Health Services

Care and Treatment Facilities

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June, 2021 Joint Committee on Finance Paper #375

Mendota Mental Health Unit Forensic Staffing and Permanent Positions for Forensic Units at Sand Ridge Secure Treatment Center (Health Services -- Care and Treatment Facilities)

[LFB 2021-23 Budget Summary: Page 303, #1 and Page 304, #2]

CURRENT LAW

The Department of Health Services operates the state's two mental health hospitals, the Mendota Mental Health Institute in Madison and the Winnebago Mental Health Institute in Oshkosh. Persons are committed to one of the mental health institutes either as the result of a criminal process or a civil process. Persons who have been committed as the result of a criminal proceeding, known as forensic patients, fall in one of three categories: (a) persons found not guilty of a crime by reason of mental disease or defect; (b) persons who have been deemed not competent to stand trial for a criminal charge as the result of mental illness and for whom the court has ordered treatment to restore competency; and (c) persons who are undergoing evaluation to determine competency to stand trial. Persons who are admitted to one of the mental health institutes under a civil process have been found to be dangerous to themselves or others as the result of mental illness or drug addiction. This can be done on an emergency, time-limited basis under a process known as emergency detention, or on a longer-term basis, known as civil commitment.

The Mendota Mental Health Institute is used almost exclusively for the treatment of forensic patients, but also has a unit for civil patients who require geriatric care. The Winnebago Mental Health Institute is used primarily for emergency detention and civil commitment patients.

The Department operates the Mendota Juvenile Treatment Center (MJTC), located on the campus of the Mendota Mental Institute. MJTC is a Type 1 juvenile correctional facility that provides psychiatric evaluation and treatment for male juveniles transferred from the juvenile correctional system whose behavior is highly disruptive and who have not responded to standard services and treatment. MJTC has 29 staffed beds. Since 2016, the Department has operated a 14-

bed unit for adult forensic patients within the MJTC building, in separate space not used for juveniles in that program.

The Sand Ridge Secure Treatment Center (SRSTC), in Mauston, houses the state's civil commitment program for sexually violent persons (SVPs). Since 2018, the Department has also operated units for forensic patients at Sand Ridge, utilizing space not needed for the SVP program. Currently the Department has two such units, with 40 beds, for forensic patients who otherwise would be at Mendota or on an admission waiting list.

Including the 14-bed unit in MJTC and the 40 beds at SRSTC, Mendota has a total capacity of 313 beds for forensic patients.

DISCUSSION POINTS

1. Beginning with the 2013-15 budget, the Legislature has provided additional resources, including funding, positions, and bonding authorization, to expand the state's capacity for forensic patients at the mental health institutes. The following timeline presents a summary of Legislative decisions.

- The 2013-15 budget provided $5.9 million in 2013-14 and $6.7 million in 2014-15 and 73.0 positions to open two 20-bed forensic units in vacant units in the west wing of Lorenz Hall. The new units were designated as admission units for court-ordered competency examinations and treatment to competency. The Lorenz Hall units, which had previously been used for civil patients, were already suitable for this purpose and so required no renovation.

- The 2013-15 biennial budget also provided a $5.7 million bond authorization for the first phase of the renovation Lorenz Hall, involving two 20-bed units in the east wing of the building. The purpose of the renovation was to make modifications necessary for use as secure treatment for forensic patients. As with the west wing units, these units were vacant and had previously been used for civil patients.

- In February of 2016, the Department requested and the Joint Committee on Finance approved a $2.0 million appropriation supplement for Lorenz Hall renovation work. Of this amount, $1.0 million was to complete renovation of the east wing and $1.0 million was to begin planning for the second phase of renovations, involving the west wing and general building improvements.

- The 2017-19 budget provided an $18.0 million bond authorization for the second phase of the Lorenz Hall renovation, involving the west wing of the building, as well as building program space and perimeter security. Patients that had been in that wing were moved to the renovated east wing units.

- The 2017-19 budget also provided $6.0 million annually and 73.0 positions to staff forensic units in temporary space, with the intent that these positions would eventually be used to staff the Lorenz Hall west wing units when the renovations were completed. The temporary space included a 14-bed unit in unused space within the building housing the Mendota Juvenile Treatment Center

(MJTC) and a 20-bed unit at the Sand Ridge Secure Treatment Center.

