualify for these services, an MA recipient must, as determined by a DHS-approved functional assessment, require more intense services than outpatient counseling services. Further, the individual must have a diagnosis of a mental disorder or a substance-use disorder and a functional impairment that interferes with, or limits one or more major life activities, and results in need for services that are ongoing and comprehensive.

Fourteen service categories are covered under the program: (a) screening and assessment; (b) service planning; (c) service facilitation; (d) diagnostic evaluations; (e) medication management; (f) physical health monitoring; (g) peer support; (h) individual skills development and enhancement; (i) employment-related skills training; (j) individual and family education regarding mental health; (k) wellness management and recovery/recovery-support services; (l) psychotherapy; (n) substance abuse treatment; and (o) non-traditional or other approved services.

The services provided to each person participating in the program must be consistent with needs identified through a comprehensive assessment completed by a recovery team made up of the person, a service facilitator, one or more licensed mental health professional, the person's family, and others as appropriate. In particular, the Department emphasizes the role played by the person in developing and implementing a care plan.

Prior to July 1, 2014, counties were responsible for the non-federal share of CCS MA benefit costs. However, 2013 Act 20 changed this policy, so that the state now pays the non-federal share, provided the county agrees to deliver the program on a regional basis according to criteria established by the Department. According to the Department's criteria, counties with a population above 350,000 may provide CSS services on a single-county basis, while counties with a population below that threshold must, in order to receive state funds, coordinate with other counties to share services or seek certification as a single, multi-county entity. Tribal governments may establish regional programs or enter into agreements with regional programs to offer services to tribal members.

Prior to Act 20, 26 counties offered CCS program services, paying the non-federal share of program costs. With the shift to state responsibility for the non-federal costs, 62 counties and four tribes have been certified or are seeking certification to provide CCS services on a regional basis.

Community Support Program (CSP). All counties are required to offer (or contract for) CSP services as a more intensive form of care for adults whose mental illness and functional limitations might otherwise require them to need institutionalized care. Persons receiving CSP services generally have more acute mental illness and require support services for a longer period of time, in comparison to persons in CCS programs.

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 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, and self-care or independent living.

Services covered under a CSP include: (a) initial assessment; (b) in-depth assessment; (c) development of treatment plans; (d) treatment and psychological rehabilitation services; and (e) case management in the form of ongoing monitoring and service coordination activities. Specific treatment services include individual, family, and group psychotherapy, medications, and crisis intervention.

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.

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. CSPs are required to set a goal of providing over 50% of service contacts in a non-office- or non-facility-based setting.

In some larger counties, the county contracts for the operation of more than one CSP, while in other counties the county operates a single CSP. In a few cases, a single CSP covers more than one county.

As with all mental health services, the amount of funding that a county budgets for its CSP may constrain the number of persons served. 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. The state has established a policy of providing supplemental payments to counties in order to provide additional services to persons on county waiting lists. In calendar year 2013, DHS allocated $939,400 GPR to counties for this purpose.

Community Recovery Services (CRS). Since 2010, Wisconsin has incorporated CRS programs in its MA program, offering residential-based, psychosocial rehabilitation services to persons, who meet all the following conditions: (a) household income at 150% of the federal poverty level or less; (b) a diagnosis of mood disorder, schizophrenia, or another psychotic disorder; and (c) a functional need for community assistance. Although all persons who meet these criteria are eligible under the CRS program, the services offered are typically geared toward adults and teens, rather than children.

Specific services under CRS fall into three categories: (a) community living support services; (b) self-help/peer support services; and (c) supported employment.

Community living supportive services allow individuals to live with maximum independence in community-integrated housing and can include meal planning and preparation, household cleaning, assistance with personal hygiene, medication management and monitoring, parenting skills, community resource access and utilization, emotional regulation skills, crisis coping skills, shopping, transportation, recovery management skills and education, financial management, social and

recreational activities, and developing and enhancing interpersonal skills.

