Wisconsin Legislative Council Staff — Madison, Wisconsin

Advisory Committee on Mentally Ill Inmates — December 3, 1986

DISCUSSION PAPER 86-6*

POSSIBLE CHANGES IN LAWS AND PROGRAMS RELATED TO MENTALLY ILL INMATES

This Discussion Paper was prepared for the Advisory Committee on Mentally Ill Inmates. It identifies alternatives for possible changes in current laws and programs related to mentally ill inmates of state prisons and county jails. The alternatives set forth in this Discussion Paper are derived primarily from recommendations and comments made by (a) interested persons, including Committee members, at meetings of the Advisory Committee on Mentally Ill Inmates and the Special Committee on Mental Health Issues; (b) the 1985 report, Jail Advisory Committee Report to the Administrator of the Division of Corrections (hereinafter called "the 1985 DOC Jail Advisory Committee Report"); and (c) speakers and participants at the symposium on "The Criminal Justice System and the Mentally Ill: A Call for Action," held in Madison, Wisconsin, on October 28 and 29, 1986.

A number of recommendations made to the Advisory Committee on Mentally Ill Inmates, related to emergency detention and standards for involuntary treatment of mentally ill persons, are not included in the body of this Discussion Paper because they are being considered directly by the Special Committee on Mental Health Issues. Appendices A and B to this Discussion Paper set forth the emergency detention and involuntary treatment alternatives contained in Parts B and D of Discussion Paper 86-4, Possible Changes in the Laws Relating to Court-Ordered Involuntary Treatment of the Mentally Ill, dated November 4, 1986, which was prepared for the Special Committee.

Also, the alternatives summarized for the Advisory Committee in Part H of this Discussion Paper, relating to criminal proceedings, are similar to those summarized for the Special Committee in Part H of Discussion Paper 86-4.

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The Paper is organized as follows:

A. JAIL OFFICER, SHERIFF AND ADMINISTRATOR TRAINING

Alternative 1: Increase the required number of hours of preparatory jail officer training from 80 hours to 120 hours.

Under current law, no person may be appointed to a permanent position as a jail officer, on or after July 2, 1983, unless the person has completed a preparatory program of at least 80 hours of jail officer training. For the purposes of this requirement, a "jail officer" includes any person employed by a county or other political subdivision for the purpose of supervising, controlling or maintaining a jail or jail inmates, regardless of whether the person has been sworn regarding his or her duties or whether the person serves on a full-time basis {s. 165.85, Stats.}.

The Law Enforcement Standards Board, which is attached, under s. 15.03, Stats., to the Department of Justice (DOJ) for administrative purposes only, establishes minimum curriculum requirements for the preparatory jail officer programs. Staff services to the Board are

provided by the Training and Standards Bureau in the DOJ's Law Enforcement Services Division.

The Law Enforcement Standards Board reimburses each political subdivision for the salary and allowable tuition, travel and living expenses incurred by jail officers who satisfactorily complete the 80 hours of training. The reimbursement is funded through a penalty assessment made whenever a court imposes a fine or forfeiture for a violation of a state law or local ordinance, except those involving nonmoving traffic violations.

Approximately eight of the current 80 hours of required jail officer training is devoted to the care and supervision of "special" inmates, including those who may be emotionally distressed, mentally ill, suicidal or developmentally disabled.

Recently, curriculum for a competency-based instruction program for jail officers has been developed. This course has been designed for 110 to 120 hours of preparatory jail officer training. Approximately 10 to 12 hours of the 110 to 120 hours would be devoted to the care and supervision of "special" inmates. {In order to accommodate the current 80-hour requirement, portions of the training guides are written to allow them to be handed out as reading materials.}

According to Dennis Hanson, Training and Standards Bureau, DOJ, Attorney General-Elect Donald Hanaway has not yet been briefed on the question of increasing the required hours of jail officer training. Mr. Hanson does not know if or when Attorney General-Elect Hanaway will request a statutory change to increase the required number of hours of training.

Based on information provided by Mr. Hanson, a rough estimate of the increased costs to reimburse local units of government for 120 hours, rather than 80 hours, of required preparatory jail officer training would be $160,000. This estimate assumes that a maximum of 300 officers per year will be trained, at a cost of approximately $13.33 per officer per hour. According to Mr. Hanson, it appears that this amount could be funded under the current level of penalty assessments.

Alternative 2: Require jail officers hired before July 2, 1983, to complete the 80 hours of preparatory jail officer training.

As described above, the current requirement for 80 hours of preparatory jail officer training applies only to jail officers hired on or after July 2, 1983. Persons testifying before the Advisory Committee on Mentally Ill Inmates and the 1985 DOC Jail Advisory Committee Report recommended requiring that all jail officers complete this training.

