Case Manager Procedure Manual

Appendix

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1. PDI Format

PREDISPOSITIONAL INVESTIGATION REPORT

Date

Demographic Information:

Name:

DOB:

Birthplace:

SS#:

Case#:

Charges:

Gender:

Ethnicity:

Address:

Phone:

Education:

Religion:

Family:

Marital Status:

Defense Attorney:

District Attorney:

Probation Agent:

Diagnosis:

Medication:

Services:

PRESENT OFFENSE

PRIOR RECORD

FAMILY BACKGROUND

PERSONAL HISTORY

Academic/Vocational Skills:

Military:

Marital Relationship:

Employment:

Financial Management:

Emotional Health:

Physical Health:

Chemical Usage:

Mental Ability:

Religion:

Leisure Time Activities:

Residence History:

Other Agency Involvement:

SUMMARY AND CONCLUSIONS

Investigators Assessment and Conclusions:

Recommendation:

Respectfully submitted

SOURCES OF INFORMATION (separate page)

PDI report distribution:

Original: The Court of Commitment

Copies: District Attorney
Defendant's Attorney
County 51.42 Board Representative
Division of Community Corrections Agent
DDES Conditional Release Specialist
Aftercare Coordinator (if applicable)
Contracted Conditional Release Provider

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

Criteria for requesting an HCR-20 –Violence Risk Assessment

1. The CR program's use of the HCR-20 is primarily targeted for **Direct Court**[1] admissions. Direct Court admissions tend to have less information available to Case Managers, and consequently have less available to contribute to the development of treatment plans inclusive of risk management features.
2. The CR program's use of the HCR-20 is also targeted for long term clients.[2] For example, Misdemeanants with commitments of 6 months or less would barely get through the evaluation/treatment plan process before being discharged from the program.
3. The following historical information will serve as general criteria for determining the use of an HCR-20:

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

   Any two of these would likely be an automatic referral. If just one is present, it can be considered on a case by case basis.

Referral Process

1. Case Managers will identify their reasons for or against requesting an HCR-20 with program managers.
2. Program managers will make a final decision on whether or not a referral will be made for the risk assessment.
3. Cases that are determined to need an HCR-20 will be referred to the evaluator by the program manager.[3]

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[1] This does not preclude program managers from having an HCR-20 done on clients who are mental health institution (MHI) admission cases. Before making this decision, MHIs should be contacted in order to determine if any risk assessments were done while the client was an inpatient.

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

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

4. Monthly invoice: Program managers will include the number of HCR-20 assessments and cost on monthly invoices submitted to CR administrative office.[4] CR Specialists will record these in the Cost Trends spreadsheet.
5. Copy of report sent to CR Specialist.
6. Copy of report sent to DCC agent.

Case Manager Responsibility:

- Following the criteria for determining risk assessment needs, case managers will identify their reasons for or against requesting an HCR-20 with program managers

Criteria for requesting a sex offender risk assessment

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

Historical:

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

Clinical:

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

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

Referral Process

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

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[4] The CR program has budgeted 40 HCR-20 evaluations (in addition to the Fox Valley region) and 10 Sex Offender Evaluations in FY07.

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

Case Manager Responsibility:

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

Conditional Release Program

Suicide Risk Assessment Checklist

Name: ________________________________
Age: __________
Gender: ____________

Part 1

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

Total Part 1:_________

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

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

Total Part 2: _______

Totals Part 1 and 2: ________

Risk Level:

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

Risk Level: ________

Date Completed____________

Date of Next Assessment__________

(updated 5/19/06)

CONDITIONAL RELEASE PROGRAM SUICIDE RISK ASSESSMENT PROTOCOL

When to Conduct a Suicide Risk Assessment (SRA)

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

Conditional Release Program Protocol for Risk Assessment Findings

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

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

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

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

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

III. A score of risk level 3:

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

IV. Scores of 1 and 2 are low risk.

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

Definitions/Guidelines

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

Part One

Previous Psychiatric History:

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

New to Community Programming:

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

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

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

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

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

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

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

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

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

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

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

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

Part Two:

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

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

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

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

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

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

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

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

Environmental Stress:
To what degree does the client feel that events in his/her life are overwhelming, painful, humiliating or presenting insurmountable obstacles? Ask questions related to these overwhelming events (job loss, anniversary of something that causes emotional

disturbance, death of friend, spouse, or other significant person, change in housing status, financial problems, etc.)

