STATE SENATOR JESSE JAMES 23RD DISTRICT

May 27th, 2025

Members of the Senate Committee on Mental Health, Substance Abuse Prevention, and Children and Families
Members of the Assembly Committee on Mental Health and Substance Abuse Prevention

**Testimony on 2025 Senate Bill 106, 107, 108, and 109**

Thank you, Chair Tittl and other members of both committees, for the opportunity to testify today. I am pleased for the opportunity today to ask for your support for four bills that were developed by the Study Committee on Emergency Detention and Civil Commitment of Minors. I had the pleasure of chairing that study committee last year, which was tasked with studying various issues related to the appropriateness of current emergency detention and involuntary commitment laws as applied to minors.

As many of you know, these issues are deeply personal to me. As a law enforcement officer, some of the most challenging moments on the job come when I'm called to assist someone in the midst of a mental health crisis. It's always difficult, but it's especially heartbreaking when that person is a child. From the start, I hoped this committee would accomplish at least two things. The first was to provide a process to have psychiatric residential treatment facilities (PRTFs) in Wisconsin so kiddos can get the help they need without having to be sent out of the state. The second was to find ways to minimize the involvement of law enforcement in mental health crises so that children in crisis are not further traumatized by being placed in handcuffs.

After careful study and thoughtful consideration, the committee crafted a package of bills that I believe will move the ball closer to these goals. Throughout the process, the committee received assistance from a wide variety of stakeholders and experts, including the Department of Health Services, the Department of Children and Families and the Counties Association, among many others. The committee voted to advance six bills, all with strong support, and the Joint Legislative Council introduced them earlier this year.

Four of these bills are in front of you today:

- **Senate Bill 106 (Assembly Bill 111)** provides a process that would allow for the establishment of Psychiatric Residential Treatment Facilities, or PRTFs, in Wisconsin. A PRTF provides psychiatric services to individuals under the age of 21 but is not a hospital. For that reason, a PRTF can provide intensive psychiatric treatment in an environment that is less restrictive than a psychiatric hospital. Wisconsin does not currently certify or otherwise regulate PRTFs, so there are none in Wisconsin. This bill provides a framework for PRTFs to operate in Wisconsin. The framework is largely based on federal law, but incorporates some additional state-specific aspects, based on feedback from stakeholders.
- **Senate Bill 107 (Assembly Bill 112)** revises requirements to obtain a minor's consent for mental health services to make it easier for a parent to get their child mental health treatment they know their kiddo needs in circumstances in which the child may be unwilling to consent to treatment. The bill allows either a minor age 14 or older, or the minor's parent or guardian, to consent to begin outpatient or inpatient mental health treatment for the minor. If a parent consented to treatment without the minor's agreement, a petition must be filed for review of the appropriateness of the treatment.
- **Senate Bill 108 (Assembly Bill 113)** establishes a framework for minors to develop and share safety plans to provide guidance to law enforcement, mental health providers, schools, and other persons or entities when they experience a mental health crisis. This bill is modeled on a successful program currently operating in Ashland and Bayfield Counties.

PO Box 7882 • Madison, WI 53707-7882
(608) 266-7511 • (888) 437-9436 • Sen.James@legis.wisconsin.gov • www.SenJesseJames.com

STATE SENATOR **JESSE JAMES** 23RD DISTRICT

- **Senate Bill 109 (Assembly Bill 114)** provides counties with the option to allow certain behavioral health clinicians to initiate the emergency detention of a minor. Most emergency detentions currently begin with a law enforcement officer taking a person into custody. This bill would provide a procedure that would minimize law enforcement involvement and permit emergency detention decisions to be made by approved behavioral health clinicians in consultation with the county human services department. This process is optional for counties under the bill. A county that elects to use the procedure would have the authority to approve individual clinicians and to review and approve each emergency detention. This new procedure would only apply to emergency detentions involving minors.

Before I conclude, I want to take a moment to thank the members of the study committee for their time and dedication. Their insights and expertise were invaluable to this process, and I truly appreciate the effort, thoughtfulness, and commitment each of them brought to our work. I also want to extend my gratitude to the teams at DHS, DCF, the Counties Association, all the other stakeholders who provided essential feedback throughout this process, as well as Legislative Council's David, Margit, and Kelly for all your assistance along the way. Thank you for considering the study committee's recommendations. I am happy to answer any questions you may have.

Respectfully,

Senator Jesse James
23rd Senate District
Sen.James@legis.wisconsin.gov

WISCONSIN STATE REPRESENTATIVE
**Shelia Stubbs**
78TH ASSEMBLY DISTRICT

May 27, 2025

**Assembly Bill 114/Senate Bill 109—Relating to: clinician initiation of emergency detention of a minor and providing a penalty.**

**Assembly Committee on Mental Health and Substance Abuse Prevention/Senate Committee on Mental Health, Substance Abuse Prevention, Children and Families**

Dear Chair Representative Paul Tittl, Chair Senator Jesse James, and Members of the Assembly Committee on Mental Health and the Senate Committee on Mental Health, Substance Abuse Prevention, Children and Families,

Thank you for the opportunity to provide my support for Assembly Bill 114/Senate Bill 109—Relating to: clinician initiation of emergency detention of a minor and providing a penalty.

Over the course of several months, the Study Committee on Emergency Detention and Civil Commitment of Minors gathered together legislators, legal experts, law enforcement, and youth mental health professionals to develop proposed legislation that will make the process of emergency detention and civil commitment for youth facing mental and behavioral health or substance abuse crises more efficient and supportive, as well as expanding Wisconsin's capacity to care for youth experiencing these issues.

Under current law, certain persons, including law enforcement officers and other individuals who are authorized to take a child or juvenile into custody under the state's child welfare laws or juvenile justice code, have the statutory ability to take an individual who the person believes is mentally ill, developmentally disabled, or drug dependent into custody for 72 hours on the basis of observable behavior that the individual is dangerous to themselves or others.

This bill would create a process for certain medical and behavioral health clinicians to initiate the emergency detention of a minor. By empowering clinicians to begin the emergency detention process in the case of a mental or behavioral health or substance abuse crisis, we will reduce the burden on law enforcement to initiate such detentions and prevent emotional escalation of an already distressed youth that can occur when police become involved.

I appreciate your time in considering my testimony and ask that you vote yes on Assembly Bill 114/Senate Bill 109. Medical and behavioral health clinicians as designated in the bill have the skill sets necessary to assess and respond to a mental health crisis, and reducing the need for law enforcement involvement in such cases will both reduce strain on law enforcement agencies and decrease potential stressors for the involved youth.

I would like to thank my colleagues on the Study Committee on Emergency Detention and Civil Commitment of Minors for coming together and proposing legislation to improve mental health crisis responses for our youth.

**STATE CAPITOL** / P.O. Box 8953, Madison, WI 53708
**TELEPHONE** / (608) 237-9178 **TOLL FREE** / (888) 534-0078 **EMAIL** / rep.stubbs@legis.wisconsin.gov

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**TO:** Honorable Chairs Senator Jesse James and Representative Paul Tittl
Honorable Members of the Senate Committee on Mental Health, Substance Abuse Prevention, Children & Families and the Assembly Committee on Mental Health and Substance Abuse Prevention

**FROM:** Kathy Markeland, Executive Director

**DATE:** May 27, 2025

**RE:** **Support and Comments on Legislation to Improve Youth Mental Health Treatment and Access**

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On behalf of the members of the Wisconsin Association of Family & Children's Agencies (WAFCA), thank you for the opportunity to appear before you today to share our support for legislation emerging from the Legislative Council Study Committee on Emergency Detention and Civil Commitment of Minors. We are grateful for the diligent and thoughtful efforts of the Study Committee participants who devoted their time and expertise to this critical policy discussion. After decades of treating children in need of mental health care as adults, and more than a decade of sending children out of their home state to receive psychiatric mental health care, this legislation reflects the sincere efforts of those closest to the policies, procedures, practices, and service array to craft solutions that respect the lived realities of the children, families, and workforce who move through our care systems daily.

WAFCA is a statewide association that represents private providers delivering essential services, often in partnership with government, and advocates for the more than 200,000 individuals, children, and families that they impact each year. Our members' services include family preservation services; community-based outpatient and day treatment therapies; crisis services; and residential care for both children and adults, among others.

As an integral part of the human services ecosystem, we actively partner with counties, health care, schools, family advocates and others throughout the state to ensure individuals, children and families have the services and supports they need, when and where they need them. Over the past decade, we have been at many tables discussing the challenges associated with our continuum of care and its inability to respond to the changing needs of Wisconsin residents – particularly children with complex needs. It is from this vantage point that we offer the following reflections on the legislation before the committees today.

WAFCA's overarching policy priorities for these proposals include the following key objectives:

- To improve timely, appropriate access to care and address capacity constraints.
- To prevent children from placement out of state.
- To move our system point of access from "placement" to "treatment"
- To deliver better outcomes for children and families by evolving Wisconsin's mental health and substance use systems into a more effective, coordinated system of care that responds to needs in a way that is more therapeutic, holistic, equitable and less punitive.

**<u>Support for SB 106/AB 111: Establishing psychiatric residential treatment facilities</u>**

SB 106/AB 111 creates a pathway for implementing psychiatric residential treatment facilities (PRTFs) in Wisconsin while empowering the state to plan for regional and statewide capacity needs. In addition, the bill

incorporates the option for facilities to adopt important safety measures, such as video recording and locked options that will support safer environments.