According to Mr. Hanson, currently, there are approximately 1,500 jail officers in Wisconsin. The DOJ does not know how many of these officers were before after July 2, 1983, and have not completed the 80-hour preparatory course. Thus, the DOJ cannot estimate the costs of training these officers. Also, the DOJ does not know how many of these officers have completed in-service or other jail officer training programs which included training related to "special" inmates.

Alternative 3: Require 24 to 40 hours of annual in-service training for jail officers.

Currently, the Law Enforcement Standards Board may recommend minimum curriculum requirements for in-service and advanced courses and programs in specialized areas for jail officers {s. 165.85 (3), Stats.}. However, currently, there are no requirements that jail officers obtain annual in-service education or training.

The recommendation for 24 to 40 hours of mandatory in-service annual training for jail officers was made in the 1985 DOC Jail Advisory Committee Report. If the Advisory Committee on Mentally Ill Inmates considers creating a requirement for annual in-service training, it will need to discuss related issues, including:

a. Should a requirement for annual in-service training be created in the statutes or should a state agency, such as the DOJ, be given the authority to require in-service training?

b. Should the statutes specify the number of hours of annual in-service training required, or should the number of required hours be determined by the administering agency?

c. Should the Department of Health and Social Services (DHSS) or the DOJ be the agency responsible for approving the content of the programs and enforcing the requirement?

d. Should a specific amount of training related to mentally ill or "special" inmates be required?

e. How will the in-service training be funded?

Alternative 4: Provide funds to the DHSS to expand its training program currently provided under a grant from the National Institute of Mental Health.

Persons testifying before the Advisory Committee on Mentally Ill Inmates and others have suggested that training for jail officers is more effective and helpful when it is provided locally, rather than in Madison,

and involves persons other than jail personnel, such as local mental health staff, law enforcement officers, attorneys, court personnel and community support group personnel. The persons testifying said that training provided locally can reflect the unique characteristics of the local jail, local resources and the local court system. Such training can also serve to bring the involved parties together to learn about each other's problems and begin to work on ways to solve problems.

One way such locally-based training is currently provided is under a federal grant received by the DHSS's Office of Mental Health. Beginning in 1984, the DHSS has received approximately $20,000 per year from the National Institute of Mental Health (NIMH) to provide training to county staff, including jail and law enforcement personnel, county mental health workers and other community support group personnel. The type of training provided under this grant is clinically oriented.

Under the NIMH grant, staff from the DHSS's Office of Mental Health go to the area of the state where training has been requested. Training may be provided at one session to persons from multiple counties, especially where a multi-county mental health board is involved. The training covers screening for mental health problems, including depression and suicide, and dealing with crises. Also included is information on civil commitment laws and the role of and services provided by county community programs departments created under s. 51.42, Stats., or community human services departments created under s. 46.23, Stats. (hereinafter, the phrase "county mental health agencies" will include both types of departments). Under this program, training can be tailored to local needs. To date, personnel from 13 Wisconsin counties have received training under the NIMH grant.

The Advisory Committee could consider expanding this program by providing the Office of Mental Health with additional funds for the program. However, if the Advisory Committee considers this alternative, it will need to discuss related issues, including:

a. How many counties are there which (1) have not received this training because of limited funds and (2) want and could benefit from the training? Would more counties want this training if it were aggressively "marketed" by the DHSS?

b. If this program is expanded, what level of funding would be needed to provide training to all interested counties?

Alternative 5: Leave jail officer training related to mentally ill inmates to local cooperative efforts between county mental health agencies and sheriffs' departments.

During a meeting of a Work Group at the October 28 and 29, 1986 symposium on "The Criminal Justice System and the Mentally Ill: A Call For Action," arguments were made that jail officer training can best be done locally through (a) cooperative efforts of county mental health agencies and sheriffs' departments and (b) one-on-one working relationships between mental health personnel and jail officers. Similar comments have been made by persons testifying before the Advisory Committee on Mentally Ill Inmates.

Under this alternative, no new state requirements would be created for jail officer training. Except for the portion of the 80-hour preparatory jail officer training devoted to "special" inmates, jail officer training related to mentally ill inmates would be left to local determination and cooperative efforts between county mental health agencies and the sheriffs' departments. {The current DHSS's Office of Mental Health training program would continue, to the extent of funds available under the NIMH grant.}

Alternative 6: Provide training for sheriffs and other jail administrators on (a) how to establish better relationships with the mental health system and (b) what information is being provided to jail officers under jail officer training programs.