Peer specialists serve as advocates, provide information, and peer support for individuals in emergency, outpatient, community, and inpatient settings and demonstrate techniques in recovery and ongoing coping skills. Peer specialists are typically persons who have experienced mental illness and have been through the treatment system.

Supported employment services assist individuals in obtaining and maintaining competitive employment. These services can include intake, assessment, job development, job placement, work-related symptom management, employment crisis support, and follow-along supports by an employment specialist.

Counties must pay the non-federal share of CRS program costs, although counties may elect not to establish a program. Because of the optional nature of the program, therefore, the CRS benefits are not available in all parts of the state.

MA coverage of CRS benefits has been provided in Wisconsin through a specific federal application process, which permits the program to be offered at the option of counties to a limited number of beneficiaries. However, due to changes in federal law, the program can no longer be offered under this special federal authorization. As of the time of the publication of this paper, the Department was considering options for the continuation of this program under alternative federal authority.

Other Mental Health Programs

While the programs described in the previous section are primarily funded from the MA program (federal funds with county or state match), DHS also administers other programs that distribute state and federal funding to counties or nonprofit organizations to support mental health services. The principal programs described in this section are: (a) the community mental health services block grant; (b) the community aids program; and (c) the coordinated services team initiative. In addition, this section provides a description of several mental health grant programs that were created during the 2013-15 legislative session.

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. 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 2014-15 MHBG allocation of $7,379,800 is summarized in Table 1. 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 ($3.0 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 the community aids program, although the MHBG funds must support services that meet the

Table 1: Expenditure Plan for Mental Health Block Grant Funds, FFY 2014-15

Program	Planned Expenditure
Community Aids Allocation	$2,513,400
Children's Initiatives	1,826,500
Consumer and Family Support	1,015,800
State Operations	710,000
Transformation Activities	530,800
Recovery, Early Intervention, Prevention	494,000
Training and Technical Assistance	160,000
Protection & Advocacy	75,000
Systems Change	54,300
Total	$7,379,800

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; or (h) development of community mental health data sets.

Children's Initiatives ($1,826,500). The MHBG is used to provide a portion of the funding for coordinated services teams, which are used to provide support for children who are involved in two or more systems of care such as mental health, substance abuse, child welfare, juvenile justice, special education, or developmental disabilities of children. This program is described in more detail below.

Consumer and Family Support Grants ($1,015,800). 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 2014, funded with the 2013-14 allocation: (a) the National Association of the Mentally Ill ($240,900); (b) Wisconsin Family Ties ($272,300); (c) Independent Living Resources ($262,800); and (d) various peer-run organizations ($275,000). These organizations provide a range of vocational training, education, and consumer and family support services.

State Operations ($710,000). DHS uses MHBG grant funds for staff costs in the Department's Bureau of Prevention, Treatment and Recovery related to mental health program development, Mental Health Council, and administrative functions.

Transformation Activities ($530,800). 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.

Recovery, Early Intervention and Prevention ($494,000). 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 ($160,000). MHBG funding supports training for mental health treatment professionals on standards, best practices, recovery principles, and emergency crisis services. Funded activities 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.

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.

System Change Grants ($54,300). 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 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.

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. Legislative Fiscal Bureau informational paper entitled "Community Aids/Children and Family Aids" provides additional information on this program.

In calendar year 2013, DHS distributed $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 2013, counties reported spending approximately $95.5 million of the BCA on services for persons with mental illness.

Coordinated Services Team Initiative

DHS distributes funding and provides guidance to assist counties or tribes in implementing a coordinated services team (CST) initiative. A CST initiative is a process established to facilitate cooperation among various local agencies for providing services to children who are involved in two or more systems of care such as mental health, substance abuse, child welfare, juvenile justice, special education, or developmental disabilities. By DHS policy, state funding is provided for initiatives to specifically target those children who are either: (a) severely emotionally disturbed; (b) at-risk of placement outside the home; (c) in an institution and are not receiving coordinated, community-based services; or (d) in an institution, but would be able to return to community placement or their homes if services were provided.

