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# services for persons with mental illness and substance abuse disorders

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# Services for Persons with Mental Illness and Substance Abuse Disorders

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# Services for Persons with Mental Illness and Substance Use Disorders

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 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 dependence," which is defined as a disease that is characterized by a person's use of one or more drugs that is beyond the person's ability to control to the extent that the person's physical health is substantially impaired or his or her social or economic functioning is substantially disrupted.

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

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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 to support 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 supportive services not covered by private insurance, or are services 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. These county agencies are usually 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).

American Indian tribes in Wisconsin assume many of the human services functions of counties for their enrolled members. There are 11 tribal human service agencies in Wisconsin.

*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 the Milwaukee County Mental Health Board (MCMHB) in that county. The MCMHB has 11 voting members appointed by the county executive representing various types of mental

health providers and consumers. By state law, 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. Since it was established in 2015, the tax levy portion of the budget has remained within the statutory limits.

*Basic County Requirements.* County departments of community programs must, within the limits of available funds, provide 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 annual reports to DHS on the number of persons receiving county human services, including mental health and substance abuse services, 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 2015 through 2019. 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 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 services 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 Office of Children's Mental Health makes 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. The Director of the Office is an unclassified position, appointed by, and serving at the pleasure of, the Governor.



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## **Mental Health and Substance Abuse Services Funded Under the Medical Assistance Program**

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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. Over the last decade, the federal share for MA benefit costs for Wisconsin's program has ranged between 58% and 60%, with the nonfederal share from approximately 42% to 40%.

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 are provided at the option of counties, however, 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 of program models.

Inpatient hospital care for mental health and substance abuse disorders is also covered under the MA program under certain circumstances, but is subject to different payment rules, depending upon the situation. This section describes some of the principal mental health 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.

### **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, and 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.

### **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.

### **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, outlining 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. 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 the treatment plan, is not using illicit drugs, and is making progress in treatment.

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.

## **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, 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 other therapy services or is a hospital inpatient or a nursing home resident.

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.

### **Crisis Care**

Within the limits of available funds, counties are required to have an emergency service program to respond to individuals experiencing a mental health crisis. At a minimum, crisis 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. Only six counties -- Bayfield, Florence, Iron, Trempealeau, Vernon, and Washburn -- do not meet this standard.

In order to receive reimbursement under MA (for services provided to MA-eligible persons), an emergency mental health services program must additionally provide a mobile crisis team for on-site 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. The program must also satisfy various personnel and training requirements and have written policies related to the procedures followed during a crisis situation. 65 counties have a crisis intervention service that meets MA certification criteria or participate in a multi-county certified program. Douglas County is the only county with crisis services that meet the basic standard but not the additional requirements for MA certification.

Prior to 2019 Act 9, the non-federal share of costs for mental health crisis care was borne by the counties. Act 9 required the state to pay a portion of these costs for counties that meet the MA certification criteria as well as an additional criterion to participate in shared regional services. All 65 counties with MA-certified programs also met this

requirement and are now receiving partial state funding.

The additional regional participation requirement is automatically met by counties whose human services departments are multi-county agencies and by single counties with more than 350,000 residents (currently Dane, Milwaukee, and Waukesha). Smaller counties that have a single-county human services department can meet the requirement either by participating in or contracting with a regional 24-hour crisis call center, or sharing a service such as staff, training, or a crisis stabilization facility with another county.

For counties that meet these requirements, the state pays the full non-federal share of costs for MA-eligible mental health crisis services after the county has spent an established contribution cap. This cap, or maintenance-of-effort requirement, is fixed at 75% of the average annual amount counties spent on crisis care over calendar years 2016 through 2018.

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 institution 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.

Generally, federal law restricts Medicaid coverage of IMD hospitalization to the elderly (over age 64) and children or adolescents (under age 21). However, under provisions of a federal waiver approved in 2018, MA can provide substance abuse treatment in an IMD for any MA beneficiaries, including non-elderly adults who would otherwise not be eligible for such coverage.

If a person is hospitalized in a state mental health institute as the result of an involuntary civil commitment (described in a later section), his or her county of residence is responsible for any costs of the hospitalization not covered by insurance. Since the mental health institutes are classified as IMDs, MA does not generally provide coverage for non-elderly adults. But, MA can be billed for persons under age 21 or over age 64. In this case, the county is required to pay the non-federal share of the MA program costs.

### **Residential Substance Abuse Treatment**

MA provides coverage of substance abuse treatment in a community-based, residential setting for individuals who are found to need a structured daily routine that is removed from their normal social environment.