The 1985 DOC Jail Advisory Committee and others have noted that, currently, there are no formal requirements or systems for training sheriffs or other jail administrators regarding the development and implementation of appropriate jail policies and procedures, including how to develop relationships with the mental health system. Also, the comment has been made that sheriffs and other jail administrators should be more familiar with curriculum for jail officers. Since, in many counties, the jail administrator is the elected sheriff, mandatory training has not been suggested. Sheriffs and other jail administrators have participated in the DHSS's Office of Mental Health training programs, described under Alternative 4, above.

If the Advisory Committee on Mentally Ill Inmates decides to recommend formalized training for sheriffs and other jail administrators, it will need to determine:

a. What department, the DHSS or the DOJ or both, should provide such training?

b. Should that department be authorized or required to provide the training?

c. How will the training programs be funded?

One way to provide training for more sheriffs and jail administrators might be to expand the DHSS's Office of Mental Health programs, described under Alternative 4, above.

B. PROGRAM STANDARDS FOR JAIL OPERATIONS

Alternative: Authorize the DHSS to establish, by administrative rule, program standards for jails which shall include:

1. A requirement that each jail develop and use a written policy and procedure manual. The development of the manual would be required to be done separately for each jail, to reflect the jail's physical characteristics, number and types of inmates and availability of outside resources.

2. A requirement that each jail develop, and include in its manual, policies and procedures for screening jail inmates for medical illness or disability, mental illness, developmental disabilities and alcohol and other drug abuse. The administrative rules would be required to establish functional objectives for screening, but would be prohibited from requiring counties to use a single method in meeting the objectives. The policies and procedures would be required to include the use of outside resources, such as county mental health staff or hospital resources, and include agreements with the resources to ensure adequate follow-up on inmates identified as needing services.

3. Required minimum staffing levels for jails. The administrative rules would be required to provide "flexible" staffing levels which recognize that the physical layout of a facility, electrical surveillance and exceptionally positive or problematic aspects of the jail may either increase or decrease the need for staff. The rules would be required to provide that there shall be at least one jail staff in the jail facility at all times who does not have simultaneous responsibilities for nonjail emergency situations, such as the responsibilities of a dispatcher.

4. A requirement that the manual specify the facilities and programs, including nonjail facilities and programs, that will

be provided for long-term inmates. The rules would be required to establish functional goals for programming for long-term inmates.

5. A requirement that jails have available 24-hour emergency services for crisis intervention.

Under current law, the DHSS does not have the authority to set program requirements for jails. This alternative is based on a number of similar separate recommendations made in the 1985 DOC Jail Advisory Committee Report and comments made by persons testifying before the Advisory Committee on Mentally Ill Inmates. {No requirement similar to item 5 was included in the 1985 DOC Jail Advisory Committee Report.}

If the Advisory Committee considers authorizing the DHSS to establish, by rule, program standards for jails, it will need to discuss related issues, such as:

1. What, if any, role should the DOJ have in creating or enforcing the standards?

2. Should the statutes require that the standards cover certain program items, such as those listed under items 1 to 5 in the alternative, above; should the program areas to be covered by standards be left to determination by the DHSS; or should the statutes require that standards be promulgated in certain areas, such as those listed above, and also authorize the DHSS to promulgate standards covering other program areas, in its discretion?

3. If the statutes specify program areas to be covered by standards, should the standards cover each of the areas listed in items 1 to 5, above? Are there additional program areas in which standards should be promulgated?

4. If jails are required to develop written policy and procedure manuals, should the manuals be approved by the DHSS?

5. If screening is required, should screening be required for each of the problems listed in item 2, above? Are there additional problems for which inmates should be screened?

6. How will compliance with the standards be enforced? Should jails be required to be "approved" or "certified" by the DHSS?

7. Should the state provide technical assistance to counties in developing the required policies and procedures and the policy and procedure manual? {See the alternatives under Part C of this Paper.}

8. Should funds be provided to counties to assist them in meeting the standards? If so, how shall the funds be allocated to the counties and how much shall be appropriated for this purpose?

C. TECHNICAL ASSISTANCE; OFFICE OF JAILS

Alternative 1: Provide state assistance (and funds) to help counties, especially smaller counties, develop jail policies and procedures.

This recommendation is based on a recommendation in the 1985 DOC Jail Advisory Committee Report. That Report stated that the development and updating of policies and procedures requires substantial time and effort. Although the DOC jail inspectors have the appropriate expertise to assist counties in this effort, they do not have sufficient time. Therefore, additional resources would be needed by counties, especially by smaller counties, to develop sound policies.

If the Advisory Committee on Mentally Ill Inmates wishes to pursue this alternative, it will need to consider the following issues:

a. Should only technical assistance, or both technical assistance and state funds, be provided to assist counties in developing policies and procedures?

b. If funds are provided, how much funds should be provided and how will they be distributed?