- The 2019-21 budget provided $3.4 million and 36.5 project positions in 2020-21 to retain the 20-bed forensic unit at Sand Ridge Secure Treatment Center for the duration of the 2019-21 biennium, once the permanent positions provided in the previous budget were deployed to open the final completed units in Lorenz Hall.

- In March of 2020, DHS opened an additional 20-bed unit at Sand Ridge, utilizing the existing staffing, which allowed the Department to create more space at Mendota for COVID-19 isolation units.

2. At or near the end of the 2019-21 biennium, two transitions involving adult forensic populations will occur, in the absence of any changes to funding and position authority in the 2021-23 biennium.

- First, in the summer of 2021, the positions and funding currently used for the 14-bed forensic unit within the MJTC building will be transitioned to the finished west wing of Lorenz Hall. Once this transition occurs, the MJTC unit would be closed and the space will be vacated. [DHS does not expect to need the unit for MJTC use in the biennium.]

- Second, the project positions and funding used to staff the 40 adult forensic beds at Sand Ridge will expire and those units will be closed. The patients currently housed at Sand Ridge would be moved back to Mendota. While a portion of these patients may be accommodated with the opening of the Lorenz Hall west wing, the overall capacity to accept new patients will likely be reduced.

3. Assembly Bill 68 and Senate Bill 111 include proposals to keep the MJTC unit and the Sand Ridge units open for adult forensic patient use. For the MJTC unit, new positions and associated funding would be provided. For the Sand Ridge proposal, permanent positions and funding would be provided to replace expiring project positions and funding. In this case, the funding and positions for the Sand Ridge units would be equivalent to the funding and positions removed under the standard budget adjustments for removal of non-continuing elements.

4. The following table shows the funding and positions for each part of the proposal.

Unit	2021-22	2022-23	Positions
MJTC Unit	$3,028,200	$3,028,200	36.5
Sand Ridge Units	2,654,300	2,654,300	36.5
Total	$5,682,500	$5,682,500	73.0

5. Although the MJTC unit has 14 beds and the Sand Ridge units have a total of 40, each would be staffed with 36.5 positions. DHS indicates that the staffing requirements for the Sand Ridge units are lower than the typical adult forensic units, primarily due to the type of patient placed there. Since establishing the forensic units at Sand Ridge, the Department has used this space for patients with long-term commitments, with relatively stable conditions, and with known treatment needs.

With relatively low patient turnover and lower treatment demands, the staffing needs are lower. The MJTC unit, by contrast, requires the more typical forensic staffing ratio since it is characterized by shorter-term stays (generally competency assessment and restoration to competency), greater turnover rate (more discharges and admissions), and patients with more acute, and less predictable, needs.

6. Although the number of positions is the same for both proposals, the total funding provided under the AB 68/SB 111 for the MJTC unit is higher, primarily because it includes funding for position-related supplies and services. The 2019-21 budget provided ongoing base funding for the supplies and services for the project positions at Sand Ridge, so no additional funding for this purpose would be needed.

7. The following table summarizes the number of staffed beds that are currently in use in comparison with two scenarios: (a) no change to base funding and positions (closure of MJTC and Sand Ridge units); and (b) approval of the AB 68/SB 111 forensic position initiative (maintain MJTC and Sand Ridge open).

Adult Forensic Patient Capacity by Unit,
Currently and Under Two Scenarios

		In 2021-22 and Thereafter:	
Unit	In 2020-21	With no Change to Base Funding and Positions	With Approval of AB 68/SB 111
Lorenz Hall West Wing	0	40	40
Sand Ridge Units	40	0	40
MJTC Unit	14	0	14
All Other Units*	259	259	259
Total	313	299	353
Change from 2020-21		-14	+40

* Includes Lorenz Hall east wing units.

8. With the approval of both proposals, the number of staffed beds for adult forensic use would increase by 40, relative to current levels. If the Sand Ridge proposal is approved, but not the MJTC proposal, the number of staffed beds would increase by 26 from current levels.

9. The proposals to add forensic beds were developed to address a persistent backlog in the number of individuals awaiting admission to Mendota. The number of forensic referrals has been increasing over the past decade, and was the impetus for initiating the Lorenz Hall renovations. Despite this added capacity, the number of individuals awaiting forensic admission has generally ranged between 60 to 80 over the past two years, exceeding the number of new beds that would be

added with approval of both of the forensic positions proposals.

