Services for Persons with Mental Illness and Substance Abuse Disorders

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Prepared by

Jon Dyck

Wisconsin Legislative Fiscal Bureau
One East Main, Suite 301
Madison, WI 53703
http://legis.wisconsin.gov/lfb

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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 and substance use disorders. 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 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 provides a description of services available to persons with mental illness and substance use disorders, with a primary focus on services offered by county human service departments and the state Department of Health Services (DHS). The first section outlines the state and county framework for the provision of publicly-supported mental health and substance abuse services available to Wisconsin residents. Subsequent sections then provide more detailed information on those services and some of the key legal procedures related to mental illness and substance use, organized as follows: (a) mental health and substance abuse services funded by the state's medical assistance program; (b) other DHS programs that provide funding and support for county mental health and substance use services; (c) the procedures for emergency detention and for the civil and forensic commitment of persons suffering from severe mental illness or substance use disorders; and (d) the mental health institutions operated by DHS.

Mental Illness and substance use disorders are distinct conditions, although they are generally addressed under a common policy and programmatic framework. For the purposes of Chapter 51, the term "mental illness" is defined to mean 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. With respect to substance use disorders, Chapter 51 generally uses the term "drug dependent," which is defined as a person who uses one or more drugs to the extent that the person's health is substantially impaired or his or her social or economic functioning is substantially disrupted.

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

Publicly-funded mental health and substance abuse services are provided through a variety of state and county programs. In general, counties are responsible for establishing and administering a behavioral 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 and substance use disorders who reside in the county. In practice, since mental health and substance abuse services are covered benefits under private health insurance plans, county services are typically provided for persons without private insurance, are sup-

portive services not covered by private insurance, or are related to involuntary commitments. In addition, county programs frequently provide or coordinate mental health care and substance abuse services provided for persons eligible for the state's medical assistance program.

Chapter 51 requires every county to establish a county department of community programs or participate in a multi-county department for the provision of community-based mental health and substance abuse services. Frequently these county agencies are part of a county department of human services.

Although counties are required to establish an agency to administer services, counties are responsible for addressing 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 Board. While Chapter 51 gives county boards the ultimate responsibility for the mental health and substance abuse 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). The MCMHB has 11 voting members appointed by the county executive representing various types of mental health providers and consumers. Under provisions of Act 203, 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 departments of community programs must, within the limits of available funds, provide directly or contract with providers to deliver mental health and substance abuse services in the least restrictive environment appropriate for an individual's needs. These services include:

- 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.

County Caseload and Expenditure Reporting. Counties are required to submit reports to DHS on the number of persons receiving county services related to mental health and substance abuse, as well as the expenditure of state, federal, and county funds for these programs. Appendix I and Appendix II to this paper show reported mental health and substance abuse expenditures by county for calendar years 2011 through 2015. DHS does not audit county expenditure reports, and since there may be variation in the methods that counties use to prepare reports, the data should be interpreted with caution.

The Department of Health Services

Basic Departmental Functions and Duties. The Department of Health Services (DHS) has primary responsibility for state mental health and substance abuse programs. The Department's Division of Care and Treatment Services oversees and provides guidance to county mental health and substance abuse programs, distributes state and federal funds for these services, and operates the state's mental health institutions.

Chapter 51 authorizes DHS to perform the following activities, related to mental health policy guidance:

- Promote coalitions among the state, counties, service providers, service consumers, families, and advocates for persons with mental illness or substance abuse disorders to advance prevention, early intervention, treatment, recovery, safe and affordable housing, opportunities for education, employment and recreation, family and peer support, self-help, and the safety and well-being of communities;

- Cooperate with counties, service providers and consumers to develop and implement a strategy to reduce stigma and discrimination against persons with mental illness and substance use disorders;

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

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

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

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

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

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

DHS is required to ensure that providers of mental health or substance abuse 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.

Other State Entities

The state has established other entities to provide policy advice and program coordination for mental health and substance abuse services.

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.

State Council on Alcohol and other Drug Abuse. The State Council on Alcohol and Other Drug Abuse provides leadership and coordination regarding alcohol and other drug abuse issues confronting the state. This includes the development, every four years, of a comprehensive plan for alcohol and other drug abuse programs, as well as other periodic reports on alcohol and other drug abuse issues.

Each biennium, the Council is required, after introduction of the executive budget bill, to review and make recommendations to the Governor, Legislature, and state agencies, regarding the plans, budgets, and operations of all state alcohol and drug abuse programs. In addition, the Council is required to review any legislation related to alcohol or drug abuse introduced in the Legislature and provide the chairperson of the committee considering the legislation an opinion of the effect and desirability as a matter of public policy of the legislation.

The Council is composed of 22 voting members, including representatives of the Governor's Office, the Attorney General, the secretaries of the departments of Corrections, Health Services, Public Instruction, and Transportation, and the Insurance Commissioner, the Chairperson of the Pharmacy Examining Board, a representative of the Controlled Substances Board, a representative of the Governor's Law Enforcement and Crime Commission, a representative of the Wisconsin County Human Service Association, four members of the Legislature, and five members of the public, appointed by the Governor. The Council has an additional ten ex officio members representing various other state agencies and other entities. DHS provides staff support for the Council.