Facilities that provide residential treatment must be licensed by DHS as either a transitional residential treatment service or medically-monitored treatment service. A transitional residential treatment service is defined as a clinically-supervised, peer-supported, therapeutic environment with clinical involvement providing substance abuse treatment in the form of counseling for three to 11 hours provided per week. A medically-monitored treatment service is defined as a 24-hour, community-based service providing observation, monitoring, and treatment by a multidisciplinary team under supervision of a physician, with a minimum of 12 hours of counseling provided per week.

Residential substance abuse treatment is provided under two separate circumstances. Some MA beneficiaries have been able to access residential treatment since May 1, 2017, as part of the services in the comprehensive community services (CCS) benefit. CCS is a psychosocial rehabilitation and support program offered under MA and is described in the next section.

Beginning in 2021, a new benefit, referred to as residential substance use disorder (RSUD) treatment, expands the range of eligible providers and covers MA recipients who are not enrolled in a CCS program. Specifically, this new benefit takes advantage of the federal waiver (described in the previous section) that allows substance abuse services to be provided for non-elderly adults in an IMD.

By federal law, Medicaid pays for the treatment costs, but does not pay for room and board costs in a community-based residential facility (not an inpatient hospital). Consequently, these costs must be paid by the county or by the individual.

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

Thirteen 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; and (m) substance abuse treatment. Substance abuse treatment may be provided in a residential treatment facility through CCS. MA pays for the cost of the treatment, but does not cover the cost of room and board.

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 professionals, 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 provided in 69 counties and three tribes, serving approximately 9,800 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, relative 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 coordinate treatment and services.

These services are designed to enable a recipient to better manage the symptoms of their illness, increase the likelihood of independent and effective functioning in the community, and reduce the incidence and duration of institutional treatment otherwise brought about by mental illness. CSPs are required to set a goal of providing over 50% of service contacts in a non-office- or non-facility-based setting.

In some larger counties, the county contracts for the operation of more than one CSP, while in other counties the county operates a single CSP. In a few cases, a single CSP covers more than one county. At least one CSP is available in 65 counties and a total of approximately 4,000 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).* CRS

programs offer residential-based, psychosocial rehabilitation services to persons who have a diagnosis of mood disorder, schizophrenia, or another psychotic disorder and 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.

CRS is offered in 14 counties, typically serving about 150 individuals.

*Funding Responsibility for the Non-Federal Share of Psychosocial Service Rehabilitation Programs.* The state pays the non-federal share of MA costs for CCS, 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 CCS 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.

### **Hub-and-Spoke Medical Home Treatment for Substance Abuse Disorders**

Beginning in 2021, DHS is implementing a "hub-and-spoke" health home treatment model to coordinate referrals and services for Medicaid-eligible people who have severe substance-use disorders and are experiencing or are at a high risk for chronic physical and mental health conditions. Under this model a hospital, health clinic, or other team of substance abuse care providers serve as a patient's "hub," assessing, planning, and coordinating their care as well as providing some of the services described in this section, such as medication assisted treatment and intensive outpatient care. "Spoke" offices could then provide other services, such as ongoing narcotic treatment services, psychosocial programs, and peer support, in close coordination with the patient's hub.

This hub-and-spoke model does not change the primary services described in this section, but does provide Medicaid matching funds for coordination



of those services, including comprehensive care management, health promotion, transitional care and follow-up, patient and family support, referrals to community and social support services, and use of health information technology to link services. During the first two and a half years that the hub-and-spoke model operates, the federal matching rate will be increased to 90% for these coordination services.

Initially, DHS is implementing the hub-and-spoke model on a pilot basis, rather than a statewide basis. The pilot program is expected to be implemented by March 2021, and continue through September 2023.

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### Other Mental Health and Substance Abuse Programs

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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 non-profit organizations to support community-based mental health and substance abuse services. This section describes these programs.

### Community Mental Health Services Block Grant

The Substance Abuse and Mental Health Services Administration (SAMHSA), an agency within 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. States are required to use MHBG funds to serve primarily adults with a serious mental illness or children with a severe emotional disturbance. States must allocate at least 10% of grant funds for early intervention programs for serious mental illness.

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. Several requirements in state statute specify uses of MHBG funds.

The state's expenditure plan for the federal fiscal year (FFY) 2020-21 MHBG allocation of \$11,793,500 is summarized in Table 1. A brief description of the uses of block grant funds follows.

**Table 1: Expenditure Plan for Mental Health-Block Grant Funds, FFY 2020-21**

Program	Planned Expenditure
Transformation/Training Activities	\$3,271,000
Community Aids Allocation	2,513,400
Recovery and Early Intervention	1,625,000
Children's Initiatives	1,548,000
Consumer and Family Support	1,507,000
State Operations	1,194,100
Protection & Advocacy	75,000
Systems Change	<u>60,000</u>
<b>Total</b>	<b>\$11,793,500</b>

*Transformation and Training Activities (\$3,271,000).* These grants fund a wide range of activities focused on evidence-based best practices, and access to services. Some of these activities 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.