On any given day, more than twenty Wisconsin children are receiving mental health heath treatment in an out-of-state facility. We know that most children leaving the state to receive psychiatric care are being served in a PRTF. Under this bill, Wisconsin would be able to establish PRTFs which are a unique setting capable of meeting the needs of children presenting with high acuity. The advantages include:

**Mental health service covered by health insurance.** Under the bill a child could access the intensive services of a PRTF without having to rely on their local county human services department or a protective services or emergency detention order.

**Higher security and safety.** PRTFs provide a locked setting, if needed, to ensure the safety of a child who may be a danger to themselves, their family, and/or the community due to their untreated or acute mental health condition. Other 24/7 care settings in Wisconsin are unable to provide these secure options due to current regulations and the populations they serve.

**Longer periods of care to stabilize and treat mental health conditions.** Other resources, such as short-term hospitalizations and/or crisis stabilization facilities, focus on stabilizing and then returning a child to the community for treatment – treatment which may or may not be accessible.

**Medicaid reimbursement.** As referenced in the bill, psychiatric residential treatment facilities can bill Medicaid and should be included in commercial health insurance plans as well. Other 24/7 care settings providing treatment for children, such as residential care centers, are paid for solely by county dollars.

PRTFs will fill an important gap in Wisconsin's continuum of care and it is imperative that the state move forward with this legislation to move us toward implementation. DHS should receive the necessary staffing and funding resources to certify and support the development of this capacity as expeditiously as possible.

**SB 107/AB 112: Revising minor/parent consent for mental health treatment**

This proposal would modify current statutes to allow for either a minor age 14 or older, or a parent or guardian, to consent to outpatient or inpatient mental health treatment. WAFCA member agencies provide outpatient mental health and substance use treatment in communities across the state of Wisconsin and appreciate the challenge that SB 107/AB 112 is seeking to address. It is noteworthy that SB 107/AB 112 would not change the expectation that consent be sought from both a minor and a guardian for mental health treatment. The bill establishes that initiation of treatment is permitted if either parent or child consents and then provides appeal options for non-consenting parties. We note that there continue to be questions and practical considerations regarding the implementation of this bill that are worthy of further discussion. For example, in the event of parental non-consent, it is unclear how payment might be secured for the treatment services. In addition, there are questions regarding the efficacy of compelling a minor to access outpatient treatment in the absence of consent.

WAFCA fully appreciates the intention informing SB 107/AB 112 and notes that other key stakeholders, who share the goal of timely access to care, are also raising reasonable questions that should be more fully explored before this legislation advances.

**SB 108/AB 113: Sharing minor safety plans**

This proposal would require DHS to develop a portal and a statewide mechanism to support sharing minor safety plans to be accessed in the event of a crisis. The proposal builds on the CAtCH Safety Plan process whose founders in northern Wisconsin provided compelling testimony regarding the efficacy of sharing safety plans within a network of key partners to better support individuals facing mental health crisis. WAFCA endorses the concept and believes that there is value in the proposed investment in further exploration. We defer to those with greater responsibility for current health care information sharing systems regarding the best options for moving the CAtCH model from a pilot into a system with broader reach.

**SB 109/AB 114: Clinician initiation of emergency detention of a minor**

This proposal creates a process for certain medical and mental health clinicians to initiate the emergency detention of a minor in counties that allow for this to occur. The bill would further require that counties opting to permit clinician initiated holds, must train and certify clinicians who seek to participate in the initiation process. WAFCA supports the intent of this legislation to establish non-law enforcement based options for initiating an emergency hold on a minor. As community-based mental health providers, WAFCA member agencies currently participate in mobile response teams and participate in crisis services/response under contract with county partners. While we envision that some additional clinicians may opt to work with counties to support options in emergency hold procedures, we appreciate that there continue to be significant questions from other stakeholder partners regarding the need for further clarity and definition in order to move the system envisioned in the bill forward. In addition, we understand the bill's allowance for county discretion in adopting this alternative initiation process, however, we question whether this statutory alternative might further exacerbate some of the inconsistencies in practice across the state rather than moving toward a more cohesive mental health crisis response system.

The complexity of the emergency detention process across the state engages a broad range of stakeholders, and WAFCA commits to continuing to engage with counties, health care, advocates, law enforcement, peers, the courts and the Legislature to seek system improvements that reduce the trauma and inequities of our current emergency response and care continuum for all those experiencing a mental health crisis.

**Improving the Continuum of Care for Wisconsin's Youth in Crisis and with Complex Mental Health Needs**

As noted previously, WAFCA members have long served children and families facing mental health crisis. Our member providers stand at the intersection of our child welfare, youth justice, educational and mental health systems. Too frequently our continuum of care fails to engage with the right response at the right time. We would be remiss in our testimony today if we did not note our support for the initiative represented in SB 110/AB 115 which is not before the committees today, but that we hope will receive serious consideration by this body in the near future. WAFCA endorses SB 110/AB 115 as a proposal to compliment the development of PRTF in the state by simultaneously advancing a statewide youth behavioral health initiative under the Medical Assistance program to provide more comprehensive, community-based, consistent assessment and services to youth with complex needs. We know that there are stakeholder questions about SB 110/AB 115 and we hope that the Legislature will authorize DHS to begin a convening a conversation toward a comprehensive Medicaid waiver for our youth with complex needs. One of the fundamental charges of the Study Committee was to find better solutions for families who are not well supported or served by our current systems, and we believe that the proposal represented in SB 110/AB 115 is a critical building block for the future system we need.

Finally, as the Legislature continues to make progress on the biennial budget, we ask for the Committees' ongoing support for the array of services within our continuum of care to better serve youth with complex needs. Specifically, we call attention to budget proposals to increase Medicaid reimbursement for mental health treatment, adolescent day treatment, school-based mental health and stable funding for specialized residential treatment services. All of these supports help prevent the use of out-of-state treatment facilities and keep Wisconsin children here in our communities for care.

WAFCA would again like to express appreciation to the legislators, legislative staff and community members who devoted their time and expertise through the Study Committee to formulating improvements to our mental health systems of care for Wisconsin children and youth. We look forward to continuing to contribute to the advancement and refinement of all of these important proposals and welcome the questions and insights of the of this body as you continue to deliberate and move these proposals forward.

**COMMENTS TO THE PUBLIC HEARING OF THE ASSEMBLY COMMITTEE ON MENTAL HEALTH AND SUBSTANCE ABUSE PREVENTION AND THE SENATE COMMITTEE ON MENTAL HEALTH, SUBSTANCE ABUSE PREVENTION, CHILDREN AND FAMILIES**

**MAY 27, 2025.**

GOOD MORNING MEMBERS OF THE ASSEMBLY COMMITTEE ON MENTAL HEALTH AND SUBSTANCE ABUSE PREVENTION AND THE SENATE COMMITTEE ON MENTAL HEALTH, SUBSTANCE ABUSE, CHILDREN AND FAMILIES. THANK YOU FOR ALLOWING ME TO SHARE MY COMMENTS REGARDING THE BILLS YOU ARE CONSIDERING THIS MORNING.

MY NAME IS SHARON McILQUHAM. I AM THE CORPORATION COUNSEL FOR EAU CLAIRE COUNTY AND I HAVE WORKED IN THE CORPORATION COUNSEL'S OFFICE FOR 24 YEARS. FOR THOSE OF YOU WHO DON'T KNOW EXACTLY WHAT THE CORPORATION COUNSEL'S OFFICE DOES, AMONG OTHER THINGS OUR OFFICE IS RESPONSIBLE FOR CHAPTER 51 MENTAL HEALTH COMMITMENTS, CHAPTER 54 AND 55 CASES – WHICH ARE GUARDIANSHIPS AND PROTECTIVE PLACEMENTS, CHAPTER 48 AND 938 CASES – WHICH ARE CHIPS (explained), JIPS (explained), AND TPR'S (explained).

I WAS A MEMBER OF THE JOINT LEGISLATIVE COUNCIL STUDY COMMITTEE ON EMERGENCY DETENTION AND CIVIL COMMITMENT OF MINORS, WHICH MET MONTHLY FROM AUGUST THROUGH DECEMBER OF 2024. OUR COMMITTEE WAS MADE UP A DIVERSE GROUP OF PEOPLE, INCLUDING MEDICAL PROFESSIONALS, SOCIAL WORKERS, LAW ENFORCEMENT, PUBLIC DEFENDER, AND JUDGE. THROUGH OUR WORK WE HAVE RECOMMENDED THE BILLS YOU ARE CONSIDERING TODAY.

IF I MAY, I WOULD LIKE TO COMMENT ON EACH OF THEM. I'LL TRY TO KEEP MY COMMENTS BRIEF, BUT GIVEN I'M AN ATTORNEY, THAT MAY BE MORE DIFFICULT FOR ME THAN OTHERS YOU'LL HEAR FROM TODAY.

