Wisconsin Community Forensic

Conditional Release Program

Case Manager Procedure Manual

Updated June 2013

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Introduction

The People You Serve

The mission of the state Department of Health Services Conditional Release Program is to ensure community safety. Community safety is enhanced by the accurate identification of client risk factors, the effective delivery of high quality mental health services and by engaging a collaborative team approach in the supervision, monitoring and treatment of the conditional release client.

Every individual you serve in the Conditional Release Program has undergone the trauma of mental illness and the stress of judicial processes from booking to hearings. Many have additional trauma and substance abuse histories. Serving clients in the Conditional Release Program takes particular skill and expertise well blended with dedication, courage, hope, and understanding.

Each client served in the Conditional Release Program is in the center of a treatment team coordinated by a case manager. The following manual outlines forensic procedures, and case manager responsibilities necessary to serve individuals adjudicated Not Guilty by Reason of Mental Disease or Defect and placed on Conditional Release in the community. Specific case manager responsibilities are highlighted in yellow throughout the manual.

Key Terms

DHS ..... Department of Health Services
CR .....Conditional Release
PDI .....Predisposition Investigation
SME .....Supplementary Mental Exam
MHI .....Mental Health Institution
NGI .....Not Guilty by Insanity
DOC .....Department of Corrections
DCC .....Division of Community Corrections
ISP ..... Individual Service Plan
CSP .....Community Support Program
SORP .....Sex offender registration program
SBN .....Special Bulletin Notification
CBRF .....Community-Based Residential Facility
ATR .....Alternative to Revocation

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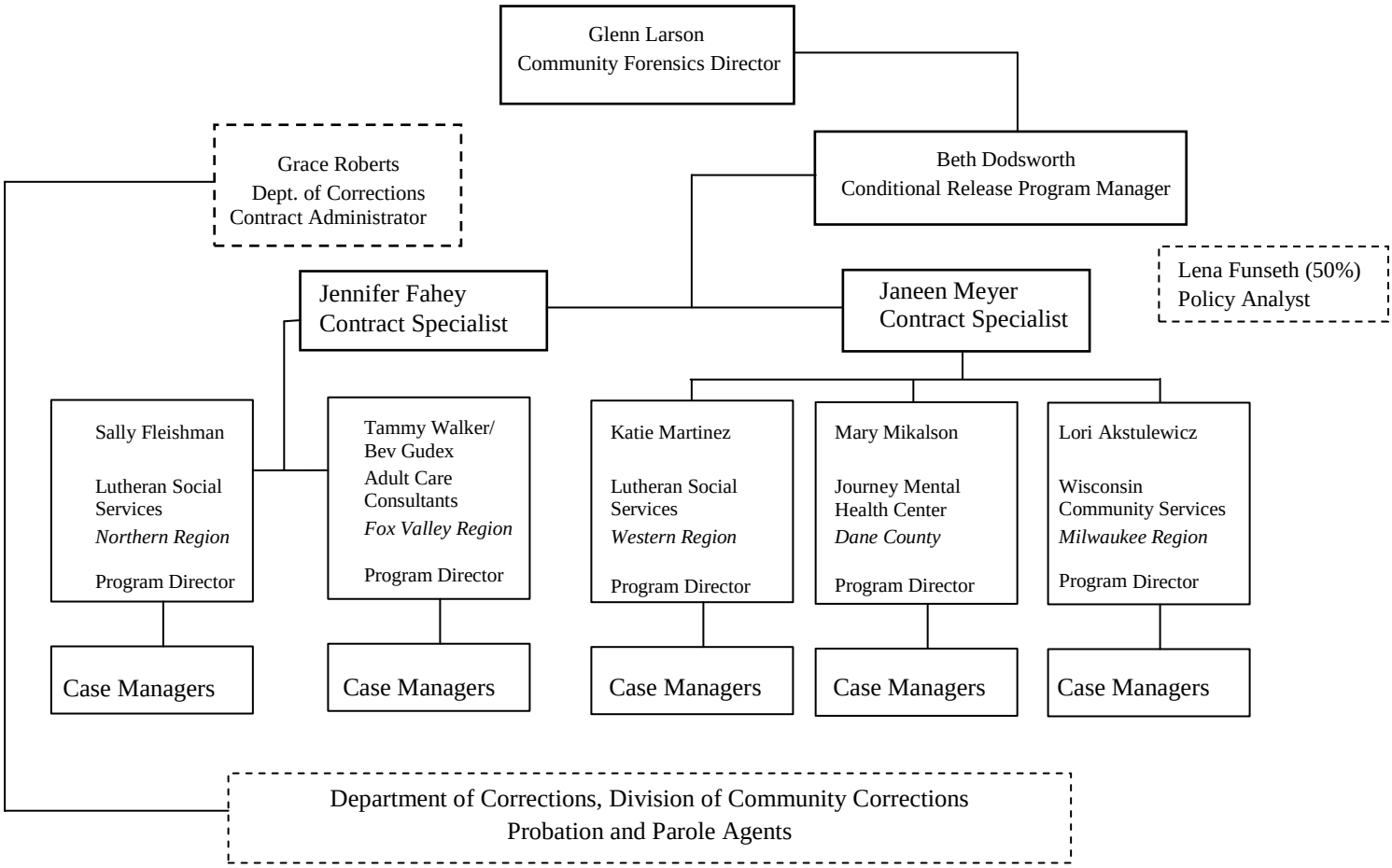
Conditional Release Program History in Brief

1993 BC (Before Case managers)
In 1993, the State Supreme Court ruled that the Department of Health Services (DHS) is responsible for funding mental health services to indigent persons on conditional release. Prior to this decision, each county of residence provided funding and services. No coordinated statewide conditional release program existed.

Today
The Conditional Release (CR) Program evolved from having two Forensic Specialists setting up contracts for services for each CR client throughout the state to dividing the state into regions and having regional providers oversee the daily management of client services. Each region relies on case managers to assess, create plans, coordinate services, and advocate for their clients. The program continues to operate as one system; however each region may differ somewhat in structure depending on the agency managing that region.

Conditional Release Program Flowchart



Community Forensic Services Regional Provider Map

DHS Forensic Services Specialists:

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(608) 267-7705

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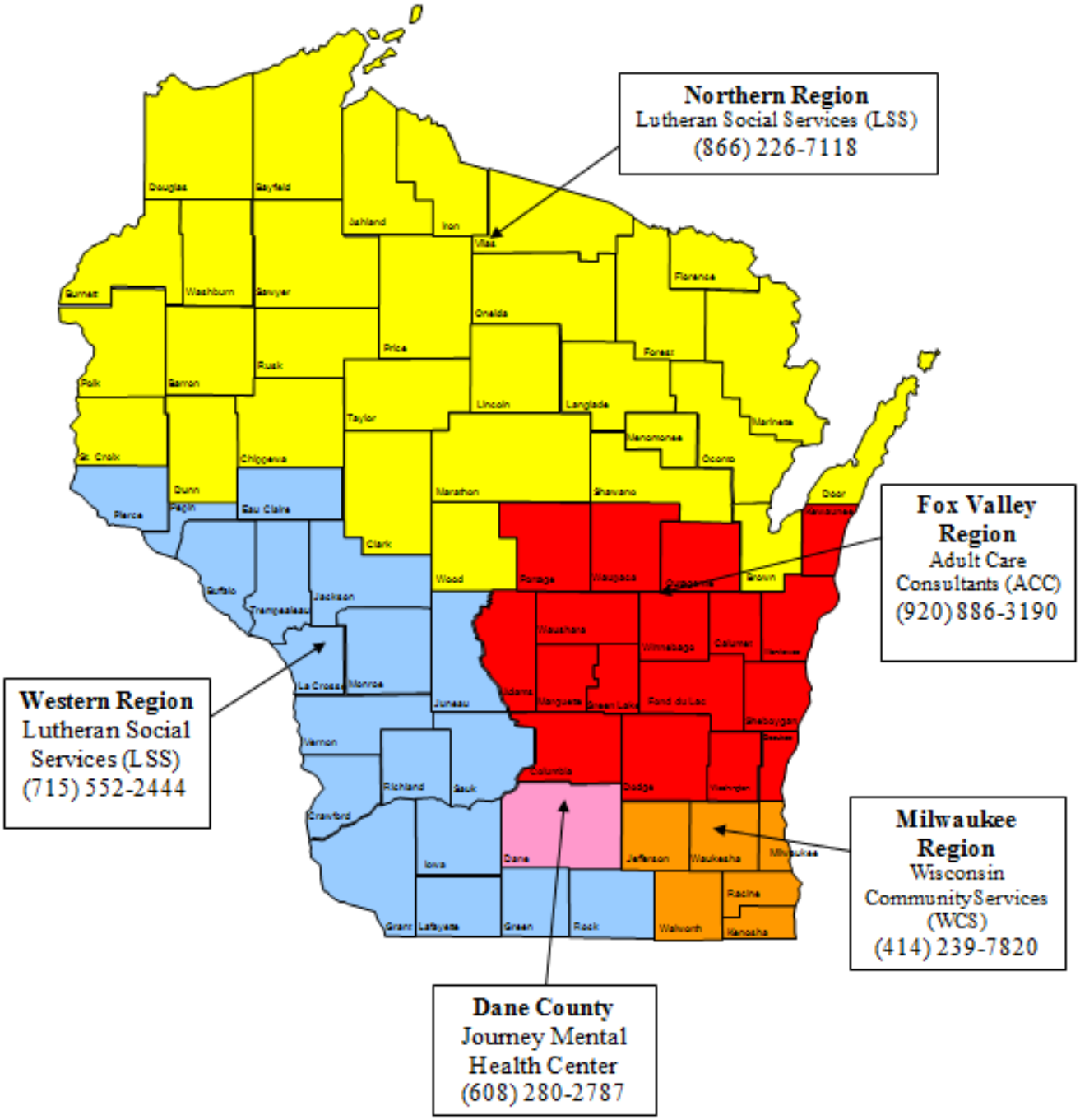

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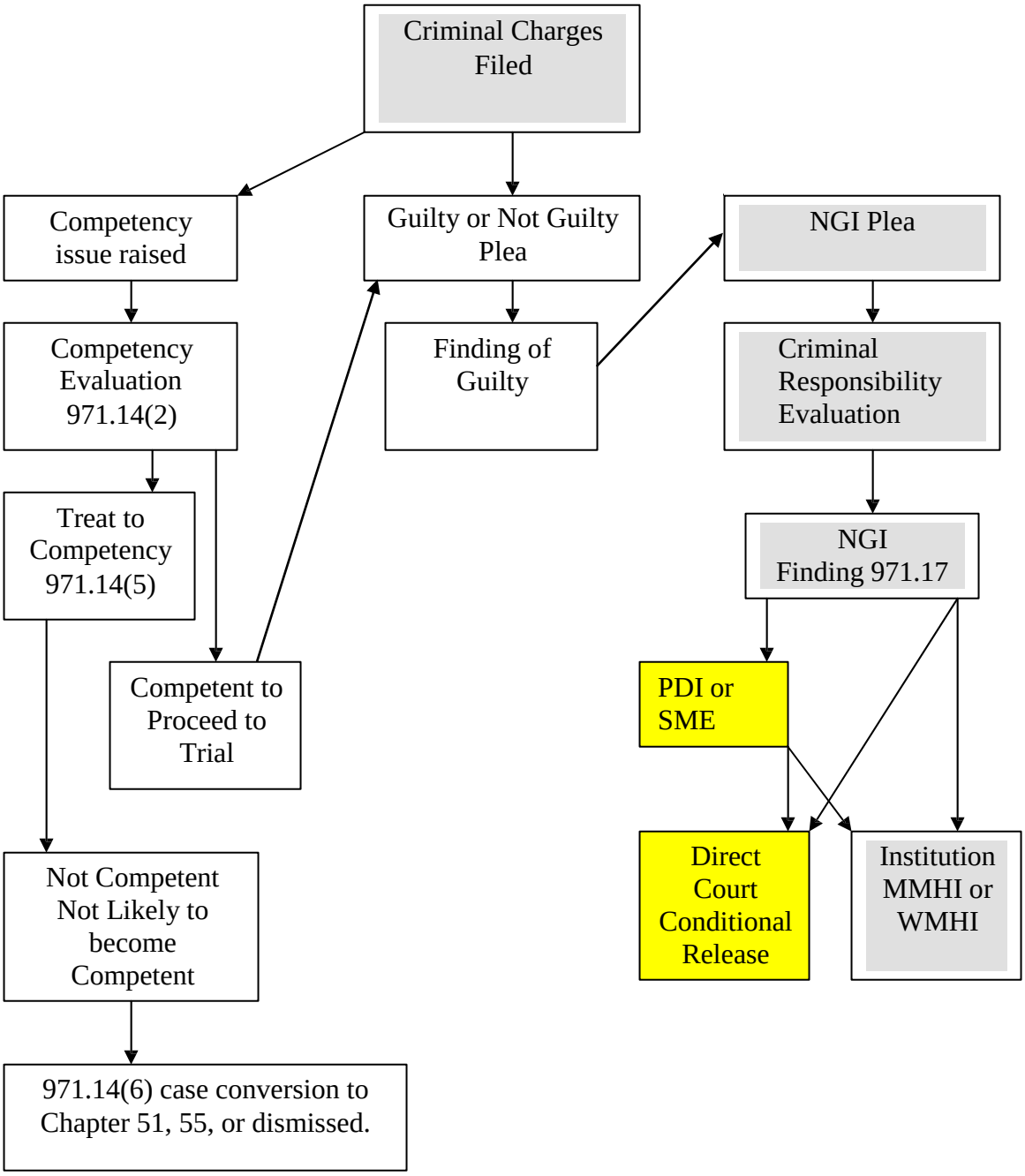
Part I: From the Court Room to Your Case Load

How an Individual becomes a Conditional Release Program Client

Not Guilty by Reason of Mental Disease or Defect

Finding and Placement Determination Chart



Not Guilty by Reason of Mental Disease or Defect
Finding and Placement Determination

I. Procedures for finding a defendant Not Guilty by Reason of Mental Disease or Defect

- **Criminal charges are filed**

- **Defendant is found guilty**

- **Not Guilty by Reason of Mental Disease or Defect**
  - Commonly referred to as "Not Guilty by Insanity" (NGI).
  - The defendant is examined by two independent examiners (not DHS employees) appointed by the court to determine the defendant's mental status at the time of the crime and whether the defendant shall be held criminally responsible for their behavior. WSS 971.16(3) *"The report shall contain an opinion regarding the ability of the defendant to appreciate the wrongfulness of the defendant's conduct or to conform the defendant's conduct with the requirements of law at the time of the commission of the criminal offense…"*
  - If the defendant is found not criminally responsible (NGI), the court commits the defendant to DHS and completes form CR-271 Order for Commitment.