Alternative 2: Direct the DHSS to establish an Office of Jails which would have responsibility for assisting counties in developing policies and programs and monitoring compliance with program standards.

This recommendation is based on recommendations in the 1985 DOC Jail Advisory Committee Report. The Report states that the Office would provide the focal-point for coordination and accountable implementation of its other recommendations. The Report also states that there is a need for more effective coordination and leadership on jail issues at the state level. The Departments of Justice, Public Instruction and Industry, Labor and Human Relations all have roles in how jails operate. The Report said that, as the department responsible for inspection of jails, the DHSS should pursue a more active leadership role in coordinating the activities and resources of other Departments to ensure that counties do not have to deal with confusing, and perhaps conflicting, state agency directions and expectations.

Also, according to the 1985 DOC Jail Advisory Committee Report, the creation of an Office of Jails would demonstrate a strong, clear, long-term commitment to jails.

If the Advisory Committee on Mentally Ill Inmates considers recommending this alternative, it will need to discuss related issues, such as:

a. How large a staff and budget should the Office of Jails have?

b. Does the DOC currently have adequate staff and resources to support an Office of Jails or will new funds need to be appropriated and new positions authorized for this purpose?

D. FUNDING OF SERVICES TO INMATES

Alternative 1: Require counties to pay for mental health services to county residents who are inmates of state prisons.

This suggestion was made during discussions of the Special Committee on Mental Health Issues by persons who expressed concern that, currently, there is an economic incentive for counties to send mentally ill persons to state prisons. If a mentally ill person remains in the county or is committed to inpatient treatment, the county must pay for mental health services and other support services for the person. If the person is in the state prison, the state pays.

If the Advisory Committee considers requiring county reimbursement for services to inmates of state prisons, it will need to discuss related issues, such as:

a. What services will be reimbursed?

b. Who shall determine whether the inmate needs the services?

c. How shall the amount or rate of reimbursement be determined?

Alternative 2: Require the state to assume responsibility for services to mentally ill persons in jails.

This alternative was suggested during discussions of the Special Committee on Mental Health Issues by persons concerned with the costs to the counties of serving mentally ill jail inmates. It was noted that the state pays for services provided to mentally ill inmates in the state prisons.

If the Advisory Committee considers requiring state reimbursement of these costs, the Committee will need to discuss related issues, such as:

a. What services will be reimbursed?

b. Shall the state assume responsibility for services to all mentally ill inmates or only to those who have been sentenced to jail?

c. Who shall determine whether the inmate needs these services?

d. Who shall provide these services? {It was not clear whether this suggestion was only for state funding of services or whether it was also intended that the state should assume some responsibility for providing the services.}

e. How shall the amount or rate of reimbursement be determined?

E. COMMUNITY-BASED NONJAIL PROGRAMS

Alternative 1: Provide additional residential alternatives for mentally ill persons with behavior problems who are placed on probation and parole.

Currently, the Bureau of Community Corrections (BCC) in the DOC purchases services from 11 privately-operated correctional halfway houses. One of the conditions of probation or parole may be that the person reside in a halfway house.

The contracts between the BCC and the halfway houses specify the types of clients who will be accepted in the halfway house. Currently, the halfway houses work with clients who are mentally ill but they cannot handle all such cases. None of the current contracts specifies mental health cases as a specialty of the halfway house.

For information on the location, total number of beds, total contract amount and daily cost per bed for each halfway house, see Memo No. 1, "Correctional Halfway Houses," dated October 20, 1986. For 1986-87, the 11 contracts provide a total of 128 beds at an annual cost of $1,790,817.40. The average daily cost per bed is $40.03.

Persons testifying before the Advisory Committee on Mentally Ill Inmates suggested the creation of additional residential alternatives for mentally ill persons who are placed on probation and parole. The homes would be staffed by persons who are capable of dealing with both mental illness and security problems.

If the Advisory Committee on Mentally Ill Inmates considers establishing additional residential alternatives for these persons, it will need to discuss related issues, including:

a. Which division in the DHSS should operate, or contract with private providers for, these facilities? The DOC? The Division of Community Services? The Division of Care and Treatment Facilities?

b. How many beds should be authorized?

c. How much will these beds cost?

d. Where, in the state, should these facilities be located?

Alternative 2: Increase state support for crisis intervention services.

Currently, county mental health agencies must provide immediate evaluation and mental health care to persons in crisis on a 24-hour-per-day, seven-day-per-week basis, within the limits of available state and federal funds and county appropriations. The services must have a 24-hour-per-day crisis telephone service; the capability of making home visits and seeing patients at other "off-headquarters" locations; and the resources to carry out on-site interventions when clinically necessary {s. 51.42 (3) (ar) 4 c, Stats., as affected by 1985 Wisconsin Acts 29 and 176, and s. HSS 61.74, Wis. Adm. Code}.