**SPECIFICALLY REGARDING ASSEMBLY BILL 111/SENATE BILL 106,** I WOULD STRONGLY ENCOURAGE YOU TO SUPPORT THIS BILL. **THIS BILL PRIMARILY DEALS WITH THE CREATION OF PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF'S) TO PROVIDE INPATIENT PSYCHIATRIC SERVICES FOR INDIVIDUALS UNDER AGE 21.** I CAN'T EMPHASIZE ENOUGH HOW IMPORTANT THIS BILL IS TO NOT ONLY EAU CLAIRE COUNTY, BUT ALL 72 COUNTIES IN WISCONSIN.

WHEN A MINOR IS EXPERIENCING A MENTAL HEALTH CRISIS AND IS DEEMED TO BE A DANGER TO THEMSELVES OR OTHERS, AN EMERGENCY DETENTION CAN BE PURSUED BY LAW ENFORCEMENT OFFICERS IF AUTHORIZED BY THE COUNTY OR THEIR DESIGNEE. IN

EAU CLAIRE COUNTY, FOR AFTER HOURS COVERAGE, WE CONTRACT WITH NORTHWEST CONNECTIONS TO PROVIDE CRISIS SUPPORT AND THE ABILITY TO AUTHORIZE AN EMERGENCY DETENTION. AN EMERGENCY DETENTION IS A 72 HOUR HOLD WHERE THE PERSON IS PLACED IN A LOCKED INPATIENT BEHAVIORAL HEALTH FACILITY FOR THEIR OWN SAFETY, TREATMENT, AND OBSERVATION. THERE ARE FEW HOSPITALS THAT HAVE AN INPATIENT BEHAVIORAL HEALTH UNIT, AND EVEN FEWER THAT ACCEPT JUVENILE OR MINOR PATIENTS. AS AN EXAMPLE, EAU CLAIRE COUNTY HAD TWO HOSPITALS WITH INPATIENT BEHAVIORAL HEALTH UNITS. HOWEVER, ONLY ONE OF THOSE HOSPITALS (HSHS, SACRED HEART) HAD THE CAPABILITY TO ACCEPT JUVENILE/MINOR PATIENTS. SINCE HSHS CLOSED IN MARCH 2024, ANY JUVENILE DETAINED IN EAU CLAIRE COUNTY HAS NEEDED TO BE TRANSPORTED ACROSS THE STATE TO WINNEBAGO MENTAL HEALTH INSTITUTE. THE PLACEMENT AT WWMI MEANS THAT AT LEAST FOR EAU CLAIRE COUNTY RESIDENTS, THESE MINOR ARE PLACED 3 HOURS AWAY FROM THEIR FAMILY MAKING IT DIFFICULT FOR MOST FAMILIES TO MAINTAIN IN PERSON CONTACT DURING THE MINOR'S PLACEMENT AT THE FACILITY. NOT ONLY IS THE TRANSPORTATION OF THE MINOR TO THE FACILITY TIME CONSUMING, BUT IT ALSO COMES AT A SIGNIFICANT COST. TRANSPORTATION FROM A CONTRACTED PROVIDER FROM EAU CLAIRE COUNTY TO WWMI IS APPROXIMATELY $1600 ONE WAY.

IT IS CRUCIALLY IMPORTANT WHEN PRTF'S ARE FORMED, THE REQUIREMENT FOR AT LEAST ONE FACILITY TO BE LOCATED IN THE NORTHERN OR NORTH-CENTRAL REGION OF WISCONSIN BE MAINTAINED IN THIS BILL. I ALSO SUPPORT THE REQUIREMENT FOR AT LEAST ONE FACILITY TO BE LOCATED IN THE SOUTHERN PART OF THE STATE. IT'S CRUCIAL THAT MINOR THROUGHOUT THE STATE HAVE ACCESS TO THESE FACILITIES WHICH SHOULD BE LOCATED CLOSER TO THEIR HOMES. IT IS IMPREATIVE THAT THE REQUIREMENT THE PRTF SERVICES BE REIMBURSABLE THROUGH MEDICAL ASSISTANCE (SUBJECT TO FEDERAL APPROVAL) SO AS TO NOT PUT AN UNDUE BURDEN ON THE FAMILIES AND THE PATIENT'S COUNTY OF RESIDENCE.

THIS BILL ALLOWS FOR VIDEO MONITORING FOR THE SAFETY OF THE PATIENTS AND STAFF IN THE COMMON AREAS, ENTRANCES, AND EXITS OF THE FACILITIES. THIS VIDEO MONITORING CAN HELP ENSURE THE PATIENTS ARE EVEN MORE CLOSELY MONITORED. ALLOWING THE VIDEO MONITORING IN THE COMMON AREAS WILL ALSO GREATLY DECREASE THE POSSIBILITY OF ELOPEMENT. I COMPLETELY SUPPORT THAT THESE VIDEO RECORDINGS REMAIN CONFIDENTIAL AND NOT OPEN TO PUBLIC INSPECTION TO PROTECT PATIENT PRIVACY CONCERNS.

THE PRTF'S CAN ALSO BE AN INCREDIBLE ASSET TO MINORS SUBJECT TO NOT ONLY A CHAPTER 51 ORDER, BUT ALSO THOSE SUBJECT TO A CHIPS ORDER. THERE ARE

UNFORTUNATELY MINORS WHO HAVE HIGH AQUITY PSYCHIATRIC NEEDS CAN BE AND ARE PLACED OUTSIDE THE STATE OF WISCONSIN DUE TO A VARIETY OF REASONS. THERE ARE SOME REASONS FOR THESE OUT OF STATE PLACEMENTS. THERE IS A DEFINITE SHORTAGE OF PSYCHIATRIC RESIDENTIAL FACILITIES IN WISCONSIN THAT ACCEPT PLACEMENTS OF MINORS. THE BEHAVIORAL AND PSYCHIATRIC NEEDS OF THE MINORS ARE SUCH THAT MANY OF THE FACILITIES IN THE STATE ARE UNABLE TO ADDRESS THE MINORS' HIGH NEEDS. IN ADDITION, MANY FACILITIES ARE UNWILLING TO ACCEPT THESE PATIENTS REGARDLESS OF THE RATES THE COUNTIES ARE WILLING TO PAY. MANY JUST DON'T WANT THE LIABILITY THAT COMES ALONG WITH MINORS WITH SUCH HIGH NEEDS.

BEFORE AN OUT OF STATE PLACEMENT IS EVEN CONSIDERED, COUNTIES HAVE SENT REQUESTS FOR PLACEMENT TO UP TO 100 FACILITIES IN WISCONSIN. MANY FACILITIES JUST REFUSE TO ACCEPT PLACEMENT OF THE MINOR DUE TO THEIR HIGH NEEDS, REGARDLESS OF THE DAILY RATE THE COUNTY IS WILLNIG TO PAY. IT WOULD BE MY RECOMMENDATION, OR SHOULD I SAY REQUEST, THAT IN ORDER TO REDUCE OR ELIMINATE THESE OUT OF STATE PLACEMENTS THAT PRTF'S BE REQUIRED TO ACCEPT THESE PLACEMENT OR BE OFFERED SOME TYPE OF INCENTIVES TO ACCEPT WISCONSIN'S MINOR RESIDENTS INTO THEIR FACILITIES, AND/OR BE REQUIRED TO "SAVE" A CERTAIN NUMBER OF BEDS FOR WISCONSIN MINORS.

THE NEED FOR WISCONSIN TO HAVE FACILITIES TO TREAT THESE HIGH AQUITY MINORS IS SIGNIFICANT. MINORS WHO ARE PLACED OUT OF STATE ARE UNABLE TO SEE THEIR FAMILY AS OFTEN AS WHEN THE MINOR IS PLACED IN WISCONSIN. WE ARE DOING A DISSERVICE TO BOTH THESE MINORS AND THEIR FAMILIES WHEN PLACEMENTS CANNOT BE LOCATED IN WISCONSIN.

**MOVING ON THE ASSEMBLY BILL 112/SENATE BILL 107, THIS BILL REVISES REQUIREMENTS TO OBTAIN A MINOR'S CONSENT FOR MENTAL HEALTH SERVICES.** THE BILL ALLOWS EITHER A MINOR AGE 14 OR OLDER, OR THE MINOR'S PARENT OR GUARDIAN, TO CONSENT TO BEGIN OUTPATIENT OR INPATIENT MENTAL HEALTH TREATMENT FOR THE MINOR. IF A PARENT CONSENTED TO TREATMENT WITHOUT THE MINOR'S AGREEMENT, A PETITION MUST BE FILED FOR REVIEW OF THE APPROPRIATENESS OF THE TREATMENT.

UNDER CURRENT LAW, IF A MINOR IS AGE 14 OR OLDER, BOTH THE MINOR'S AND THE PARENT'S MUTUAL CONSENT ARE REQUIRED FOR OUTPATIENT OR INPATIENT MENTAL HEALTH TREATMENT. VERY GENERALLY, IF A MINOR OR PARENT REFUSES TO PROVIDE

CONSENT FOR TREATMENT, THE OTHER PARTY MAY PETITION FOR REVIEW AND APPROVAL TO BEGIN OUTPATIENT OR INPATIENT TREATMENT. IF THE MINOR IS UNDER AGE 14, THE PARENTS/GUARDIANS HAVE THE AUTHORITY TO CONSENT TO THEIR MINOR CHILD TO RECEIVE INPATIENT MENTAL HEALTH TREATMENT.