II. The court has two placement options: inpatient or outpatient

- Placement is at the court's discretion.
- If the court lacks sufficient information to determine placement, it may adjourn the hearing and order the DHS to conduct a Predisposition Investigation (PDI) using form CR-272 Order for Predisposition Investigation
- Or a Supplementary Mental Exam (SME) using form CR-273 Order for Supplementary Mental Examination to be completed inpatient by Mental Health Institution (MHI) staff.
- Or both, to assist the court in reaching a decision regarding placement.

Case manager responsibility:

- Using the PDI format, complete the PDI within the court ordered timeframe.
- **When the court orders both** an SME and a PDI, notify the Conditional Release Program Court Liaison. The MHI examiners or CR Program Court Liaisons shall contact the court to seek permission to collaborate on one report. Both reports address the same question, whether institutional care or conditional release is appropriate.
- If the court insists on both, the PDI and SME are both conducted by DHS, whether Institute staff or CR Program staff, and therefore should provide the court with the same recommendation.

Predisposition Investigation (PDI)

PDIs are completed by DHS Conditional Release Program regional providers. The PDI provides information and a placement recommendation for institutional care or conditional release. PDI orders should be sent directly to the DHS Conditional Release Provider serving that county.

Since the client is not on Conditional Release there is no Department of Corrections involvement during the PDI process.

III. Inpatient Option: Mental Health Institution placement

- If the court orders inpatient care, the defendant shall be sent to either Mendota Mental Health Institute (MMHI) or Winnebago Mental Health Institute (WMHI) for inpatient treatment.
- The defendant may petition the court every six months for conditional release.

IV. Outpatient Option: Conditional Release Program

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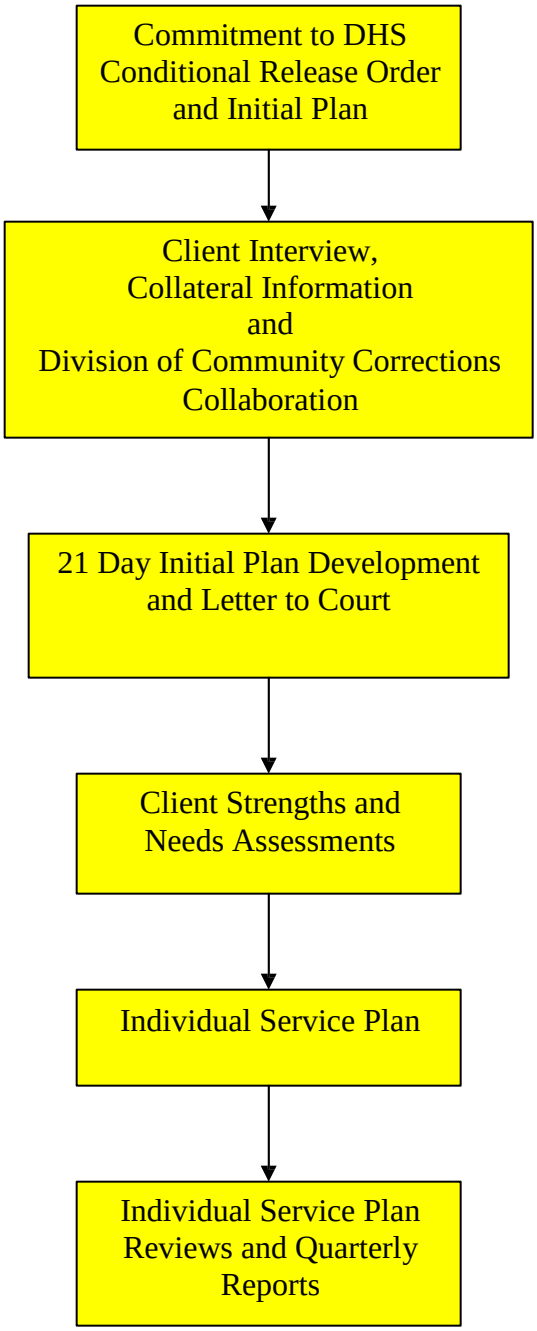
Part II: Serving Clients Released Directly from Court

From Conditional Release Order to Individual Service Plan

Direct Court Conditional Release Chart



Direct Court Conditional Release

I. Direct Court Release

- After a court accepts an NGI plea, the defendant is committed to the DHS.
- The court may determine that the client can be safely released directly into the community without placement at WMHI or MMHI in which case the court grants a Conditional Release.
- When a client is granted a Conditional Release directly from court, the client is immediately the responsibility of the Conditional Release Program.
- Usually, at the time of a direct court release, the committing court will also order the DHS and the 51.42 Board of the county of residence to develop a plan to be submitted to the court for approval by completing form CR-274 Order for Conditional Release Plan, to be accompanied by form CR-271 Order for Commitment.

Immediate Supervision

- The NGI client shall report **immediately** to the local Department of Corrections (DOC) Division of Community Corrections (DCC) office, upon leaving the court for a DCC agent assignment and reporting instructions.
- The DCC agent shall have the NGI client sign the Conditional Release Rules and Conditions form (F-25614).
- Occasionally, the DCC becomes aware of a new Direct Court Release before the case manager. The DCC intake office and/or assigned agent shall contact the DHS Forensic Services Specialist and case manager immediately to ensure that necessary services and court ordered reports are received promptly.

Case manager responsibility:

- Inform the client that he or she needs to meet with a DCC agent
- Contact DCC office for agent assignment
- Arrange client transportation to the DCC office if necessary
- Immediately notify DHS Forensic Services Specialist of the new client and forward to DHS the Order of Commitment, Criminal Complaint and Forensic Computation and any other paperwork.

Client Interview and Gathering Collateral Information

Case manager responsibility:

- Provide the client with information about the CR program.
- Provide Client Rights information orally and in writing.
- Interview the client and have release of information form (F-82009) signed.
- The case manager may choose to begin with the Psycho-Social Assessment or schedule the assessment for a later date. The case manager must complete the Suicide Risk Assessment and when clinically appropriate offer the client a Trauma Screen.
- Investigate collateral information from previous treatment facilities, providers, family, etc., and request a report from the Criminal Investigation Bureau (CIB).

***Release of information**: Release of information: The DHS contracts directly with the DOC and with the regional conditional release providers for services. As such, agents, the contracted case managers, WMHI /MMHI staff and DHS Forensic Services Specialists may communicate with each other about NGI clients without the need for a signed release of information from the NGI client.

For those individuals and agencies with whom the DHS does not directly contract, a release of information is necessary from the client to share any information regarding the client's treatment records.

Best practice: Signed releases help clients know who has what information, and helps them be participants in the treatment team process. **If there is any question as to whether or not a signed release is necessary, have the client sign a release.**

II. Initial Treatment Plan

- The initial treatment plan is reported to the court in the form of a letter **within 21 days of the order**.
- The plan submitted to the court should be specific about services and conditions. Include the following when outlining the plan:
  1. Placement name, address, phone # and contact person.
  2. Case manager, agency, name and phone #.

3. Medications: who will monitor them and how, psychiatrist name and affiliation, how they will be dispensed (i.e. pharmacy, mail, CBRF)
4. Agencies and services' location and contact person for; CSP, day programs, vocational services, substance abuse treatment, etc.
5. DCC Agent including; phone #, plan for supervision (i.e. high risk, EMP), standard and special rules to be signed.
6. Distribution: The **original** plan should be submitted to the court. Copies of the plan should be sent to the following:

District Attorney
Defense Attorney
51.42 Board Representative
Division of Community Corrections Agent
Conditional Release Forensic Services Specialist
CR client

Case manager responsibility:

- Contact the client's county 51.42 Board and supervising DCC agent for input into the initial plan
- Confirm all services with service providers
- Document appointment dates and times
- At a minimum, complete the initial treatment plan as indicated above within 21 days.
- Review the plan with CR client
- Be prepared to give testimony regarding the plan

III. Placement

Placement Order

A CR-275 Order for Placement form specifying placement on conditional release is necessary prior to placement.

Case manager responsibility:
Attach the standard form (CR-275) to the proposed plan and request the court to return a signed copy. This is the most expedient way to obtain an Order for Placement and approval of the plan.

Community Placement

- Implement the initial treatment plan

- Following the initial treatment plan submitted to the court, the case manager creates an Individual Service Plan (ISP) in coordination with the client and other treatment team members.

- Individual Service Plan is to be **completed within 90 days** of CR program admission.

Case manager responsibility:

- Verify initial appointments for services deemed necessary (i.e. psychiatrist, substance abuse assessment, etc.). Establish frequency of case manager contacts.
- Notify the DCC agent of the Order for Placement. Make arrangements for the patient to meet with the Agent to review and sign all Conditional Release rules of supervision (the court may have added several). The DCC agent shall arrange registration with local law enforcement.
- Assure that client's transportation and housing needs are met.
- Assist client with Social Security application and appeal immediately if denied.

Individual Service Plan Development

Following the initial treatment plan submitted to the court, the case manager creates an ISP in coordination with the client and other treatment team members. The ISP is to be completed within 90 days of admission to the CR Program.

The ISP includes client centered treatment goals, assessment of readiness to change, strengths and areas of need to be discerned through a combination of functional assessment tools, client input, and treatment team deliberation. Additional assessments may be necessary, such as risk of violence, sexual offending, substance abuse, and/or trauma.

Case manager responsibility:

- All aspects of ISP coordination and development are the responsibility of the case manager.

I. Individual Service Plan (ISP)

Assessment

- The foundation of the ISP includes a strength based functional assessment, a suicide risk assessment, and any additional assessments deemed necessary to identify specific client needs (such as substance abuse treatment, violence risk, sexual offending risk, trauma history)
- Assessments must include a psycho-social assessment and suicide risk assessment, these must be completed upon admission.
- Specific criteria for risk of violence and sexual offending assessment
    - Referrals are detailed in the **Risk Assessment – Referral Process** section of this manual.

Identify the client's treatment team and facilitate team collaboration

- Development of the ISP is a collaborative effort coordinated by the case manager.
- The client, case manager, DCC agent, and service providers must work together to form an effective team.
- A typical team might also include psychiatrist, therapist, substance abuse counselor, residential placement staff, family and other informal support.

- Include the Forensic Services Specialist for all high profile cases such as individuals who have been committed for offenses such as murder, sex offenses, or have received significant media attention.

At a minimum, the ISP includes:

1. Client centered goals and strengths
2. Issues/areas of need
3. Goals for each issue and the stage of change the client is at with that goal.
4. Interventions for each goal - Interventions include what the client will do to work toward his or her goals, as well as how various treatment team members will assist the client using a stage appropriate (stages of change) intervention.