*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. The amount of MHBG funds

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

*Recovery and Early Intervention (\$1,625,000).* 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.

*Children's Initiatives (\$1,548,000).* 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.

*Consumer and Family Support Grants (\$1,507,000).* 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 organizations receiving grants provide a range of vocational training, education, and consumer and family support services.

*State Operations (\$1,194,100).* DHS uses MHBG grant funds for staff costs in the Department's Bureau of Prevention, Treatment, and Recovery related to mental health program development, the Mental Health Council, and administrative functions.

*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 (\$60,000).* System change grants support the initial phasing in of recovery-oriented system changes, prevention and early intervention strategies, and consumer and family involvement for individuals with mental illness.

### **Substance Abuse Prevention and Treatment 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 and at least 5% on treatment services for pregnant women and women with dependent children. State primary prevention programs must serve 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 2020-21 expenditure plan for SABG funds, totaling \$27,199,500. A brief description of each category of treatment and prevention programs shown in the table follows.

*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

**Table 2: Expenditure Plan for Substance Abuse and Treatment Block Grant Funds, FFY 2020-21**

Program	Planned Expenditure
Community Aids Allocation	\$9,735,700
Women's AODA Initiatives	3,613,400
Department of Children and Families	3,016,000
Primary Prevention Activities	2,710,500
Treatment Related Grants	2,657,400
State Operation and Administration	2,497,500
Juvenile Justice Treatment Grants	1,621,600
Department of Corrections	<u>1,347,400</u>
Total	\$27,199,500

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 (\$3,613,400).* 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.

*Department of Children and Families (\$3,016,000).* 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. These services include parenting support, family interaction, respite care, 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.

*Primary Prevention Activities (\$2,710,500).* In addition to the primary prevention activities funded through the county community aids allocation and DCF, DHS funds a variety of other substance use disorder primary prevention activities. These include initiatives for the prevention of substance abuse among American Indians and prevention of HIV infection.

*Treatment Related Grants (\$2,657,400).* 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.

*State Operations and Administration (\$2,497,500).* DHS uses SABG funds to support staff costs in the Department's Bureau of Prevention Treatment and Recovery, staffing the Wisconsin State Council for Alcohol and Other Drug Abuse, and administrative functions related to the grant.

*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 are awarded through the Department of

Children and Families to counties for use in the juvenile justice system. In addition, funding is 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 tribal residential treatment facility operated under contract with the Division of Community Corrections; (c) other substance abuse treatment programs of the Division of Community Corrections; and (d) substance abuse treatment programs administered by the Division of Juvenile Corrections.

### **State Use of Federal Grants to Address Opioid Addiction**

In 2016, Congress passed the 21<sup>st</sup> Century Cures Act, which included funding for several grant programs for state and local initiatives to address opioid addiction. The state targeted response (STR) to the opioid crisis program was the principal grant program for state efforts. Under that program, the Wisconsin Department of Health Services received \$7.6 million per year in federal fiscal years 2017 and 2018. The federal Substance Abuse and Mental Health Services Administration distributed STR grant funding to states and territories under a formula that considers the number of individuals in the state or territory with unmet opioid use disorder treatment needs and the number of drug poisoning deaths.

DHS allocated most STR funding to counties and organizations that provide opioid treatment and prevention activities. This includes funding

for hospital-based peer recovery coaches, for counties and tribes to address backlogs in treatment needs, to establish regional opioid treatment programs in high needs areas, for expansion of medication assisted treatment initiatives, and for an addiction recovery resource hotline. Additional STR funding was used for DHS staffing and other administrative costs associated with directing the Department's opioid response efforts.

The federal fiscal year 2018 appropriations act provided additional funding for opioid addiction initiatives, through the creation of the state opioid response (SOR) grant program. This program has essentially replaced the STR grant program and is currently the primary source of federal support for state and local opioid treatment efforts. As with the STR program, funding is allocated to states under a formula that considers unmet treatment needs and drug poisoning deaths. Beginning in federal fiscal year 2019-20, states could use SOR grant funds for address substance use disorders involving stimulants, including methamphetamine and cocaine.

In 2019-20, the state received an SOR grant of \$16.8 million. Of this amount, approximately one-half was used for treatment costs for individuals and the remainder is used for prevention programs, overdose response, and supporting expansion of treatment options.

### **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's informational paper entitled, "Community Aids/Children and Family Aids" provides additional information on this program.

DHS distributes approximately \$170 million annually 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.

*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 \$24.3 million. 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 state GPR, program revenue and federal community mental health services block grant funds. In 2020, 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 RISE, a nonprofit health organization, to provide services for eligible children.