10. The size of the forensic population (including those on the admissions waiting list) is generally outside the Department's control, since the Department is statutorily required to accept all forensic patients committed by the court. In the interest of fulfilling its legal responsibilities to provide prompt treatment in an inpatient setting for forensic patients who require a secure environment, the Department asserts that an increase in the forensic bed capacity is needed.

11. Persons who require inpatient competency evaluations or treatment to competency, but for whom no bed space is available, typically remain in the county jail while waiting for admission. While counties have some capacity to manage persons with mental health conditions, the Department maintains that jails are not appropriate for many persons with mental illness and that a lengthy stay in the jail environment may worsen their condition, ultimately increasing the time needed for treatment. The county jail is responsible for the cost to hold a person with a forensic commitment.

12. The Department identifies several strategies that are used to control the size of the inpatient forensic population. Among these are the development and expansion of the outpatient competency restoration program, which allows the Department to avoid inpatient admissions in some cases, or else shorten the length of inpatient treatment in other cases. The Department also points to its court liaison program, which works to expedite competency hearings with the goal of shortening the length of time that a person must remain at one of the mental health institutes following treatment to competency. Finally, the conditional release program allows persons to be discharged from the mental health institutes and continue treatment in the community if approved by the court. The Department believes, nevertheless, that these measures are not sufficient to reduce the admissions list given the existing staffed capacity at Mendota.

13. The trend toward increasing court-ordered forensic referrals is a nationwide issue. A 2017 study produced by the National Association of State Mental Health Program Directors indicates that most or all states reported seeing such an increase over the previous decade, and that many report that their state psychiatric hospitals are operating at or above capacity. As in Wisconsin, this trend appears to be driven primarily by an increase in the number of individual referred for restoration to competency treatment. The report also indicates that many states are employing the same measures as Wisconsin to address the issue, including outpatient or jail-based restoration to competency services.

14. One potential explanation for the growth in forensic patient admissions is a greater sensitivity by the courts to the degree to which mental illness can inhibit a person's competency to stand trial. In this sense, the trend toward an increase in forensic referrals, while imposing greater costs on the state, may reflect a move toward a judicial system that is attempting to meet its obligations with respect to the treatment of individuals with mental illness.

15. The care of forensic patients is the Department's statutory responsibility. Given the current waitlist for admission already exceeds the total capacity of the proposed units, and has been at that level for at least two years, a case could be made that the state must address the deficiency in its forensic capacity. In this case, the Committee could provide additional positions and funding to maintain forensic units in operation by adopting one or both of the forensic position proposals.

16. When the budget bill provides additional positions, normal practice is to provide the equivalent of nine months of salary and fringe benefit funding in the first year. This accounts for the expectation that an agency would not be able to recruit for and fill those positions immediately upon the start of the fiscal year and so they would be vacant for, on average, the first three months. However, since the permanent positions for the Sand Ridge units would replace project positions that would otherwise expire and these positions are expected to be filled at the time of this transition, AB 68/SB 111 would provide a full year of salary and fringe benefits funding ($2,654,300 annually) for those positions [Alternative 1a].

17. While the MJTC unit is currently staffed with permanent positions, it is expected that those positions will be transitioned to the Lorenz Hall west wing units. Thus, DHS would need to conduct a recruitment to continue to staff the MJTC unit. Following the standard practice for budgeting new positions, salary and fringe benefits could be provided for nine months in the first year. In this case, the MJTC unit alternative would provide 36.5 GPR positions, beginning in 2021-22, and $2,372,500 in 2021-22 and $3,028,200 in 2022-23 [Alternative 1b].

ALTERNATIVES

1. Adopt one or both of the following alternatives to add capacity for adult forensic patients utilizing existing space:

a. Provide $2,654,300 GPR annually and 36.5 GPR positions, beginning in 2021-22, to staff 40 forensic beds in two units at the Sand Ridge Secure Treatment Center. The positions would replace an equal number of expiring project positions and the funding would equal the funding associated with the project positions, which is removed from the base appropriation under a standard budget adjustment.

ALT 1a	Change to Base	
	Funding	Positions
GPR	$5,308,600	36.50

b. Provide $2,372,500 GPR in 2021-22 and $3,028,200 GPR in 2022-23 and 36.5 GPR positions, beginning in 2021-22, to staff a 14-bed unit in the building that houses the Mendota Juvenile Treatment Center.