Currently, no state aids are provided specifically for crisis intervention programs; community aids funds may be used for the programs.

Persons testifying before the Advisory Committee on Mentally Ill Inmates suggested increasing state support for crisis intervention programs to allow mentally ill persons to come into contact with the mental health system before criminal proceedings are commenced. If the Advisory Committee wishes to pursue this alternative, it will need to discuss related issues, such as:

a. What amount of funds should be appropriated for this purpose?

b. How shall the funds for crisis intervention services be distributed? Under a competitive grant program? Under a formula? By distributing the funds under the community aids allocations and specifically requiring that a portion of the aids be used for crisis intervention?

c. May any new funds provided for crisis intervention be used for existing services or should counties be required to maintain current

expenditures for crisis intervention services and spend any new amounts on new services?

F. SEGREGATION OF MENTALLY ILL PRISONERS

Alternative: Amend s. 53.36 (1), Stats., to clarify that only mentally ill prisoners who are "unstable" must be segregated from other prisoners.

Currently, s. 53.36 (1), Stats., requires that all jails:

> ...shall be provided with suitable wards or buildings or cells...for the separation of...persons alleged to be mentally ill.

Persons testifying before the Advisory Committee on Mentally Ill Inmates and others said that not all mentally ill prisoners need to, or should, be segregated and that it is particularly difficult for small jails to segregate mentally ill prisoners. Arguably, however, s. 53.36 (1), Stats., requires the separation of all mentally ill inmates.

If the Advisory Committee wishes to consider clarifying this requirement, it could consider:

1. Deleting, from the statutes, the requirement that mentally ill inmates be segregated. This would leave the determination of whether to segregate an inmate to the determination of the local jail administrator.

2. Specifying, in the statutes, the circumstances when a mentally ill inmate must be segregated. For example, segregation might be required when the inmate is likely to experience mental deteriorization unless he or she is segregated or when the inmate is likely to cause substantial disruptions of jail operations.

G. INVOLUNTARY COMMITMENT STANDARD FOR STATE PRISON INMATES

Alternative: Repeal the "sunset" date which applies to the civil commitment standard which allows state prison inmates to be committed without a finding of dangerousness.

Under current law, the involuntary civil commitment standards that apply to other persons also apply to inmates of state prisons and jails. Under these standards, to be involuntarily committed, an inmate must be:

1. Mentally ill, drug dependent or developmentally disabled;

2. A proper subject for treatment; and

3. Dangerous under one of four standards of dangerousness.

However, due to the problem of proving dangerous behavior of persons who are confined to correctional institutions, an alternative standard has been developed for inmates of state prisons. Under this standard, an allegation of dangerousness is not required in the petition commitment; instead, the petition may allege that:

1. The person is mentally ill, a proper subject for treatment and in need of treatment; and

2. The appropriate, less restrictive forms of treatment have been attempted and have been unsuccessful.

Prior to filing a petition for commitment under this alternative standard, the DHSS must attempt to use less restrictive forms of treatment, such as voluntary treatment within the prison or a mental health facility. Also, the inmate must be fully informed about his or her treatment needs, the mental health services available to him or her and his or her rights under the civil commitment statutes. The inmate must be given the opportunity to discuss his or her needs, the services available to the inmate and his or her rights with a licensed physician or psychologist. The alternative standard may not be used for emergency transfers; for emergency transfers, dangerousness must be found {s. 51.20 (1) (ar) and (19) (a), Stats.}.

This alternative standard for state prison inmates is scheduled to "sunset" on July 1, 1987, or the effective date of the 1987-89 Biennial Budget Act, whichever is later {s. 51.20 (1) (ar) 2, Stats.}.

Walter J. Dickey, Administrator, DOC, DHSS, recommended to the Advisory Committee that the sunset date be repealed. He said that there are, at most, five prisoners who have been involuntarily committed under this law at any given time. If the Advisory Committee wishes to extend this law beyond the current sunset date, it could consider:

a. Extending the law to a new sunset date, such as July 1, 1989, or the enactment of the 1989-91 Biennial Budget; or

b. Repealing the sunset date, thus, allowing the law to continue indefinitely.

H. CRIMINAL PROCEEDINGS

Alternative 1: Create statutory authority for a criminal court to order a defendant to be held for a mental health assessment before the defendant is charged with a crime.