Under the statutory requirements for the program, each initiative must establish a coordinating committee to establish policies for the local CST. Because services provided to children in the target population are administered by multiple agencies, the coordinating committee must designate a single service coordinating agency and facilitate the development of an interagency agreement for the delivery of services.

For each individual enrolled in a CST initiative, the coordinating agency is required to assign a service coordinator, who assembles a coordinated services team. The team, which must include family members, service providers, and others, develops a plan of care for the child. The plan must identify short-term and long-term goals for the child, the services and resources needed by the child, the organization that will provide those services and resources, and the criteria to be used for measuring the effectiveness and appropriateness of the plan of care.

The Department's CST initiative grants are funded by an appropriation of state funds (GPR), federal mental health block grant funds, federal substance abuse block grant funds, medical assistance hospital diversion funds, and funding from the Department of Children and Families. The local initiative is required to contribute a 20% match to receive the funds, which may be provided in cash or in-kind resources.

The 2013-15 biennial budget act (Act 20) increased funding for CST grants from $2.8 million in 2012-13 (all funds) to $4.0 million in 2013-14 and to $5.2 million in 2014-15. This increase was provided with state GPR with the intention of increasing the number of counties with a CST initiative and providing ongoing, rather than start-up funding. Prior to the Act 20 increase, DHS provided grants to support CST initiatives in 38 counties and limited support for a period of five years. In 2014-15, CST grants were awarded to nearly all counties and Native American Tribes. Grants average approximately $60,000.

Milwaukee and Dane Counties do not receive grants under the program, but both counties operate similar programs. 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.

2013-15 Legislative Session Initiatives

The Legislature adopted several initiatives during the 2013-15 legislative session that created new mental health programs or expanded existing programs. Some of these initiatives are discussed elsewhere in this paper, including the transfer of Milwaukee County mental health oversight to the Milwaukee County Mental Health Board, expansion of comprehensive community service benefits under the MA program, the expansion of coordinated service team initiative grants, and the provision of funding to open two new forensic units at the Mendota Mental Health Institute. Other initiatives were included in the 2013-15 budget act (Act 20) or were enacted as stand-alone legislation. Those initiatives are summarized briefly below.

Crisis Intervention Grants. Act 20 provided $125,000 annually for grants for training law enforcement agencies and correctional officers on how to respond effectively to mental health crisis situations.

Child Psychiatry Consultation Program. Act 127 provided $500,000 annually to allow DHS to contract with organizations to provide professional consultation services to assist medical clinicians in providing enhanced care to pediatric patients with mental health care needs. The act requires the Department to establish regional hubs for consultation services and specifies that the organization must employ a psychiatrist as well as any additional staff, as required by the Department.

Peer-Run Support Initiatives. Act 20 provided $1,200,000, beginning in 2014-15 to allow DHS to make grants for three regional peer-run, residential respite centers to assist persons experiencing a mental health or substance abuse crisis. Staff at peer-run centers have successfully participated in mental health or substance abuse recovery or treatment programs. Act 20 also provided funding for a position in DHS to manage the peer-run program.

Act 129 provided an additional $125,000 annually, beginning in 2013-14, to allow DHS to contract with a peer-run organization to establish peer-run respite centers.

Individual Placement and Support Program.

Act 131 provided $970,000 in the 2013-15 biennium, on a one-time basis, to establish individual placement and support programs in five regional centers in the state. Individual placement and support programs assist persons with mental illness in finding employment. Programs are based on a program model developed by the Dartmouth College Psychiatric Research Center.

Mental Health Mobile Crisis Units. Act 132 provided $125,000 annually, beginning in 2013-14, to fund grants to counties or multi-county regions to establish MA-certified mental health mobile crisis teams.

Emergency Detention and the Commitment and Treatment of Civil and Forensic Patients

Chapter 51 establishes procedures for the emergency detention of persons with mental illness, as well as procedures for the commitment of certain persons for mental health treatment, under either a civil or criminal court proceeding. Depending upon the circumstances, commitment may entail involuntary confinement in a treatment facility, but it may also mean treatment and supervision in a community-based setting. This section provides a description of these procedures. State law also has a separate process for the civil commitment of persons who are convicted of a sexually violent offense and who, upon completion of a prison term, are determined by a court to be likely to commit acts of sexual violence. This process and the Department's Sand Ridge Secure Treatment facility are described in the Legislative Fiscal Bureau informational paper entitled "Civil Commitment of Sexually Violent Persons."