ALT 1b	Change to Base	
	Funding	Positions
GPR	$5,400,700	36.50

2. Take no action.

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June, 2021 Joint Committee on Finance Paper #376

Care and Treatment Facilities Overtime Reestimate (Health Services -- Care and Treatment Facilities)

[LFB 2021-23 Budget Summary: Page 304, #3]

CURRENT LAW

The Department of Health Services' Division of Care and Treatment Services operates seven residential institutions, including three intermediate care facilities for individuals with intellectual disabilities (Central, Northern, and Southern, hereafter "state centers"), the state's two mental health institutes (Mendota and Winnebago), the Wisconsin Resource Center (WRC), and the Sand Ridge Secure Treatment Center (SRSTC). The funding source for these costs is assigned to GPR and PR appropriations, depending upon the mix of residents. The cost of services for forensic patients and the mental health institutes and for residents at the WRC and SRSTC is funded with GPR, while services for residents at the state centers and for civilly-committed patients at the mental health institutes is funded with PR, using revenue collected from Medicaid and charges levied on counties.

All seven facilities are staffed on a 24-hour and 365-day per year basis. In total, DHS has 4,100.43 authorized positions for the facilities, which includes 1,971.42 GPR positions and 2,129.01 PR positions. Base funding for the facilities (excluding debt service and utilities and other auxiliary functions) is $430,372,600, composed of $218,791,500 GPR and $211,581,100 PR.

State employees receive overtime pay in accordance with standards established under state law and the federal fair labor standards act (FLSA). With some exceptions, these laws generally require that employees are paid 1.5 their normal wage for hours worked exceeding 40 in a work week.

DISCUSSION POINTS

1. The biennial budget typically includes "standard budget adjustments" to modify the base budget to reflect the anticipated ongoing cost of maintaining existing position salary and fringe benefits. These adjustments may be positive or negative, depending upon various factors. The costs that agencies incurred for overtime are, in effect, removed from a program's budget as part of the full funding of salary and fringe benefit costs decision item, and then an amount for overtime costs is added back through a separate overtime standard budget adjustment decision item. Prior to the 2013-15 biennium, the overtime and night/weekend differential adjustments were generally based on actual costs that agencies incurred for these purposes. Since that time, however, agencies have received overtime adjustments based on the amount that they received in the prior year (with minor adjustments to reflect current fringe benefit rates). If no supplemental funding is provided, an agency will receive the same budget for overtime as in the prior biennium, even if actual overtime costs have risen.

2. Assembly Bill 68 and Senate Bill 111 would provide overtime supplements for DHS facilities of $5,827,600 GPR and $3,351,800 PR annually. These amounts are equal to the difference between actual overtime costs that the facilities incurred in 2019-20 and the amount provided under the overtime standard budget adjustment. When added together, the adjustment provided under the overtime standard budget adjustment and the proposed overtime supplement would equal the amount that would have been provided through the standard budget adjustment alone using the calculation method used prior to the 2013-15 biennium.

3. The following table shows, by facility and fund source, the annual overtime funding provided under the standard budget adjustment decision item and the funding increase provided under the proposed supplement, along with the total funding adjustment. The Committee approved the standard budget adjustments in its earlier action on LFB Issue Paper #101.

Annual Overtime Funding for DHS Care and Treatment Facilities, by Source Under AB 68/SB 111

	Standard Budget Adjustments			Proposed Overtime Supplement			Total Annual Overtime Budget		
Facility	GPR	PR	Total	GPR	PR	Total	GPR	PR	Total
Mendota MHI	$1,623,500	$550,600	$2,174,100	$3,164,800	$1,073,300	$4,238,100	$4,788,300	$1,623,900	$6,412,200
Winnebago MHI	504,100	1,660,800	2,164,900	327,000	1,077,300	1,404,300	831,100	2,738,100	3,569,200
WI Resource Center	1,040,700	0	1,040,700	852,700	0	852,700	1,893,400	0	1,893,400
Sand Ridge STC	323,900	0	323,900	1,483,100	0	1,483,100	1,807,000	0	1,807,000
Central WI Center	0	2,628,800	2,628,800	0	1,090,100	1,090,100	0	3,718,900	3,718,900
Southern WI Center	0	2,163,900	2,163,900	0	15,100	15,100	0	2,179,000	2,179,000
Northern WI Center	0	403,600	403,600	0	96,000	96,000	0	473,700	473,700
Total	**$3,492,200**	**$7,407,700**	**$10,899,900**	**$5,827,600**	**$3,351,800**	**$9,179,400**	**$9,319,800**	**$10,759,500**	**$20,079,300**

4. The overtime standard budget adjustment for the facilities' PR-funded costs is closer to current overtime expenditures than the corresponding GPR standard budget adjustment. This is because the 2019-21 budget bill provided an overtime supplement for PR appropriations, based on

2017-18 PR-funded expenditures, an adjustment that has now been built into the overtime standard budget adjustment calculation for the 2021-23 biennium. However, no overtime supplement has been provided since the current method for calculating the overtime standard budget adjustment was established in the 2013-15 budget.