### **Opioid and Methamphetamine Treatment Centers**

Under the opioid and methamphetamine treatment grant program, DHS is required to provide four to six grants to establish regional treatment programs. These programs provide medication-assisted treatment, residential services, counseling, or abstinence-based treatment, either directly or through coordination with providers of these services.

When the program was originally established during the 2013 legislative session, the grants were directed to centers focusing on the treatment of opioid use disorder, and the use of methadone as a treatment modality was not allowed. Since that time, the program has been broadened to include treatment programs for methamphetamine and the prohibition on methadone treatment was eliminated.

Since 2015, DHS has provided a total of \$2,016,000 annually to three organizations in northern Wisconsin (\$672,000 to each) to provide services under the program: (a) the Northeast Wisconsin Heroin Opioid Prevention Education, 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 North-Lakes Community Clinic, serving Ashland, Bayfield, Burnett, Douglas, Sawyer, and Washburn counties, and the Bad River, Lac Courte Oreilles, and Red Cliff tribes.

The 2017-19 biennial budget act increased

funding for the program to expand the number of treatment centers. In 2019, the Department also provided \$333,300 each to two other centers: (a) the Ladysmith Alcohol and Drug Recovery Center, serving Barron, Polk, and Rusk counties; and (b) the Lake Superior Community Health Center, serving Douglas County.

The Department has established the following goals to evaluate the success of each treatment center: (a) provide regional stabilization and residential detoxification services and treatment and support services to individuals addicted to opioids or methamphetamines in rural, high-need areas; (b) increase retention in treatment programs, improve quality of life and reduce relapses for participants; (c) reduce the number of deaths associated with opioid use; and (d) reach women of childbearing age who are addicted to opioids, offering priority admission to pregnant women and reduce the number of infants affected by opioids.

In 2019, the five centers funded under the program provided services to 939 individuals.

### **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 penalty levied upon each OWI conviction, in addition to the fine or forfeiture. 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 2019-20, DHS distributed \$712,000 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 who have been

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, and 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 51 counties. In 2019-20, OARS served 396 participants, at a cost of \$3,926,500. Program costs are funded with a DOC appropriation.

### **Peer Support Initiatives**

In the past decade, peer supports have increasingly been recognized as an important component of the treatment of mental health and substance abuse disorders. In this context, a *peer* is a person who has had lived experience with mental health or substance abuse disorders, as well as clinical treatment systems. Relying on this experience, a peer may be able to support a person who is experiencing a crisis or who is in recovery. This support may range from practical advice regarding accessing treatment or social services, to presenting a hopeful example of someone who has had success in recovery.

In recognition of the role that peers can play in behavioral health treatment and recovery, the state has established programs to facilitate the effective use of peer resources.

*Peer Specialist Certification Program.* DHS administers a certification program for peer specialists, which establishes training standards, scope of practice guidelines, and core competencies. Certification is provided for peer specialists, for persons who have personal experience as a client in mental health or substance abuse treatment systems, and for parent peer specialists, who have experience raising a child with behavioral health challenges. In 2020, there were 1,522 persons certified as a peer specialist and 48 certified as a parent peer specialist.

Adding to the current certification programs, 2019 Act 122 established training and practice standards for a peer recovery coach, which is defined as an individual who practices in the recovery field and who provides support and assistance to individuals who are in treatment or recovery from mental illness or a substance use disorder. The Act also required DHS to establish a program for facilitating providers of drug overdose treatment to use peer recovery coaches to encourage individuals to seek treatment following an overdose. In addition, it established peer recovery coach services as a reimbursable service under the medical assistance program, provided those services meet certain requirements, including a requirement that the peer recovery coach works under the supervision of persons holding certain mental health professional credentials.

*Peer-run Respite Center Grant Program.* DHS provides annual grants to peer-run, residential respite centers to assist persons experiencing a mental health or substance abuse crisis. Staff at peer-run centers may assist guests by discussing their common experiences, engaging in wellness activities, and connecting with other community resources. The services are provided at no charge to the participants. In 2019-20, the Department provided grants to three peer-run respite centers, each with four to five beds, in Appleton, Madison, and Menomonie. Each center receives \$441,600, for a



total of \$1,324,800.

In 2020, the Department also awarded a grant of \$450,000 to Mental Health of America to establish a peer-run respite center for military veterans in Milwaukee.

### **Child Psychiatry Consultation Program**

DHS contracts with the Medical College of Wisconsin to provide professional consultation services to assist primary care physicians and clinics in providing care to pediatric patients with mental health care needs. The program is intended to address a shortage of child psychiatrists and other pediatric mental health professionals in some parts of the state. Under the current contract, MCW provides consultation services in Milwaukee County as well as northern Wisconsin counties. MCW partners with Children's Hospital of Wisconsin to provide this service.