Timeframe and review schedule

Case Manager Responsibility:

- ISPs must be completed within 90 days of the Conditional Release Order.
- ISPs are forwarded to the Forensic Services Specialists upon completion.
- ISPs are reviewed and updated at six month intervals, and when there are significant changes in client status (met goals, new goals, new issues, etc.).
- ISP reviews and updates include all members of the treatment team.
- Follow CR Program reporting procedures for progress notes

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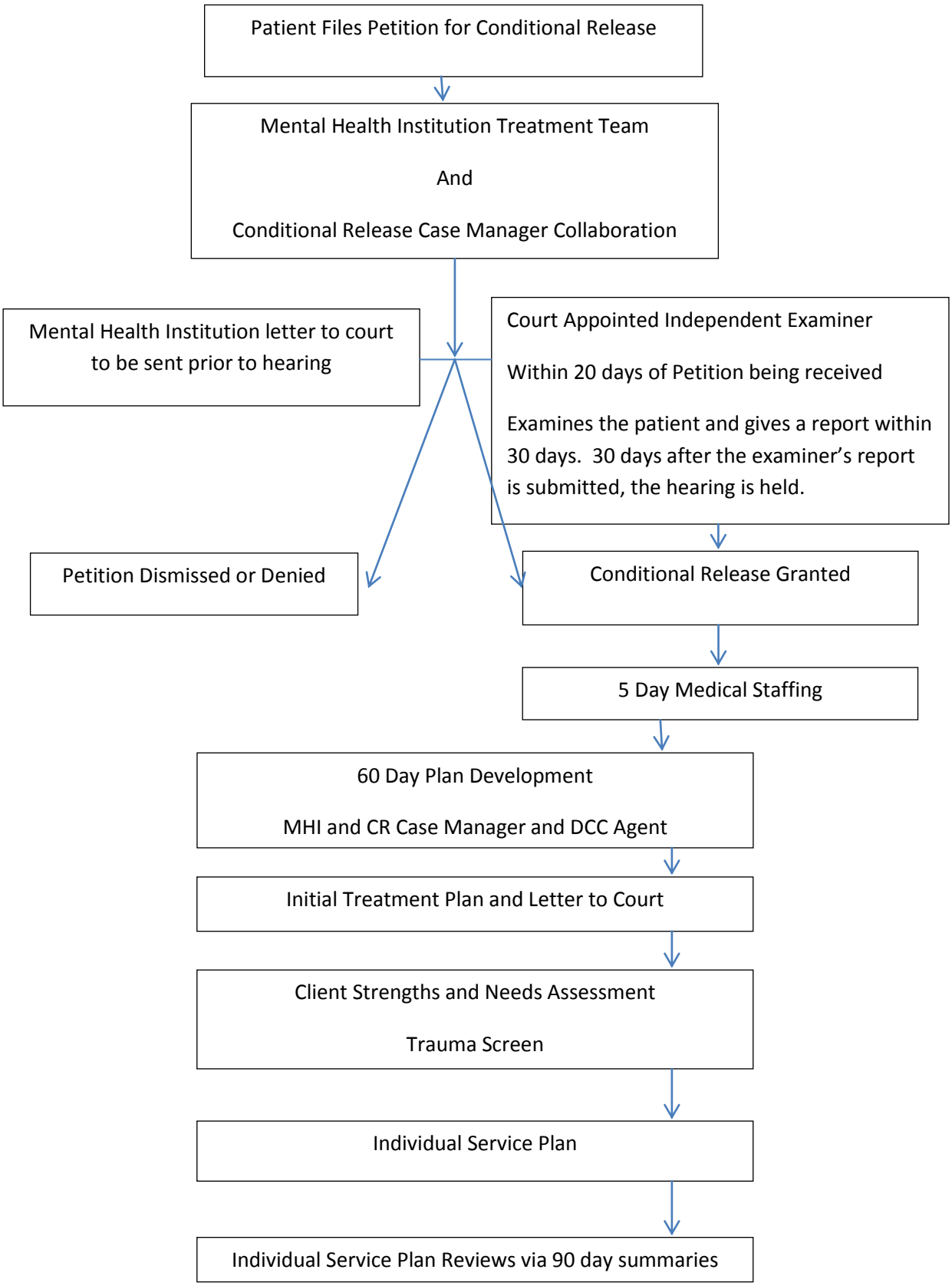
Part III: From Inpatient to Outpatient

Receiving Clients on Conditional Release from State Mental Health Institutions



Petitioning for Conditional Release

- Any person who is committed for institutional care may petition for conditional release if at least 6 months have elapsed (except for commitments prior to January 1, 1991) since the initial commitment was entered, the most recent petition was denied or the most recent order for conditional release was revoked.
- A person may not be prohibited from filing a petition even if the 6 months have not elapsed. It is up to the court to deny the petition.
- Individuals may petition with the assistance of Institute staff, on their own or with an attorney.
- The Institute social worker must assist any patient who requests to petition, regardless of the staff's opinion regarding appropriateness for conditional release.

  - **Petition for Re-Examination (F-25392)**
    This petition is submitted to the court if the committing offense occurred prior to January 1, 1991. Persons committed under the "old law" may petition the court for conditional release every 120 days.

  - **Petition for Conditional Release (F-25393)**
    This petition is submitted to the court if the committing offense occurred after January 1, 1991. Persons committed under the current WSS 971, may petition the court for conditional release every 6 months.

  - **Notification of Petition**
    The **original petition must be submitted to the committing court** with a copy for the District Attorney and Defense Attorney. A cover letter should accompany the petition including court case number, maximum release date and the institution contact person and their phone number. Persons who must be notified or copied that a petition has been submitted include:

    District Attorney
    Defendant's Attorney
    County 51.42 Board representatives
    Division of Community Corrections Agent
    DHS Conditional Release Specialist
    Aftercare Coordinator (if applicable)
    Contracted Conditional Release Program Director
    Admissions Coordinator
    Court Liaison for the Appropriate Region

- **High Profile Cases**
- DHS must be notified of persons petitioning who meet the guidelines under **Division Directive DHS 50-01.08.** In particular,
    - A patient who is likely to be granted release; and/or has been granted release, in cases where there has been extreme public controversy or previous media exposure.
    - New charges filed against the patient
    - A change in case plans or activities that could meet with public or legal controversy
    - Unauthorized absence of the patient

Case manager responsibility:

- Contact a member of the client's Mental Health Institution (MHI) treatment team upon notification of the client's petition.
- The MHI treatment team must include case manager input when formulating a letter to the court regarding the client's status in treatment and readiness for release.

Mental Health Institution Court Letter Guidelines

A court letter should be submitted from the Institute when a patient petitions for conditional release. The purpose of this letter is to provide the court with current information about the patient to assist the court in making an informed decision.

Case manager responsibility:

- Participate in MHI court letter process
- Gain knowledge of the client's strengths and needs
- Provide CR Program information to the MHI treatment team.
- Advise the MHI treatment team on whether resources exist to meet the client's identified needs.

Initial Conditional Release Plan
(Mental Health Institute (MHI) Release)

I. Process for the initial Conditional Release Plan Development

If the patient has been **granted a conditional release**, the court will prepare CR-274 Order for Conditional Release Plan and send it to the MHI.

Notification

- Institute staff shall notify the contracted conditional release case manager and the DCC Agent of the conditional release status.
- The contracted conditional release case manager must be notified immediately and the established process for developing a conditional release plan with those agencies followed.

Collaboration

- If no recommendations were made prior to the client's conditional release hearing, institute social worker/staff and conditional release case manager shall convene a meeting with the DCC agent to identify appropriate referral agencies and conditional release plan development.
- The plan presented to the court must be submitted by the conditional release case manager within 60 days if a petition being granted.
- While establishing the initial plan, arrangements must be made for all aspects of transitioning the client from the MHI to Conditional Release community living. Addressing **medical issues** must be part of the transition plan.

Medication and Medical Issues Transition Planning

Initial Planning Meeting:

- **Within 5 days** of notification that a Conditional Release is granted, MHI staff will facilitate a meeting with the Medical staff (RN and MD) on the discharging unit, the Social Worker on the discharging unit, Conditional Release Case Manager and other unit staff.
- The convened staff will review all medical issues, medications (psychiatric and physical - both prescription and non-prescription), treatments that are occurring at the Mental Health Institute and how these will all be managed in the community. The goal of this meeting is to create a comprehensive aftercare plan whereby all medication and medical issues are addressed and plans for community transition are secured well in advance.
- Conditional Release Case Managers shall make efforts to be available for these meetings in person whenever possible but teleconference is acceptable EXCEPT in cases where clients have complex medical issues. In complex cases, Case Managers shall be present at the meeting to discuss issues and be sure all aspects are clearly stated and covered in the transition plan and the community-based treatment plan.

The following issues, at a minimum, shall be discussed during the medical issues meeting:

- Use the Discharge Checklist developed by the Forensic Services System Team (FSST) and the respective discharge forms at the MHIs (DHS-6025 at MMHI and (DHS-5605 at WMHI) as the agenda for the above discussion to insure all areas of the individual's community
  - needs are addressed and a plan is being developed to meet those needs (such as attaining an **Identification card**, **Social Security application** and other benefit applications, **transportation** to community placement, etc.)
  - PRN medications and how these will be handled in the community

- Dosages of current medications (psychiatric and somatic medications) to determine whether the frequency of the medication (i.e.: 4 times per day) is realistic in the community and determines whether alternative dosing would be advisable during the 60 day period of plan development. The period of time leading up to community transition should resemble the anticipated medication schedule the client will receive in the community.
- Supply of medications, 3 days or 7 days must be determined for the transition period. If 7 days is necessary the reasons must be documented and put into the plan by the MHI staff. When the Community Case Manager knows what pharmacy will be filling the client's prescriptions, that pharmacy name and fax number will be provided to the MHI RN working with the MD and arrangements will be made to fax the prescriptions directly to the pharmacy prior to discharge.
- Medical supplies such as glucometer, syringes, CPAP machine, etc. that are being used to meet physical health needs at the MHI must be included in the client's transition plan and community treatment plan. Patient education regarding how to use these machines independently must take place at the MHI within the 60 day time frame prior to community placement.
- Non-prescription medications, the purpose of these meds, whether over the counter is appropriate, and how these will be provided in the community setting shall be included in the medical staffing.

Follow Up Meeting:

- **30 days prior to scheduled Conditional Release Plan Hearing**, MHI staff will convene another meeting with all staff identified above to verify the status of the plan, what still needs to be put in place, etc. The date the prescriptions should be faxed should be set at the meeting.
- If this is a very complex case another follow up should be done within
- 2 weeks of the scheduled Conditional Release Plan Hearing.

Referral

- Institute staff shall remain in contact with the conditional release case manager to obtain information about available services and possible referral sources.
- MHI staff shall explain supervision and contracting to the referral sources obtain signed releases from the patient and submit referral information to the agencies and establish a response time, explaining the court ordered time limit for confirming services.
- It is good practice to have the referral agency representative for residence meet with the patient prior to acceptance, at the Institute or at the community agency. Additionally, if the patient will be participating in a Community Support Program (CSP), the CSP Case Manager should also meet with the patient prior to placement.

County of Residence

- Referrals for out-of-county placement or services **must not** be made unless all county of residence services have been exhausted.
- Approval must then be obtained from the Forensic Services Specialist in the DHS Administrator's Office.
- In the event of an out-of-county placement, the Agent must transfer supervision and the new Agent's supervisor **must** accept the case prior to release to the community.
- If the client is being **placed in a county other than the county of residence**, the following language must be in the CR plan sent to the court with copies to both the sending and receiving county departments:

As (client name) is a (county) resident, it is acknowledged that (county) will be responsible for coordinating any medical services that may be required by (client name), unless (client name) is able to pay for services. It is also to be noted that as (client name) progresses to a less-restrictive environment, the transition will be made back to (county), as that is her/his county of residence

Case manager responsibilities:

The case manager plays an integral role in the development of the initial treatment plan and is responsible for submitting the plan to the court.

- Collaboration is the key to plan development.
- Coordinate with the county of residence/placement 51.42 Board, Mendota Mental Health institute (MMHI) or Winnebago Mental Health Institute (WMHI) treatment team staff, division of Community Corrections (DCC) Agent and community service providers to create the initial treatment plan.
- If placing a client in a county other than county of residence, work with both county of placement and county of residence, following above protocol.
- The plan must address supervision, medication, community support services, residential services, vocational services, and AODA treatment.
- Coordinate and participate in the MHI staffing with MHI treatment team to identify any significant medical treatment issues;
  Develop a transition plan to meet identified needs.
- Include the Forensic Services Specialist for all high profile cases such as individuals who have been committed for offenses of murder, sex offenses, or have received significant media attention.
- The plan must be presented to the court for its approval within **60 days**.

Funding

- Funding for the services established in a conditional release plan **must** be approved by the Conditional Release Regional Provider representing DHS.
- Services required as court ordered conditions of release and established by statute are typically covered.
- Services not covered include necessary medical services (i.e. blood pressure and diabetes medications, dental services, etc.) unless they are specifically related to conditional release services (i.e. blood draws for Clozaril, lithium).
- Clients must contribute to their cost of services according to their ability to pay. Therefore, income from work, entitlements, and/or assets will be used to offset costs.