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 and Substance Abuse Services Funded Under the Medical Assistance Program

Wisconsin's medical assistance (MA) program provides coverage for a variety of mental health and substance abuse 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 are shared between the federal government and the state (or local government, in some instances) according to 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 non-federal share is approximately 42%.

Some medical services offered to MA recipients for the treatment of mental illness or substance use disorders, 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 hospital care for mental health and substance abuse disorders are also covered under the MA program under certain circumstances, but are subject to different payment rules, depending upon the situation. This section describes some of the principal mental health and substance abuse services covered under the MA program.

Most MA services described in this section are provided for the treatment of either mental illness or substance use disorders, although there are exceptions, which are noted.

Outpatient Psychotherapy

Outpatient psychotherapy refers to the diagnosis and treatment of mental, emotional, or behavioral disorders, conditions, and addictions using established psychological principles for the purpose of assisting people in modifying their behaviors, cognitions, emotions, and other personal characteristics. Psychotherapy is intended to offer a person with mental illness or substance abuse disorders 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.

Under MA, psychotherapy may be offered by a physician who has completed a residency in psychiatry, a psychologist, an advanced practice nurse prescriber with a certification in a psychiatric specialty, or various other mental health practitioners who are employed by a certified outpatient mental health clinic or outpatient hospital facility. Generally, mental health practitioners who are not physicians, psychologists, or advanced practice nurse prescribers must be certified social workers or therapists with at least a master's degree.

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.

Outpatient Substance Abuse Counseling

Although persons with a substance abuse disorders may receive psychotherapy services, particularly if they are dually-diagnosed with a mental illness and substance use disorder, they also may receive treatment under the MA program's outpatient substance abuse services benefit.

Outpatient substance abuse treatment may be provided by a physician, a psychologist, or a certified alcohol and other drug abuse (AODA) counselor employed by a certified outpatient clinic or hospital outpatient facility and practicing under the supervision of a physician or psychologist. An AODA counselor must have a minimum of a high school diploma or equivalent, plus meet other training and counseling experience requirements.

Counseling sessions may be provided on an individual, group, or family/couple basis. Services may generally be provided in an office, school, nursing home, or hospital outpatient setting.

Persons receiving outpatient substance abuse counseling must first receive a medical examination by a physician, including diagnosis, medical history, and a recommendation for enrollment in a substance abuse treatment program.

A provider must obtain prior authorization for continued treatment after reaching $825 or 15 hours of treatment in a calendar year.

Narcotic Treatment Service

A narcotic treatment service provides medication assisted treatment to persons who are physically and psychologically dependent on an opiate drug. In medication assisted treatment, medications, such as methadone or buprenorphine, are administered on a periodic basis to prevent withdrawal symptoms, reduce drug cravings, or block the euphoric effects of opiates, thereby helping drug dependent persons to stop the use of illicit drugs. Along with medication, the narcotic treatment service provides drug abuse counseling in order to help patients to improve their social and psychological functioning with the goal of avoiding situations that lead to drug use.

To receive state certification, a narcotic treatment service is required to have on staff, at a minimum, a physician designated as a medical director and a registered nurse to supervise the dosing process. The service must also employ or contract with substance abuse counselors, working under the supervision of a clinical supervisor.

To be enrolled in a narcotic treatment service, a person must have been dependent on a narcotic for at least one year. The treatment service must arrange for a comprehensive physical examination, any indicated laboratory work, and psychosocial assessment for all eligible persons seeking admission. Upon admission, the narcotic treatment service conducts an assessment of the person's drug use, as well as screens for related physical conditions, such as tuberculosis, viral hepatitis, and sexually transmitted disease. The patient is then given an initial treatment plan, out-

lining medication dosage and counseling schedule.

For at least the first 90 days following admission, patients are expected to travel to the narcotic treatment service for the administration of medications six days per week (Sundays excluded). Following this initial period, the patient may be allowed to receive take-home medication on a limited basis if the treatment staff determines that he or she is adhering to treatment plan, is not using illicit drugs, and is making progress in treatment. MA generally limits the total length of methadone treatment to two years.

Throughout the duration of treatment, the patient's progress is monitored through periodic drug tests. Any positive tests for drugs must be recorded in the patient's case record.

Prescription Drugs

In addition to therapy services, treatment for individuals with mental illness and substance abuse can frequently include the use of medication. The MA program covers medication used to treat mental illness or substance abuse disorders that is determined to be medically necessary and if prescribed by a physician or other professional with prescribing authority. Of particular relevance to substance use disorders are drugs used in the course of medication assisted therapy provided by a narcotic treatment service.

Day Treatment

Day treatment services are available for the treatment of both mental illness and substance use disorders, although the requirements with respect to staffing of the service, the admission criteria, and the types of services offered differ.

Day treatment for mental health conditions is a nonresidential program in a medically supervised setting that provides case management, medical care, psychotherapy or other therapies, skill development, substance abuse counseling, and follow-up services to alleviate problems related to mental illness or emotional disturbances related to a diagnosed mental illness. The MA program covers day treatment for both adults and children, although the applicable prerequisites and prior authorization requirements differ.