Consultation services include: (a) support for participating clinicians to assist in the management of children and adolescents with mental health problems and to provide referral support for pediatric patients; (b) a triage-level assessment to determine the most appropriate response to each request for service, including appropriate referrals to other mental health professionals; and (c) when medically appropriate, diagnostic, and therapeutic feedback. Consultation may be provided may provide services by teleconference, video conference, voice over Internet protocol, electronic mail, pager, or in-person conference.

In 2019-20, the DHS provided \$1.0 million to MCW to provide consultation service. The 2019-21 budget increased funding for the program to \$1.5 million in 2020-21, with the intention of expanding consultation services to more areas of the state.

In addition, 2019 Act 117 established a three-year school-based consultation pilot program to

offer services for schools located in Outagamie County. The act provided \$175,000 GPR in 2020-21 for DHS to contract with consultation with school-based providers, to help manage students with mental health care needs. The service requirements are similar to those used for the existing child psychiatry consultation program.

### **Addiction Medicine Consultation Program**

DHS contracts with the University of Wisconsin School of Medicine and Public Health to provide consultation services for primary care providers who are treating patients who may have an addiction. The program is staffed by experts in addiction medicine, psychiatry, and psychology, to provide consultation services for health care providers in all parts of the state. DHS provides \$500,000 annually to support the cost of the service.

### **Nonnarcotic Drug Treatment Grants**

Under the nonnarcotic drug treatment grant program, DHS provides grants of \$750,000 annually to counties or tribes for the purchase of nonnarcotic, injectable medically assisted treatment for jail inmates who voluntarily receive treatment within five days prior to their release. In order to receive a grant, a county or tribe must establish a drug court and provide care coordination for inmates leaving jail. In 2019-20, DHS provided grants to 15 counties under the program.

### **Youth Crisis Stabilization Facility Grants**

The 2017-19 biennial budget act (2017 Act 59) required DHS to establish standards and a certification process for youth crisis stabilization facilities (YCSF). The purpose of these facilities is to provide a residential center for youth age 17 or younger to receive immediate care to prevent or treat a mental health crisis, with the intention of averting hospitalization, as well as connecting the youth with resources for ongoing treatment. A

YCSF may have no more than eight residential beds.

In addition to establishing the youth crisis stabilization facility definition and regulatory structure, Act 59 established a grant program to support the operation of a limited number of YCSFs in the state. In 2020, DHS awarded grants totaling \$1,178,500 to county social services agencies to establish three YCSFs, as follows: (a) \$705,400 for Milwaukee County; (b) \$363,300 for North Central Healthcare (joint agency for Langlade, Lincoln, and Marathon counties), and (c) \$109,800 for Ashland County.

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

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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 to 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. If, however, the person is in a hospital emergency room at the time of the assessment, the hospital must determine if the transfer to a treatment facility is medically appropriate.

The law enforcement agency that initiated the emergency detention is responsible for transporting the person to a treatment facility. However, law enforcement agencies may contract with another agency, an ambulance service provider, or a third-party vendor to provide these transportation services.

Upon arrival at a treatment 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 indecency 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 referred to as 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 a 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 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, 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.

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### **Institutional Services**

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The Department of Health Services operates four facilities that provide mental health services: two mental health institutes (Mendota, in Madison, and Winnebago, in 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 in Oshkosh. These facilities provide psychiatric services to adults, adolescents, and children who either are civilly-committed or are forensic patients committed as a result of a criminal proceeding. In addition to providing psychiatric services, both facilities are licensed and accredited hospitals that provide training and research opportunities.

Mendota operates 13 inpatient regular treatment units for forensic patients with a total capacity of 302 and one civil geropsychiatric unit for elderly patients with a capacity of 16. The forensic units have a range of security levels, designed to provide treatment services in an environment appropriate to each patient's needs. One forensic unit is used for female patients, while the others are used for males.

In order to address a need for additional space for forensic patients, the Department has recently opened two units, with a total staffed capacity of 58 beds, in vacant space at the Sand Ridge Secure Treatment Center in Mauston.

In addition to the Mendota Mental Health Institute units, Mendota operates two units at the Mendota Juvenile Treatment Center (MJTC) 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. In 2018, the Legislature passed a requirement that DHS construct an expansion of MJTC with at least an

additional 29 beds and authorized \$15 million in general fund-supported bonding for construction of the expansion. The 2019-21 biennial budget act amended the bonding authorization for that project to provide a total of \$44.0 million for the project. However, as of the end of the 2019-21 legislative session, the Joint Committee on Finance had not yet given final approval for the expansion, a necessary step for the Department to proceed with construction.

