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Forensic Assertive Community Treatment (Health Services -- Care and Treatment Facilities)

[LFB 2021-23 Budget Summary: Page 306, #5]

CURRENT LAW

Persons who are committed by a court to the Department of Health Services for treatment as the result of a criminal proceeding are referred to as forensic patients. Forensic patients fall into three categories: (a) persons charged with an offense and whose competency to proceed to trial is questioned; (b) persons deemed not competent to stand trial as the result of mental illness present at the time of the trial; and (c) persons who are found not guilty by reason of mental disease or mental defect present at the time that the offense was committed.

The Department of Health Services operates two mental health institutes for inpatient evaluation and treatment of forensic patients. The Mendota Mental Health Institute in Madison is the treatment facility for male and some female forensic patients; the Winnebago Mental Health Institute in Oshkosh is used primarily for persons committed for treatment as the result of a civil process, but also is used for female forensic patients.

A forensic patient who is committed and admitted to a mental health institute after being found not guilty as the result of mental disease may periodically petition the court for conditional release. The court that originally committed the person to institutional care is responsible for ruling on the petition. If the court determines that the patient does not meet the standard for institutional care, the person is placed on conditional release. For persons on conditional release, the person's county of residence and DHS jointly develop a plan for the treatment and supervision of the person. DHS is financially responsible for treatment and supervision of a person on conditional release. DHS contracts with a treatment provider for case management and treatment services and with the Department of Corrections for supervision.

The Department also has vendor contracts for some pre-trial competency evaluations and for restoration to treatment services occurring outside the mental health institutes. These services may be provided in county jails or, in certain cases, in a community setting.

DISCUSSION POINTS

1. Individuals with mental illness comprise a disproportionate share of people with involvement within any part of the criminal justice system, including the jail and prison population. Various estimates put the percentage of jail and prison inmates who have serious mental illness at 15% to 20%. DHS estimates that nearly two-thirds of jail inmates and one-half of state prison inmates have some mental illness.

2. One of the reasons frequently cited for the persistence of high incidence of persons with mental illness in the criminal justice system is a lack of adequate and appropriately targeted systems of community-based treatment and supports for persons living with mental illness. Certainly not all criminal behavior can be attributed to mental illness, and not all mental illness is associated with criminal behavior. But many professionals working in both the criminal justice and behavioral health systems agree that some persons with mental illness who fall through gaps in the mental health treatment system sometimes end up in the criminal justice system. Often, these individuals are arrested, not for serious or violent offenses, but for reasons related to symptoms of untreated mental illness.

3. The U.S. Supreme Court, in *Dusky v. United States* (1960), ruled that individuals standing trial in a criminal case have a right to an evaluation to determine their competency to stand trial. The Court determined, furthermore, that to meet the competency standard, the defendant must be able to understand the charges against him or her and to be able to assist in his or her defense. A court may refer a person for competency evaluation prior to, or during, a criminal proceeding, whenever there is reason to doubt a defendant's competency to proceed with the trial.

4. In Wisconsin, the Department of Health Services is responsible for conducting court-ordered competency evaluations. Following an examination, the Department's (or the Department's examiner) issues an opinion on a person's competency to stand trial, and also an opinion on the likelihood that the defendant, if provided treatment, may be restored to competency within 12 months (or within the maximum sentence for the charged offense, if that is less). The court makes a determination of competency based on the Department's report. If the court determines that the defendant is not competent, but is likely to become competent with treatment within the allowed period, the court suspends the criminal proceedings and commits the defendant to the custody of the Department for treatment. Both the order for competency evaluation and the order for competency restoration treatment are known as forensic referrals.

5. Another type of forensic referral occurs when, following a criminal trial, a jury reaches a verdict of not guilty by reason of mental disease or mental defect, and the court commits the person to the custody of the Department. In these cases, the court is required to order institutional care for a persons who is committed under these provisions, if the court finds that the person would pose a significant risk of bodily harm to himself or herself or to others or of serious property damage. The

commitment period may be not more than the maximum sentence of imprisonment for the crime, in the case of felonies, or not more than two-thirds of the maximum sentence, in the case of misdemeanors.