During presentations to the Advisory Committee on Mentally Ill Inmates, a number of jail, mental health and court personnel expressed frustration with the inability of criminal courts to delay or divert criminal proceedings for the purpose of obtaining a mental health assessment. They suggested that criminal courts be authorized to order an arrestee to be detained for a short period, such as 24 hours, preferably in a mental health facility, for a mental health assessment. This would assist the courts in determining, before a criminal charge is brought, whether the criminal proceeding, a commitment or some other civil proceeding is more appropriate.

The Advisory Committee could consider authorizing a criminal court to order that the defendant's initial court appearance, under s. 970.01, Stats., be delayed for 24 hours and that the defendant be held for evaluation if specified criteria are met.

If the Advisory Committee wishes to pursue this alternative, it will need to consider issues including:

a. Under what circumstances may the delay be ordered? The Committee could consider, for example, authorizing the delay where the court has reasonable grounds to believe that an evaluation of the defendant's mental condition by the county mental health agency may provide information to the court, the district attorney or the defendant's attorney which will affect: (1) the district attorney's decision regarding what charges, if any, to bring; (2) arguments made at the bail hearing by the district attorney or the defendant's attorney; or (3) the bail decision made by the court at the hearing.

b. If a delay is granted, should the county mental health agency be ordered to evaluate the person within the 24-hour time period?

c. Who should have access to the evaluation records or other treatment records of the defendant prior to the initial appearance?

Alternative 2: Authorize the court in a criminal proceeding to convert the action to a civil commitment proceeding or to initiate an emergency detention.

Once a criminal action is commenced, it is extremely difficult to halt or delay the proceeding to get mental health treatment for a

defendant who appears to be mentally ill. The judge or court commissioner presiding over the criminal action currently has no authority to convert the case to a civil commitment action or to initiate an emergency detention.

Dane County Court Commissioner Todd Meurer, and others, have suggested that authority be given to judges and court commissioners to convert a criminal case to a civil commitment or protective placement proceeding. One way to implement this alternative might be as follows:

a. Provide that, in lieu of the three-party petition, the judge or court commissioner in the criminal case may file a petition to initiate involuntary commitment, if requested by the state. The allegations required to be made in the petition would be the same as those required in a three-party petition.

b. Provide that the judge or court commissioner who files the petition may not hear any of the proceedings in the civil commitment case.

c. Provide that, when the state asks the criminal court to petition for civil commitment, the state shall also move to dismiss the criminal case without prejudice, so that the state may refile the criminal action in the future.

Alternative 3: Authorize a criminal court to order that a person on parole or probation be taken to a mental health treatment facility, rather than to jail, when a condition of probation or parole relating to taking medications is violated.

Criminal courts frequently impose taking medications as a condition of probation or parole for persons convicted of criminal violations. If this type of condition is violated, a probation or parole officer is authorized to hold the person in jail until a hearing is held. The DHSS is required to pay the costs of persons detained in county jails solely for parole or probation violations (i.e., if no other criminal charges are pending) after the initial 60 days of the confinement. The reimbursement rate is $30 per day; however, for fiscal year 1986-87, if $400,000 is insufficient to provide complete reimbursement at that rate, the DHSS shall prorate the payments to counties {s. 53.33 (2), Stats., as affected by 1985 Wisconsin Act 29}.

Parole and probation officers and other law enforcement officers have suggested that holding a person in a mental health treatment facility would be more appropriate than jail where the violation is failure to take medications.

If the Advisory Committee wishes to pursue this alternative, it will need to consider related issues, such as:

a. What treatment facilities may be used for this purpose?

b. Will certain treatment facilities be required to accept these persons?

c. Who will pay the costs of holding the person in the facility?

d. Should emergency detention or commitment be required as a prerequisite to court-ordered treatment, whether inpatient or outpatient, of a person on parole or probation?

Alternative 4: Improve the mechanism for transferring seriously mentally ill inmates to mental health treatment facilities.

Current law provides for the voluntary transfer of jail and prison inmates to a mental health facility. Current law also provides for their involuntary transfer under an emergency detention or a petition for civil commitment. As described in Part G of this Paper, for inmates of state prisons, a specific allegation of dangerousness need not be made in a commitment petition {ss. 51.20 (1) (a) and (ar) and 51.37 (5), Stats.}.

During discussions of the Special Committee on Mental Health Issues and the Advisory Committee on Mentally Ill Inmates, it was suggested that it is too difficult to transfer inmates from jails, due to the number of persons and agencies involved; the complexity of the situations and laws involved; and the reluctance of the mental health system to accept corrections clients. However, no specific changes to current procedures were suggested.

The comment was also made that it is easier to commit a person from a state prison than from a jail. The alternative commitment standard, described in Part G of this Paper, is not available for committing jail inmates. Also, fewer agencies are involved with state prison inmates than with jail inmates.