Winnebago has a total of seven treatment units with a total capacity of 185, including six adult units and one youth civil unit. Units at Winnebago are generally categorized by security level, age (youth versus adult) and gender. Whereas Mendota is used primarily for forensic patients (the exception being the geropsychiatric unit), Winnebago is used for both civil and forensic patients. The forensic unit is for female patients only.

In 2019-20, Mendota had 578 admissions and Winnebago had 3,052 admissions. Persons admitted for emergency detention or civil commitments tend to have shorter stays than forensic patients. The average length of stay at Winnebago was 15 days, while the average length of stay at Mendota was 57 days.

Table 3 provides information on the average number of patients by type in each institution in 2019-20. Although the amounts shown in the table

**Table 3: Average Daily Populations at the Mental Health Institutes by Type of Unit -- 2019-20**

	Mendota	Winnebago	SRSTC*
Forensic	270.6	94.6	29.2
Youth -- Civil	0.0	29.2	0.0
Adult -- Civil	0.0	43.7	0.0
Geriatric -- Civil	15.9	0.0	0.0
Juvenile Treatment	<u>22.5</u>	<u>0.0</u>	<u>0.0</u>
Totals	309.0	167.5	29.2

\*Forensic patients only; does not include patients committed under Chapter 980 of the statutes as sexually violent persons.

reflect the average daily populations during the fiscal year, the averages were affected by the COVID-19 pandemic, which reduced admissions during the last several months.

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, 2020.

**Table 4: Mental Health Institutes Inpatient Daily Rates as of October 1, 2020**

Adult Psychiatric Services	\$1,174
Geropsychiatric	1,149
Child/Adolescent	1,201
Forensic-All Security Levels	1,174
Emergency Detention Add-On*	274
Non-typical Services Add-On	274

\*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 (PR). 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, and transfers from other agencies such as the Department of Corrections. In 2019-20, Mendota had a budget of \$92.8 million (\$72.6 million GPR and \$20.2 million PR) and Winnebago had a budget of \$74.5 million (\$22.4 million GPR and \$52.1 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, behavioral issues, or substance use disorders. 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, in Oshkosh. The WRC has a total staffed capacity of 443 beds for male and female inmates.

The WRC facilities are divided into units, each generally housing between 10 and 30 inmates. There are currently 16 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 or 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 2019-20, the DHS budget for WRC operations was \$58.5 million GPR, while Department of Corrections spent \$7.8 million for security.

## APPENDIX I

### Services for Individuals with Mental Illness, County Expenditures\* Calendar Years 2015 through 2019

	2015	2016	2017	2018	2019
<b>Statewide Total</b>	<b>\$504,346,390</b>	<b>\$556,841,237</b>	<b>\$566,135,552</b>	<b>\$632,089,291</b>	<b>\$698,554,819</b>
Adams	\$1,948,101	\$2,857,882	\$3,373,166	\$4,091,018	\$4,238,341
Ashland	1,107,103	2,417,678	2,548,208	2,886,161	2,433,877
Barron	3,315,310	3,201,037	2,653,417	2,745,926	4,098,187
Bayfield	1,257,329	2,342,670	2,296,567	1,795,010	1,367,788
Brown	14,457,876	17,140,006	15,498,211	16,673,948	17,414,341
Buffalo	606,065	666,159	730,147	651,537	1,011,777
Burnett	610,366	836,414	785,272	868,995	591,871
Calumet	3,194,441	3,316,484	3,523,995	3,475,942	3,778,139
Chippewa	3,348,650	3,904,665	3,421,879	12,020,370	5,683,458
Clark	1,945,242	1,708,309	2,750,977	2,611,125	3,114,803
Columbia	3,488,484	4,183,259	4,873,319	5,702,347	6,824,820
Crawford	1,429,519	1,744,321	1,622,881	1,598,260	1,590,820
Dane	34,723,101	41,059,961	48,115,047	53,169,306	63,348,815
Dodge	5,289,735	4,758,114	7,037,649	8,352,313	9,055,587
Door	2,229,974	2,812,154	3,463,626	3,628,289	4,396,393
Douglas	3,210,242	3,321,647	3,383,876	4,030,643	3,642,149
Dunn	2,636,923	1,954,166	2,867,279	2,807,020	2,689,267
Eau Claire	6,246,719	7,033,293	9,692,742	13,988,533	17,321,274
Florence	89,698	293,294	232,421	119,295	180,152
Fond du Lac	7,321,271	7,864,976	9,183,457	10,009,943	10,562,088
Forest/Oneida/Vilas	6,693,254	7,635,548	7,798,962	7,700,523	7,411,439
Grant/Iowa	3,068,292	3,321,084	2,495,149	2,850,703	2,676,963
Green	2,682,680	2,852,959	3,169,700	3,533,854	3,476,154
Green Lake	1,536,995	978,834	1,722,468	1,677,067	1,399,268
Iron	**	1,195,573	965,772	1,166,385	1,641,589
Jackson	687,410	1,429,675	1,081,420	2,211,463	1,463,235
Jefferson	7,134,740	8,594,384	9,360,712	8,354,671	9,724,961
Juneau	2,677,039	3,196,074	3,501,488	4,249,763	4,041,157
Kenosha	13,957,943	16,489,782	17,401,527	19,142,535	21,207,642
Kewaunee	1,756,756	2,172,043	2,121,023	2,670,490	2,612,633
La Crosse	14,297,574	15,890,796	16,089,875	15,912,158	19,182,206
Lafayette	1,458,426	1,505,890	1,488,920	1,429,744	1,079,336
Langlade/Lincoln/ Marathon	19,830,432	23,612,883	22,411,726	25,922,091	32,312,813
Manitowoc	6,466,762	7,247,399	7,620,782	8,637,163	8,808,696
Marinette	3,166,952	4,230,398	4,397,655	4,503,995	4,686,269