5. Without an overtime supplement, the overtime standard budget adjustment alone would fund 37% of anticipated GPR overtime costs and 69% of anticipated PR overtime costs. These percentages vary by facility. The standard budget adjustments fund 18% of anticipated overtime costs at Sand Ridge and 33% of costs at Mendota, while it covers 61% of costs at Winnebago and 55% at the Wisconsin Resource Center.

6. Each of the Department's facilities generally has its own appropriation (or set of GPR and PR appropriations) that combine the funding for all salaries and fringe benefits, resident food service, medical services, and other non-food supplies and services. If the Department's overtime costs exceed the amount budgeted for that purpose, the Department must allocate funding from amounts budgeted for other purposes within each appropriation. Since the Department, like other employers, is required to pay 1.5 of an employee's normal wage for overtime hours, a shortfall in the amounts budgeted for overtime pay results in an unspecified cut in funding available for other costs.

7. The following table compares the projected overtime shortfall by fund source (the amount of the proposed supplement) with the base budget, by facility. For each facility, the overtime shortfall is expressed as a percentage of the base budget, representing the magnitude of the funding cut to other facility functions that would need to be absorbed to fund overtime costs, if no supplement is provided.

Projected Overtime Shortfall as a Percentage of Base Budget, By Facility

	GPR Budget			PR Budget		
	Appropriation Base	Projected Shortfall	Percentage	Appropriation Base	Projected Shortfall	Percentage
Mendota MHI	$79,255,400	$3,164,800	4.0%	$23,939,400	$1,073,300	4.5%
Winnebago MHI	22,305,500	327,000	1.5	55,076,900	1,077,300	2.0
Sand Ridge STC	56,069,200	1,483,100	2.6	10,400	0	0.0
WI Resource Center	61,161,400	852,700	1.4	20,200	0	0.0
Central WI Center	$0	$0	0.0%	$73,852,400	$1,090,100	1.5%
Norther WI Center	0	0	0.0	12,176,500	96,000	0.8
Southern WI Center	0	0	0.0	46,505,300	15,100	0.0
Totals	$218,791,500	$5,827,600	2.7%	$211,581,100	$3,351,800	1.6%

8. Facilities that provide 24-hour care and treatment must maintain a minimum staffing level regardless of personnel availability. In some cases, overtime hours are necessary to cover facility posts due to position vacancies. When frontline care or treatment positions are vacant, the Department can use the salary and fringe benefits funding that would otherwise be used for that position to pay overtime costs associated with filling vacated shifts. However, there are several reasons why vacancy savings may not be sufficient to fund overtime costs. First, the budget bill includes a turnover

reduction standard budget adjustment, calculated at 2.0% of total base permanent salary costs, to remove a portion of the salary savings associated with position vacancy. Second, since overtime is paid at a 1.5 rate, overtime salary costs exceed vacancy savings. Third, some vacancy salary savings must be allocated to the salary, fringe benefit, and training costs of new employees during the training period.

9. Overtime hours are incurred at facilities for reasons other than filling in for vacancies. At times, employees at the treatment facilities incur overtime to address a crisis, where a shift change would otherwise cause the facility to be understaffed for the situation. In addition, since higher staff resources are often needed at the time of new admissions, an increase in the admission rate, even if it doesn't increase the overall facility population (due to shorter duration stays, for instance), may increase the need for overtime.

10. The proposed overtime supplements are based on the assumption that 2019-20 overtime expenditures are representative of the overtime costs that the Department will incur during the 2021-23 biennium. The Department indicates that disruptions related to COVID-19 likely increased the use of overtime in the final two or three months of 2019-20. Nevertheless, the Department believes that these costs remain a reliable representation of likely overtime costs in the 2021-23 biennium, even if COVID-19 is not expected to significantly affect overtime needs. The 2019-20 overtime expenditures are generally consistent with an overall upward trend in overtime at the facilities. The following table shows the number of overtime hours by facility for the past several years.