Applications for entitlements (i.e. SSI, SSDI, VA benefits) **must** be submitted **60 days** prior to release by MHI social worker upon notification of petition granted. Often, it takes 30-90 days for processing the applications**. If Mental Health Institution (MHI) staff fails to do so, Conditional Release Program case managers will assist clients with applications within one week of discharge from the MHI, and will assist with appeals if denied.**

Extension

If an extension is necessary in order to establish a conditional release plan, a request must be submitted to the court **7-14 days** prior to the 60 day deadline. Extension requests must include the following:

1. Reason for the extension, explaining the delay (i.e. unable to confirm acceptance from CBRF, difficulty placing client due to history of arson).
2. The established plan to date, including referrals and rejections.
3. Inform the court of the plans that will be carried out during the extension period (i.e. referral to other CBRFs).
4. How long the extension will be needed (30-60 days).
5. Inform the Institute, patient and 51.42 representatives of the extension request.

II. Submitting the Plan

Plan Specifics

The plan submitted to the court should be specific about services and conditions. Include the following when outlining the plan:

1. Placement name, address, phone # and contact person.
2. Date of discharge from Institute, admission to community residence.
3. Case manager, agency, name and phone #.
4. Medications: who will monitor them and how, psychiatrist name and affiliation, how they will be dispensed (i.e. pharmacy, mail, CBRF)
5. Agencies and services' location and contact person for; CSP, day programs, vocational services, AODA treatment, etc.
6. DCC Agent including; phone #, plan for supervision (i.e. high risk, EMP), standard and special rules to be signed.

Distribution

The **original** plan should be submitted to the court. Copies of the plan should be sent to the following:

District Attorney
Defense Attorney
51.42 Board Representative
Division of Community Corrections Agent
DHS Forensic Services Specialists
MHI Social Worker (if applicable)
Patient
Medical Record (MHI)

III. Placement

Placement Order

A CR-275 Order for Placement form specifying placement on conditional release is necessary prior to placement. Standard form (CR-275) shall be attached to the proposed plan and request the court to return a signed copy. This is the most expedient way to obtain an Order for Placement and approval of the plan.

Community Placement Preparations

The following arrangements shall be made at or prior to placement:

- Establish initial appointments for services (i.e. psychiatrist, AODA Intake).
- Notify the Agent of the discharge/admission plan and make arrangements for the patient to meet with the DCC agent to review and sign all rules prior to discharge.
- Transportation and property arrangements are made with MHI staff.
- The DCC agent shall arrange registration with local law enforcement.

Conditional Release Hearing

The court, without a jury, shall hear the petition within 30 days after the court-appointed examiner has filed their report with the court, unless the petitioner waives this time limit. The Community Forensic Court Liaison will track the petition through the court process to facilitate timeliness of the court process.

I. Hearing

Testimony

MHI Treatment team staff may be requested to testify. Staff is not required to do so without a subpoena. Testimony should be consistent with the court letter information. Staff must only testify within the standards of their professional discipline. The court may establish those that testify as expert witnesses, therefore staff should be prepared to discuss their credentials and experience. Staff may request to testify by phone.

Case manager responsibility:
If the court letter recommends conditional release or includes a possible conditional release plan, the case manager will generally attend the hearing to be of assistance to the court.

II. Post-hearing:

Obtain the court order (CR-274)

There may be a substantial delay in receiving a court order regarding the decision for conditional release. The Institute social worker or admissions coordinator should contact the court clerk or D.A. to obtain the disposition information and to request a copy of the court order. It is important to obtain the order in a timely manner, as the time to develop an initial plan is limited to 60 days.

Procedure for Obtaining Medical Record Information from MHIs For Direct Court or MHI CR Clients

Records Request

Case Manager Responsibility:

- Obtain Treatment records from MHI
- Format the Records Request from MHIs on your agency letterhead
- Fill out Medical Record Request Letter for appropriate Medical Record Department (either MMHI or WMHI, Appendix 18)
- Be sure to check the items you wish to receive.
- Complete the "other" section for items specific to the client which may not be included in the generic list of items.
- In the case of WMHI, if you have been receiving information regularly, please be sure to check only those items to supplement what you are currently receiving.
- Mail directly to the Address on the model letter (one formatted for WMHI the other formatted for MMHI)
- Expected turnaround time from the MHI Medical Records department is 5-7 work days.

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Part IV: Checks and Balances:

Reporting Procedures

Reporting Requirements

Community providers will observe the following protocols to keep DHS Forensic Specialists informed of CR client status in the community.

Case Manager Responsibility:
- Follow all reporting requirements outlined below.

Comprehensive progress notes, which outline each person's current treatment goals and the progress toward meeting those goals, will be forwarded to the Community Forensic Specialists for updating the FSIS database and filing in the client charts on a **quarterly** basis (every three months).

The Community Forensic Specialists require **IMMEDIATE** notice by case managers on the following occurrences either via e-mail or telephone contact:

- New clients both Direct Court and MHI's CR including the following information: Date of CR, Max. Date, MHI Release date, DOB, Court Case Number, County of Commitment, DOC DCC agent name and number and DOC number (Send CR 271, 272, 274, 275 and 276 as soon as you receive them.)
- Placement in custody, reason and date
- Placement in community hospital with MA, reason and date
- Elopements/absconding
- Revocation decision by court (CR 275 & 276)
- Change in residence (address, phone number, etc.)
- Change in case manager or agent
- Death of a client
- When a client petitions for early discharge
- Early discharge by court of client with date of discharge (Send copy of order of discharge.)
- New charges or convictions
- Media attention on any CR client and/or client behavior likely to promote media attention according to Protocol for High Profile Reporting

Treatment Plan Submission:
Completed ISP treatment plans shall be submitted to Community Forensic Specialists within 90 days of admission to CR program, and reviewed not less than every six months.

Treatment Plan (ISP) and Progress Note Guidelines

Priority Issues: Based on the comprehensive assessment, list the treatment that needs to be addressed first and foremost to effect the desired change.

Desired Outcome by Max date: **Sample: Client will maintain psychiatric stability- Client will communicate with his psychiatrist about the benefits of current medications and take medications as prescribed.**

Short Term Goal: To be achieved in six months or less: **Sample: Client will complete DVR assessment and job seeking classes (100% attendance 2x per week)**

- **Residence:** Limit time in CBRF's and Out-of-County placements; address transition plan from CBRF and/or supported apartment to gradual independent living; also address transition back to county of residence; measurable objective, time frame for achievement.

- **Skill Building:** Define type of skill needed for desired level of independence, social engagement, money management, self and domicile care, etc.; measurable objective, time frame for achievement.

- **Psychiatric Services** (including Medication Management): frequency of MD visits, medications and doses; measurable objective, time frame for achievement.

- **Medication Monitoring:** Define type and frequency (blood draw, external administration, self-administration, documentation used, etc.); measurable objective, time frame for achievement.

- **AODA:** Define type and frequency of treatment; monitoring/screening for use; Behavior restrictions; measurable objective, time frame for achievement.

- **Vocational/Educational Development:** Define employment (competitive, supported, sheltered, volunteer, etc.), list # hours worked per week, money earned per hour, etc. Define education, # hours and/or classes per week, etc. State measurable objective, time frame for achievement.

- **Mental Health Counseling:** type (stress management, anger management, assertiveness training, AODA support, behavioral contracting, etc.), frequency, measurable objective, time frame for achievement.

- **Offense Specific Interventions:** SOT, cognitive restructuring, anger management, domestic abuse classes, etc.; measurable objective, time frame for achievement.

- **Supervision:** frequency, measurable objective, time frame for achievement.

- **Case Management:** type of supportive counseling, symptom monitoring, behavioral observation, etc.; frequency, measurable objective, time frame for achievement.

- **Contributions According to Ability to Pay:** disclosure of financial status, assets, debts, benefits, application status on benefits, insurance, etc.; client contributions; measurable objective, time frame for achievement.

- **Crisis Plan:** Reference as needed.

- **State of Change:** Assessment of Client's Readiness for Change

- Other issues that may or may not fall in the above categories but are needed for optimal functioning: parent training, marital or couples' counseling, compliance with medical recommendations for physical problems, etc.

Progress Notes

For each category that there is a treatment objective and an intervention, there needs to be a progress note that defines the outcome within the stated time frame.

- **State the desired goal.** List measurable objective

- **Describe the treatment results.** State progress toward the objective, achievement of the objective, or lack of progress

- **Describe why the above results were achieved.** State writer's assessment of outcome, appropriateness of intervention/approach, appropriateness of measurable objective and any other factors that impacted on the progress.

- **Describe the next course of action.** Establish new treatment plan. Redefine measurable objective and/or treatment approach if goal was not achieved. Or set new goal based on the achievement and need to advance to new level of accomplishment, keeping in mind the ultimate objective for Max date.

Client Rights Information

- **Review of information.** Client rights need to be reviewed with each client annually.

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Part V: Client Transfers

Ensuring Efficient and Well Planned Client Transfers within the Conditional Release Program

Transferring a Client

I. Intra-region Transfer of Cases:

County to county transfer within one regional provider boundary

- When a treatment team determines that a client would be better served in a different county, the case manager will create a transition plan receiving input from the client's DCC agent, 51.42 board reps from the receiving county, and the DHS Forensic Services Specialist assigned to the region.
- If a different case manager is assigned, include the new case manager in all transition plans.
- If the receiving county is covered by a different DCC agent, include the receiving agent in transition planning. Assignment/Transfer of Supervision is initiated from sending DCC agent to receiving DCC agent.
- A staffing should occur involving all treatment staff and CR staff (case manager/agent, etc.) and 51.42 board reps from the receiving county as appropriate, in order to insure that all treatment needs will be addressed and that all services are established in the receiving county PRIOR to the client moving into the new county.

I I . Transfer of Cases between CR Providers:

Client transfer from one region to another

Initial Determination of Transfer Need:

Case Manager Responsibility:

- Immediately upon information that a client either wishes to be transferred to another provider region, or the treatment team determines that a transfer would be in the best interest of the client, the Program Director from the sending region should send an e-mail to the Program Coordinator of the proposed receiving region outlining the facts of the case and the identified reasons for considering a transfer. A copy of that e-mail should go to the Forensic Services Specialist(s) in the Administrator's Office.

Initial Discussion of Transfer Process:

Case Manager Responsibility:

- An initial discussion should occur between the sending region Program Director and the proposed receiving region Program Director to determine whether the plan has merit, discuss concerns identified by the receiving provider, etc.
- Create an initial plan for the transfer process, i.e. who will schedule treatment team staffing, formulation of the plan for transfer, including notification and approval by the receiving 51.42 system.

Sharing Information:

Case Manager Responsibility:

- Packet of clinical materials should be shared with the proposed receiving Conditional Release Program Director including:
    - Commitment Order
    - Order for Conditional Release
    - Criminal Complaint
    - PDI or SME if applicable
    - Psycho-Social results
    - HCR-20 report, if applicable
    - Court Treatment Plan
    - Current Treatment Plan
    - Summary or Quarterly Progress Report

Determination of Transfer Appropriateness is Made

Case Manager Responsibility:

- Both receiving and sending Program Director, Forensic Services Specialist(s), and DCC agents agree with the transfer plan.
- Assignment of case manager in receiving provider region to work with the case manager in sending region
- Assignment/Transfer of Supervision initiated from sending DCC agent to receiving DCC agent.
- Staffing should occur involving all treatment staff and CR staff from both provider regions (case manager/agent, etc.) and 51.42 board reps from the receiving county as appropriate, in order to insure that all treatment needs will be addressed and that all services are established in the receiving county PRIOR to the client moving into the new region or county.

III. Out of State Travel

NGI clients may not leave the state of Wisconsin. HFS 98.04(3)(k) states that NGI clients "May not live, work, travel or be trained or educated in another state, because persons committed to the department under s.971.17 or 980.06, Stats., are not covered by the interstate compact under s. 304.13, Stat., or by s. 304.135, Stats." This prohibition for out of state travel cannot be waived by the agent or the committing court.