**APPENDIX I (continued)**

**Services for Individuals with Mental Illness, County Expenditures\*  
Calendar Years 2015 through 2019**

	2015	2016	2017	2018	2019
Marquette	\$1,320,938	\$1,060,755	\$1,060,755	\$1,472,390	\$1,675,133
Menominee	912,336	907,685	1,191,093	972,303	675,651
Milwaukee	154,997,375	165,600,387	175,382,488	178,372,434	196,509,719
Monroe	2,048,019	2,013,402	2,671,423	3,572,360	5,569,998
Oconto	1,736,035	2,146,861	1,927,312	1,606,571	1,942,159
Outagamie	13,033,364	14,464,545	18,860,837	20,459,594	19,029,819
Ozaukee	3,016,950	2,326,191	1,515,262	1,536,494	1,943,783
Pepin	138,067	406,589	372,875	497,470	864,521
Pierce	1,219,850	2,079,121	2,499,469	2,705,981	4,109,475
Polk	3,479,991	3,490,699	3,536,722	4,753,450	7,097,355
Portage	2,598,333	3,974,088	4,329,682	5,283,274	5,922,968
Price	831,013	956,066	991,840	987,034	618,868
Racine	10,575,902	9,003,795	10,150,208	8,098,335	12,011,793
Richland	1,706,876	1,986,735	2,069,326	2,780,956	3,204,110
Rock	19,698,380	19,750,359	21,678,544	18,870,280	20,161,392
Rusk	676,357	682,701	631,440	693,589	972,140
Sauk	7,102,336	8,419,929	9,344,278	11,525,156	12,991,869
Sawyer	1,961,194	2,119,655	2,654,218	2,571,605	2,645,304
Shawano	2,166,335	2,631,085	2,926,046	3,465,933	3,614,852
Sheboygan	7,250,075	8,340,047	9,906,349	10,294,658	9,245,421
St. Croix	5,412,827	5,290,490	5,349,431	4,969,743	8,538,945
Taylor	1,286,378	2,101,864	2,486,652	2,310,595	2,391,704
Trempealeau	979,755	948,202	1,617,383	1,654,481	1,894,571
Vernon	2,155,501	2,150,296	2,075,142	2,176,737	2,749,029
Walworth	9,426,208	9,969,162	9,655,030	9,260,725	9,836,201
Washburn	797,962	827,272	943,073	969,156	1,710,861
Washington	11,415,784	11,043,219	9,999,123	9,937,265	11,025,734
Waukesha	22,361,521	26,269,351	**	25,607,053	26,970,168
Waupaca	3,274,326	2,810,336	2,571,721	3,973,995	5,116,326
Waushara	2,404,941	2,234,847	2,434,047	2,326,455	2,475,705
Winnebago	12,639,916	13,928,200	13,824,058	13,524,612	14,268,875
Wood	11,850,141	13,137,492	11,798,410	13,670,021	15,702,062

\* Data obtained from county Program Participation System (PPS) collected by DHS.

\*\*No data reported by the county.