Adult day treatment services for mental health 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.

Mental health 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.

A substance abuse day treatment service provides treatment planning, group and individual counseling, member education when necessary for effective treatment, and rehabilitative services to ameliorate or remove the disability and restore effective functioning. Typically, a substance abuse day treatment program provides counseling or other services in accordance with a daily and weekly schedule for a period of four to six weeks.

Day treatment services are available for persons who have a demonstrated need for structure and intensity of treatment that is not available in outpatient treatment, but who have the ability to function in a semi-controlled, medically supervised environment. The service must include at least 12 hours of counseling per week, or at least 60 hours within a six-week period of time. Reimbursement is limited to five hours per day and all substance abuse day treatment services require prior authorization.

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 persons who are receiving care from multiple providers. Among the recipients of case management services are persons who have serious and persistent mental illness, persons who are alcoholic or drug dependent, and children who are determined to be severely emotionally disturbed.

Case management consists of: (a) a comprehensive assessment to determine the recipient's abilities, deficits, and needs; (b) the development of a care plan to address the recipient's needs; and (c) ongoing monitoring of services and service coordination. The case manager assists the recipient or the recipient's family to gain access to, coordinate, and monitor necessary medical, social, educational, and vocational services. Only the assessment, care planning, and ongoing monitoring are reimbursed under the MA case management benefit.

Case management services to adults with mental illness or substance abuse disorders are provided by, and at the discretion of, counties or tribes. If a county or tribe elects to provide case management services to its residents or members, MA only provides reimbursement of the federal share of eligible costs, while the nonfederal share of the cost is borne by the county or tribe.

Inpatient Care

In general, MA program coverage for inpatient care for mental health or substance abuse 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 provided under the direction of a physician and must be deemed medically necessary. Typically, care provided to persons for conditions related to mental health or substance abuse that is provided in a general hospital is for persons who need short-term stabilization or who are hospitalized for physical conditions.

In cases where a person requires hospitalization for mental health or substance abuse needs for a longer period of time, the hospitalization typically occurs in an institute for mental disease (IMD). 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.

Generally, 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). However, a recent change in federal regulations permits Medicaid coverage of treatment in an IMD for persons between the age of 21 and 65 if the person is enrolled in a health maintenance organization, the inpatient stay is less than 15 days in a calendar month, and the treatment is voluntary.

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.

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

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 or substance abuse disorders, 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 or substance abuse treatment 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 or a substance abuse disorder 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 disor-

der 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.

CCS is currently offered in 63 counties, serving approximately 4,000 individuals.

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. For the purposes of this benefit category, alcoholism or drug dependency are not considered when determining eligibility, although persons with serious and persistent mental illness may also have substance abuse disorders. 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 coor-

dinate 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. At least one CSP is available in 62 counties and a total of approximately 5,600 persons are enrolled.

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.

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.

Funding Responsibility for the Non-Federal Share of Psychosocial Service Rehabilitation Programs.

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.

With respect to the other two psychosocial rehabilitation programs (CSP and CRS), counties are responsible for the non-federal share of program costs.

Other Mental Health and Substance Abuse 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 and substance abuse services. The principal programs described in this section are: (a) the federal community mental health services block grant; (b) the federal substance abuse prevention and treatment block grant; (c) the community aids program; (d) the coordinated services team initiative; (e) the opioid treatment program; (f) the intoxicated driver program; (g) the opening avenues to reentry success program; (h) peer-run respite initiatives; and (i) the child psychiatry consultation program.

Community Mental Health Services Block Grant

The Substance Abuse and Mental Health Services Administration (SAMHSA) 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 federal fiscal year (FFY) 2016-17 MHBG allocation of $8,267,100 is summarized in Table 1. The following paragraphs provide a brief description of the uses of block grant funds.

Table 1: Expenditure Plan for Mental Health Block Grant Funds, FFY 2016-17

Program	Planned Expenditure
Community Aids Allocation	$2,513,400
Children's Initiatives	1,826,500
Recovery, Early Intervention, Prevention	1,232,000
Consumer and Family Support	1,127,300
State Operations	710,000
Transformation Activities	546,800
Training and Technical Assistance	181,800
Protection & Advocacy	75,000
Systems Change	54,300
Total	$8,267,100

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 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 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.

Recovery, Early Intervention and Prevention ($1,232,000). This allocation supports evidence-based early intervention services for people suffering from first-episode psychosis, as well as suicide prevention efforts with a focus on reducing disparities among cultural subgroups and veterans.

Consumer and Family Support Grants ($1,127,300). 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 2016, funded with the 2015-16 allocation: (a) the National Association of the Mentally Ill ($240,900); (b) Wisconsin Family Ties ($265,900); (c) Independent Living Resources ($209,000); (d) various peer-run organizations ($297,148); (e) and Access to Independence ($114,352). 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 ($546,800). 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, training counties and providers on quality improvement and evaluation services, promoting tribal best practices for the treatment of co-occurring disorders, and addressing issues of homelessness and mental health.

Training and Technical Assistance ($181,800). 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.

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.