THIS CHANGE GIVES MORE ABILITY, SUBJECT TO REVIEW, FOR EITHER THE PARENT/GUARDIAN OR THE MINOR TO CONSENT TO TREATMENT. WHILE I'VE HEARD QUESTIONS OR STATEMENTS REGARDING THIS PROPOSED CHANGE MAY ERODE THE PARENTAL AUTHORITY, I DO NOT VIEW IT THAT WAY. WHILE I WOULD IMAGINE MOST OF YOU WHO ARE PARENTS OR GUARDIANS WOULD LIKELY CONSENT TO YOUR MINOR CHILD RECEIVING NECESSARY MENTAL HEALTH SERVICES, THERE ARE MANY SITUATIONS I'M FAMILIAR WITH WHERE THE PARENTS/GUARDIANS ARE REFUSING TO ALLOW THEIR MINOR CHILD TO RECEIVE THE NECESSARY SERVICES, DESPITE THE FACT THAT THE MINOR WANTS THEM. DURING MY TIME AT THE CORPORATION COUNSEL'S OFFICE, FOR APPROXIMATELY 14 YEARS I WAS RESPONSIBLE FOR THE JUVENILE CASES, IN CASES WHERE THE MINORS WERE VICTIMS OF CHILD ABUSE OR NEGLECT. SOME OF THE PARENTS/GUARDIANS OF THOSE CHILDREN WHO WERE UNDER A CHIPS ORDER DID NOT WANT THEIR MINOR CHILD TO RECEIVE ANY TYPE OF MENTAL HEALTH SERVICES, EVEN IF THE MINOR CHILD WANTED TO RECEIVE SUCH SERVICES. I'VE SPECULATED THE POSSIBLE REASON FOR THIS COULD BE THEIR DISTRUST OF MENTAL HEALTH PROFESSIONALS OR THE GOVERNMENT, OR EVEN THE POSSIBLITY THEY ARE CONCERNED WHAT THE MINOR MAY DISCLOSE DURING THEIR TREATMENT.

REGARDLESS OF THE REASONS, THIS BILL ALLOWS FOR EITHER THE PARENT/GUARDIAN OR THE MINOR AGE 14 OR OLDER TO CONSENT TO MENTAL HEALTH SERVICES, SUBJECT TO A REVIEW THAT CAN BE REQUESTED BY EITHER PARTY. I SUPPORT THIS CHANGE TO THE CURRENT STATUTE AND ENCOURAGE YOU TO SUPPORT IT AS WELL.

**ASSEMBLY BILL 113/SENATE BILL 108 ALLOWS FOR ADDITIONAL CONSENTUAL EXCHANGE OF IMPORTANT MENTAL HEALTH INFORMATION.** THE PLAN IS FOR A SAFETY PLAN SHARING PORTAL TO BE DEVELOPED THAT WOULD BE AVAILABLE THROUGHOUT THE STATE. THESE SAFETLY PLANS WOULD BE SHARED WITH THE WRITTEN CONSENT OR A RELEASE OF INFORMATION SIGNED BY THE MINOR. THIS SAFETY PLAN CAN BE ACCESSED BY LAW ENFORCEMENT DURING A MENTAL HEALTH CRISIS IN ORDER TO OBTAIN VALUABLE INFORMATION TO PROVIDE SUPPORTS AND ASSISTANCE TO THE MINOR. AT PRESENT, A PROGRAM LIKE THIS, CALLED THE "CATCH" PROGRAM IS BEING UTILIZED IN ASHLAND AND BAYFIELD COUNTIES. HAVING A STATEWIDE PORTAL THAT ALLOWS FOR ACCESS TO THIS ESSENTIAL INFORMATION CAN BE VERY BENEFICIAL TO

THE MINOR WHO HAS AGREED TO THE RELEASE OF INFORMATION. DUE TO MENTAL HEALTH INFORMATION, ESPECIALLY THAT OF A MINOR, BEING CONFIDENTIAL AND PROTECTED, WHEN A LAW ENFORCEMENT OFFICER RESPONDS TO A CRISIS SITUATION, THEY HAVE LITTLE TO NO KNOWLEDGE OF WHAT ISSUES OR CHALLENGES THE MINOR FACES. IF THERE IS ACCESS TO INFORMATION THAT CAN ASSIST WITH DE-ESCALATION OR FINDING SUPPORTS FOR THE MINOR, IT MAY BE POSSIBLE TO AVOID ANY FURTHER TYPE OF COURT INTERVENTION, YET STILL PROVIDE THE NECESSARY ASSISTANCE TO THE MINOR. THIS SYSTEM WOULD BE BENEFICIAL TO LAW ENFORCEMENT, EMERGENCY SERVICE PERSONNEL, HUMAN SERVICES AND MENTAL HEALTH PROVIDERS, AS WELL AS SCHOOL DISTRICTS, WHO WITH THIS INFORMATION WILL BE BETTER ABLE TO PROVIDE ASSISTANCE TO THE MINOR. AND GIVEN THAT THE MINOR CONSENTS TO THE SAFETY PLAN BEING SHARED, THE MINOR MAY BE MORE WILLING TO COOPERATE IN THE SERVICES BEING OFFERED. I BELIEVE THIS IS A GOOD START AT PROVIDING THE NECESSARY INFORMATION TO ASSIST MINORS EXPERIENCING MENTAL HEALTH CRISES.

**ASSEMBLY BILL 114/SENATE BILL 109 -** THIS BILL ALLOWS A COUNTY, OTHER THAN MILWAUKEE COUNTY, TO ELECT TO AUTHORIZE CERTAIN MEDICAL AND BEHAVIORAL HEALTH CLINICIANS TO INITIATE EMERGENCY DETENTIONS OF MINORS AND CREATES A PROCESS FOR CLINICIAN-INITIATED DETENTIONS IN COUNTIES THAT ELECT TO ALLOW CLINICIANS TO INITIATE EMERGENCY DETENTIONS. CURRENTLY, EMERGENCY DETENTIONS ARE PRIMARILY INITIATED BY LAW ENFORCEMENT OFFICERS, OR POSSIBLY BY COUNTY CRISIS SOCIAL WORKERS.

THIS BILL EXPANDS THE ABILITY TO DETAIN TO AUTHORIZED MEDICAL AND BEHAVIORAL HEALTH CLINICIANS TO INITIATE AN EMERGENCY DETENTION OF MINORS. AN IMPORTANT PART OF THIS LEGISLATION REQUIRES THESE PROVIDERS OBTAIN THE NECESSARY TRAINING PRIOR TO THEIR AUTHORITY TO DETAIN AND STILL REQUIRES COUNTY APPROVAL FOR THE DETENTION TO OCCUR. THE PROVISIONS OF HOW THE EMERGENCY DETENTION PROCEEDS THROUGH THE LEGAL PROCESS REMAINS THE SAME, WITH THE REQUIREMENT FOR THE CLINICIAN TO PROVIDE THE NECESSARY PAPERWORK TO THE COUNTY CORPORATION COUNSEL THE NEXT BUSINESS DAY.

THE BILL GIVES EACH COUNTY THE ABILITY TO CHOOSE WHETHER THEY ELECT TO ALLOW CLINICIANS TO INITIATE EMERGENCY DETENTIONS, A PROVISION I SUPPORT AS I BELIEVE EACH COUNTY IS IN THE BEST POSITION TO ASCERTAIN WHETHER OR NOT THIS TYPE OF EXPANSION OF THE CURRENT LAW IS SOMETHING THEY WANT TO OR ARE WILLING TO EXPLORE.

**IN CLOSING** I WANT TO EXPRESS MY GRATITUDE FOR THE OPPORTUNITY TO PARTICIPATE IN THE JOINT LEGISLATIVE COUNCIL STUDY COMMITTEE ON EMERGENCY DETENTION AND CIVIL COMMITMENT OF MINORS. I MET SEVERAL COLLEAGUES WHO ALL SHARED THE SAME COMMITMENT AS I DO, WHICH IS TO DO WHAT WE COULD TO IMPROVE OUR CURRENT SYSTEM OF HANDLING MENTAL HEALTH COMMITMENTS FOR MINORS. THE MEMBERS EXPRESSED SIGNIFICANT SUPPORT FOR CREATING PRTF'S TO ALLOW FOR ADEQUATE AND MORE LOCAL MENTAL HEALTH TREATMENT FOR THE MINORS WHO ARE IN NEED OF SUCH SERVICES. I SUPPORT ALL THE LEGISLATION FORWARDED BY THE STUDY COMMITTEE AND HOPE MY COMMENTS TODAY WILL HELP YOU TO UNDERSTAND THE IMPORTANCE OF SUPPORTING THIS LEGISLATION AS WELL.

THANK YOU FOR YOUR TIME AND ATTENTION TODAY AND I WOULD WELCOME ANY QUESTIONS YOU MAY HAVE.