6. DHS contracts for jail-based competency evaluation and restoration to competency treatment for individuals awaiting admission to the mental health institutes. Providing these services prior to admission is intended to shorten the period of hospitalization, and, in turn, reduce the number of individuals awaiting forensic admission. These services are part of a set of services that the Department has established to provide treatment, supervision, and supportive services to persons in the forensic patient system, but that are delivered outside the mental health institutes or the Department's secure treatment facilities. The Department generally contracts with vendors for these services.

7. The Department notes that the number of forensic referrals for institutional care is increasing, placing a strain on the capacity of the mental health institutes, primarily Mendota. The number of individuals awaiting admission to Mendota has generally ranged from 60 to 80 over the past two years, which equates to about 20% to 25% of current forensic bed capacity. DHS indicates that the demand for forensic treatment is being driven, in particular, by an increase in the number of individuals referred for treatment to competency, which is consistent with a nationwide trend.

8. Assembly Bill 68 and Senate Bill 111 include a proposal for a new initiative within array the community-based forensic treatment services, with the goal of reducing the number of individuals with severe mental illness who require admission to Mendota and, ultimately, the number who enter the forensic patient system. The proposal would establish a treatment program, called forensic assertive community treatment (FACT), targeted to individuals whose severe mental illness and functional impairments have resulted in, or put that at risk to have, repeated forensic referrals.

9. The proposed forensic assertive community treatment program would be an adaptation of the treatment program delivered under the assertive community treatment (ACT) model. The ACT model was developed in Wisconsin by staff at the Mendota Mental Health Institute in the 1970s and is currently used widely, both in the United States and internationally, for treatment of individuals experiencing several mental illness and functional impairments.

10. The impetus for the development of the ACT model was the problem of recurring hospitalizations experienced by some individuals. Mendota staff saw a need for continuing the type and intensity of treatment that is offered in an inpatient setting, but delivered after discharge from the hospital, in a community-based setting.

11. The ACT model relies on a team-based approach to treatment, with a high staff-to-client ratio. Teams consist of a psychiatrist, social workers, nurses, and peer specialists. One ACT staff member is assigned to no more than ten clients at any one time and someone on the treatment team is on call for assistance on a 24 hour, seven days per week basis.

12. ACT provides supportive and rehabilitative services in addition to clinical treatment. These services might include life skills training, employment support, assistance with finding housing, and working with family members. To promote successful integration into the community,

team members work with the client directly in varying community settings, such as places of employment, retail stores, or other public settings. The use of real-life settings is intended to help the person learn strategies to mitigate symptoms associated with a serious mental illness when they arise.

13. Because of the high staff to participant ratio and intensity of services provided, the ACT model is more costly than other community treatment services available for individuals with severely mentally illness. Nevertheless, if it can be targeted to individuals who have a high likelihood of needing other high-cost services, such as inpatient hospitalization, and if it can reduce the need for those high-cost services, it can be cost-effective intervention.

14. The ACT model is the basis of the community support program (CSP), a psychosocial rehabilitation service category under the state's medical assistance (MA) program. An individual qualifies for services in a CSP if he or she has a serious and persistent mental illness that requires repeated acute treatment, or prolonged periods of institutional care. Typically these individuals have a diagnosis of schizophrenia, affective disorder, delusional disorder, or other psychotic disorders. CSP treatment services are tailored to an individual's medical and social needs. Services include individual, family, and group psychotherapy, employment adjustment training, medication management, assistance with housing, and crisis intervention.

15. The FACT proposal would be an adaptation of the ACT model for persons with frequent forensic referrals, meant to address both the client's serious mental illness as well as risks for continuing criminal behavior. With an intensive treatment approach, the goal of the FACT program would be to reduce the need for law enforcement intervention and reduce hospitalization, and eventually reduce forensic referrals to the mental health institutes. The Department envisions, in addition, that enrollment in FACT could serve as an alternative to admission to Mendota for certain forensic patients.