Substance Abuse Treatment and Prevention Block Grant

In addition to the MHBG, SAMHSA also distributes funding to states under the substance abuse prevention and treatment block grant (SABG), to assist states with the prevention and treatment of substance abuse. States must use at least 20% of SABG funds on substance abuse

primary prevention activities. State primary prevention programs must target both the general population and population subgroups that are at high-risk for substance abuse. In addition, states must enact and enforce laws aimed at preventing access to tobacco products for youth under age 18.

Table 2 summarizes the state's FFY 2016-17 expenditure plan for SABG funds. The following paragraphs provide a brief description of each category of treatment and prevention programs shown in the table.

Table 2: Expenditure Plan for Mental Health Block Grant Funds, FFY 2016-17

Program	Planned Expenditure
Community Aids Allocation	$9,735,700
Women's AODA Initiatives	3,558,200
Treatment Related Grants	3,423,000
Department of Children and Families	3,158,000
State Operation and Administration	2,219,600
Primary Prevention Activities	2,134,500
Juvenile Justice Treatment Grants	1,621,600
Department of Corrections	1,347,400
Total	$27,198,000

Community Aids ($9,735,700). As with the MHBG, state statutes specify the amount of SABG funds that must be allocated to the community aids basic allocation. Counties are required to prepare an annual plan indicating how this portion of the basic allocation is spent. Consistent with federal requirements, counties are required to spend at least 20% of the funds for substance abuse prevention activities.

Women's AODA Initiatives ($3,558,200). Federal block grant provisions and state statutes require the establishment and funding of specialty substance use disorder treatment for women and their families. These grants provide substance abuse, mental health, and other psychosocial treatment programs, as well as educational, vocational, and housing services. In particular, grants prioritize the reduction of drug and alcohol use among pregnant and post-partum women. Grants are awarded to counties and private entities for community-based programs.

Treatment Related Grants ($3,423,000). DHS provides funding from the SABG for the following grant programs: (a) treatment alternatives program (TAP), for criminal justice diversion and drug court services; (b) urban black and hispanic residential and other treatment services; (c) injection drug use treatment in high need communities; (d) coordinated services team initiatives; (e) methamphetamine treatment in high need communities; (f) grants to help communities establish operating while intoxicated treatment courts; (g) tribal treatment programs; (h) anti-stigma and peer specialist services development; and (i) training and technical assistance for trauma informed care and evidence-based substance use disorder treatment.

Department of Children and Families ($3,158,000). Funding is provided to the Department of Children and Families (DCF) for two programs. The first is for prevention and treatment for families involved in the child welfare system affected by substance abuse. Specific services include parenting support, family interaction, respite, psychological evaluation, transportation, drug testing, supervised visitation or substance abuse treatment, and recovery support services. The second grant to DCF is for the brighter futures initiative (BFI) primary prevention grant program. BFI funds are used to promote healthy families and youth, school success, and youth safety in their families, along with positive youth development with the goal of substance use disorder prevention.

State Operations and Administration ($2,219,600). DHS uses SABG funds for staff costs in the Department’s Bureau of Prevention Treatment and Recovery, for staffing the Wisconsin State Council for Alcohol and Other Drug Abuse, and for administrative functions related to

the grant.

Primary Prevention Activities ($2,134,500). In addition to the primary prevention activities funded through the county community aids allocation and to DCF, DHS funds a variety of other substance use disorder primary prevention activities. These include targeted initiatives for the prevention of substance abuse amount tribal families, inner city youth, the IV drug using population, and pregnant mothers. Programs and agencies that receive funding include regional Alliance for Wisconsin Youth agencies, Tribal Brighter Futures, the Tribal Family Service program, and My Baby and Me.

Juvenile Justice Treatment Grants ($1,621,600). The purpose of these funds is to create and improve community efforts to increase screening, intervention and treatment of juvenile alcohol and drug problems for Wisconsin's at-risk youth population, including expectant mothers. Grants were awarded to Dane, Kenosha, Milwaukee, Portage and Rock counties under a request for proposals process. In addition, funding was provided to the Department of Justice for a gang diversion and substance use disorder prevention grant. The goal of these grants is to inform and educate youth and parents about tobacco, alcohol, and other drug abuse.

Department of Corrections ($1,347,400). The federal SABG law designates funding for community-based services and limits the funding for correctional institution services to the amount spent historically in the state. DHS provides funding for substance use disorder treatment and supports to the following DOC program areas: (a) alcohol and other drug abuse programs at Taycheedah correctional institution; (b) a halfway house for women operated by the Division of Community Corrections; (c) a tribal residential treatment facility operated by the Division of Community Corrections; (d) other substance abuse treatment programs of the Division of Community Corrections; and (e) substance abuse treatment programs operated by the Division of Juvenile Corrections.

Community Aids

Basic County Allocation. 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 2016, DHS distributed $169.8 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 2015, counties reported spending approximately $96.7 million of the BCA on services for persons with mental illness and $8.8 million on substance abuse treatment services.

Community Mental Health Allocation. In addition to the BCA, the community mental health allocation directs funds to counties specifically for community mental health services. The 2015-17 biennial budget act created this allocation through the consolidation of five existing county mental health grant programs into a single program, with an annual distribution of $24,348,700. The amount received by each county is close to, although not exactly the same as, the sum of the amounts received under the five eliminated programs.