State of Wisconsin
Department of Health Services
Tony Evers, Governor
Kirsten L. Johnson, Secretary

**TO:** Members of the Senate Committee on Mental Health, Substance Abuse Prevention, Children and Families and of the Assembly Committee on Mental Health and Substance Abuse Prevention

**FROM:** Arielle Exner, Legislative Director

**DATE:** May 27, 2025

**RE:** Senate Bill 106/Assembly Bill 111, Senate Bill 107/Assembly Bill 112, Senate Bill 108/Assembly Bill 113

The Department of Health Services appreciates the opportunity to submit written testimony for information only on three of the six bills brought forward by the Legislative Council Study Committee on Emergency Detention and Civil Commitment of Minors. The Department appreciated its collaboration with the Study Committee over the latter half of last year on potential solutions to addressing the behavioral health needs of our state's children. While DHS has additional context to provide regarding SB 107/AB 112, the Department recommends that SB 106/AB 111 and SB 108/AB 113 be amended to include the grant funding and necessary resources for DHS to carry out the tasks enumerated.

DHS came before the Study Committee twice throughout its deliberations. During the Department's presentation at the August Study Committee meeting, the Department provided an overview of the emergency detention and involuntary commitment procedures as well as the Department's crisis services and facilities. At the December Study Committee meeting, the Department raised specific concerns and recommendations on the prior iterations of these three pieces of legislation. Additionally, the Department expressed support for the cross-agency proposal, now SB 110/AB 115 as introduced by the Study Committee, which authorizes DHS to create a new behavioral health Medicaid program for children and youth with the most complex needs by allowing the Department to submit a Medicaid waiver to the U.S. Department of Health and Human Services to provide reimbursement for these services.

**SB 106/AB 111**

Under this proposal, DHS may certify psychiatric residential treatment facilities (PRTFs) to provide inpatient psychiatric services for individuals under age 21, under the direction of a physician, with services provided by a facility that meets PRTF standards under federal regulations. PRTF services would be reimbursable as a Medical Assistance (MA) benefit and DHS would be allowed to seek any necessary federal approvals for the creation of PRTFs.

DHS appreciated the Study Committee's ongoing discussion about the need to establish PRTFs in Wisconsin in order to serve some of the state's most vulnerable children by addressing a gap in the state's mental health continuum of care with the goal of diminishing the number of out-of-state placements. DHS thanks the Study Committee for incorporating many of the recommendations the Department provided.

However, DHS would like to reiterate that this proposal would allow PRTFs to deny admission, therefore, the Department anticipates that out-of-state placements would continue, most likely for children with the most complex needs. For example, since the establishment of PRTFs upon passage of legislation in 2015, the Minnesota Department of Health Services have shared ongoing concerns about these facilities denying admission, especially given none of these facilities serve children with co-occurring disorders.

This legislation gives the Department the authority to distribute grants for development of PRTFs without providing funding. In his 2023-25 and 2025-27 biennial budget proposals, Governor Evers included $1.8 million for the Department to support PRTFs. This grant funding could help support start-up costs for a facility, fund costs for uninsured youth, and supplement operations cost, particularly when a facility is under utilized. Notably, contract agreements would allow DHS to ensure the state's objectives are being met, such as curtailing the denial of high acuity admissions.

Lastly, this legislation provides the position authority for four new FTE positions, as the Department requested at the December meeting, to develop the administrative rules, manage the certification process, establish Medicaid rates, and monitor and evaluate the program. However, the legislation does not include the funding for those positions. It would not be feasible to pursue opening a PRTF in Wisconsin if these staffing needs are not met.

**SB 107/AB 112**

This legislation modifies the consent process for minors aged 14 and older seeking mental health treatment, shifting from the current system where both the parent or guardian and the youth must consent to treatment. Under the current law, if both parties do not consent to treatment, there is a mechanism for the consenting party to petition for review and approval of treatment. Under this proposed bill, either the minor or the parent may consent independently, and if one party disagrees, a petition for review can be filed under Chapter 51.14. The Department acknowledges the sensitivity of altering the consent process, and the lack of agreement amongst professionals about the appropriate age for consenting to services.

As the Department discussed with the Study Committee, the Department remains interested in future discussions with the State Legislature about how to ensure youth and families know their rights and that providers are knowledgeable and can participate in the petition process.

**SB 108/AB 113**

SB 108/AB 113 directs DHS to develop and maintain a statewide portal to facilitate the sharing of safety plans for minors among safety plan partners. DHS recognizes that a shared portal may help facilitate and inform responses to a behavioral health crisis for those minors. The legislation does not include resources nor funding for the one FTE position included. The cost for the Department itself to develop and maintain the platform as the bill requires would be high and cannot be determined at this time. Per the legislation, the Department could also make payments to the state's electronic health information exchange to develop and maintain a portal. If the Department were to contract for a system, DHS expects to need $546,200 GPR in the first year and $455,200 GPR annually thereafter with costs rising annually along with inflation. Without the necessary resources, the Department will not be able to successfully implement this statewide information sharing system.

DHS thanks both Committees for the opportunity to provide testimony.

Wisconsin Nurses Association

3162 County Road B
Stoughton, WI 53589
Nurses: Visible, Valued, Vital

May 27, 2025

State Senator Jessie James, Chair
Senate Committee on Mental Health, Substance Abuse Prevention, Children and Families
Room 319 South, State Capitol
Madison, WI 53707

RE: Relating to: clinician initiation of emergency detention of a minor and providing a penalty.

Dear Chairperson James and members of the Committee on Mental Health, Substance Abuse Prevention, Children and Families

Thank you, Chairperson James, for holding this public hearing on SB 109 clinician initiation of emergency detention of a minor and providing a penalty. On behalf of the Wisconsin Nurses Association (WNA)I would like to share our support of SB 109 which provides for clinician initiation of emergency detention of a minor and providing a penalty. In review of SB 109, I noticed that one of the psychiatric mental health advanced practice registered nurse is not on the list created on page 5, Section 2. 51.15 (4r) a. 1. Clinician-initiated emergency detention of a minor. **I respectfully request that the Psychiatric Mental Health Clinical Nurse Specialist be added to this section.**

Like the Psychiatric Mental Health Nurse Practitioner that is listed on page 5 Line 1.c., the Psychiatric Mental Health Clinical Nurse Specialist, requires the same criteria to practice in Wisconsin. The Psychiatric Mental Health Clinical Nurse Specialist holds national board certification as a Clinical Nurse Specialist and practice in the field of psychiatric mental health nursing. Both of these credentialed advanced practice nurses understand the purpose, rationale and the criteria for emergency detention for adults. Minors exhibiting behaviors of imminent danger to self or to others, or unable to care for basic needs due to their mental health crisis are indicators for the need for psychiatric and mental health provider assessment, discussion and determination of the need for emergency detention.

These providers have experience in working with individuals who are in crisis, law enforcement, family and other psychiatric mental health providers in determining the need for emergency detention.

SB 109 will provide support and safety for those minors who are in need of expedited psychiatric mental health services. Utilizing our psychiatric mental health Nurse Practitioners and Clinical Nurse Specialist will be advocates for the mental health care of the minor and family. WNA wants to thank the Wisconsin's Joint Legislative Council for addressing this issue. Thank you, Chairperson James and Members Committee, on Mental Health, Substance Abuse Prevention, Children and Families for listening and consideration WNA's recommendation to add the psychiatric mental health clinical nurse specialist to list of other providers who can lend support to these at-risk minors.
I will gladly answer any questions you may have.

Sincerely,
Gina Dennik-Champion MSN, RN, MSHA

Gina Dennik-Champion

WNA Executive Director

WISCONSIN HOSPITAL ASSOCIATION

ADVOCATE. ADVANCE. LEAD.

5510 Research Park Drive
P.O. Box 259038
Madison, WI 53725-9038
608.274.1820 | FAX 608.274.8554 | www.wha.org

**TO:** **Members of the Senate Committee on Mental Health, Substance Abuse Prevention, Children & Families**
**Members of the Assembly Committee on Mental Health and Substance Abuse Prevention**

**FROM:** **Matthew Stanford, General Counsel**
**Kyle O'Brien, Senior Vice President, Government Relations**

**DATE:** **May 27, 2025**

**RE:** **Outstanding clarity questions regarding Clinician Initiation of Emergency Detention of Minors - SB 109/AB 114**

Wisconsin has a uniquely complex mental health care system, and crisis services and emergency detention public policy is even more complex due to important and overlapping considerations including:

- State/community interests in preserving life (danger to self),
- Community safety interests (danger to others),
- Civil liberties considerations (involuntary/detention),
- Abuses of the past (institutionalization through 1980s), and
- Stigma codified in law (e.g. mental health services excluded from Medicaid; regulatory and payment silos and barriers not applicable to physical health services.)

As a result of these overlapping fundamental considerations, unlike other health services, multiple entities have a role in emergency detention, including:

- Emergency departments,
- Law enforcement,
- County government,
- Inpatient psychiatric units,
- Psychiatrists, emergency department physicians and other clinicians,
- Patient and family groups, and
- DHS

A commonality across all of these stakeholders is a shared desire for positive outcomes. While each stakeholder brings different experiences and expertise that shape their views on the best path to that positive outcome, **all struggle with complexity of the system. That complexity results in variation in interpretation, and in turn variation in services, access barriers and undesired outcomes for patients.**

Guided by WHA's Member Mental Health and Addiction Care Forum of over 100 individuals providing mental health services in hospitals and clinics throughout Wisconsin, WHA provided to the Legislative Council Study Committee on Emergency Detention and Civil Commitment of Minors at its December 18 meeting a list and description of several of questions and areas of potential confusion contained in LRB 062/P5, which is now SB 109/AB 114.