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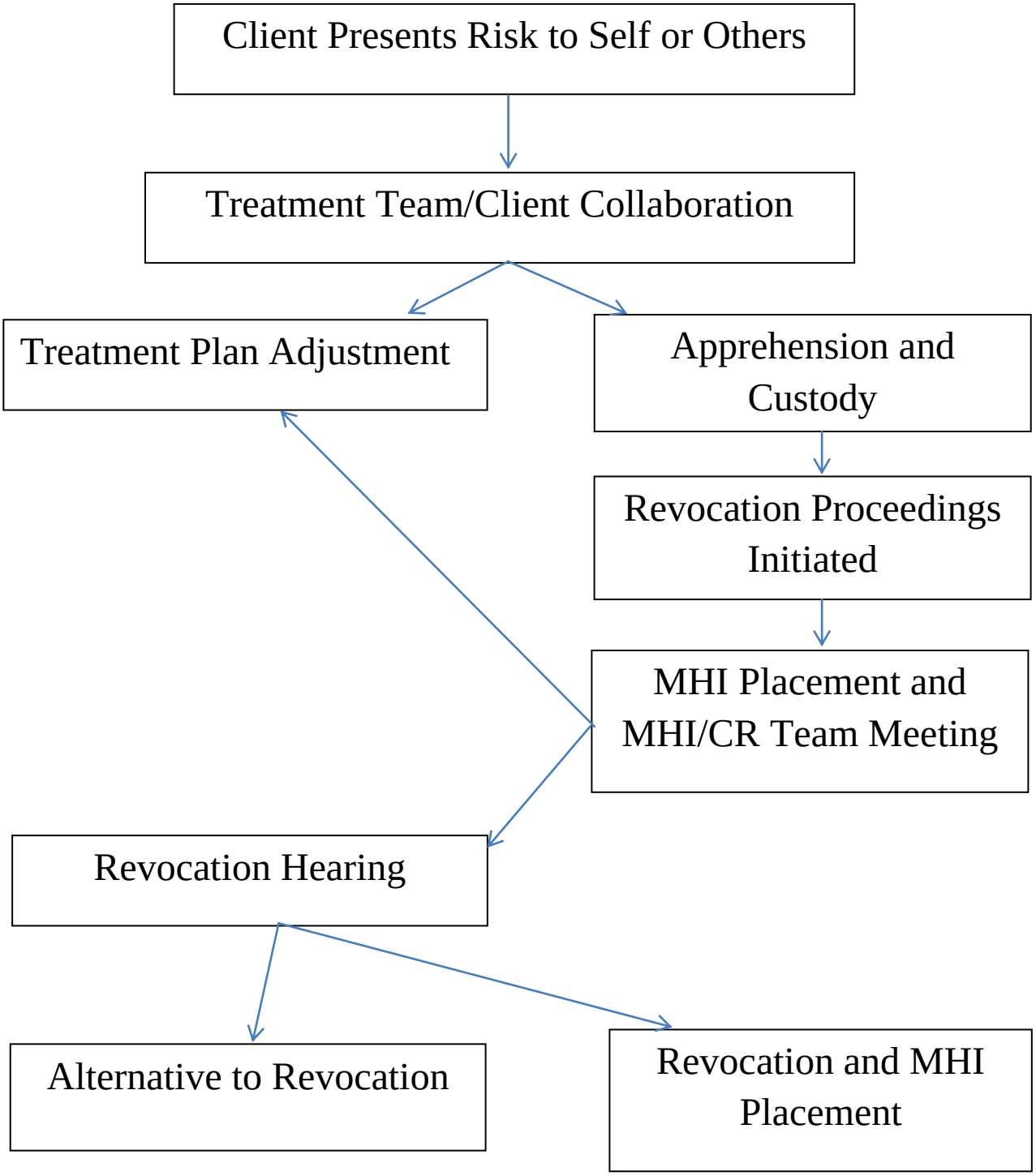
Part VI: Placement Disruptions:

Revocation Procedures Chart



Revocation Procedures

Prior to Initiating Custody
When a client refuses to work within the guidelines of his or her Individual Service Plan (ISP), the case manager, Division of Community Corrections (DCC) agent, and other treatment team members will convene for a staffing with the client and make an effort to determine the reasons for the client's refusal. If possible, a **Treatment Plan Adjustment** should be established using community resources including, if necessary, community based hospitalization.

Custody

Reasons for taking a Conditional Release client into custody include:

Custody for investigation or revocation proceedings

1. Client exhibits behavior that presents dangerousness to self or others. The client is taken into custody to protect the client, or to protect those at risk of harm by the client. Dangerous behavior could be a result of psychiatric instability or behavioral in nature.
2. Client is suspected of illegal activity, or arrested for a new offense, and is placed in custody while an investigation is initiated. This behavior is a result of psychiatric instability or behavioral in nature.

Behavioral Custody

3. Client refuses to follow certain aspects of the established treatment plan that historically puts him or her at elevated risk for failure/harm to self or others. Behavioral custody may not be used for clients who are psychiatrically unstable.

Behavioral Custody
Behavioral custody in the Conditional Release Program is intended to gain some clinical traction with clients who choose to continue high risk behaviors rather than learning and practicing self-management skills. This kind of custody should be used only if the client is psychiatrically stable, and there is evidence that a brief custody will benefit the client. Other non-custody options must be exhausted first. The treatment team must identify the client's specific unacceptable behavior, and the expected behavioral outcome of the behavioral custody. Behavioral custody should not be used repeatedly for a client. If this intervention is not effective, the treatment team must work out other means to help the client participate in his or her treatment plan. As always, if the client presents a risk of harm to self or others then revocation proceedings will be initiated.

Mandatory Custody
Custody is mandatory if the client:

1. is alleged to have participated in physical or sexual assault on another person
2. is alleged to have been involved in dangerous conduct, i.e., threat or use of weapon or act that has the potential of physical harm to person or persons. This includes verbal threats to do physical harm, if there is a history of carrying out such threats, or a credible reason to believe the offender may carry out the threat.

***In all custodies**, the DCC agent must submit a Statement of Probable Cause (F-25177) within 72 hours (not including weekend and holidays) of detention. If the team knows that revocation will not be sought, the agent will make note of this in the cover sheet accompanying the Statement of Probable Cause.

Staffings and notifications:

Upon clients' placement in custody, communicate the following information to the Forensic Specialist:

- Client's behavior/precipitating events
- Previous interventions attempted
- Expected date of release from custody
- Anticipated behavioral outcomes resulting from custody intervention
- Proposed adjustments to the treatment plan upon release

A note on custody related staffings:

Cases reaching the point of custody need to be discussed among the entire treatment team (CM, agent, Forensic Specialist, contracted treatment providers). When a client presents behaviors that put his or her community placement at risk, hold a staffing with the client. Do not use custody as a threat. Identify the specific behavioral problems that need to change, and identify specific behavioral expectations. Help the client identify a means to achieving the behavioral expectations, and help the client think through all of the consequences of not changing the dysfunctional behaviors. Among the consequences, include the fact that if the behaviors do not change, the treatment team will need to place him or her in custody in an effort to help the client stop the dysfunctional behaviors and work toward self-management.

If a staffing was not held in advance of the custody, hold a staffing/conference call as soon as possible, **within five days** of the custody. Most likely, the client's Individual Service Plan (ISP) would be revised as a result.

The group's first and primary responsibility is to work together in the best interest of the client and the safety of the community. All participants will give voice to their opinions and assessments. When there are differences of opinion, the group is expected to articulate the reasons for the differences and to continue working toward consensus. Revocation will be pursued unless the DHS and the DOC agree to an ATR.

Case Manager Responsibility:

- Work diligently to understand the client's reasons for not following the ISP
- Convene a staffing with the client and treatment team to identify ATR options
- Adapt the ISP accordingly
- Anytime a custody appears eminent, include the Forensic Specialist in the staffing.
- Understand the apprehension and custody procedures that the DCC agent must perform in order to follow and support your client throughout the process.
- Upon client's placement in custody, email the specific information referenced above to the Forensic Specialist.
- If a staffing was not held in advance of a custody, hold a staffing as soon as possible **within five days** of the custody to address the specific problematic behaviors as a unified team.

When a client is placed in Mendota Mental Health Institute or Winnebago Mental Health Institute, by the fifth (5th) work day of the client's detention at the institution, the CR case manager will arrange a conference call to include not less than the case manager, Institution social worker, the DCC agent, and the designated DHS Forensic Services Specialist.

Case Manager Responsibility:

- For clients sent to MMHI – send information packet to the admissions office (Fax: 608-301-1358).
  This includes: Order of Commitment, Criminal Complaint, doctor's report, Order for CR, CR Plan, case notes and adjustment summary. The agent will Send the 5177 and Order to Transport.
- By the fifth (5) work day of the client's detention at the institution, the CR case manager will arrange a conference call to include not less than the case manager, institution social worker, the DCC agent, and the designated DHS Forensic Services Specialist.
- The conference call should address the nature and details of the violation; the impression of the client's difficulties (including client's self-report) in the community and his or her specific needs; and possible alternatives to revocation. The client's needs will offer direction to the group's assessment of community treatment plan viability.
- If a recommendation for or against revocation is not determined at this conference call, the team will need to reconvene for that purpose. If the group decides to develop an alternative to revocation plan (ATR), schedule the next conference call and determine what the group participants will be working on to accomplish this goal.
- If an ATR is established and the client will be returned to the community, transportation to community placement is the responsibility of the case manager.
- Be prepared to testify as to the treatment team's recommendations.

Apprehension – DCC Procedures

- When an NGI client violates the court ordered conditions of release or the standard conditional release rules and the client's whereabouts and activities are unknown, the DCC agent may issue an Apprehension Request (DOC-58).

Custody – DCC Procedures

- Every time an NGI client is placed in custody, the DCC agent must submit the completed Statement Of Probable Cause For Detention And Petition For Revocation Of Conditional Release (F-25177) to the committing court and the regional office of the State Public Defender responsible for handling cases in the county where the committing court is located **within 72 hours of detention, excluding weekends and legal holidays.** Copies of the F-25177 should also be forwarded to the District Attorney's office and to the DHS Forensic Services Specialist.
- A revocation hearing must be scheduled, by the court, **within 30 days of the date of detention,** unless the hearing or time deadline is waived by the detained Person through their attorney.

- The supervising DCC agent will determine where the client is to be detained pending the revocation hearing (as noted on the F-25177). In most cases, when revocation is being pursued, transportation is arranged to the appropriate mental health institute. The DHS Forensic Specialist shall contact the admissions office at MMHI toad the client to place the client on the MHI admission list. Clients generally are returned to the institution they were conditionally released from. Female NGI clients go to WMHI. Agents should consult with the Forensic Specialist if they are unsure which institution the client should be returned to. The agent prepares the Order To Transport (F-25205) for the committing courts signature. The court then forwards the Order to Transport to the sheriff's office to affect the transport.

- When a DCC agent takes a CR client into custody, he or she must follow: Notification Procedures for Conditional Release (NGI)

Case Manager Responsibility:

- Conduct client Risk Assessment
- Transport medications to the jail if needed
- Monitor mental health needs until admitted to MH

Client is Presenting as Suicidal - Emergency Revocation Admissions to an MHI

1. Case manager must update the Suicide Risk Assessment. WMHI or MMHI will need any updated information from staff regarding the urgent need for admission upon asking for a priority admission to the MHI.
2. Contact the Forensic Services Specialist in Administrator's Office by either the case manager or the agent. Once we agree that the person is suicidal and needs inpatient care, the agent completes the Statement of Probable Cause/Petition for Revocation (F-25177) and has the court sign the Order to Transport (F-25205). The Forensic Services Specialist will be the point of communication with the MHI.
3. Involve the client's therapist and psychiatrist, in the decision making as to whether the person needs inpatient treatment.
4. The protocol for admission is as follows:
   The Forensic Services Specialist will contact:
   - Mary Nitz at WMHI and Paul Lane at MMHI
   - Admissions Office at MMHI
5. Admissions at both MHI's are requesting that the Statement of Probable Cause/Petition for Revocation, (F-25177), and a copy of the original Order of Commitment be faxed ASAP prior to the person being admitted to the MHI

Case Manager Responsibility:

- Complete Suicide Risk Assessment
- Contact Forensic Specialist, DCC agent, key service providers such as therapist, psychiatrist.
- Provide MHI staff with pertinent information/documentation
- Liaison with jail mental health team/jail staff

Revocation Hearing

When revocation is pursued, the hearing is conducted by the committing court. The District Attorney is responsible for establishing clear and convincing evidence that a rule or condition of release has been violated, or that the safety of the person or others requires that the conditional release be revoked. The agent and case manager may be called to testify as to the reason(s) for the requested revocation.

Revocation Withdrawal

If revocation is not pursued, the agent withdraws the petition, advises the committing court of this decision and if approved by the court, returns the client to active supervision/community placement.

MHI Admission Following Revocation

When a client is placed at WMHI or MMHI, the institution social worker will contact the agent and the CR case manager to discuss the nature and details of the violation. A staffing should be scheduled with the community and MHI treatment team by the 5th day of admission to the MHI.