Emergency Detention

A law enforcement officer (or a person authorized to take a child or juvenile into custody under the state's children code or juvenile code) may take a person into custody if the officer has cause to believe all of the following: (a) the person is mentally ill; (b) the person evidences a substantial probability of physical harm to himself or herself or to others, including an inability to satisfy his or her basic needs due to mental illness; and (c) taking the person into custody is the least restrictive alternative appropriate to the person's needs. The law establishes various criteria for determining whether a person meets the standard related to posing a danger of physical harm to himself or herself or to others.

If the county department for mental health programs agrees for the need for detention, a person taken into custody must be delivered to an approved treatment facility, if the facility agrees to take the individual, or to a state mental health institute. Upon arrival at the facility, the person must be notified of his or her rights with respect to the detention procedure, including the right to contact an attorney or a member of his or her immediate family, the right to have the services of an attorney at public expense, and the right to remain silent.

The procedures for detention in Milwaukee County are different than those used in the rest of the state. In Milwaukee County, the treatment director of the detention facility has 24 hours to determine if the person meets the criteria for detention. In all other counties, the treatment director is not required to make an affirmative determination on the question of whether the emergency detention criteria have been met within a specified time period, but must discharge the person when, upon the advice of the treatment staff, he or she determines that the criteria are no longer met. In all cases, the person may not be held in detention for a period exceeding 72 hours from the time that the person was taken into custody, exclusive of Saturdays, Sundays, and legal holidays, unless a probable cause hearing for involuntary civil commitment has been held.

If it is determined that a person meets the criteria for detention, the facility may evaluate, diagnose, and treat the individual during detention only if the person consents.

Civil Commitment

Involuntary civil commitments for mental health ailments are sought in cases where a person is considered to meet all of the following criteria: (a) has a mental illness; (b) is a proper subject for treatment; and (c) is dangerous to themselves or others, based on one of five statutory standards. The process for involuntary civil commitment begins once a petition is submitted to the court assigned to probate matters in the county of the person's residence. With a few exceptions the petition must be signed by three adults, at least one of whom has personal knowledge of the person's conduct. In many cases the petition is filed following or during an emergency detention.

The court must review a petition for involuntary commitment within 24 hours to determine if an order of detention should be issued. An initial hearing to review the petition is then held within 72 hours to determine if there is probable cause to believe the individual meets the standards for commitment. Prior to the hearing, the court must refer the person to the State Public Defender's Office, which must appoint legal counsel for the person without regard to the person's indigency status. The hearing must conform to standards for due process and fair hearing, including the person's right to a jury trial.

If the court determines, as the result of the hearing, that the probable cause standard is met, the court may order that the person remain in detention, or may release the person. A full hearing must occur within 14 days of the person's initial detention (extensions to this time frame are allowed in certain circumstances) if the person remains under detention, or within 30 days if the person is released.

Prior to the full hearing, the court must appoint two mental health professionals (psychiatrist or psychologist) to conduct an examination. One of the professionals may be selected by the person.

The issue before the court at the final hearing is whether clear and convincing evidence exists that the person meets all of the criteria for commitment. The court may either issue an order for commitment if the standards are met, may dismiss the petition and release the person, or may convert the case to hearing on protective services or protective placement.

The cost of the care provided to civil commitment patients is the responsibility of the county of the person's residence, although the person (or the person's private insurance, if any) may be charged for the cost of treatment. Treatment must be provided in the least restrictive environment necessary to meet the person's needs, and so does not necessarily require confinement to a treatment facility.

Examination, Treatment, and Commitment of Forensic Patients.