Counties must spend funds received under the community mental health allocation on community-based services for adults or children with a mental health diagnosis who have or are at risk of

having a serious mental illness or a serious emotional disorder. Some of the services that may be funded are psychosocial rehabilitation programs, crisis intervention, peer support programs, case management, counseling or therapeutic resources, adult family homes, group homes, and day treatment.

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 distributes $4.6 million annually to counties and tribes, using a combination of GPR ($2.6 million), federal mental health block grant funds ($1.2 million) medical assistance hospital diversion funds ($0.7 million), and funding from the Department of Children and Families ($0.1 million). In 2016, CST grants were awarded to nearly all counties and Native American Tribes. Each county and tribe receives $60,000 per year. The local initiative is required to contribute a 20% match to receive the funds, which may be provided in cash or in-kind resources.

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.

Opioid Treatment Centers

The Department is required to provide grants to two to three regional opioid treatment programs in rural, underserved areas of the state. These programs may provide medication-assisted treatment (although not using methadone), residential services, counseling, or abstinence-based treatment. Total funding for these treatment initiatives is $2.0 million.

In 2016, DHS contracted with three organiza-

tions in northern Wisconsin to provide services: (a) Northeast Wisconsin Opioid Treatment Services, serving Florence, Marinette, Menominee, and Oconto counties and the Menominee Tribe; (b) the HOPE Consortium, serving Forest, Iron, Oneida, Price, and Vilas counties and the Forest County Potawatomi, Lac du Flambeau Chippewa, and Sokaogon Chippewa tribes; and (c) the NorthLakes Community Clinic, serving Ashland, Bayfield, Burnett, Douglas, Sawyer, and Washburn counties, and the Bad River, Lac Courte Oreilles, and Red Cliff tribes. Each agency received $672,000 in 2016.

Intoxicated Driver Program

The Department's intoxicated driver program (IDP) provides the framework for the assessment and treatment of persons who have been convicted of operating a motor vehicle while intoxicated (OWI). As with other mental health and substance abuse programs, the state's counties and tribes play an important role in administering the program's requirements, while the Department establishes standards and provides some funding.

Any person who has an implied consent refusal or who is convicted of an OWI offense must undergo an assessment of his or her alcohol or controlled substance use at an approved treatment facility, designated by his or her county of residence. Each county establishes a single driver assessment facility (although certain counties share a single facility), according to standards developed by the Department. Tribes may establish an assessment facility for tribal members. Assessments are conducted according to a standardized interview procedure, but may also involve an analysis of other relevant information, including a review of available records and reports, and information provided by other persons. Following the completion of the assessment review, the assessor issues a finding, which ranges from "irresponsible use" of alcohol or drugs, to alcohol or drug dependency.

The assessor's finding is used in the development of a driver safety plan, which outlines the driver's obligations in response to the finding. Response measures vary depending on the type of finding. For instance, a person who is found to have irresponsible alcohol use is required to attend a traffic safety program (or a similar educational program), in which participants discuss, in a group setting, their intoxicant use habits and lifestyle modifications that may help avoid intoxicated driving. Persons who are found to have an alcohol or drug dependency are required to undergo a more comprehensive substance abuse treatment program, which may include up to 30 days of inpatient services. Driver safety plans may also include other elements, at the option of the assessment agency, including mandatory attendance at an intoxicated driving victim impact panel, or a psychiatric evaluation. The treatment or other measures required under a driver safety plan are provided by service providers approved by the county. The person may choose the provider from a list of approved facilities within the geographic area.

The driver safety plan is in effect for a period determined by the assessor. Plans generally may not exceed one year, but can be extended beyond the one-year period with the approval of the Department of Transportation. Other elements of a plan may be amended if recommended by the plan provider or assessment agency.

Each county establishes an assessment fee, which is paid by the person subject to the assessment order. The fees are intended to cover the cost of the assessment, and generally range from about $200 to $300 (although a few have fees higher than this range). Some counties also charge additional fees for rescheduled appointments or failure to appear for an assessment. Fees can be paid in installments, but must be paid in full prior to the assessment.

The person who is subject to a driver safety plan is charged a fee for plan services. The fee

for certain services may be waived or reduced if it is determined that the person is unable to pay the full fee, but the fee for a traffic safety or alternative educational program may not be waived. The cost of some services may be offset from other sources, depending upon the type of service. For instance, private health insurance plans or the MA may cover the substance abuse treatment services included in the plan.

In addition, both driver assessment and driver safety plan services are financed by revenues collected from the OWI driver improvement surcharge, a $435 surcharge levied upon each OWI conviction. Counties retain 50.3% of surcharge revenues ($218.80 if the full amount is collected), while the remainder is forwarded by courts to the state. The county uses its share of surcharge revenues to fund IDP costs. In addition, a portion of the state's share of OWI driver improvement surcharge revenue is used by DHS to provide supplemental funding to counties or tribes that demonstrate that their own surcharge revenues are insufficient to support IDP costs. In 2016, DHS distributed $1.0 million to counties and tribes under this program.