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

Client's Assessment of Strengths, Interests, and Goals (CASIG)
Staff Observations and Client Information (SOCI)

The CASIG and SOCI are comprehensive assessments used in the Conditional Release Program to plan individualized treatment, program evaluation, and may be used for research on course/outcomes.

- The assessment involves two versions: Self-Report (CASIG) and Informant (SOCI). Both assess:
  - Community Functioning (Money Management, Health Management, Food Preparation, Friends, Vocational, Transportation, Leisure, Personal Hygiene, Care of Personal Possessions)
  - Medication compliance and side effects
  - Symptoms
  - Problematic community behaviors

- CASIG includes necessary elements for individual service planning.
  - Client's overall goals for improved functioning in five areas: Housing, Money/Vocation, Health, Social, Spiritual, as well as the client's views of what type of support, and how much, will be necessary to achieve each goal
  - Client's desire to improve performance in each area of functioning, medication compliance, each symptom, each problematic behavior
  - Client's quality of live and quality of treatment

- Begin treatment with CASIG and SOCI, creating a service plan based on the results. Repeat the CASIG to evaluate treatment.
- CASIG/SOCI can be used to graph the client's progress – some clients find this very helpful and motivating, particularly if they are more visual than auditory learners.
- Programs may want to summarize CASIGs across program participants for program evaluation.
- Case managers will use the CASIG/SOCI to correlate with other variables to investigate hypothesis
- Individual Service Plan (ISP) development begins with the assessment
  - Client and case manager collaboratively review the CASIG/SOCI and discuss results
  - Set incremental goals that are the steps to achieving overall goals
  - Design the ISP so that it specifies services needed to achieve each incremental goal
- ISPs often identify services that:
  - Teach specific skills necessary for improved functioning
  - Increase independence while improving environmental supports

Institution Letter to Court

Statutory guidelines for recommendations by Institute staff

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

Process for submitting court letters

❖ **Team meeting**

The treatment team must meet to discuss their recommendation to the court regarding appropriateness for conditional release. The recommendations should consider the community resources available, matching patient needs and resources. The Institute social worker, and other institute team members shall include the Conditional Release Program case manager in the formulation of the treatment team's recommendation regarding Conditional Release. The Division of Community Corrections (DCC) agent assigned to the client must be contacted to obtain information and recommendations if the team plans to recommend a conditional release. When the team makes a recommendation, the specific clinical reasoning should be clearly stated.

Case manager responsibility:

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

❖ **Writing the letter**

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

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

- **Application of WSS 980 and WSS 301.45**
  The court letter must reference applicable sex offender laws and processes if the petitioner meets criteria to be considered under these statutes.

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

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

Records Request from MHIs

Provider Letterhead Stationery:

Date:

MHI address:

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

Dear MMHI Health Information Manager:

I am writing to request information from the medical record of *client's name:* . This information will assist me in fulfilling my obligation as a representative of a DHFS/DDES Contracted Conditional Release Regional Service Provider, *agency name:, address:, city:, state:, zip:, phone:*. Pursuant to the contractual agreement between my agency, *initials of agency:* and DHFS/DDES and acting on behalf of the latter, I do not need to provide MMHI/WMHI with a release of information consent form. If you have any questions or concerns about this request, please contact *Paul Jones (301-1243) or Fred Siggelkow* at MMHI or *Lynne Adolphson/Glenn Larson (depending on county of residence),* DDES Community Forensic Services Specialist.

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

DHFS/DDES REGIONAL SERVICE PROVIDER REQUEST FOR REFERRAL INFORMATION: A CHECKLIST

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

1. _____ Original Commitment Order

2. _____ Computation Sheet with Maximum Release Date

3. _____ Criminal Complaint

4. _____ Admissions Face Sheet

5. _____ Initial Assessment

6. _____ Social Service Data Base

7. _____ Therapeutic Services Data Base

8. _____ Psychological Evaluation (if applicable)

9. _____ Copy of most recent Treatment Plan

10. _____ Copy of most recent Physical Exam

11. _____ Copy of Physician Order Sheets

12. _____ Copy of most recent Annual Data Base

13. _____ Other ____

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

14. _____ Conditional Release Order

15. _____ Discharge Summary and Treatment Recommendations

16. _____ Other ____

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

Sincerely,

Name of Person Initiating the Request:

Title of Position:

Mailing Address:

CORRESPONDENCE/MEMORANDUM

State of Wisconsin
Department of Corrections
Division of Community Corrections
3099 East Washington Avenue
Madison, Wisconsin 53704
Phone: 608-240-5311

DATE: April 20, 2006

TO: DCC Community Supervision Staff

FROM: William Rankin
Corrections Services Supervisor

RE: **Notification Procedures for Conditional Release (NGI) and Supervised Release (980) Emergencies**

The Division of Community Corrections supervises persons committed to the Department of Health and Family Services (DHFS) under s.971.17 or s.980.06/.08. DHFS has delegated to DCC complete authority to take action in the event of emergencies, including issuing an Apprehension Request or placing a person in custody. However, in those circumstances, it is important that DHFS be notified as soon as possible. It is also important that DCC staff be aware of differences in statutory requirements that apply to persons supervised under NGI and/or 980 commitments. This memo is intended to clarify procedural differences and provide a reminder for staff who have less frequent involvement with these cases.

Procedures during regular work hours:

If an **agent issues an Apprehension Request or places a NGI or 980 person in custody**, the agent shall immediately notify the Conditional Release (NGI) Specialist or Supervised Release (980) Specialist. If an agent becomes aware that the DCC Monitoring Center has issued an Apprehension Request or authorized detention of a NGI or 980 person, the agent should likewise contact the Conditional Release Specialist or Supervised Release Specialist as soon as possible.

In **NGI cases involving custody**, the agent must file a DDE-5177 Statement of Probable Cause and Petition for Revocation of Conditional Release with the committing court and the public defender within *48 hours* of when the person went into custody, *including weekends and holidays.*

In **980 cases involving custody**, the agent must file a DDE-5536 Statement of Probable Cause and Petition for Revocation of Supervised Release with the committing court and

the public defender within *72 hours* of when the person went into custody, *excluding weekends and holidays.*

Procedures outside regular work hours:

If the **DCC Monitoring Center issues an Apprehension Request for a NGI person**, the Monitoring Center will fax a notice to the agent of record. The Monitoring Center will leave a message on the DCC On-Call Supervisor's office voice-mail.

In the event of a **law enforcement contact with a NGI person**, the Monitoring Center will contact the DCC On-Call Supervisor for a decision about custody. The Monitoring Center will advise the DCC On-Call Supervisor of the person's NGI status. If custody is authorized, the DCC On-Call Supervisor must decide whether it is necessary to authorize the Monitoring Center to contact the agent of record, in order to remain within the statutory requirement for filing the Statement of Probable Cause. In either case, the Monitoring Center will fax a report to the assigned agent's office.

If the **DCC Monitoring Center issues an Apprehension Request for a 980 person**, the Monitoring Center will fax a notice to the agent of record and will leave a message on the DCC On-Call Supervisor's office voice-mail. **In addition, the Monitoring Center will notify the DHFS Community Services Director or the shift Captain at Sand Ridge Secure Treatment Center.**

In the event of a **law enforcement contact with a 980 person**, the Monitoring Center will contact the DCC On-Call Supervisor for a decision about custody. The Monitoring Center will advise the DCC On-Call Supervisor of the person's 980 status. If custody is authorized, the Monitoring Center will fax a report to the assigned agent's office. **In addition, the Monitoring Center will notify the DHFS Community Services Director or the shift Captain at Sand Ridge Secure Treatment Center.**

Contact Information:

Conditional Release (NGI) Specialists:

Glenn Larson
(608) 266-2862
LarsoGP@dhfs.state.wi.us

Beth Dodsworth
(608) 267-7705
DodswBA@dhfs.state.wi.us

Supervised Release (980) Specialists:

Rich Green
(608) 847-4438, ext. 2494
Pager: (608) 376-4839
GreenRD@dhfs.state.wi.us

Dave Kopplin
(608) 847-4438, ext. 2293
Pager: (608) 376-4838
KopplDA@dhfs.state.wi.us

980 Community Services Director

Deb McCulloch
(608) 847-1737
Pager: (608) 376-4757
McCulDJ@dhfs.state.wi.us

Sand Ridge Secure Treatment Center – Central Control
(608) 847-4438

Questions about this or other procedures relating to supervision of NGI or 980 persons may be directed to me at (608)240-5311.

cc. Doug Milsap, DCC Monitoring Center
Deb McCulloch, Linda Harris, DHFS/DDES
Regional Chiefs
Bill Grosshans
Quala Champagne

Sample Memorandum to Regional Licensing Chief

DEPARTMENT OF HEALTH AND FAMILY SERVICES
DIVISION OF CARE AND TREATMENT FACILITIES
(MMHI/WMHI)

MEMORANDUM

To: (DSL Regional Licensing Chief)

From: (MMHI/WMHI Social Worker)

Date: Today's Date

Re: Conditional Release Planning for John Doe, MMHI/WMHI Patient

John Doe, a patient at (MMHI/WMHI), has been granted a conditional release on (date) pursuant to sec. (cite appropriate section of 971.17).