Persons who are committed for treatment as the result of a criminal proceeding are termed "forensic patients." Forensic patients fall into three categories: (a) persons charged with an offense and whose competency to proceed to trial is questioned; (b) persons deemed not competent to stand trial as the result of mental illness present at the time of the trial; and (c) those who are found not guilty by reason of mental disease or mental defect present at the time that the offense was committed.

Competency Examinations and Treatment. Prior to, or during, a criminal proceeding, a court may refer a person to DHS whenever there is reason to doubt a defendant's competency to proceed with the trial. In this context, a person is deemed "incompetent" if he or she lacks substantial men-

tal capacity to understand the proceedings or assist in his or her own defense. In these cases, the court orders an examination of the defendant by a mental health professional. The examination may be conducted on an outpatient basis or at mental health treatment facility, such as a state mental health institute. The Department contracts for outpatient examinations and conducts inpatient exams with Department staff at the mental health institute where the person is held.

The examiner must submit a report within 15 days (or within 30 days if the court approves) that contains information on the nature of the examination, the examiner's clinical findings, and his or her opinion regarding the present competency of the defendant. In addition, if the examiner believes that the defendant is not competent, the report must include his or her opinion on the likelihood that the defendant, if provided treatment, may be restored to competency within 12 months (or within the maximum sentence for the charged offense, if that is less).

Following submission of the report, the court holds a hearing to determine the defendant's competency to stand trial, which has one of three outcomes. First, if the court determines that the defendant is competent, then the trial may proceed. Second, if the court determines that the defendant is not competent, but is likely to become competent with treatment within the allowed period, the court suspends the proceedings and commits the defendant to the custody of the Department for treatment. Third, if the court determines that the defendant is not competent and is unlikely to become competent within the allowed period, then the court is required to release the defendant, unless it determines that the conditions for emergency detention apply. In this case, the court may order the person to be taken into custody and placed in a treatment facility, initiating the civil commitment process.

In 2013-14 the Department conducted or contracted for 1,292 competency evaluations and provided or contracted for return to competency treatment for 398 forensic patients.

Not Guilty by Reason of Mental Disease. Under Wisconsin law, a person cannot be held responsible for criminal conduct if, at the time of such conduct, the person lacked substantial capacity either to appreciate the wrongfulness of the conduct or to conform his or her conduct to the requirements of the law, and that this deficiency was the result of a mental disease or defect.

To help reach a verdict on a plea of not guilty by reason of mental disease or mental defect, the court may appoint between one and three mental health professionals to examine the defendant and report to the court. The defendant also has the right to be examined by a mental health professional of his or her choice. The examiner or examiners submit a report to the court addressing the question of whether the defendant meets the standard for not guilty by reason of mental disease or mental defect.

If a jury reaches a verdict of not guilty by reason of mental disease or mental defect, the court commits the person to the custody of the Department of Health Services. The commitment period may be not more than the maximum sentence of imprisonment for the crime, in the case of felonies, or not more than two-thirds of the maximum sentence, in the case of misdemeanors.

The court is required to order institutional care for a forensic patient who is committed under these provisions, if the court finds that the person would pose a significant risk of bodily harm to himself or herself or to others or of serious property damage. DHS provides institutional care at one of the two state mental health institutes.

A person who is committed to institutional care may periodically petition the court for conditional release. The court that originally commit-

ted the person to institutional care is responsible for ruling on the petition.

If the court determines that the patient does not meet the standard for institutional care, then the person is placed on conditional release. For persons on conditional release, the person's county of residence and DHS jointly develop a plan for the treatment and supervision of the person. A person on conditional release is under the care of DHS and the Department is financially responsible for any treatment and supervision costs, although some costs may be offset by the person's own income, insurance, or government benefits. The Department contracts with the county or other organizations for case management and treatment services, and contracts with the Department of Corrections for supervision functions.

In 2013-14, the Department served a daily average of 236 forensic patients at the mental health institutes who were found not guilty by reason of mental disease or mental defect and an additional 313 forensic patients in its conditional release program.