Opening Avenues to Reentry Success

DHS administers the opening avenues to reentry success program (OARS), in conjunction with the Department of Corrections (DOC), to provide support services to persons being released from prison who have identified mental health needs and who are assessed to have a moderate to high risk of reoffending. Participation in the program is voluntary.

The program has a designated case manager who works with the program participant, DOC institution social worker, DOC community corrections agent, as well as other community resources to develop an individualized service plan for the participant. Services include assistance with obtaining and maintaining housing, medication management, psychiatric care, structured social, educational, and employment activities, assistance with transportation, and financial support. Services are provided both prior to and after release from the correctional institution.

DHS contracts with social service agencies to provide case management services. OARS currently operates in 36 counties. In 2015-16, OARS served 256 participants, at a cost of $2,504,400. Program costs are funded with a DOC appropriation.

Peer-Run Respite Initiatives

DHS provides annual grants to 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. In 2016, the Department provided grants totaling $1.45 million to peer-run support facilities in Appleton, Madison, and Menomonie.

Child Psychiatry Consultation Program

DHS is budgeted $500,000 GPR annually 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 Department is required to establish regional hubs for consultation services. The Department contracts with the Medical College of Wisconsin, which provides consultative services in Milwaukee County as well as northern Wisconsin counties.

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

Chapter 51 establishes procedures for the emergency detention of persons experiencing a mental health or substance abuse crisis, as well as

procedures for the commitment of certain persons for 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 or drug dependent; (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 or drug dependency; 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.

Once a person is in custody, the county department of human services must conduct a crisis assessment, either in person, by telephone, or by telemedicine or video conferencing technology, to determine if the person meets the criteria for emergency detention. If, following this assessment, the county department agrees for the need for detention, the person 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 or substance abuse disorder are sought in cases where a person is considered to meet all of the following criteria: (a) has a mental illness or substance abuse disorder; (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 issue an order for commitment if the standards are met, dismiss the petition and release the person, or 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 mental 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.

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 committed 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.

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 14 inpatient treatment units for forensic patients with a total capacity of 273 and one civil geropsychiatric unit for elderly patients with a capacity of 15. Of the 14 forensic units, six are maximum security, six are medium security, and two are minimum security.

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 seven treatment units with a total capacity of 184, including six adult units with a total capacity of 150, and one youth civil unit with a capacity of 34. Of the adult units, two are medium security and two are minimum security forensic units for females, and two are civil units for both males and females. 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.

In 2015-16, Mendota had 506 admissions and Winnebago had 3,280 admissions. Persons admitted for emergency detention or civil commitments tend to have shorter stays than forensic patients. Of the patients who were admitted and released during 2015-16, the average length of stay at Winnebago was 14 days, while the average length of stay at Mendota was 52 days.

Table 3 provides information on the average number and percentage of patients by type in each institution in 2015-16. 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

Table 3: Average Daily Populations (ADP) at the Mental Health Institutes by Type of Unit -- 2015-16

	Mendota		Winnebago	
	ADP	Percent	ADP	Percent
Forensic	254.9	85.1%	78.4	40.9%
Youth -- Civil	0.0	0.0	35.0	18.3
Adult -- Civil	8.3	2.8	78.3	40.9
Geriatric -- Civil	15.9	5.3	0.0	0.0
Juvenile Treatment	28.8	9.6	0.0	0.0
Totals	299.6	100.0%	191.6	100.0%

Note: Totals do not add due to rounding.

that are committed, the Department serves patients in excess of staffed capacity using temporary accommodations and overtime staffing.

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 4 shows the daily rates DHS established for each patient population group at Mendota and Winnebago that were in effect as of October 1, 2016.

Table 4: Mental Health Institutes Inpatient Daily Rates as of October 1, 2016

	Mendota	Winnebago
Adult Psychiatric Services	$1,039	$1,039
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

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. In 2015-16, Mendota had a budget of $78.7 million ($59.8 million GPR and $18.9 million PR) and Winnebago had a budget of $58.6 million ($21.3 million GPR and $37.3 million PR).

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 2015-16, the Center housed a weekly average of 380 inmates, including 339 men and 41 women.

The WRC facilities are divided into units, each generally housing between 20 and 34 inmates. There are currently 14 units for men and 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 2015-16, the DHS budget for WRC operations was $52.1 million GPR, while Department of Corrections spent $7.8 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 I

Services for Individuals with Mental Illness, County Expenditures*
Calendar Years 2011 through 2015