Those questions and areas of confusion remain. Attached to this memo are the questions and issues in WHA's December 17 comments and questions to the Study Committee, updated to reflect the introduced bill numbers.

WHA looks forward to continuing engagement with the Senate and Assembly committees and partner stakeholders to address these outstanding questions and opportunities for better clarity in the bills. Our intent of such work is to help reduce the likelihood of variation in interpretation of emergency detention statutes and procedures across Wisconsin, and in turn reduce variation in services and outcomes for patients experiencing a mental health crisis.

WISCONSIN HOSPITAL ASSOCIATION
ADVOCATE. ADVANCE. LEAD.

## SB 109/AB 114 – Clinician Initiators - Initial Questions

"Initiate" is not defined in SB 109/AB 114 nor current s. 51.15, which could create confusion and further inconsistency in the application of the emergency detention statute across Wisconsin's 72 counties.

As a practical matter under current law and practice, clinicians **commonly** contact either law enforcement or county crisis to request an emergency detention – sometimes referred to as an EM1 - if the clinician believes the clinician's patient needs involuntary treatment and meets the criteria for emergency detention under s. 51.15(1)(ar), including the non-clinical standards for emergency detention in s. 51.15 (1)(ar)1.-3. The "detention" – which triggers the changes in rights and granting of authorities - under s. 51.15 only begins after law enforcement arrives to take custody of the patient.

Given the lack of definition of "initiate" in SB 109/AB 114, there are several areas of potential confusion regarding how SB 109/AB 114 should be interpreted and applied in the context of the current emergency detention process which currently relies on "clinicians". Initial questions include:

- Prohibition on non-certified clinicians contacting law enforcement or crisis? Under SB 109/AB 114, is it intended that a clinician would be prohibited from contacting law enforcement or county crisis to request an EM1 unless the clinician is certified by a county under the process specified in SB 109/AB 114?
    - If not, is it clear to all readers - including clinicians, families, patients, law enforcement, county crisis staff, corporation counsel, defense counsel, and courts - that the language does not prohibit such "initiation" of the emergency detention process?

- Transfer of EM1 form obligation to clinicians who contact law enforcement or crisis? Under SB 109/AB 114, if a clinician contacts law enforcement or county crisis to request an EM1, does SB 109/AB 114 transfer the current requirements for law enforcement to complete the EM1 statement of emergency detention form to the clinician who contacts law enforcement or county crisis?
    - If not, is it clear to all readers that if a clinician contacts law enforcement or county crisis to request an EM1, which is currently a common practice, that such request does not transfer the obligation to complete the EM1 statement of emergency detention form from law enforcement to the contacting clinician?

- Transfer of testifying to EM1 form contents at probable cause to clinicians who contact law enforcement or crisis? Under SB 109/AB 114, if a clinician contacts law enforcement or county crisis to request an EM1, and if SB 109/AB 114 transfers the current requirements for law enforcement to complete the EM1 statement of emergency detention form to the clinician who contacts law enforcement or county crisis, does that transfer also result in a new obligation on the contacting clinician to testify at a probable cause hearing?

- What is practically meant by the clinician's "determination" that emergency detention is "appropriate" is "subject to the approval of the county?" Under current s. 51.15, law enforcement does not need approval of the county under s. 51.15(2)(a) to take a person into custody under s. 51.15(1)(ar), but does need approval of the county under s. 51.15(2)(a) to transport the individual in custody "for detention" to a treatment facility under s. 51.15(2)(d). In contrast, SB 109/AB 114 does not require county approval of transport of an individual "for detention" to a treatment facility, but instead states on page 7 lines 5-8, that "the clinician initiator's determination that emergency detention is appropriate...is subject to the approval of the county...."

    - Is it intended that the clinician's "determination" of the need for emergency detention cannot happen until county crisis has evaluated and "approved" the emergency detention?
    - As a practical matter, how do a patient's rights and a clinician's authorities and responsibilities under s. 51.15 as modified by SB 109/AB 114 change from the time prior to the clinician making a "determination" in comparison to the time period between when the clinician has made a "determination," and county crisis has "approved" the "determination?"
    - Based on the answer to the above question, what is the intended purpose of having the clinician making a "determination" rather than simply having county crisis directly evaluate the individual and approving the emergency detention?

- What are the responsibilities of the initiating clinician if county crisis declines approval of the clinician's "determination" under the bill? As a practical matter, an emergency detention process should only be started if the individual is "reasonably believed to be unable or unwilling to cooperate with voluntary treatment," per. s. 51.15(1)(ag). Thus, if no emergency detention is approved, the individual is likely to leave the facility where the emergency detention process began against medical advice.

    - Is the initiating clinician liable in any way to the individual or others if the individual leaves against medical advice after county crisis declines approval of the clinician's "determination?"

- Who has custody responsibility to the patient and community under the clinician-initiated process? Additional practical clarity is needed regarding custody both before and after the county approves the detention under the proposed clinician initiator process. SB 109/AB 114 at page 7, lines 15 – 21 states that the individual is "in custody" *after* the county approves the detention.

    - In whose custody is the individual before the county approves the detention, but after the clinician "initiates" the emergency detention?
    - Prior to county approval, is the individual in the "custody" of the "initiating clinician?" If so, as a practical and legal matter, what does that mean for the clinician and the individual?
    - After county approval SB 109/AB 114 at page 7, lines 18 -24 indicates "the minor is in the custody of the county" until custody is transferred to the person transporting the minor for emergency detention. As a practical and legal matter for the individual, clinicians,

law enforcement and counties, what does that it mean to be "in the custody *of the county*?"

- What is the practical rationale for county approval of the clinician initiator's determination that emergency detention is appropriate? SB 109/AB 114 at page 7, lines 5-8 specify that even though a clinician initiator as trained and authorized by a county may "initiate" an emergency detention under the bill, that clinician initiator's determination that emergency detention is appropriate is subject to approval of the county department of community programs for the county in which the minor resides.

    - Particularly when the county approval under s. 51.15(2)(c) is made by a mental health professional with lesser licensure qualifications than the clinician initiator, what is the practical rationale for having county approval of the clinician initiator's determination that emergency detention is appropriate?
    - Are there concerns that if no county approval were required, non-county clinicians would be significantly more likely to determine involuntary hospitalization is the safest option, resulting in significantly more need for inpatient hospital options in Wisconsin than currently exist?

- What information does SB 109/AB 114 expect clinician initiators to provide to corporation counsel? SB 109/AB 114 at page 8, line 1-9 describes a process in which a clinician initiator shall provide "all information relating to the emergency detention" to county corporation counsel no later than the next business day after initiation.
    - How does this obligation on clinician initiators compare to current requirements for law enforcement and county crisis staff?
    - Does this obligation fully preempt state and federal confidentiality laws applicable to health care providers but not law enforcement?
    - Will this specification in the statute increase or reduce the likelihood of legal challenges to individual emergency detentions at probable cause and subsequent court hearings?

- Change in EM1/ME-901 Statement of Emergency Detention Form? ME-901 – Statement of Emergency Detention Officer – as posted by the Wisconsin Court System (https://www.wicourts.gov/forms/ME-901.DOC, attached) asks the filing officer to provide evidence of "dangerous behavior" including a request to "Describe Behavior" and to provide name and contact information of "witnesses to the dangerous behavior." The form does not ask the officer to describe or specify clinical information regarding the individual's mental illness, drug dependency or developmental disability, nor does it require the officer to describe how taking the subject into custody is the "least restrictive alternative appropriate to the subject's needs." Rather it requires the filing officer to state the time and location of the "Dangerous Behavior," to "Describe Behavior" and provide names and contact information for "Witnesses to the dangerous behavior (including officers who observed behavior)."

    - The "statement of emergency detention" in SB 109/AB 114 page 6, line16 through page 7, line 4 uses language different than what is specified in ME-901 and the language regarding the statement of emergency detention in s. 51.15(5). Is it intended that SB 109/AB 114 is creating a different standard for what must be in a "clinician initiators"

statement of emergency detention, compared to what must be provided in form ME-901?

- Why is a clinician in a better position than law enforcement to gather and provide evidence of dangerousness as required by s.51.15(1)(ar)1-2, especially evidence of "threats of" suicide or serious bodily harm or evidence "that others are placed in reasonable fear of violent behavior and serious physical harm to them?"

**STATE OF WISCONSIN, CIRCUIT COURT, _____ COUNTY**

IN THE MATTER OF THE CONDITION OF

_____
Name of Subject

_____
Date of Birth

# Statement of Emergency Detention by Law Enforcement Officer

Court Case No. _____

Law Enforcement Agency No. _____

- ***File this statement with the court immediately and with the detention facility upon admission. A probable cause hearing must be held within 72 hours after the subject is taken into custody.*** ***(In Milwaukee County, file this statement with detention facility only.)***
- ***Please print or type all information below. All blanks must be filled in.***

I am a law enforcement officer and have cause to believe that:

- The subject is mentally ill, drug dependent, or developmentally disabled.
- The subject evidences behavior which constitutes a substantial probability of physical harm to self or to others, or as otherwise set forth in §51.15(1), Wisconsin Statutes.
- Taking the subject into custody is the least restrictive alternative appropriate to the subject's needs.