Institutional Services

The Department of Health Services operates four facilities that provide mental health services: two mental health institutes (Mendota, in Madison, and Winnebago, near Oshkosh), the Wisconsin Resource Center (adjacent to the Winnebago Mental Health Institute), and the Sand Ridge Secure Treatment Center (in Mauston). This section provides a description of the two mental health institutes and the Wisconsin Resource Center. As previously noted, the Legislative Fiscal Bureau informational paper entitled "Civil Commitment of Sexually Violent Persons" provides information on the Sand Ridge facility.

State Mental Health Institutes

DHS operates the Mendota Mental Health Institute in Madison and the Winnebago Mental Health Institute near Oshkosh. These facilities 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.

Mendota operates 13 inpatient treatment units for forensic patients with a total capacity of 259 and one civil geropsychiatric unit for elderly patients with a capacity of 15. Of the 13 forensic units, five are maximum security, six are medium security, and two are minimum security. The 2013-15 biennial budget act provided $5.9 million in 2013-14 and $6.7 million in 2014-15 and 73 positions to open two new forensic units at Mendota. The new units (included in the total above) were opened in space that previously was used for civil commitments, but had been vacant.

In addition to these units, Mendota operates two units at the Mendota Juvenile Treatment Center that have the capacity to serve 29 adolescent males from Wisconsin's juvenile correctional facility whose behavioral and treatment needs exceed the resources available at that facility.

Winnebago has a total of six treatment units with a total capacity of 184, including four adult units with a total capacity of 158, and one youth civil unit with a capacity of 26. Of the adult units, two are medium security and two are minimum security. Units at Winnebago serve both males and females.

Historically, Mendota and Winnebago each served both forensic and civil patients. However, beginning in April of 2014, the Department changed the placement policy, so that all civil patients are now placed at Winnebago (other than

civil patients requiring care at Mendota's geropsychiatry unit), all male forensic patients are placed at Mendota, and all female forensic patients are placed at Winnebago. This policy has generally applied to new admissions only, so as to avoid disrupting the treatment of patients.

Table 2 provides information on the average number and percentage of patients by type in each institution in October of 2014. By that time the Department had implemented its policy regarding the placement of new civil and forensic patients, as described above, but some patients of each type remained at the original facility. In some cases, the average daily population exceeds the staffed capacity for a particular unit or facility. Since the mental health institutes must accept all patients that are committed, the Department serves patients in excess of staffed capacity using temporary accommodations.

Table 2: Average Daily Populations (ADP) at the Mental Health Institutes by Type of Unit -- October, 2014

	Mendota		Winnebago	
	ADP	Percent	ADP	Percent
Forensic	248.4	82.2%	84.6	44.3%
Youth -- Civil	0.0	0.0	38.1	20.0
Adult -- Civil	8.7	2.9	68.1	35.7
Geriatric -- Civil	16.0	5.3	0.0	0.0
Juvenile Treatment	29.0	9.6	0.0	0.0
Totals	302.2	100.0%	190.8	100.0%

Note: Totals do not add due to rounding.

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 3 shows the daily rates DHS established for each patient population group at Mendota and Winnebago that were in effect as of October 1, 2014.

Operations at the mental health institutes are

Table 3: Mental Health Institutes Inpatient Daily Rates as of October 1, 2014

	Mendota	Winnebago
Adult Psychiatric Services	$1,025	$1,025
Geropsychiatric	1,052	---
Child/Adolescent	---	1,100
Forensic-All Security Levels	1,025	1,025
Emergency Detention Add-On*	250	250
Non-typical Services Add-On	250	250
Day School		$30/hour

*For first three days of service

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 4 identifies funding from each of these sources for the mental health institutes in 2013-14.

Wisconsin Resource Center

In addition to the mental health institutes, DHS operates the Wisconsin Resource Center (WRC) for the treatment of male and female inmates referred by the Department of Corrections who have severe impairments in daily living due to mental health and behavioral issues. The WRC provides treatment focusing on problems of acute mental illness, suicidality, self-injurious behavior, and maladaptive responses to incarceration. The WRC is located adjacent to the Winnebago Mental Health Institute, near Oshkosh.