County	2011	2012	2013	2014	2015
Statewide Total	**$430,152,269**	**$444,546,291**	**$469,656,487**	**$473,517,341**	**$504,346,390**
Adams	$1,702,525	$1,240,558	$1,362,471	$2,036,861	$1,948,101
Ashland	1,510,667	1,458,765	1,153,331	1,385,885	1,107,103
Barron	2,791,161	2,802,180	3,061,809	3,192,219	3,315,310
Bayfield	1,468,568	1,282,800	1,365,411	1,560,885	1,257,329
Brown	16,126,168	15,394,215	16,761,260	15,899,283	14,457,876
Buffalo	787,954	384,609	659,367	506,331	606,065
Burnett	1,153,502	856,144	693,071	446,664	610,366
Calumet	3,030,071	3,181,764	3,133,057	3,534,516	3,194,441
Chippewa	2,801,605	2,651,270	3,031,158	3,305,789	3,348,650
Clark	2,943,213	3,276,783	3,318,411	2,305,872	1,945,242
Columbia	2,046,891	2,289,071	2,887,037	2,476,839	3,488,484
Crawford	1,227,677	1,406,885	1,434,417	1,570,737	1,429,519
Dane	33,456,129	34,635,155	35,212,846	34,042,769	34,723,101
Dodge	6,149,900	6,321,527	6,170,831	8,039,439	5,289,735
Door	1,938,796	1,968,910	2,017,886	2,099,116	2,229,974
Douglas	2,894,162	3,020,664	2,602,044	2,660,490	3,210,242
Dunn	2,201,822	2,067,871	2,211,623	2,311,119	2,636,923
Eau Claire	6,011,714	6,057,252	6,133,440	6,099,118	6,246,719
Florence	78,497	127,015	140,013	102,701	89,698
Fond du Lac	7,066,504	6,750,506	7,330,902	6,733,622	7,321,271
Forest/Oneida/Vilas	4,354,297	5,825,240	6,026,717	6,687,699	6,693,254
Grant/Iowa	2,569,701	2,494,446	2,513,402	2,894,072	3,068,292
Green	2,273,049	2,305,818	2,587,474	2,636,038	2,682,680
Green Lake	1,289,815	1,189,276	1,485,463	1,172,038	1,536,995
Iron	573,919	586,292	702,034	844,635	**
Jackson	1,456,634	1,129,094	931,078	833,527	687,410
Jefferson	7,032,315	6,503,919	6,012,153	7,276,002	7,134,740
Juneau	2,468,900	2,202,330	2,312,580	2,523,942	2,677,039
Kenosha	9,771,063	10,344,197	10,734,879	10,158,000	13,957,943
Kewaunee	904,747	848,417	1,273,926	1,363,666	1,756,756
La Crosse	8,262,554	8,587,622	9,604,289	11,341,618	14,297,574
Lafayette	1,119,559	1,056,489	1,405,721	1,268,151	1,458,426
Langlade/Lincoln/ Marathon	17,492,693	17,034,855	17,543,223	16,389,745	19,830,432
Manitowoc	6,274,301	5,331,122	5,678,276	5,296,241	6,466,762
Marinette	3,542,626	3,473,616	3,732,959	3,170,744	3,166,952

APPENDIX I (continued)

Services for Individuals with Mental Illness, County Expenditures*
Calendar Years 2011 through 2015

County	2011	2012	2013	2014	2015
Marquette	$1,095,424	$1,032,677	$1,071,804	$1,172,772	$1,320,938
Menominee	**	**	906,021	1,085,059	912,336
Milwaukee	129,942,247	129,257,310	139,586,016	139,656,052	154,997,375
Monroe	**	1,866,737	1,865,179	2,254,659	2,048,019
Oconto	1,374,366	1,331,356	1,512,633	1,420,076	1,736,035
Outagamie	11,118,053	12,732,643	13,359,410	13,454,536	13,033,364
Ozaukee	2,745,112	2,517,462	2,995,100	2,668,570	3,016,950
Pepin	339,885	316,197	365,708	345,738	138,067
Pierce	1,239,591	1,120,315	1,465,019	1,564,176	1,219,850
Polk	4,177,079	4,041,874	3,759,628	3,915,163	3,479,991
Portage	3,230,019	3,569,967	3,297,347	3,112,343	2,598,333
Price	885,134	840,119	846,139	744,764	831,013
Racine	9,000,827	9,849,403	9,903,625	8,990,200	10,575,902
Richland	2,292,045	1,994,656	1,852,225	1,838,582	1,706,876
Rock	17,209,117	17,539,354	17,445,994	18,530,971	19,698,380
Rusk	890,710	925,095	697,074	750,734	676,357
Sauk	5,956,018	5,887,670	5,441,488	6,145,151	7,102,336
Sawyer	1,448,423	1,469,391	945,156	1,786,501	1,961,194
Shawano	1,132,869	1,568,440	1,892,749	1,850,287	2,166,335
Sheboygan	7,199,610	7,314,819	7,508,025	7,839,546	7,250,075
St Croix	**	4,855,506	4,801,690	5,703,482	5,412,827
Taylor	772,180	1,234,215	1,106,148	1,088,713	1,286,378
Trempealeau	1,806,639	1,345,994	930,874	986,744	979,755
Vernon	2,074,578	2,295,913	2,506,539	2,673,872	2,155,501
Walworth	2,529,560	4,814,227	8,684,844	7,744,745	9,426,208
Washburn	918,854	947,436	1,021,309	851,926	797,962
Washington	9,135,878	9,087,982	9,674,284	10,061,555	11,415,784
Waukesha	19,920,412	20,146,985	22,182,019	21,986,796	22,361,521
Waupaca	3,864,209	3,704,661	3,559,314	3,671,543	3,274,326
Waushara	2,761,959	2,944,224	2,436,726	2,606,265	2,404,941
Winnebago	10,312,003	11,349,108	11,648,328	12,286,045	12,639,916
Wood	8,005,769	10,557,878	11,163,513	10,563,402	11,850,141