My belief is based on specific and recent dangerous acts, attempts, threats, omissions, and/or statements made by the subject as observed by me or reliably reported to me as stated below:

**Dangerous Behavior**

**When:** _____

**Where:** _____

**Describe Behavior:**

☐ **See attached page**

Witnesses to the dangerous behavior: (including officers who observed behavior)

| Name of Witness | Telephone | Mailing Address | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

[Name] _____ of the _____ County department of community programs (§51.42(3), Wis. Stats.) board approves the need for this detention.

The subject was taken into custody for the purposes of this emergency detention on [Date] _____ at [Time] _____ ☐ am. ☐ pm.

The potential detention facility is _____

| Subject's Street Address | City | County | State | Zip Code | Phone Number |
|---|---|---|---|---|---|
| | | | | | |

DISTRIBUTION:
1. Court
2. §51.15(2) Detention Facility
3. Subject with Notice of Rights

| Signature of Officer | Department |
|---|---|
| Name Printed or Typed | Telephone |



**This form shall not be modified. It may be supplemented with additional material.**

NAMI Wisconsin
National Alliance on Mental Illness

Date: May 27, 2025

From: NAMI Wisconsin, the National Alliance on Mental Illness,

Mary Kay Battaglia, Executive Director

Sita Diehl, Public Policy and Advocacy Director

To:

Senate Committee on Mental Health, Substance Abuse Prevention, Children and Families

Assembly Committee on Mental Health and Substance Abuse

NAMI Wisconsin applauds the Wisconsin Legislature for the intent to improve statutes concerning the emergency detention of minors in psychiatric crises. The Legislative Committee on the Emergency Detention of Minors process has been thorough and has produced helpful recommendations. NAMI Wisconsin is the state organization of the National Alliance on Mental Illness. We represent Wisconsin residents with serious mental illness, their families and supporters. NAMI 22 local affiliates offer support, education, and advocacy to improve quality of life for people with mental illness and promote recovery.

NAMI Wisconsin recognizes and supports system improvements which improve early identification of mental health needs and early, community-based intervention which address serious mental illness as it emerges. Positive and supportive response to these crises enable the person to pursue a meaningful, productive life and avoid long term disability and dependence on public resources. We also recognize that, even when these safeguards are in place, there will continue to be children and youth who require involuntary commitment to psychiatric care. NAMI generally supports the following legislation to address this need, although we have concerns and suggest further analysis for the proposal for consent to treatment for minors who are age 14 and older which we note in comments below.

**Clinician initiation of emergency detention of a minor: SB109/ AB114.**

NAMI Wisconsin supports this legislation to authorize certain medical and behavioral health clinicians to initiate the emergency detention of a minor and would create a process for clinician-initiated detentions in counties that elect to allow clinicians to initiate emergency detentions. It is our view that current Wisconsin statute relies too heavily on law enforcement in the emergency detention process. Requiring law enforcement to place the commitment order creates the impression that emergency detention is a criminal process, rather than a civil and medical process, adding stress and confusion for the youth in crisis and the family or guardian. This bill would bring Wisconsin into alignment with practice in most states by allowing either a designated clinician *or* law enforcement officer to place an emergency hold on an individual for the purpose of determining eligibility for involuntary commitment.

**Psychiatric residential treatment facilities, providing an exemption from emergency rule procedures, and granting rule-making authority: SB106/ AB111**

NAMI Wisconsin supports this bill to authorize the Department of Health Services (DHS) to establish a certification process for and certify psychiatric residential treatment facilities (PRTFs) to provide inpatient psychiatric services for individuals under age 21, with PRTF services being a reimbursable Medical Assistance (MA) benefit. On any given day, as many as twenty Wisconsin children receive mental health services in psychiatric residential treatment facilities (PRTF) outside of Wisconsin because we do not have the right level of care to support them here. Supporting high needs children in-state will provide for better transition from inpatient to community care and improve opportunities for family and school engagement.

**Consent to mental health treatment by minors who are age 14 or older: SB107/ AB112**

The bill revises requirements to obtain a minor's consent for mental health services. The bill allows either a minor age 14 or older, or the minor's parent or guardian, to consent to begin outpatient or inpatient mental health or substance use treatment for the minor. If a parent consented to treatment without the minor's agreement, a petition must be filed for review of the appropriateness of the treatment. NAMI Wisconsin views this as an improvement on current law which prevents treatment from proceeding if either the minor or the parent/guardian refuses. However, we have the following concerns:

- NAMI recommends insertion of a requirement that the minor **and parent/guardian** must receive information on the consent provisions of this bill at the earliest opportunity in the process of applying for inpatient or outpatient treatment. This should include written information and verbal instruction on the minor's rights and the parent/guardian rights

and responsibilities. Too often, such information is provided too late in the process to enable the parent/guardian or minor to make informed decisions or take action.

- The language in the bill moves from mental illness, developmental disability, and minors with treatment for alcoholism or drug abuse inconsistently. Is the intent to differentiate the services and who can request treatment?
- We are concerned about who has liability and who pays for treatment when the child consents, but the parent or guardian refuses care. If a component of the parent's refusal is based on concern for the financial obligation, what alternative provisions would be available to pay for care?
- If there is disagreement between the minor and their parent/guardian about outpatient treatment, we would like the minor to receive initial treatment while a decision to refuse care is under consideration by the court.
- Would a facility take the liability if the child elects to participate in inpatient care and the parent or guardian refuses? Who is liable if the minor is harmed or harms another person while in the facility? We understand that a facility is currently liable to maintain safety for individuals in their care, but we are concerned that treatment proceeding despite parental refusal may increase the likelihood of legal action.
- For inpatient care, we concur with the recommendation of the Wisconsin Psychological Association that the minor should receive treatment for 5 working days or until the court makes a dispensation on the case, whichever is soonest.
- We highly recommend inclusion of a requirement that this legislation would apply to only recognized standard mental health practice and/or evidence-based therapies.

**Sharing minors' safety plans:** SB108/ AB113

NAMI Wisconsin supports this legislation with one recommendation regarding the WISHIN health information system. We promote the use of crisis plans and safety plans as an effective practice to enable the person and their supporters to prevent mental health crises, to share necessary information and to describe and state preferences for action should a crisis occur. We applaud the CAtCH Safety Plan process on which this legislation is based, allowing information not protected under confidentiality statute to be shared as specified by the person and with parties specified by the person. We fully support the inclusion of these plans in the WISHIN health information system, although we encourage the legislature to consult with WISHIN personnel prior to this bill moving forward to ensure that provisions will allow for information to be collected and shared as intended in the legislation.

**A pilot school-centered mental health program:** AB260/ SB245

NAMI Wisconsin supports this pilot of school-centered mental health services to serve at-risk students and families at school, at home, and in the community and serve students and families year-round. The pilot will include classroom observations and pupil-specific behavior intervention, including evidence-based individual or family therapy, and provide family coaching that is aligned with therapeutic goals. We prefer the model identified in this bill because it brings specialty mental health expertise into the school. This facilitates continuity of evidence-based care and allows services to be provided on site without requiring parents to take time from work to transport their children to appointments. This model enables children and families to continue care and coaching when school is not in session or when the child is unable to attend school. Finally, embedding mental health experts on site at the school allows for faculty consultation on in-class supports, and general education of faculty and the student body regarding healthy school culture.

NAMI Wisconsin is encouraged by these proposed bills that will promote early intervention, effective crisis response and access to mental health care for children and youth. Should you require further information, please contact NAMI Wisconsin's Executive Director, Mary Kay Battaglia at marykay@namiwisconsin.org.

WISCONSIN COUNTIES ASSOCIATION

22 EAST MIFFLIN STREET, SUITE 900
MADISON, WI 53703
TOLL FREE: 1.866.404.2700
PHONE: 608.663.7188
FAX: 608.663.7189
WICOUNTIES.ORG

# MEMORANDUM

**TO:** Honorable Members of the Senate Committee on Mental Health, Substance Abuse Prevention, Children and Families
Honorable Members of the Assembly Committee on Mental Health and Substance Abuse Prevention

**FROM:** Chelsea Shanks, Government Affairs Associate

**DATE:** Tuesday, May 27, 2025

**SUBJECT:** Position of Wisconsin's Counties on Bills Related to Mental Health for Youth

Assembly Bill 111/Senate Bill 106: Psychiatric Residential Treatment Facilities (PRTF)

Currently in Wisconsin, there is a gap in our child welfare system as it relates to youth with disabilities, substance use, and behavioral needs. Due to a reduction of in-state residential capacity, Wisconsin has been sending children out of state for years to receive care for intensive mental health needs.

Current providers licensed by the Department of Children and Families only care for children who have been removed from their homes through the child welfare system, or those in need of services through the youth justice system. As a result, there is an inherent gap in our children's system of care.

The benefits of PRTF services include: mental health services covered by health insurance, high security and safety, longer periods of care to stabilize and treat conditions, and Medicaid reimbursement.

Creating a PRTF in Wisconsin is a key component in ensuring that we are keeping the children in our state safe and as close to home as possible. A 2022 study by the Wisconsin Association of Family & Children's Agencies found that all the children at risk of being placed out of state had a mental health, disability, and/or medical need that could not be matched with available in-state services. They were placed wherever there was space, not necessarily because it was what they needed. Without these facilities, children in our state are suffering.