The WRC has a total 385 beds for male and female inmates. In 2013-14, the Center housed a weekly average of 313 men and 35 women.

The WRC facilities are divided into units, each generally housing between 20 and 34 inmates. There are currently 14 units for men and

Table 4: Mental Health Institutes Operating Revenue, by Source
Fiscal Year 2013-14

	Mendota		Winnebago	
	Amount	% of Total	Amount	% of Total
State GPR	$49,379,900	69.8%	$30,480,400	46.2%
Medical Assistance	2,551,900	3.6	14,720,900	22.3
Counties	9,945,800	14.1	13,880,100	21.0
Private Insurance	1,050,400	1.5	4,057,500	6.1
Medicare	3,274,900	4.6	2,578,200	3.9
Other Gov. Agencies	4,400,600	6.2	94,700	0.1
Miscellaneous	136,800	0.2	210,600	0.3
Total	$70,740,200	100.0%	$66,022,400	100.0%

three for women. Inmates are placed into a unit based on their treatment or management needs. For instance, currently certain units provide treatment for alcohol and drug addictions in anticipation of release, some are designed to provide psychiatric care for varying levels of mental illness, while others function to manage the most disruptive behaviors.

Criminal commitments of individuals to WRC 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, and is in need of psychiatric or psychological treatment. If the prisoner voluntarily consents to a transfer to WRC, 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.

DHS is responsible for the facility and treatment costs of the WRC, while the Department of Corrections is responsible for providing perimeter security (other than overtime security, which is the responsibility of DHS). In 2013-14, DHS spent $51.6 million (state GPR) for WRC operations while Department of Corrections spent $7.5 million for security.

Additional Resources

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

Wisconsin Department of Health Services
https://www.dhs.wisconsin.gov/mh/index.htm

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

National Institute of Mental Health
www.nimh.nih.gov/index.shtml

APPENDIX

Services for Individuals with Mental Illness, County Expenditures*
Calendar Years 2009 through 2013

County	2009	2010	2011	2012	2013
Statewide Total	**$428,614,385**	**$443,292,623**	**$430,152,269**	**$444,546,291**	**$469,656,487**
Adams	$1,285,557	$1,560,767	$1,702,525	$1,240,558	$1,362,471
Ashland	1,048,767	1,171,579	1,510,667	1,458,765	1,153,331
Barron	3,260,014	3,104,835	2,791,161	2,802,180	3,061,809
Bayfield	1,001,352	1,036,845	1,468,568	1,282,800	1,365,411
Brown	16,247,424	16,531,281	16,126,168	15,394,215	16,761,260
Buffalo	378,614	439,105	787,954	384,609	659,367
Burnett	613,777	975,561	1,153,502	856,144	693,071
Calumet	3,145,416	3,078,825	3,030,071	3,181,764	3,133,057
Chippewa	2,124,047	2,935,296	2,801,605	2,651,270	3,031,158
Clark	3,437,159	2,891,577	2,943,213	3,276,783	3,318,411
Columbia	2,402,817	3,154,196	2,046,891	2,289,071	2,887,037
Crawford	1,371,723	1,303,903	1,227,677	1,406,885	1,434,417
Dane	30,059,879	31,803,862	33,456,129	34,635,155	35,212,846
Dodge	6,007,896	6,625,294	6,149,900	6,321,527	6,170,831
Door	1,298,510	1,821,266	1,938,796	1,968,910	2,017,886
Douglas	2,863,650	1,631,631	2,894,162	3,020,664	2,602,044
Dunn	1,941,834	2,014,631	2,201,822	2,067,871	2,211,623
Eau Claire	6,750,927	6,010,450	6,011,714	6,057,252	6,133,440
Florence	172,363	207,055	78,497	127,015	140,013
Fond du Lac	6,716,909	6,746,572	7,066,504	6,750,506	7,330,902
Forest/Oneida/Vilas	3,925,577	4,379,496	4,354,297	5,825,240	6,026,717
Grant/Iowa	2,605,185	2,241,721	2,569,701	2,494,446	2,513,402
Green	2,143,432	2,185,952	2,273,049	2,305,818	2,587,474
Green Lake	1,400,775	1,116,641	1,289,815	1,189,276	1,485,463
Iron	910,140	1,186,699	573,919	586,292	702,034
Jackson	1,761,124	1,551,511	1,456,634	1,129,094	931,078
Jefferson	5,563,107	6,789,305	7,032,315	6,503,919	6,012,153
Juneau	2,589,717	2,307,395	2,468,900	2,202,330	2,312,580
Kenosha	9,904,245	10,298,995	9,771,063	10,344,197	10,734,879
Kewaunee	670,486	904,627	904,747	848,417	1,273,926
La Crosse	8,105,943	8,409,717	8,262,554	8,587,622	9,604,289
Lafayette	1,385,309	1,110,204	1,119,559	1,056,489	1,405,721
Langlade/Lincoln/ Marathon	16,082,349	15,957,276	17,492,693	17,034,855	17,543,223
Manitowoc	4,659,956	4,333,341	6,274,301	5,331,122	5,678,276
Marinette	3,462,424	3,417,404	3,542,626	3,473,616	3,732,959