## APPENDIX II

### Services for Individuals with Substance Use Disorders, County Expenditures\* Calendar Years 2015 through 2019

	2015	2016	2017	2018	2019
<b>Statewide Total</b>	<b>\$70,554,979</b>	<b>\$71,703,754</b>	<b>\$74,173,696</b>	<b>\$84,017,420</b>	<b>\$87,633,158</b>
Adams	\$515,008	\$737,911	\$333,171	\$563,966	\$468,979
Ashland	144,558	129,652	82,843	98,217	92,806
Barron	393,495	352,720	316,160	361,749	496,283
Bayfield	295,251	311,078	243,621	168,545	226,007
Brown	1,317,341	2,226,426	4,643,518	2,236,770	2,868,523
Buffalo	50,460	37,914	47,930	21,800	169,812
Burnett	365,255	334,394	333,508	344,441	321,890
Calumet	193,564	255,155	187,208	165,352	136,533
Chippewa	759,417	541,938	1,348,767	371,173	1,209,148
Clark	155,825	181,308	246,680	210,569	266,330
Columbia	187,620	182,858	889,707	865,320	1,132,376
Crawford	136,072	91,049	31,432	71,703	108,233
Dane	7,997,684	8,485,675	9,591,983	10,791,070	6,775,948
Dodge	5,378,055	1,269,286	826,156	1,696,901	1,933,570
Door	320,515	293,336	286,495	279,801	590,640
Douglas	372,046	286,638	250,548	340,575	379,212
Dunn	528,775	1,679,192	753,358	638,600	552,703
Eau Claire	1,102,647	676,272	731,432	898,190	1,047,298
Florence	40,523	29,393	33,385	24,093	24,481
Fond du Lac	905,445	947,617	1,053,719	1,034,634	763,722
Forest/Oneida/Vilas	1,875,160	1,739,127	1,375,007	917,173	933,240
Grant/Iowa	497,162	599,585	684,391	800,674	974,083
Green	550,708	576,087	744,766	792,343	961,726
Green Lake	292,124	221,242	201,995	537,047	456,299
Iron	**	138,210	164,867	95,148	181,964
Jackson	160,215	143,886	196,354	180,460	86,176
Jefferson	856,880	963,016	939,999	1,670,080	1,464,497
Juneau	329,839	322,161	306,989	191,413	193,269
Kenosha	1,717,452	2,144,103	2,503,281	2,573,369	4,475,577
Kewaunee	159,329	245,647	269,272	207,183	197,348
La Crosse	1,258,306	1,099,394	943,479	3,206,325	2,319,759
Lafayette	170,753	122,731	212,334	173,303	228,303
Langlade/Lincoln/					
Marathon	3,926,481	3,987,807	4,644,194	6,546,391	7,539,147
Manitowoc	696,703	637,759	752,377	822,562	1,117,687
Marinette	945,013	967,204	986,834	995,330	1,024,045

**APPENDIX II (continued)**

**Services for Individuals with Substance Use Disorders, County Expenditures\*  
Calendar Years 2015 through 2019**

	2015	2016	2017	2018	2019
Marquette	\$220,725	\$348,579	\$348,579	\$251,974	\$251,501
Menominee	234,755	303,118	242,735	499,352	152,637
Milwaukee	14,268,712	14,925,199	16,294,310	17,589,990	17,145,597
Monroe	453,439	474,630	353,265	387,090	509,769
Oconto	261,796	272,196	252,383	236,346	261,454
Outagamie	2,343,858	2,343,971	2,702,484	2,804,908	3,189,030
Ozaukee	395,632	530,600	427,452	428,375	398,489
Pepin	**	35,279	55,313	99,242	325,148
Pierce	389,970	296,180	287,179	295,682	657,388
Polk	448,991	837,912	930,232	940,755	1,187,312
Portage	454,029	533,308	496,409	702,449	382,050
Price	95,707	55,877	118,712	117,064	145,666
Racine	1,277,640	874,895	1,910,586	1,396,762	1,451,652
Richland	129,132	124,628	105,736	123,138	235,342
Rock	1,580,186	1,027,865	1,031,501	2,207,995	2,424,424
Rusk	65,017	80,428	73,229	60,477	58,958
Sauk	428,240	1,412,247	1,468,029	1,665,851	1,374,956
Sawyer	745,670	648,367	354,932	271,697	201,918
Shawano	69,098	166,737	477,507	638,678	934,556
Sheboygan	1,853,351	2,336,291	1,208,892	847,536	1,499,818
St Croix	771,006	844,509	870,215	943,840	1,391,716
Taylor	201,244	213,240	244,735	277,934	447,778
Trempealeau	125,997	122,525	124,479	153,379	279,530
Vernon	63,491	147,496	156,548	136,908	165,176
Walworth	1,174,426	1,152,908	1,332,684	1,191,053	1,126,288
Washburn	87,272	65,534	76,920	121,368	369,750
Washington	843,975	764,562	688,270	666,102	849,355
Waukesha	3,346,483	3,403,961	**	3,450,193	3,848,678
Waupaca	236,151	542,319	531,102	196,055	258,719
Waushara	363,535	511,375	497,687	621,217	689,462
Winnebago	1,993,791	2,166,784	2,345,867	3,096,136	2,994,781
Wood	1,035,979	1,182,463	1,007,964	705,604	706,646

\* Data obtained from county Program Participation Reports collected by DHS.

\*\*No data reported by the county.