16. Similar to CSP benefit under MA, FACT participants would have a care plan that includes access to psychiatric services, medical care, life skills training, transportation, financial management skills, and skills training for family members, if applicable. With a particular emphasis on addressing the individual's past history with the criminal justice system or law enforcement, the Department envisions that the FACT team would include input from law enforcement and probation officers. In addition, the Department envisions that FACT teams would include "peer navigators" to maintain close contact with individuals enrolled in the program.

17. DHS indicates that FACT would be targeted to areas of greatest need, particularly to individuals who have been referred by courts on multiple occasions for forensic evaluation and treatment. Referrals would be made from court diversion programs, social service agencies, law enforcement agencies, jails and prisons, or parole and probation providers. As an indication of the potential demand for services, DHS indicates that in recent years approximately 155 individuals per year have been the subject of more than one forensic referral.

18. To implement the program, DHS would contract for personnel for FACT teams to assess individuals for enrollment, work with county providers and the justice system personnel to establish treatment plans, and provide treatment services or assist in enrolling participants in county CSPs or other county mental health programs. The Department proposes to contract for a staff sufficient to

serve 100 participants. The staff would include a psychiatrist, two registered nurses, a peer specialist, and 14 service coordinators of varying classification. The Department estimates the annual cost for this contract at $1,294,000.

19. To the extent possible, FACT services delivered though a county mental health programs would be billed to medical assistance, most likely through a CSP. Under CSP, counties receive the federal share of the reimbursement payment (approximately 60% of the total), but are responsible for the nonfederal share (around 40%). DHS indicates that when CSP enrollment slots are limited by county budgets, counties may prioritize individuals involved in the civil commitment, rather than forensic referral system. In order to ensure that FACT participants are immediately enrolled in a CSP, instead of being placed on a waiting list, the program would reimburse counties for the nonfederal share of CSP services provided to these enrollees. The Department estimates that the cost of this county reimbursement would be $517,600 annually.

20. AB 68/SB 111 would provide $2,273,800 GPR annually for the proposed FACT initiative, the combined estimate for the FACT personnel contract and for the county reimbursement. The Committee could provide this funding if it agrees the proposal to establish a new FACT services program is a promising approach to addressing the mental health needs of persons who live with serious mental illness and who have frequent interaction with the criminal justice system [Alternative 1].

21. Since it typically takes time to develop a new contracted service and award a contract, the funding could be delayed until 2022-23 [Alternative 2].

22. If the Committee agrees with the proposal to establish a new FACT initiative, but does not wish to commit to funding a program with the scope of the proposal included in AB 68/SB 111, it could reduce the amount provided. While the bill was premised on a program capacity for 100 individuals, the Committee could start with a program approximately one-half of that size, beginning in 2022-23. In this case, the funding would be $1,136,900 in 2022-23 [Alternative 3]. After the program is established, DHS may gain a fuller understanding of the number of individuals who would be appropriate for FACT enrollment, and request additional resources if warranted.

23. The Committee could determine that providing funding to establish a new FACT program is not warranted [Alternative 4]. As noted, counties currently operate community support programs and other mental health services programs that provide psychosocial treatment for persons living with serious mental illness. These programs are not specifically designed for and targeted to individuals with frequent forensic system referrals. Nevertheless, in the absence of funding for a FACT program, as proposed by AB 68/SB 111, the Department may work with counties to develop CSP practices for these individuals. Counties that are willing to commit funding to serve these individuals in CSPs may benefit if such programs are successful in reducing county justice system costs.

ALTERNATIVES

1. Provide $2,273,800 GPR annually for a forensic assertive community treatment

program with a capacity for approximately 100 enrollees. This amount includes funding for contracted personnel and for the nonfederal share for community support program services delivered through the medical assistance program for FACT enrollees,

ALT 1	Change to Base
GPR	$4,547,600

2. Provide $2,273,800 GPR in 2022-23 for a forensic assertive community treatment program with a capacity for approximately 100 enrollees, beginning in 2022-23.

ALT 2	Change to Base
GPR	$2,273,800

3. Provide $1,136,900 GPR in 2022-23 for a forensic community assertive community treatment program with a capacity for approximately 50 enrollees, beginning in 2022-23.

ALT 3	Change to Base
GPR	$1,136,900

4. Take no action.

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