Alternative 5: Extend the duration of supervisory authority over persons committed under s. 971.15, Stats., but conditionally released based on a finding that the person is not dangerous.

Under current law, a criminal defendant who has been found not guilty by reason of mental disease or defect is automatically committed to the DHSS for placement in an appropriate facility. The commitment may be continued for the maximum period for which the defendant could have been imprisoned if convicted. During that period, however, a court may

conditionally release the person if, upon reexamination, it appears that the person is not dangerous. If the person is released, the court's authority to supervise the person and to revoke the release order extends for only five years, even if the maximum period for which the person could have been sentenced and, thus, the maximum period for which the person could have been committed, is longer {s. 971.17, Stats.}.

Several mental health professionals and probation and parole officers have suggested extending the supervisory authority over persons who have been released to the maximum period for which they could have been committed.

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Appendix A

ALTERNATIVES RELATED TO EMERGENCY DETENTION

REVIEWED BY THE SPECIAL COMMITTEE ON MENTAL HEALTH ISSUES

The following three alternatives were reviewed by the Special Committee on Mental Health Issues at its November 11, 1986 meeting. The Special Committee decided not to pursue Alternative 1 and directed staff to prepare bill drafts on Alternatives 2 and 3 for the Committee's further examination. No final decisions have been made by the Special Committee on Alternatives 2 or 3.

Alternative 1: Extend the authority to initiate emergency detention procedures under s. 51.15, Stats., to persons other than law enforcement officials.

Currently, emergency detention, under s. 51.15, Stats., may be initiated by a law enforcement officer or a person authorized to take a child into custody under ch. 48, Stats.

Persons testifying before the Advisory Committee on Mentally Ill Inmates suggested extending this authority to: persons designated by county mental health agencies; probation and parole officers; judges; and court commissioners.

Alternative 2: Require special training for persons authorized to initiate emergency detention procedures.

Currently, no specialized training is required for law enforcement officers who are authorized to initiate emergency detentions. A number of mental health professionals and law enforcement officers have said that many law enforcement officers are reluctant to initiate emergency detentions, because they are unfamiliar with the standards for emergency detention, the procedures involved and the available resources.

Alternative 3: Provide a presumption of good faith for purposes of immunity from civil liability for persons initiating emergency detentions.

Section 51.15 (11), Stats., provides immunity from civil liability to persons initiating emergency detentions and to persons in treatment facilities in which the mentally ill persons are detained under this procedure. Despite this statutory immunity, a number of law enforcement officers and mental health treatment personnel have expressed concern that fear of civil liability inhibits law enforcement officers from taking persons to facilities under their emergency detention authority and inhibits treatment facilities from accepting persons under this procedure.

The Special Committee could consider strengthening this immunity by creating a statutory presumption that the persons involved in an emergency detention are acting in good faith. The presumption of good faith could be overcome only by showing bad faith by clear and convincing evidence.

Appendix B

ALTERNATIVES RELATED TO THE STANDARDS FOR INVOLUNTARY TREATMENT REVIEWED BY THE SPECIAL COMMITTEE ON MENTAL HEALTH ISSUES

The following six alternatives were discussed by the Special Committee on Mental Health Issues at its November 11, 1986 meeting. The Special Committee directed staff to prepare drafts related to Alternatives 2 and 6. No final decisions have been made by the Special Committee on these six alternatives.

Alternative 1: Create a new standard permitting involuntary civil commitment on a basis other than dangerousness.

Under current law, involuntary civil commitment must be based on a finding that the subject is mentally ill, a proper subject for treatment and dangerous under one of four standards. The four dangerousness standards are:

a. The person evidences a substantial probability of physical harm to himself or herself;

b. The person evidences a substantial probability of physical harm to other individuals;

c. The person evidences such impaired judgment that there is a substantial probability of physical impairment or injury to himself or herself; and

d. The person evidences behavior that, due to mental illness, he or she is unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt and adequate treatment so that a substantial probability exists that death, serious physical injury, serious physical debilitation or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for this mental illness [s. 51.20 (1) (a), Stats.].

Various "nondangerousness" standards have been suggested for purposes of involuntary civil commitment to inpatient or outpatient facilities. One standard, included in 1985 Assembly Bill 311, would allow involuntary

civil commitment based on a finding that the person: (a) evidences a substantial probability of serious, mental or emotional deterioration unless treatment is provided; and (b) is incapable, because of mental illness, of expressing an understanding of the advantages and disadvantages of accepting treatment and of the alternatives to the particular treatment offered, after the advantages, disadvantages and alternatives have been explained to the individual.