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

APPENDIX II

Services for Individuals with Substance Use Disorders, County Expenditures*
Calendar Years 2011 through 2015

County	2011	2012	2013	2014	2015
Statewide Total	**$72,553,079**	**$72,239,697**	**$71,184,366**	**$68,569,499**	**$70,554,979**
Adams	$392,376	$565,820	$508,087	$613,058	$515,008
Ashland	145,399	168,976	176,910	135,033	144,558
Barron	577,136	568,372	572,022	580,431	393,495
Bayfield	431,350	559,443	372,873	375,299	295,251
Brown	1,226,792	945,596	1,024,645	997,878	1,317,341
Buffalo	88,533	66,208	93,863	107,047	50,460
Burnett	173,939	188,024	185,316	333,894	365,255
Calumet	260,811	320,372	322,260	346,453	193,564
Chippewa	212,821	281,154	266,923	291,154	759,417
Clark	270,282	249,098	265,825	165,144	155,825
Columbia	199,438	206,715	158,274	137,598	187,620
Crawford	234,022	238,715	387,363	257,896	136,072
Dane	8,615,240	7,955,326	7,999,167	8,109,439	7,997,684
Dodge	697,568	781,573	663,365	751,161	5,378,055
Door	787,933	752,153	493,949	402,255	320,515
Douglas	457,291	446,947	378,290	357,701	372,046
Dunn	454,250	527,604	473,321	453,456	528,775
Eau Claire	1,300,726	1,505,659	1,475,150	1,473,751	1,102,647
Florence	44,008	49,288	68,259	47,544	40,523
Fond du Lac	1,058,086	1,005,141	868,130	920,417	905,445
Forest/Oneida/Vilas	2,823,807	1,772,670	1,832,702	2,146,259	1,875,160
Grant/Iowa	502,786	543,839	535,577	526,995	497,162
Green	445,605	493,134	510,824	531,184	550,708
Green Lake	134,305	183,395	122,942	91,637	292,124
Iron	60,720	82,939	115,339	18,164	**
Jackson	183,721	272,468	184,743	168,055	160,215
Jefferson	497,185	1,021,118	822,952	816,548	856,880
Juneau	192,301	262,835	285,740	343,849	329,839
Kenosha	1,529,750	1,764,593	1,890,917	1,431,908	1,717,452
Kewaunee	563,473	367,821	220,164	210,419	159,329
La Crosse	1,363,214	1,335,978	860,802	717,862	1,258,306
Lafayette	200,966	226,191	247,365	287,696	170,753
Langlade/Lincoln/ Marathon	3,960,690	4,329,956	3,958,822	2,741,090	3,926,481
Manitowoc	803,704	1,076,813	1,071,307	924,164	696,703
Marinette	759,201	742,504	935,058	940,196	945,013

APPENDIX II (continued)

Services for Individuals with Substance Use Disorders, County Expenditures*
Calendar Years 2011 through 2015

County	2011	2012	2013	2014	2015
Marquette	$171,907	$210,880	$184,394	$152,225	$220,725
Menominee	**	**	316,250	230,980	234,755
Milwaukee	18,455,210	17,658,505	17,412,853	15,870,078	14,268,712
Monroe	**	519,260	517,510	552,553	453,439
Oconto	297,309	169,590	233,784	234,426	261,796
Outagamie	1,741,348	1,839,180	1,994,221	2,093,583	2,343,858
Ozaukee	533,777	603,265	524,018	611,225	395,632
Pepin	16,030	17,843	27,909	11,569	**
Pierce	363,094	324,663	372,855	403,817	389,970
Polk	371,251	366,791	328,097	460,600	448,991
Portage	949,954	1,030,732	860,373	745,538	454,029
Price	144,057	113,756	103,308	105,298	95,707
Racine	1,099,387	1,188,787	1,250,946	1,057,843	1,277,640
Richland	165,026	132,195	119,332	129,132	129,132
Rock	1,417,420	1,301,766	1,155,597	1,783,688	1,580,186
Rusk	67,804	93,589	79,594	90,622	65,017
Sauk	416,455	407,354	440,038	531,790	428,240
Sawyer	844,639	680,197	280,647	1,027,722	745,670
Shawano	496,991	234,221	238,200	235,307	69,098
Sheboygan	1,751,467	1,702,228	1,613,402	1,456,836	1,853,351
St Croix	**	865,449	949,773	771,237	771,006
Taylor	234,793	205,309	224,478	200,842	201,244
Trempealeau	123,972	164,064	100,668	125,237	125,997
Vernon	95,620	75,091	65,845	72,630	63,491
Walworth	783,708	849,185	1,262,935	1,318,543	1,174,426
Washburn	133,152	127,139	154,328	79,172	87,272
Washington	1,526,196	1,137,739	834,749	914,289	843,975
Waukesha	4,094,640	4,278,029	4,873,078	4,297,322	3,346,483
Waupaca	343,409	329,983	261,129	262,106	236,151
Waushara	397,455	313,930	374,282	401,051	363,535
Winnebago	2,055,946	2,325,856	2,231,833	1,990,559	1,993,791
Wood	1,811,633	1,114,683	1,448,694	1,599,044	1,035,979

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