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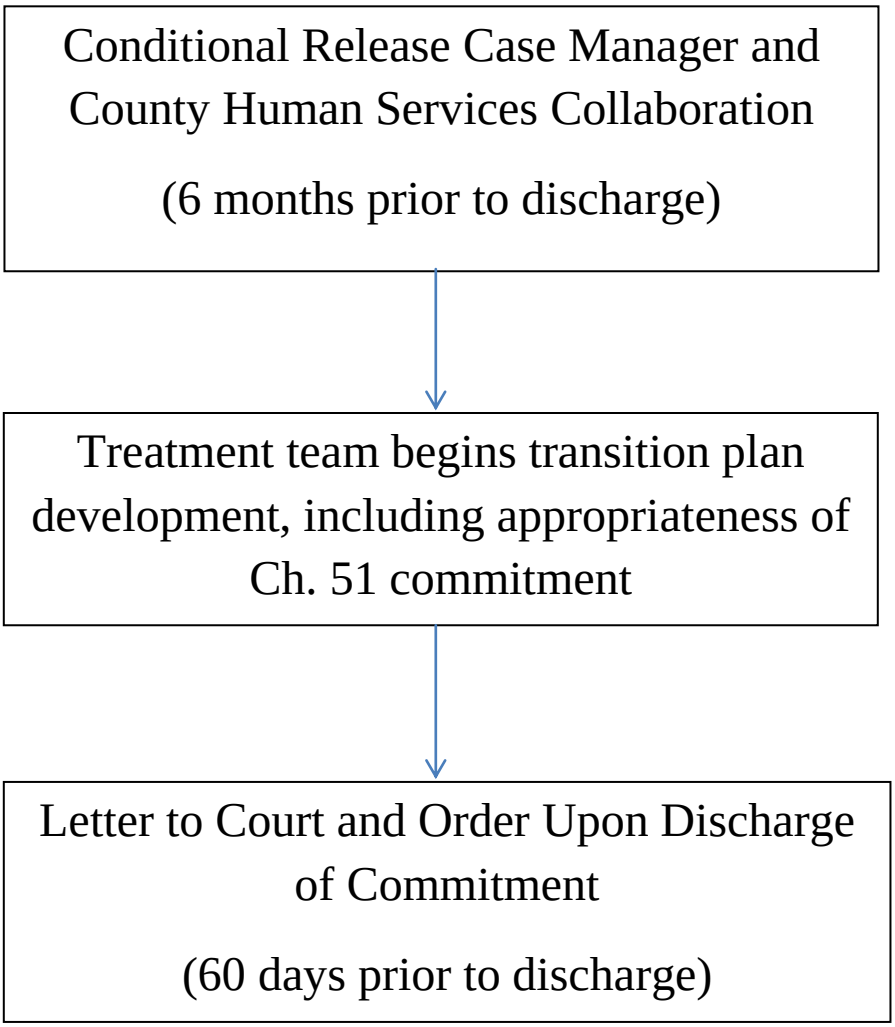
Part VII: End of Commitment

End of Commitment and Transfer to County Human Services



Clients Reaching Maximum Release: Expiration of Commitment

Case Manager Responsibility:

- Notify the Client's 51.42 Board no less than six months from the Maximum Release date.
- In coordination with the 51.42 Board, prepare a plan that transitions the client from the CR program to county services.
- Notify the court of the transition plan no less than 60 days from the Maximum Release date.
- Place a copy of the signed Discharge Order in CR file

Establishing an Aftercare Plan:

- When a patient is within no less than six months of their maximum release date, the treatment team should meet to discuss the patient's specific needs upon discharge.
- Within six months of the maximum release date, the conditional release case manager must be in contact with the client's county of residence 51.42 board to establish a continuum of services aftercare plan. The team should consider whether the patient needs services under Chapter 51 or 55.
- If the patient is assessed to be unable to care for herself or himself without the provision of specific services currently provided by the Conditional Release Program, or is dangerous to self or others, the process for civil commitment should be initiated by contacting the 51.42 board of the county of residence.

Letter to Court and Obtaining a Discharge Order:

- Case manager must send a court letter a **minimum of 60 days** prior to the expiration of the commitment to the committing court. This letter is to provide aftercare plan information to the court. Sixty days prior to the maximum release date, the supervising DCC agent must submit F-25180 to the court for a signature. The DCC agent sends copies to the following:
    - Regional Provider
    - DHS Conditional Release Specialists (DHS will close their file)
    - DOC Central Records (a termination # is issued)

Order of Discharge Upon Expiration of Commitment (NGI)

Process & Procedure for Distribution

Conditional Release cases may only be terminated by order of the court. In addition, the DOC/CRU cannot remove the client from their records without a signed discharge order from the committing court.

- **Clients Currently on Conditional Release (CR):** The DOC Agent will submit ***(via mail)*** the ORDER OF DISCHARGE UPON EXPIRATION OF COMMITMENT (F-25180), to the committing court at least sixty (60) dates prior to the commitment expiration date.

- **Clients Currently in the state mental health institution (MHI):** The DHS Social Worker will submit ***(via mail)*** the ORDER OF DISCHARGE UPON EXPIRATION OF COMMITMENT (F-25180), to the committing court at least sixty (60) dates prior to the commitment expiration date.

- Our Department respectfully requests that the Court sign and return the Order form ***(via fax),*** as soon as possible, to the ***Sender*** at the number they have provided.

  DOC Agent/Office: ***Fax number will be provided by the Agent***

  Mendota Mental Health Institute: ***(608)301-1358,***
  Attn: Social Worker who submitted

  Winnebago Mental Health Institute: ***(920)237-2041,***
  Attn: Social Worker who submitted

- If the client is in the community, upon receiving the signed ORDER OF DISCHARGE UPON EXPIRATION OF COMMITMENT (F-25180) from the committing court, the DOC Agent will forward the order to the DHS Forensic Services Specialist and CM**.**

- If the client is in the state mental health institution, upon receiving the signed ORDER OF DISCHARGE UPON EXPIRATION OF COMMITMENT (F-25180) from the committing court, the DHS Social Worker will forward the order to the DHS CR Program Manager. The DHS Forensic Services Specialist will then forward the order to the agent and the community case manager.

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Case Manager Procedure Manual

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1. PDI Format

PREDISPOSITIONAL INVESTIGATION REPORT

Date

Demographic Information:

Name:

DOB:

Birthplace:

Case#:

Charges:

Gender:

Ethnicity:

Address:

Phone:

Education:

Religion:

Family:

Marital Status:

Defense Attorney:

District Attorney:

Probation Agent:

Diagnosis:

Medication:

Services:

PRESENT OFFENSE

PRIOR RECORD

FAMILY BACKGROUND

PERSONAL HISTORY

Academic/Vocational Skills:

Military:

Marital Relationship:

Employment:

Financial Management:

Emotional Health:

Physical Health:

Chemical Usage:

Mental Ability:

Religion:

Leisure Time Activities:

Residence History:

Other Agency Involvement:

SUMMARY AND CONCLUSIONS

Investigators Assessment and Conclusions:

Recommendation:

Respectfully submitted

SOURCES OF INFORMATION

PDI report distribution:

Original: The Court of Commitment

Copies: DHS Conditional Release Specialist
Contracted Conditional Release Provider

Conditional Release Program: Risk Assessments
Criteria for requesting an HCR-20
Criteria for requesting a sex offender risk assessment

Criteria for requesting an HCR-20 –Violence Risk Assessment

1. The CR program's use of the HCR-20 is also targeted for long term clients.[1] For example, Misdemeanants with commitments of 6 months or less would barely get through the evaluation/treatment plan process before being discharged from the program.
2. MHIs should be contacted in order to determine if any risk assessments were done while the client was inpatient.
3. The following historical information will serve as general criteria for determining the use of an HCR-20:

Historical:

- Charged/Convicted/Committed for crimes against persons, i.e. Assault, Strong Arm Robbery, etc.
- Previous violence not noted in legal history
- Failure on supervision
- Personality Disorder
- Substance abuse related to violent behavior

A referral should be considered on a case by case basis.

Direct Court Referral Process

1. Case Managers will identify their reasons for or against requesting an HCR-20 with program managers.
2. Forensic Services Specialists will make a final decision on whether or not a referral will be made for the risk assessment.
3. Cases that are determined to need an HCR-20 will be referred to the evaluator by the program manager.[2]
4. Monthly invoice: Program managers will include the number of HCR-20 assessments and cost on monthly invoices submitted to CR administrative office. Forensic Service Specialists will record these in the Cost Trends spreadsheet.
5. Copy of report sent to CR Specialist.
6. Copy of report sent to DCC agent.

[1] If program managers feel strongly that a short term case would benefit from an HCR-20 – especially if there are concerns about follow-up treatment from county services – then the risk assessment should be scheduled.

[2] Program managers (rather than case managers) will make the referrals in order to 1) assure the approval process has been followed, 2) limit the number of referral sources for evaluators to keep track of.

MHI Referral Process:

1. Case Managers will identify their reasons for or against requesting an HCR-20 with program managers.
2. Forensic Services Specialists will make a final decision on whether or not a referral will be made for the risk assessment and refer to Forensic Director at the MHI.

Case Manager Responsibility:

- Following the criteria for determining risk assessment needs, case managers will identify their reasons for or against requesting an HCR-20 with program managers
- If a HCR-20 need is determined, follow appropriate referral process

Criteria for requesting a sex offender risk assessment

The following historical/clinical information will serve as general criteria for determining the need for a sex offender risk assessment:

Historical:

- Charged/Convicted/Committed for sex offense and, sexual offending/sexual preoccupation is not a result of psychotic episode that is now controlled through medication
- More than one sex offense Charge/Conviction/Commitment.
- History of sexual violence that has not resulted in legal system involvement (such as documented assaults against other patients, inmates, etc.)

Clinical:

- Deviant sexual preoccupation/pro-offending attitudes such as – children like sex with adults, women want/deserve to be raped, etc.

Note: Clients admitted from MHIs may have been evaluated for sexual re-offending. MHI medical records should be contacted to enquire.

Referral Process

Because sex offender risk assessments are more involved and costly than the HCR-20, program managers will contact the Forensic Services Specialists (Janeen Meyer/Jenny Fahey) to initiate the referral process. The Forensic Services Specialist will notify the sex offender risk assessment evaluator, providing the evaluator with contact information.

Monthly invoice: Program managers will include the number of sex offender risk assessments and cost on monthly invoices submitted to CR administrative office. The Forensic Services Specialists will keep track of sex offender risk evaluations and cost in the Cost Trends spreadsheet.

Case Manager Responsibility:

- Refer clients who meet the above criteria to your program manager.
- The program manager will contact the Forensic Services Specialists to initiate the assessment referral process.
- Collateral information will be gathered by case managers and sent to the evaluator.
- If needed, transportation arrangements for the evaluation will be made by the case manager.

CONDITIONAL RELEASE PROGRAM SUICIDE RISK ASSESSMENT PROTOCOL

When to Conduct a Suicide Risk Assessment (SRA)

1. Upon admission to the Conditional Release Program all clients will be assessed using the standard Conditional Release SRA. Each client will routinely be assessed at six-month intervals as a part of the treatment plan review process.
2. The tool will also be administered when there is a crisis/significant loss in the client's life, custody placement or when the case manager determines a need based on concerns related to suicide risk.
3. The SRA should be administered in a setting that allows strict confidentiality.

Conditional Release Program Protocol for Risk Assessment Findings

I. Client has a plan with a method on hand and/or is making final plans/has a note:

- Case manager consults with the DCC agent. Agent initiates revocation proceedings. Inform transport of the severity of the case.
- Case manager and DCC agent consults broader treatment team to determine the following:
  1. The client should be carefully monitored. Determine who will monitor the client while transportation is arranged.
  2. Have the client stay in a designated safe environment i.e. not in a kitchen where there are knives, or where fixtures could be used to hang oneself.
  3. Person monitoring remains with the client (1:1).
  4. As a last resort, if the client is uncooperative and in immediate danger of self-harm and no safe location can be established for monitoring call local law enforcement immediately. Explain the situation and that transport to a state hospital is in process – client needs a safe location until transport is arranged.

II. Risk Scores: Scores in risk level 4 and 5 are considered high scores.

- If a client has a high score, but does not have a plan/method, the treatment team needs to identify with the client their concerns for suicide risk.
- The treatment team will review the client's treatment plan with the client to determine whether or not the client's psychiatric status is being adequately addressed (depression, agitation?).
- Review the number of contacts the client has each week. The client should have daily contact with providers or subcontracted providers who have knowledge of the client's risk assessment score. This may be a combination of persons from the treatment team.
- The assessment tool should be administered weekly until the score is reduced to a risk level of 3 or less. If at any point, however, the treatment team is uneasy with the client remaining in the community, then revocation proceedings must be

initiated. The treatment team may not ignore or reduce the perceived risk demonstrated by the assessment tool. The treatment team may have a greater sense of caution than the risk assessment tool indicates and should initiate revocation if they feel it is in the best interest of client safety.

III. A score of risk level 3:

- Discuss the score with the client and the concern for suicide risk.
- Talk with the client about the ways in which the treatment team supports and encourages the client.
- Review the number of contacts the client has each week. If the client tends to isolate, increase contacts.
- Administer the assessment tool in 4-6 weeks.

IV. Scores of 1 and 2 are low risk.

- Discuss score with the client and any concerns the treatment team has, reiterating their support and encouragement to the client.
- Administer assessment at 6-month intervals.

Definitions/Guidelines

The following definitions are based on those presented in the Suicide Risk Assessment Checklist. A few modifications were made, including adding points for being new to community programming and removing a section on "no suicide" contract. This particular tool was chosen due to its reliability across varying experience and educational levels of the raters. This assessment was developed with the understanding that documentation is a necessary component of a standard of care for clinical and legal reasons. Standardized documentation ensures that a comprehensive assessment has been addressed and is consistent across the entire program and from one client to the next. For more information on the Suicide Risk Assessment development, read *Development and psychometric analysis of the Suicide Assessment Checklist*, in the Journal of Mental Health Counseling, July 1994.