The State of Washington's commitment laws provide another example of commitment standards based on criteria other than recent acts evidencing dangerousness. Under Washington law, a person may be committed if, as a result of a mental disorder, the person is gravely disabled. "Gravely disabled" is defined to include manifesting severe deterioration in one's routine functioning, evidenced by repeated and escalating loss of cognitive or volitional control.

Alternative 2: Create a new standard permitting involuntary civil commitment on a basis other than dangerousness, applicable to outpatient commitment only.

Under this Alternative, the current dangerousness standards would continue to apply to all inpatient and outpatient commitments; and a new standard would be created that would be applicable only to outpatient commitments. A standard suggested for outpatient commitment, in 1985 Assembly Bill 661, is the deterioration standard in 1985 Assembly Bill 311 described under Alternative 1, above.

The Georgia outpatient commitment law provides another example of an outpatient commitment standard. Under this standard, a mentally ill person may be committed to outpatient treatment if that person is found to meet all of the following criteria:

a. The person is not appropriate for inpatient commitment but, based on the person's treatment history or current mental health status, will require outpatient treatment in order to avoid predictably and imminently becoming an inpatient;

b. The person, because of his or her current mental status, mental history or nature of the mental illness, is unable voluntarily to seek or comply with outpatient treatment; and

c. The person is in need of involuntary treatment.

[For a discussion of nondangerousness standards for outpatient commitment in other states, see Wisconsin Legislative Council Staff Information Memorandum 86-21, dated September 10, 1986.]

Alternative 3: Create a new standard based on criteria other than dangerousness applicable to inpatient or outpatient commitment only for short periods of time.

Under current law, commitments under the "dangerous to self," "dangerous to others" or "impaired judgment" standards of dangerousness may be initially for periods of not more than six months; subsequent extensions under these standards may be for periods of not more than one year. Initial commitments under the "unable to satisfy basic needs" standard of dangerousness may not continue longer than 45 days in any 365-day period; subsequent commitments under this standard may be extended for more than 45 days within a 365-day period [s. 51.20 (13) (g), Stats.].

Mental health professionals have suggested creating a new standard based on criteria other than dangerousness for commitments for very short periods, such as seven days, for the purpose of evaluation or stabilization. No specific standard or time period has been suggested for this purpose.

Alternative 4: Redefine dangerousness to include causing substantial harm to property.

The current dangerousness standards apply only to dangerousness to self or dangerousness to others. There is no provision for commitment of a mentally ill person who has caused or threatened to cause substantial damage to property.

Mental health professionals testifying before the Advisory Committee on Mentally Ill Inmates suggested that the creation of a dangerousness standard applying to damage to property would assist in diverting mentally ill persons who have committed misdemeanors, such as breaking windows, from the criminal justice system to the mental health system. North Carolina and Washington commitment standards include a provision for commitment of persons who are dangerous to others based on a finding that a person has engaged in the destruction of property.

Alternative 5: Make no change to the current standards for involuntary civil commitment.

Several persons, including the researchers for the National Center for State Courts in its evaluation of the involuntary civil commitment process in Milwaukee County, have suggested that no change to the standard for involuntary civil commitment is appropriate until adequate community-based mental health services are available and nonstatutory means are pursued to divert mentally ill persons to voluntary treatment.

Alternative 6: Create a new procedure, in the statutes, for appointing limited guardianships for the purpose of providing involuntary outpatient treatment to certain mentally ill persons.

Under current law, a court may find a mentally ill person to be incompetent and appoint a guardian for the limited purpose of making treatment decisions. Under these procedures, protective services, including psychotropic medications, may be involuntarily administered on an outpatient basis [ss. 51.67, 55.05 (2) (d) and 880.33, Stats.].

These provisions are not integrated into a single procedure under a single chapter of the statutes and do not include: (a) specific criteria for finding a person incompetent to make decisions regarding medications; (b) criteria for determining the types of treatment that may be administered; or (c) the maximum duration of the guardianship. [Dane County's use of the current limited guardianship procedures is described in MEMO NO. 8 to the Special Committee on Mental Health Issues, dated November 4, 1986.]

It has been suggested that procedures for using limited guardianships for the involuntary administration of psychotropic medications on an outpatient basis be codified into a single section of the statutes. An ad hoc committee was formed by the Council on Mental Health for the purpose of developing such a proposal. The ad hoc committee suggested that the criteria for appointment of a limited guardian for the administration of medications include a determination of incompetency and the demonstration of a pattern of psychotic deterioration when medication and treatment have been refused. The committee also suggested that the procedure provide for a maximum of 15 days of inpatient care, for the purpose of involuntarily administering medications, for persons under limited guardianship who continue to refuse to take medications voluntarily. Inpatient treatment would be available only if medical testimony shows that the subject would become unmanageable or dangerous if medication is not administered.