By law, (MMHI/WMHI) and (name of county) county are required to present a conditional release plan within sixty days from the date of the release decision.

We are presently in contact with the following CBRF's about the possibility of placement:

1. (Name and address of facility)
2. (Name and address of facility)

Please contact me at (appropriate institute phone number) if you have any questions.

cc: Forensic Services Specialist, DCTF-AO
Contracted Conditional Release Team

Sample Memorandum to Regional AA

DEPARTMENT OF HEALTH AND FAMILY SERVICES
DIVISION OF CARE AND TREATMENT FACILITIES
(MMHI/WMHI)

MEMORANDUM

To: (DSL Regional AA)

From: (MMHI/WMHI Social Worker)

Date: Today's Date

Re: Conditional Release Planning for John Doe, MMHI/WMHI Patient

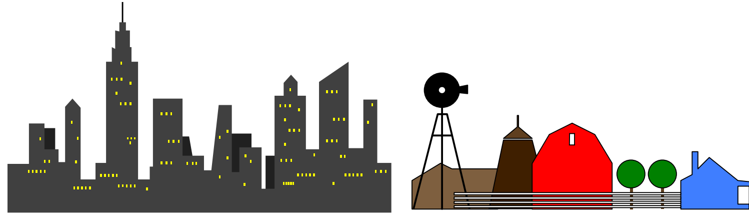
John Doe, a patient at (MMHI/WMHI), has been granted a conditional release on (date) pursuant to sec. (cite appropriate section of 971.17).

By law, (MMHI/WMHI) and (name of county) county are required to present a conditional release plan within sixty days from the date of the release decision.

Please contact me at (appropriate institute phone number) if you have any questions.

cc: Forensic Services Specialist, DCTF-AO
Contracted Conditional Release Team

WORKING WITH FORENSIC CLIENTS IN THE COMMUNITY



SOME SUGGESTIONS FOR MAINTAINING STAFF SAFETY

The Department of Health and Family Services
Community Forensic Services Program

THE CONDITIONAL RELEASE PROGRAM
CASE MANAGER SAFETY TRAINING

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

The safety of staff, clients and the community is a primary concern for our program. Our forensic population is the most challenging group one can work with in the criminal justice field. The majority of our clients are committed to our department for assualtive felonies. The combination of major mental illness, chemical dependency, deficits in education, financial resources and social support are common issues for our clients. The

potential volatility that these factors can contribute to criminal activity are without parallel with any other single group.

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

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

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

KNOWING YOUR CLIENT - *RELATIONSHIP SECURITY*

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

Sources of client information:

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

Dynamic Security: the best security, dynamic security, lies in maintaining a positive relationship with the client. Good trusted communication between the staff and client is the best preventive measure.

Situations leading to increased aggression.

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

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

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

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

OFFICE SAFETY

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

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

FIELD SAFETY

Assessing the area around the clients residence

- Assess the environment around your client's residence before entering. Drive around the block; is it an area where open-air drug transactions occur? Is it an area of active gang activity? Watch for gang-related graffiti. Look for individuals hanging out on porches or steps in the neighborhood. Look for solitary children watching the area (possible lookouts for drug houses). Listen to what your "gut level" comfort is telling you.
- If the residence is set back from the street or in a rural area, be more cautions and aware of activity around you.
- Try to stay clear of bushes or structures that could conceal an individual.
- Attempt to park your car as close to the residence as possible.
- Avoid parking your car close to visual obstructions such as larger vehicles, dumpsters or other objects which prevent you from scanning the area around your car.
- Try to schedule home visits in the morning when there is less general activity in the neighborhood. Avoid Friday afternoons when early weekend party goers may be present.
- Determine how much time you will spend on a home visit. Avoid leaving a residence in the dark.
- Be aware of the presence and quality of the lighting where the home is and where your car is parked.
- Make staff aware of your schedule and expected time of return to the office or make some other arrangement to notify staff when your field operations have concluded for the day.
- Have your cell phone preprogrammed to 911.