APPENDIX (continued)

Services for Individuals with Mental Illness, County Expenditures*
Calendar Years 2009 through 2013

County	2009	2010	2011	2012	2013
Marquette	$1,120,707	$975,327	$1,095,424	$1,032,677	$1,071,804
Menominee	1,081,536	**	**	**	906,021
Milwaukee	127,322,100	132,031,274	129,942,247	129,257,310	139,586,016
Monroe	2,393,100	**	**	1,866,737	1,865,179
Oconto	1,329,655	1,283,719	1,374,366	1,331,356	1,512,633
Outagamie	10,010,349	10,102,475	11,118,053	12,732,643	13,359,410
Ozaukee	2,702,921	3,045,165	2,745,112	2,517,462	2,995,100
Pepin	391,674	416,606	339,885	316,197	365,708
Pierce	1,320,251	1,061,040	1,239,591	1,120,315	1,465,019
Polk	3,337,180	4,015,789	4,177,079	4,041,874	3,759,628
Portage	2,956,119	3,169,851	3,230,019	3,569,967	3,297,347
Price	692,943	1,064,690	885,134	840,119	846,139
Racine	9,491,915	10,046,303	9,000,827	9,849,403	9,903,625
Richland	2,087,809	2,074,808	2,292,045	1,994,656	1,852,225
Rock	13,812,601	15,531,563	17,209,117	17,539,354	17,445,994
Rusk	713,246	992,469	890,710	925,095	697,074
Sauk	5,154,893	5,926,651	5,956,018	5,887,670	5,441,488
Sawyer	1,358,536	1,417,935	1,448,423	1,469,391	945,156
Shawano	1,651,750	1,654,849	1,132,869	1,568,440	1,892,749
Sheboygan	8,042,524	8,268,673	7,199,610	7,314,819	7,508,025
St. Croix	5,249,620	5,882,087	**	4,855,506	4,801,690
Taylor	644,715	795,531	772,180	1,234,215	1,106,148
Trempealeau	1,876,321	2,096,755	1,806,639	1,345,994	930,874
Vernon	1,814,042	1,815,215	2,074,578	2,295,913	2,506,539
Walworth	5,276,026	6,313,641	2,529,560	4,814,227	8,684,844
Washburn	945,695	948,657	918,854	947,436	1,021,309
Washington	13,742,972	16,439,190	9,135,878	9,087,982	9,674,284
Waukesha	21,065,494	19,442,642	19,920,412	20,146,985	22,182,019
Waupaca	2,927,338	3,789,651	3,864,209	3,704,661	3,559,314
Waushara	2,730,095	2,468,819	2,761,959	2,944,224	2,436,726
Winnebago	10,620,874	10,316,504	10,312,003	11,349,108	11,648,328
Wood	7,450,980	8,669,929	8,005,769	10,557,878	11,163,513

* Data obtained from county Human Services Revenue Reports (HSRR) collected by DHS
**No data reported by the county.