Part One:

Previous Psychiatric History:

The answer here is always going to be **yes** with our clients. They are in our program because they have a psychiatric history even if brief. They may not have a history prior to the NGI commitment, but the commitment itself is a documentation of psychiatric history.

New to Community Programming:

This answer will be yes if they have entered community programming for the first time in the past 12 months whether coming from an institution or directly from court.

Client has a Definite Plan:
A plan means that a client has thought out and formulated a process by which to commit suicide.

Plan involves:
If a plan exists, what method has been chosen? Select from the options given.

Method on Hand:
Is the method readily available to the client as opposed something that needs to be obtained? If the method is readily available then answer yes.

Making Final Plans:
Is the client taking care of any unfinished business and/or giving away prized possessions?

Prior Attempts:
Has the client admitted to previous suicide attempts including hidden or disguised attempts? Sometimes family, friends, or past psychiatric history will alert the provider to a suspicious life-threatening accident(s) at some point in the client's history. Follow-up questions might include "How did you feel at the time of the accident?" "Did you want to die?" "Was this an attempt at ending your life?" The answer is yes if the client admits to a previous attempt or psychiatric history demonstrates an attempt.

Suicide Note:
Has the client written a suicide note, or plans to write a note placing blame for the action, leaving instructions to survivors, or saying "good bye?"

Suicide Survivor:
Has the client had a close friend, or a relative commit suicide?

Drug and/or Alcohol Use:
Does the client use drugs or alcohol at any level?

Male 15-35 or 65 and older:
Is the client male in either category?

Dependent Children at Home:
Does the client have one or more children 18 years or younger living in the household?

Marital Status:
What is the marital status of the client?

Part Two:

This section is based on **your impressions** of the client's status or feelings. This is not a section for the client's impressions of themselves, or what the client "should" be feeling.

Sense of Hopelessness:
To what degree does the client feel that there is no hope to improve his/her situation in the future? Sample questions: "Do you think your situation is going to improve?" "Are you hopeful about the future?"

Sense of Worthlessness:
To what degree does the client feel that she/he has no personal worth or value to self or others? Sample questions: "Do you feel that people are unfriendly?" "Do people generally like or dislike you?" "Do you feel that you are helpful to others?" "What do you like about yourself?"

Social Isolation:
To what degree does the client feel that she/he has no friends or relatives to whom to turn? Sample questions: "Do you have friends or relatives to whom you can turn when feeling blue or in need of something?" "Can you name some friends whom you trust?" Do you feel lonely even when you are with others?"

Depression:
To what degree does the client exhibit signs of depression i.e., inactivity, lack of interest, disrupted eating and/or sleeping habits, etc? Sample questions: "How many meals do you eat each day/what do you eat?" "Are you having trouble sleeping or feel that you are sleeping too much?" "What activities did you do this week?" "What are your interests?" "Are you feeling interest in things?" "Are you feeling down or blue?"

Impulsivity:
To what degree does the client exhibit impulsive behavior i.e., acting with little rational thought to outcomes? Observation and questions about particular events/incidents primarily assess this – "Did you think about what may happen as a result of . . ."

Hostility:
How much anger does the client seem to have towards self, others, institutions? Sample questions: "Do you have temper outbursts?" "Do you generally feel – angry, happy, sad, . . ." "Do you have thoughts of hurting yourself? Others?" "Do you have thoughts of destroying property?"

Intent to Die:
To what degree does the client seem determined to carry out plans to their conclusion? Sample questions: "Do you wish you were dead?" "How close have you come to committing suicide?" If the client wishes to die - "What are your plans for ending your life?"

Environmental Stress:
To what degree does the client feel that events in his/her life are overwhelming, painful, humiliating or presenting insurmountable obstacles? Ask questions related to these overwhelming events (job loss, anniversary of something that causes emotional disturbance, death of friend, spouse, or other significant person, change in housing status, financial problems, etc.)

Future Time Perspective:
To what extent is the client able to focus on the future or positive future events as opposed to focusing on only present or negative future events? (1 = ability to focus on the future, 5 = absence of positive future time perspective)

Conditional Release Program

Suicide Risk Assessment Checklist

Name: _____
Age: _____
Gender: _____

Part 1

		Score
Previous Psychiatric History	**If yes, score 4**	
New to Community Program	**If yes, score 5**	
Client has a Definite Plan	**If yes, score 6**	
Plan Involves: • Firearm (10) • Drowning (6) • Drugs/poison (6) • Car Exhaust (7) • Suffocating (6) • Cutting (3) • Hanging (9) • Jumping (5) • Other (3)	**Score according to the type of plan as indicated**	
Method on hand	**If yes, score 5**	
Making final plans	**If yes, score 6**	
Prior Attempt(s)	**If yes, score 5**	
Suicide note	**If yes, score 6**	
Suicide Survivor	**If yes, score 6**	
Drug and/or alcohol use	**If yes, score 5**	
Male 15-35 or 65 and older	**If yes, score 5**	
Dependent Children at Home	**If yes, score -4 (minus 4)**	
Marital Status: • Single (3) • Married (2) • Divorced (5) • Separated (5) • Widowed (5)	**Score as indicated based on status**	

Total Part 1:_____

Part 2:
Initial perception of client's status (to be completed by case manager):

Circle appropriate rating:	None				Extreme
Sense of Hopelessness	1	2	3	4	5
Sense of Worthlessness	1	2	3	4	5
Social Isolation	1	2	3	4	5
Depression	1	2	3	4	5
Impulsivity	1	2	3	4	5
Hostility	1	2	3	4	5
Intent to Die	1	2	3	4	5
Environmental Stress	1	2	3	4	5
Future Time Perspective	5	4	3	2	1
Total Part 2:					

Total Part 2: _____

Totals Part 1 and 2: _____

Risk Level:
70 and above: 5 (High)
69-55: 4
54-38: 3
37-20: 2
<20 1(low)

Risk Level: _____

Date Completed_____

Date of Next Assessment_____

Institution Letter to Court

Statutory guidelines for recommendations by Institute staff

The treatment team shall consider the standard that the court..."*shall grant the petition unless it finds by clear and convincing evidence that the person would pose a significant risk of bodily harm to himself or herself or to others or of serious property damage if conditionally released. In making this determination, the court may consider, without limitation because of enumeration, the nature and circumstances of the crime, the person's mental history and present mental conditions, where the person will live, how the person will support himself or herself, what arrangements are available to ensure that the person has access to and will take necessary medication, and what arrangements are possible for treatment beyond medication*".

Process for submitting court letters

Team meeting

The treatment team must meet to discuss their recommendation to the court regarding appropriateness for conditional release. The recommendations should consider the community resources available, matching patient needs and resources. The Institute social worker, and other institute team members shall include the Conditional Release Program case manager in the formulation of the treatment team's recommendation regarding Conditional Release. When the team makes a recommendation, the specific clinical reasoning should be clearly stated.

Case manager responsibility:

- Participate in MHI court letter process
- Gain knowledge of the client's strengths and needs
- Provide CR Program information to the MHI treatment team.
- Advise the MHI treatment team on whether resources exist to meet the client's identified needs.

Writing the letter

The court letter is to be a product of the treatment team and must be written by a MHI team member. In addition to institution treatment staff, the treatment team must include a Conditional Release Program case manager. The court letter **shall not** replace the court-ordered examiner's report and should be stated so in the letter. Under **no** circumstances should more than one or conflicting letters be

submitted from Institute staff or Conditional Release Provider to the court. **In the event that there is disagreement among team members, effort should be made to resolve the conflict. The letter may reflect differing positions but should be explained to the court.**

Application of WSS 980 and WSS 301.45

The court letter must reference applicable sex offender laws and processes if the petitioner meets criteria to be considered under these statutes.

Submitting the letter

The court letter must be submitted within **30 days** of petitioning. If there are any significant events from the date of the letter until the hearing, an update should be submitted to the court by the MHI staff. The **original** letter should be sent to the committing court and a copy of the court letter should be sent to the following:

District Attorney
Defendant's Attorney
Division of Community Corrections Agent
County 51.42 Board
DHS Forensic Services Specialist
Contracted Conditional Release Case Manager
Admissions/Registrar
Aftercare Coordinator (if applicable)
Patient
Medical Record

Records Request from MHIs

Provider Letterhead Stationery:

Date:

MHI address:

Re: Client Name, Case Number, DOB (if available)

Dear MHI Health Information Manager:

I am writing to request information from the medical record of *client's name:* . This information will assist me in fulfilling my obligation as a representative of a DHS Contracted Conditional Release Regional Service Provider, *agency name:, address:, city:, state:, zip:, phone:*. Pursuant to the contractual agreement between my agency, *initials of agency:* and DHS and acting on behalf of the latter, I do not need to provide MMHI/WMHI with a release of information consent form. If you have any questions or concerns about this request, please contact Paul Jones or Paul Lane at MMHI or Carol Thomas or Mary Nitz at WMHI and Janeen Meyer or Jenny Fahey DHS Community Forensic Services Specialist. *(Depending on county of residence and MHI)*

Please send copies of documents that I have noted on the following checklist:

DHS/DHS REGIONAL SERVICE PROVIDER REQUEST FOR REFERRAL INFORMATION: A CHECKLIST

When the Regional Service Provider becomes aware of a 971.17 MHI admission from the provider's region, the provider may request copies of the following documents in order to develop a file and/or to prepare a predispositional investigation report. (And also request for distribution to DOC and the 51:42 Board as needed.)

1. _____ Original Commitment Order

2. _____ Computation Sheet with Maximum Release Date

3. _____ Criminal Complaint

4. _____ Admissions Face Sheet

5. _____ Initial Assessment

6. _____ Social Service Data Base

7. _____ Therapeutic Services Data Base

8. _____ Psychological Evaluation (if applicable)

9. _____ Copy of most recent Treatment Plan

10._____ Copy of most recent Physical Exam

11._____ Copy of Physician Order Sheets

12. _____ Copy of most recent Annual Data Base

13._____ Other _____

When 971.17 persons are granted conditional release from MHI's, Regional Service Providers may request copies of updated documents numbered 8-11 above & 12-14 below. (And also request copies for distribution to NGI Agent; DHS Community Forensic Services Specialist, and the 51:42 Board as needed to affect timely referrals for services.)

14. _____ Conditional Release Order

15. _____ Discharge Summary and Treatment Recommendations

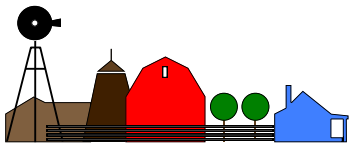
16._____ Other _____

Thank you for your timely attention to this request. If needed, you may contact me at *Phone:.* Please mail the requested documents to me at the address listed below.

Sincerely,

Name of Person Initiating the Request:
Title of Position
Mailing Address:

WORKING WITH FORENSIC CLIENTS IN THE COMMUNITY



SOME SUGGESTIONS FOR MAINTAINING STAFF SAFETY

Wisconsin Department of Health Services
Community Forensic Services Program

THE CONDITIONAL RELEASE PROGRAM
CASE MANAGER SAFETY TRAINING

Welcome to the State of Wisconsin, Department of Health Service's Community Forensic Services Program. Through the combined efforts of our staff, we have developed a national reputation for innovation and program effectiveness in the field of community forensic services.

The safety of staff, clients and the community is the primary mission for our program. Our forensic population is one of the most challenging groups one can work with in the criminal justice field. The majority of our clients are committed to our department for assualtive felonies. The combination of major mental illness, chemical dependency, deficits in education, financial resources and social support are common issues for our clients. The potential volatility that these factors can contribute to criminal activity are without parallel with any other single group.

At the core of our programs success is the operational concept of working as a member of a cohesive treatment team. The client is a participating member of the team. The client's progress in the community is monitored by and issues are addressed through the coordinated expertise and resources of the other team members. These members may include staff at Mendota and Winnebago Mental Health institutions, the supervising Division of Community Corrections Agent, community treatment providers and the assigned Case Manager. By providing the client with consistent and sound case management responses, treatment success and community safety are maximized.

The suggestions listed here for maintaining staff safety are just that, suggestions. **They will not guarantee your safety**. They are intended to provide a framework for considering a number of factors, which potentially could impact upon your safety in the office and field. Specific case knowledge of your clientele, awareness of basic safety issues, vigilance in attending to these factors and above all, sound decision making on your part, offer the greatest potential to enhance your safety.

Again, we welcome you as a valued member of the Conditional Release Program treatment team. We trust that your involvement with our dynamic program will prove to be both personally and professionally rewarding to you.

KNOWING YOUR CLIENT - *RELATIONSHIP SECURITY*

One of your best safety precautions is to be as thoroughly knowledgeable about the client as possible. Initial availability of client information will vary on whether they were released directly by the court into the community or were released from one of the mental health institutions. At a minimum, the case manager should obtain and review the following documents as soon as possible.