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

Assessing the building in which the client resides.

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

Assessing the client and residence before you enter.

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

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

Assessing the client's residence after you enter.

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

Case Manager attire / preparation for home visits.

- Wear clothing that allows you to move freely, shoes you can run in.
- If you are going to wear a tie, use a clip on type that will easily come off if pulled.
- If you are wearing an identification badge on a lanyard, make sure that it has at least two (2) break away connections. Lanyards could be used as a garrote, noose or leash.
- Take only what is necessary. Do not carry purses, bags, or shoulder strap type accessories. Avoid note taking during the interview.
- While walking, always try to keep your hands free.
- Tie up long hair.

- Avoid using your personal vehicle, if possible. License plates are relatively easy to trace to home addresses. Make sure you lock your car.
- When leaving or returning to your car, be alert to your surroundings; watch out for individuals approaching you. As you near your car, watch for any individual who may be hiding behind or near your car. Have your car keys in your hand; lock your doors immediately upon entering your car.
- Consider obtaining an unlisted phone number or at a minimum, do not list your home address.

SAFETY TIP: DISCIPLINE YOURSELF TO REMAIN IN A HEIGHTENED STATE OF ALERT AND AWARNESS DURING HOME VISITS. INTENTIONALLY FOCUS ON AS MANY OF THE ABOVE DESCRIBED SAFETY POINTS AS YOU CAN. PRACTICE THIS ON EACH AND EVERY HOME VISIT UNTIL THEY COME TO YOU NATURALLY, MUCH LIKE DEFENSIVE DRIVING.

DCC Supervision Standards

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

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

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

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

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

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

Psychiatric and Medical Questions to Ask The MHI Treatment Team When Preparing for Client's Conditional Release

In addition to the Coordinated Planning Procedures outlined by DHFS, the MHI discharge checklists and MHI aftercare forms…

General Mental Health/Psychiatric Related Questions to Ask:

1. What are the prescribed medications? How often does the client take prescribed medication? ____________________
2. What are the side effects? Does the client currently suffer from side effects? If so, what is the suggested treatment for such (if any)? ____________________
3. Does the client have blood draw requirements? What is the frequency? ____________________
4. Is the client prescribed PRN's? If so, what are they and how is it suggested that this be managed in the community?____________________

Case Specific Mental Health/Psychiatric Related Questions to Ask:

1. Is there a way to simplify the client's medication regimen (for example, a client that takes medication 4 times a day… can we adjust the dosages to allow for medication to be taken 2 or 3 times daily)?____________________
2. For clients that have a history of medication noncompliance, is it possible to utilize Decanoates/injectables or quick dissolving pills? ____________________
3. For clients prescribed Decanoates/injectables, what is the frequency? ____________________

Medical/Health Related Questions to Ask:

1. What are the prescribed medications? How often does the client take prescribed medication?____________________
2. What are the side effects? Does the client currently suffer from side effects?- If so, what is the suggested treatment for such (if any)? ____________________

3. What are the current medical needs (for example, Diabetes, CPAP machines, etc.)? Are any of these medical needs directly related to their mental health diagnosis or course of mental health treatment?____

4. If a diagnosis is discussed and you are unclear of how it is treated and what is necessary for follow up, ask the treating physician at the institution for the details so we can plan accordingly (for example: Hepatitis). ____

5. Does the client have special dietary needs/restrictions? ___________________________

Case Specific Medical/Health Related Questions to Ask:

1. **Diabetes**: Does the client have access to a glucometer? Does the client know how to check their blood levels/readings using the glucometer? Do we have a prescription for syringes and test strips? How will this client have all of the diabetic needs met in the community? Physician appointment? ____

2. **Sleep Apnea**: How is this being treated? Does the client have a CPAP machine? Does the client know how to use it? Will the CPAP machine be released to the client upon discharge or do we need to have a prescription for such? * Be sure the same or similar brand name is available upon discharge so the client is aware of how to operate the machine. How will this client have all of their needs met for this illness in the community? Follow up physician appointment?________________________________

3. **Prescribed Vitamins, Supplements and non-prescription medication**: What is necessary for the client to continue upon discharge?_______________________________