Number of Overtime Hours by DHS Facility

	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Mendota MHI	50,755	69,443	96,900	117,917	138,170	161,675
Winnebago MHI	70,551	73,198	80,043	87,420	112,206	87,399
Sand Ridge STC	19,859	35,078	35,503	32,240	38,101	45,578
WI Resource Center	14,255	21,024	22,873	21,427	36,486	22,579
Central WI Center	79,269	99,589	82,317	75,867	98,890	106,318
Northern WI Center	14,124	17,716	14,390	11,647	17,484	16,372
Southern WI Center	57,565	74,817	69,147	62,450	69,787	62,474
Total, All Facilities	306,377	390,865	401,173	408,967	511,124	502,396

11. Although trends in overtime vary by facility, the overall recent trend is towards increased overtime. The Department indicates that the trend toward increased utilization of overtime is largely driven by circumstances over which it has limited control. For instance, increased admissions at the mental health institutes places a strain on staff resources. In addition, over this period the Department faced high employee turnover for many frontline position classifications, requiring more use of overtime by remaining employees.

12. Since the 2015-17 budget, the Department of Corrections has received an overtime supplement to make up the all or at least a portion of the difference between actual overtime expenditures in the prior year and the overtime standard budget adjustment. AB 68/SB 111 would include another such supplement for DOC for the 2021-23 biennium. The funding proposed for the

DOC supplement is based on the same principle and the method for the calculation of the amount is similar to that used for the proposed DHS supplement. If the Committee determines that the DHS facilities should be given a similar funding adjustment to cover actual overtime costs, it could approve the proposal in AB 68/SB 111 [Alternative 1].

13. While the 2019-21 budget bill provided a PR overtime supplement for DHS facilities, the funding for a GPR supplement ($3,878,400 annually) was instead placed in the Committee's program supplements appropriation. DHS submitted a request in June of 2020 for release of these funds for overtime costs incurred in 2019-20, but the Committee did not meet on the Department's request. Subsequently, the Department received approval to use federal Coronavirus Relief Fund moneys for this purpose, on the grounds that a portion of the overtime was unbudgeted costs resulting from COVID-19 pandemic. The Department submitted a request for an overtime supplement for 2020-21 on June 3, 2021.

14. Similar to the 2019-21 budget bill, the Committee could reserve funding for an overtime supplement in the GPR and PR program supplements appropriations, instead of providing an increase to the facility appropriations. In this case, the Department could request a supplement under s. 13.10 of the statutes, based on actual overtime costs [Alternative 2].

15. While DHS has not received regular overtime supplements like DOC, this also means that the DHS facilities have been operating with a budget that is below the fully funded level for the past several years. The consequences of this shortfall on facility treatment programing and operations is difficult to discern since it cannot be known how facility operating budgets would have been structured differently if supplements had been provided on a regular basis. As actual overtime costs increase, the gap between these costs and the overtime budget will grow, forcing larger reductions to other facility functions. If the Committee determines that no overtime supplement should be provided, the Department would be required to continue to absorb any additional overtime costs [Alternative 3].

ALTERNATIVES

1. Provide $5,827,600 GPR and $3,351,800 PR annually to fully fund anticipated overtime costs at the Department's care and treatment residential facilities.

ALT 1	Change to Base
GPR	$11,655,200
PR	6,703,600
Total	$18,358, 800

2. Provide $5,827,600 GPR and $3,351,800 PR annually in the Committee's program supplements appropriation for overtime costs at the Department's care and treatment residential facilities. Under this alternative, the Department could request release of additional overtime funding from the Joint Committee on Finance under s. 13.10 of the statutes.

ALT 2	Change to Base
GPR	$11,655,200
PR	6,703,600
Total	$18,358, 800

3. Take no action.

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June, 2021 Joint Committee on Finance Paper #377

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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Health Services -- Care and Treatment Facilities

LFB Summary Items for Which No Issue Papers Have Been Prepared

Item #	Title
4	Contracted Mental Health Services
6	Food and Variable Nonfood Supplies and Services
7	Mental Health Institutes Funding Split
9	Fuel and Utilities
10	Mendota Juvenile Treatment Center - Funding Transfer From DOC