For these reasons the Wisconsin Counties Association and the Wisconsin County Human Services Association respectfully request your support for AB 111/SB 106. Thank you for your consideration.

Assembly Bill 114/Senate Bill 109: Clinician Initiation of Emergency Detention of a Minor

This legislation essentially creates two processes for the emergency detention (ED) of a minor: 1) the current law enforcement initiation and 2) a new option for county approved/contracted clinicians.

After many discussions and collaborative conversations during the study committee meetings, county human services professionals have some recommendations for amendments that we believe will help keep the process efficient and effective.

1. **Approved clinicians:** The bill specifies that county human service departments may approve behavioral health clinicians to initiate EDs . To ensure the expanded authority to initiate is tightly controlled, the eligible clinicians should be employees or contractors of county human service departments. Without this, other community clinicians might seek county approval to initiate EDs , which could create conflicts between human service departments and their community partners.

   Amendment: Page 5 lines 9-10
   …county may elect to authorize clinicians who ~~have been approved by~~ are employees or contractors of the county to initiate emergency detentions.

2. **Law Enforcement Assistance:** There will be situations where county clinicians may initiate an ED of a child, but the situation could become dangerous and require assistance from law enforcement. It would provide assurance for county human service departments if there was specific language stating that county departments may request assistance from law enforcement for EDs initiated by clinicians if there are safety issues taking children into custody or transporting children.

   Amendment: On page 8, add a new paragraph specifying that the county department initiating the emergency detention may request assistance from law enforcement to take the child into custody or transport the child if the county department has concerns about the safety of the child or county staff.

3. **Training:** Require the Department of Health Services (DHS) to develop a statewide training program on the ED process for clinicians authorized to initiate detentions. Counties must ensure their clinicians complete the training. The program could also be offered to law enforcement and attorneys to improve consistency and understanding.

Since the legal process is the same for children and adults, the training could be made available to all professionals involved.

Amendments:

- Add a provision modifying 51.15(11m) to specify that DHS develop a training on the 51.15 emergency detention process.
- On page 5, line 22 of the bill add a reference to the new statewide training under 51.15(11m) for the training clinicians will be required to take.
- Modify the existing 51.15(m) so the current training requirement for law enforcement officers references the new statewide training. The current language about training for law enforcement being provided through in-service training at the county department of community programs could be eliminated to provide more flexibility about how the training can be provided to law enforcement.

DHS will need additional resources to develop the ED training. It is recommended that at least $200,000 of one-time funding be provided to allow DHS to develop a training curriculum that can be delivered through multiple modalities and to different audiences.

4. **Responsibility to testify:** The bill requires clinicians who initiate EDs for children to submit a statement to county corporation counsel to begin the legal process. Counties recommend clarifying that these clinicians must testify at the 72-hour probable cause hearing to support the detention.

   Amendment: On page 8, line 9 add a sentence that the clinician who initiates the emergency detention must provide testimony for why the detention was necessary at the probable cause hearing under 51.20(7).

5. **Placement in residential care:** The ED process is sometimes viewed as a way to get children admitted to residential care. County human service departments are responsible for placements of children in residential care under Chapters 48 or 938. It would be helpful to clarify that if a county clinician takes a child into custody for emergency detention, any subsequent placements of the child following the ED hospital stay must be done under the Chapters 48 or 938 placement procedures.

   Amendment: On page 8, add a new paragraph specifying that if a county takes a child into custody for emergency detention, once the child is released from detention the county may pursue placement of the child in out-of-home care using the Chapters 48 and 938 placement procedures.

6. **Evaluation:** Expanding the scope of professionals that can initiate ED of children is a major change in emergency mental health practice. To assess the impact of the change,

counties recommend that a formal evaluation be done. The evaluation of the expanded authority to initiate EDs should review the impact on the number of detentions; availability of transportation services; workload and financial impacts on county human service departments; and outcomes for children detained.

Amendment: A non-statutory provision could be added to the bill directing that an evaluation be done by the Legislative Audit Bureau or other independent evaluation resource.

**The Wisconsin Counties Association believes that recommendations 1 and 2 are critical amendments necessary for county human services professionals to be supportive of AB 114/SB 109.** These amendments are essential items to human services departments and their ability to ensure that staff and youth are safe.

Thank you for your time and consideration of our recommendations and please do not hesitate to contact WCA with any questions.

Contact: Chelsea Shanks, Government Affairs Associate
608.663.7188
shanks@wicounties.org

Good morning all,

My name is Sheila Carlson. I have been a participating member of this study committee over the last year. For the last 8 years, I have worked in law enforcement. I was a patrol officer for 4 years, a Behavioral Health Officer for 4 years, and am currently a Detective. While in my role as a Behavioral Health Officer, my primary focus was decriminalizing mental health by reverting mental health related calls for service over to service connections rather than the criminal justice system. To tell you it was difficult to get kids to talk to me about their mental health struggles would be an understatement. When I was called to situation, the juvenile's assumption that they were going to jail. Families regularly communicated their inability to find alternative options that did not involve law enforcement leaving them with no other option than to call police on their child.

The reason for this is that the Wisconsin State Statute Chapter 51.15 clearly states law enforcement is the primary and often only option to take custody of a child for an emergency detention. The definition of custody in the current statute states "An individual is in custody when the individual is under the physical control of the law enforcement officer." Law enforcement officers, based on safety reasons, policy restrictions, or both, place juveniles into handcuffs on emergency detentions. Handcuffs are reasonably correlated with jail. Then, the child goes into a squad car where criminals are placed after committing crimes. Handcuffs, marked squad cars, and uniformed police officers inherently tell the child in crisis that they are in trouble.

Many people believe Chapter 51.15 is only used in cases where the child is exceptionally uncooperative and combative to where law enforcement is necessary to intervene with the tools and restraints they are trained to use. I will tell you, in my 8 years, I have seen more children go to places like Winnebago Mental Health on a Chapter 51.15 when they are unwilling but compliant or they are completely voluntary but due to insurance issues, parental absence, or capacity issues at local psychiatric facilities, they are compelled to go on a Chapter 51.15. These children who are cooperative, non-combative, and are looking for help, are placed into handcuffs, transported in a marked squad car, by a uniformed police officer.

Aside from the trauma this will induce on children, it also ties up community law enforcement resources. An emergency detention to Winnebago Mental Health for my department, which is a larger agency for the state of Wisconsin, can take anywhere from 5 hours to 16 hours. That is two uniformed officers taken off the streets to stay with a person who is going through the medical clearance process then transporting that person for a noncriminal-based situation. In smaller agencies, that may take away their only officer from responding to calls for service in that community. This reduces the response time for emergency situations, potentially costing precious moments a person may not have the ability to lose.

When a person has a heart attack, we don't have police sit with that person while they are seeking medical treatment. When a person is experiencing a diabetic episode, we don't have

police stay with that person until they are turned over to the accepting facility. We don't put those people in handcuffs and transport them in squad cars. If a hospital doesn't have the tools needed for a patient, they find a hospital that does and transfers that patient for their specified needs. We don't do that for mental health emergencies. As a state, we use the police to take custody of people for their mental health crises. As a state, we use law enforcement to maintain custody of that person until they are accepted to a facility that fits their needs. As a state, we use law enforcement to transport that person to the accepting facility. As a state, we criminalize mental health.

As a law enforcement officer and as a mother, I ask that you consider what LRB-0629/1 is proposing. An alternative to law enforcement to detain a juvenile who meets the standards for a Chapter 51.15. There are better suited professionals who are more trained and well versed in the world of mental health. Law Enforcement has a place in the cases of exceptional danger and highly combative individuals, however, most of these kids are not either of these things. If my child were to ever experience a mental health crisis, I would want him to stay within the medical system like any other medical crisis. As a parent, I would never want to see my child in the back of a squad car to receive psychiatric help. LRB-0965/1 provides an alternative to a squad car. This recommendation allows for a third-party transport option that does not say POLICE on the side of the car. That is more trauma informed, less intimidating, and more appropriate for these cases without involving law enforcement.

Finally, LRB-0615/1 relating to consent to mental health treatment by minors who are age 14 or older. I have been on both sides of this conversation. One being the parent of a 15-year-old believes the child needs psychiatric treatment, but the child refuses and they are sent back home with no follow up options. The other being the 15-year-old in foster care, their guardian is unreachable, and the child wants psychiatric treatment but due to the guardian not being accessible, they are denied. Both cases ended up where the 15-year-old was placed on an emergency detention. The first was due to the child's symptoms worsening resulting in emergency inpatient hospitalization and the second due to the guardian not being accessible to sign off on treatment. Both are preventable forced hospitalizations. Child already don't always make the best choices. A mental health crisis can be life altering or even life ending. This recommendation would allow parents to step in when their children are not well enough to make those medical decisions. This recommendation would also allow at risk youth who are seeking help to receive that help in a voluntary manner. We don't turn away a child when they are wanting emergency medical help for other medical situations, why do we do it for mental health? When the juvenile is unable to access mental health treatment voluntarily due to their guardian not being accessible, police are called, the child is placed into custody, and they are transported via squad car with a uniformed police officer. Again, we criminalize mental health.

We must do better for our children, for the parents in our state, and for our communities. This bill will not be the end all be all for decriminalizing mental health but it will certainly point us in the right direction.