Sources of client information:

- Committing offense.
- Criminal complaint.
- Psychiatric evaluations.
- Crime Information Bureau report (CIB).
- Hospitalization records.
- Documented historical "red flags" of client aggression and decompensation.
- Client self report of aggression and decompensation triggers
- Family member reports of client aggression and decompensation triggers.

Dynamic Security: the best security, dynamic security, lies in maintaining a positive relationship with the client. Good trusted communication between the staff and client is the best preventive measure. However: if a client is under the influence of alcohol other drugs or is psychiatrically unstable – all bets are off – ***do not*** rely on the concept of dynamic security to provide you with any margin of personal safety.

Situations leading to increased aggression:

- Violations / custody's / potential revocation situations.
- AODA
- Psychosis / psychiatric decompensation.
- Situational stress.
- Recent failures / disappointments (relationships, employment, family issues).
- Anger / resentment toward legal status, case manager, agent.

Causes that may lead to a decline in client investment to follow treatment plan:

- Losses – family, friends.
- Medication changes,
- Family interactions.

SAFETY TIP: MAKE YOUR INITIAL CONTACT WITH A NEW CLIENT AT YOUR OFFICE. CONSIDER REQUESTING THAT THE ASSIGNED AGENT ACCOMPANY YOU ON YOUR FIRST HOME VISIT.

OFFICE SAFETY

- General office layout.
- Location of facility exits.
- Access to securable rooms.
- Location of other office telephones you can access.
- Presence or lack of other office staff.
- Programmed emergency numbers.
- Code words or phrases for staff to call police in emergencies.
- Location of your office exits.
- Arrangement of furniture for space between you and client.
- Ability for you to exit your office.
- Presence of and location of potential weapons (e.g., lamps, computers, nameplates, staplers, tape dispensers, scissors, letter openers, excess pens and pencils, throw able chairs, other heavy objects.)

SAFETY TIP: NEVER PREVENT A CLIENT FROM LEAVING YOUR OFFICE.

FIELD SAFETY – *SITUATIONAL AWARENESS*

Assessing the area around the clients residence

- Assess the environment around your client's residence before entering. Drive around the block; is it an area where open-air drug transactions occur? Is it an area of active gang activity? Watch for gang-related graffiti. Look for individuals hanging out on porches or steps in the neighborhood. Look for solitary children watching the area (possible lookouts for drug houses). Listen to what your "gut level" comfort is telling you.
- If the residence is set back from the street or in a rural area, be more cautions and aware of activity around you.
- Try to stay clear of bushes or structures that could conceal an individual.
- Attempt to park your car as close to the residence as possible.
- Avoid parking your car close to visual obstructions such as larger vehicles, dumpsters or other objects which prevent you from scanning the area around your car.
- Try to schedule home visits in the morning when there is less general activity in the neighborhood. Avoid Friday afternoons when early weekend party goers may be present.
- Determine how much time you will spend on a home visit. Avoid leaving a residence in the dark.

- Be aware of the presence and quality of the lighting where the home is and where your car is parked.
- Make staff aware of your schedule and expected time of return to the office or make some other arrangement to notify staff when your field operations have concluded for the day.
- Have your cell phone preprogrammed to 911.

SAFETY TIP: TRUST YOUR INSTINCTS, IF IT DOESN'T FEEL RIGHT, LEAVE THE AREA. YOU CAN ALWAYS RESCHEDULE.

Assessing the building in which the client resides:

- Where in the building, exactly is the client located, which apartment, which floor.
- What is the quality of lighting in the entranceway and hallways?
- Are other tenants hanging out in the hallways, is a party going on? Are other tenant's doors open? **Leave immediately if you are uncomfortable within the building.**

Assessing the client and residence before you enter:

- Is the client appropriately dressed?
- Did s/he remember you were coming?
- Take a moment to evaluate the client's demeanor.
- Try to be aware of any sights or smells that might indicate the client has been using alcohol or other drugs
- Ask the client who is present in the residence and what their relationship is to the client.

If you are uncomfortable with any aspect, which cannot be remedied <u>quickly</u> (such as having the clients friend(s) leave), have the client contact you later that day for a new appointment. Be clear and direct with the client as to your expectations of the client and the residence when you schedule an appointment.

Assessing the client's residence after you enter:

- Attempt to always keep clients in front of you and within your visual field, avoid allowing them to follow behind you.
- Keep at least an arms length distance between you and the client at all times.
- Note the locking system on the entrance door. Is it locked now? Would you be able to exit quickly? Can others enter during your home visit?
- Be respectful of the client's residence. However, if the television or radio is at a noise level that makes interviewing difficult, ask them to lower the volume or turn it off.
- On your first home visit, request a short tour of the residence. Note exits; using the *Structured Scanning* technique, visually scan each area from ceiling to floor. Be aware of any alcohol, drugs or drug paraphernalia, magazines, posters, or books of a disturbing nature (e.g., High Times; Soldier of Fortune; How to Build a Bomb, etc.). Note any real or potential weapons (e.g., rifles, handguns, baseball bats, knives, etc.) which are out in the open.
- Don't get into a power struggle or agitated argument with the client on his or her own turf. Hot issues should initially be addressed at your office.
- Avoid unscheduled home visits without another staff person, agent or law enforcement personnel accompanying you.

Case Manager attire / preparation for home visits:

- Wear clothing that allows you to move freely, shoes you can run in.
- If you are going to wear a tie, use a clip on type that will easily come off if pulled.
- If you are wearing an identification badge on a lanyard, make sure that it has at least two (2) break away connections. Lanyards could be used as a garrote, noose or leash.
- Take only what is necessary. Do not carry purses, bags, or shoulder strap type accessories. Avoid note taking during the interview.
- While walking, always try to keep your hands free.
- Tie up long hair.
- Avoid using your personal vehicle, if possible. License plates are relatively easy to trace to home addresses. Make sure you lock your car.
- When leaving or returning to your car, be alert to your surroundings; watch out for individuals approaching you. As you near your car, watch for any individual who may be hiding behind or near your car. Have your car keys in your hand; lock your doors immediately upon entering your car.
- Consider obtaining an unlisted phone number or at a minimum, do not list your home address.

SAFETY TIP: DISCIPLINE YOURSELF TO REMAIN IN A HEIGHTENED STATE OF ALERT (NOT ALARMED) AND AWARNESS DURING HOME VISITS.

USE THE TECHNIQUE KNOWN AS STRUCURED SCANNING WHERE YOU VISUALLY SCAN INDIVIDUALS TOP TO BOTTOM. PAY ATTENTION TO WHERE THEIR HANDS ARE AND WHAT THEY ARE HOLDING.

DISPLAY A STRONG SENSE OF AWARENESS OF YOUR SURROUNDINGS – BY LOOKING AROUND YOU SEND THE MESSAGE TO POTENTIAL ATTACKERS THAT YOU WOULD NOT BE AN EASY VICTIM TO OVERPOWER

INTENTIONALLY FOCUS ON AS MANY OF THE ABOVE DESCRIBED SAFETY POINTS AS YOU CAN. PRACTICE THIS ON EACH AND EVERY HOME VISIT UNTIL THEY COME TO YOU NATURALLY, MUCH LIKE DEFENSIVE DRIVING.

CALLING 911

- Get to a safe location before calling, if possible.
- Tell the 911 operator exactly where you are located. Be as specific as possible for example; provide the address and room number; or a compass reference; "I am on the northeast corner of 1st and Vine Streets".
- Stay calm – take a deep breath.
- Allow the 911 operator to lead the conversation.
- Answer all the operators' questions.
- Follow all of the operator's directions.
- Meet the responders when they arrive; direct them to the emergency.

Always carry your identification with you. Carry a card which lists any medications you take, chronic health conditions, blood type, etc.

Occasionally 911 calls will ring multiple times before the operator is able to answer – DO NOT hang up, wait for them to answer.

SAFETY TIP: NOT ALL CELL PHONES HAVE GPS CAPABILITY. PROVIDING THE 911 OPERATOR WITH YOUR EXACT LOCATION IS CRITICAL TO A TIMELY EMERGENCY RESPONSE.

WHEN IN DOUBT, CALL 911.

DOC DCC Supervision Standards

CONTACT STANDARDS Supervision contact standards for the established levels are as follows:

Intensive – One face-to-face contact every 7 days; one home visit every 30 days (no waivers, offender or collateral contact required); 2 collateral contacts every 30 days. Monthly contact with employer. (See sex offender supervision manual for further information.)

Enhanced Supervision - One face-to-face contact every 7 days; one home visit every 30 days (agent must enter the home); monthly verification of employment and other collaterals as appropriate.

Maximum - One face-to-face contact by an agent every 14 days; home visits once every 30 days; collateral contacts as appropriate.

Medium - One face-to-face contact every 30 days; home visits by an agent every 60 days. Minimum - One face-to-face contact every 90 days, with DOC-8 mailed by offender during non-report months. Home visits as appropriate.

Administrative – One face-to-face contact is encouraged every six months, with reports by mail or phone during non-report months. Home visits as appropriate.

Pre-Release from Institution Checklist (CM Checklist)

Treatment Team Members Present:

__Unit Manager
__ Social Worker
__Psychiatrist
__Nurse
__AODA
__Rehab Staff
_____Other

Client Name:_____

Date: _____

MEDICAL

Prescribed Medications

Obtain most recent list medications from MHI

Medication schedule: _____
_____

Meds be simplified:_____

Injectables or quick dissolve available:_____

Frequency:_____

Side Effects: Yes No

If yes, how are the side effects treated: _____

Any prescribed PRNs: _____

If yes, how manage in the community: _____

Blood Draw Requirements/frequency: _____

Pharmacy to be Used: _____

How many day supply:_____

Prescription written: Yes No

Administer meds independently: Yes No

If yes, for how long?_____

Medication Allergies:_____

General Health

Conditions:_____

Treatment:_____

Dietary needs/restrictions:_____

Vitamins/supplements/non-prescription medications:_____
_____

Doctor/Hospital:_____

Independent health management: Yes No

If no, assistance needed: _____

Smoker: Yes No Quit How Long?_____

Medical
Equipment

Diabetic Supplies:_____
CPAP Needs:_____
Inhalers:_____
Other Supplies:_____
Medical condition related to mental health issues:_____

CLIENT IDENTIFICATION

State ID Card:_____
Driver's License:_____
Birth Certificate:_____
Social Security Card:_____

FINANCIAL INFORMATION

Social Security benefits:_____
MA/T19:_____
VA Benefits:_____
Need payee: Yes No
If yes, previous payee:_____

INSTITUTION TREATMENT/WORK HISTORY

Work records/vocational assessment:_____
_____
_____
Wages earned:_____
Independent living skills:_____
_____
_____
Leisure Interest:_____
_____
AODA treatment:_____
Relapse Prevention Plan/WRAP
completed: Yes No Copy available?

CLIENT PROPERTY

Guardian:_____
General Contents:_____
_____
Transportation of property:_____

OTHER

Release of Information:_____
_____
_____
Community Support:_____
_____

DISCHARGE ARRANGEMENTS/RECOMMENDATIONS

Discharge Date:_____
Discharge Destination:_____
Discharge Transportation:_____
CR Rules Signed:_____

Scott Walker
Governor

Kitty Rhoades
Secretary-Elect

State of Wisconsin
Department of Health Services

DIVISION OF MENTAL HEALTH & SUBSTANCE ABUSE SERVICES
1 WEST WILSON STREET
PO BOX 7851
MADISON WI 53707-7851

Telephone: 608-266-2717
FAX: 608-266-2579
TTY: 888-241-9432
dhs.wisconsin.gov

April 2, 2013

To: DHS Contracted Case Managers and Directors
DOC/DCC NGI Agents
DHS Forensic Services Specialists
Conditional Release Clients

From: Beth Dodsworth
Conditional Release Program Manager

Re: Notifying employers and volunteer agencies of an NGI legal status

The mission of the Department of Health Services, Conditional Release Program is to ensure community safety by the appropriate monitoring, supervision and service delivery for each individual who was found Not Guilty by Reason of Mental Disease or Defect (NGI) and conditionally released by the courts into our communities.

Having daily activities that we find meaningful is important to all of us. Employment and volunteer activities offer structure, social contacts, job satisfaction and income. The Conditional Release Program seeks to support and advocate for conditional release clients to become involved in activities that they find meaningful.

To support the programs mission and its clientele, it is the policy of the Conditional Release Program that all clients who are employed, engaged in volunteer work or who are seeking to obtain employment or a volunteer position share with the employer their legal status and sign a release of information form to enable the assigned case manager and supervising Division of Community Corrections agent to communicate with the employing agency.

Clients must first obtain permission from their agent prior to applying for an employment or volunteer position. Clients should provide the employer with contact information for their case manager and agent if the employer would like additional information regarding the clients legal status.

Through a combination of oversight and advocacy, the conditional release treatment team can assist clients in this important component of successful community reintegration.