Mental Health Court Referral Checklist

Forms to be turned in with your referral

☐ **Outagamie County Release**-Please have the potential referral **initial the checked boxes on the first page** and **sign and date the back**.

☐ **Outagamie County Treatment Courts Referral Form-**Please fill out **ALL** sections of this form. Please be sure to have the potential referral fill out the last 3 questions.

☐ **Documentation of the Mental Illness-** Please include **medical record**s which indicate that the potential referral does have documentation of a severe and persistent mental illness.

☐ **Waiver of Ex Parte Contact with the Treatment Court Judge-** Please review with the potential referral and have the potential referral sign and date.

*****Referrals will not be considered until all of the above documentation is submitted. Please send information attention to the Mental Health Court Coordinator via mail or fax. Contact information is below:**

Shayla Russell- MHC Coordinator
Outagamie County Government Center
Health and Human Services-200
320 S. Walnut Street
Appleton, WI 54911
Fax: 920-832-5488
Direct line: 920-968-5729
Email: Shayla.Russell@Outagamie.org

For your Information

Participation Criteria-This lists the eligibility requirements for Mental Health Court; besides needing to have a diagnosis of mental illness, there are several other requirements one needs to meet in order to be eligible for Mental Health Court. Please review this form before you send a referral.

Treatment Conditions- These are the expectations that one will have in Mental Health Court. Please review this with your potential referral to see if, found eligible, they are even willing to participate in court. Mental Health Court is a Voluntary program.

After all the relevant forms are sent to the Mental Health Court Coordinator, the coordinator will screen the referral and present the referral to the team. The Mental Health Court Team will then make a decision regarding acceptance to Mental Health Court. The coordinator will send a letter to the referring party with the final decision. Please contact the Mental Health Court Coordinator with any questions.

Outagamie County Mental Health Court Participant Criteria

Potential candidates must meet the following criteria to be considered for participation in the program:

- Participant must be at least 18 years of age and an established resident of Outagamie County according to the Wisconsin Department of Health and Family Services Residency Manual, as defined by:
    - Physical Presence, Voluntary, Intent to Remain, and Fixed Habitation: stable residence that is fixed on a site and the intent is to remain for the foreseeable future, does not include cars or other motorized vehicles, emergency shelters, CBRF, nursing home, or residential facility where a person's stay is temporary to address acute care needs.
- Participant has been diagnosed with a *severe and persistent* mental illness
    - Adults with a serious mental illness are persons: (1) age 18 and over, (2) who currently or at any time during the past year, (3) have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM)-III-R, (4) that has resulted in functional impairment which substantially interferes with or limits one or more major life activities…All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects. *Federal Register Volume 58 No. 96 published Thursday May 20, 1993, pages 29422-29425.*
- The severe and persistent mental illness **MUST** be the **Primary** diagnosis.
- Participant has been found to be medium to high risk according to the Correctional Officer Management Profiling for Alternative Sanctions (COMPAS) Assessment Tool.
- Participant is likely to benefit from treatment in a community based setting and has some insight into personal involvement with the criminal justice system.
- Participant must have at least 24 months of supervision left with probation/parole.
- Participants should be currently under supervision for a charge with a legitimate potential of at least 6 months jail time if revoked from probation
- Participant agrees to sign all releases of information, as requested.
- Participant agrees to comply with the Mental Health Court's (MHC) Treatment Conditions/Terms of Participation.

If the potential participant meets one or more of the following criteria, he/she will be ineligible for the program:

- Participant has a medical or psychiatric condition causing a degree of impairment or instability such that it would interfere with program participation, treatment and/or functioning.
- Participant is currently under a Chapter 54 guardianship.
- The level of violence of the current offense will be strongly considered as a factor of admission.
- Participants who have a prior violent crime or weapons charge may be considered at the discretion of the Mental Health Court Team.
- Participant has open warrants.
- Participant understands that if the court discovers a participant meets one or more of the ineligibility criteria after admission, that participant may be terminated from the program.

Final eligibility will be determined at the conclusion of the screening process by the Mental Health Court (MHC) Team

OUTAGAMIE COUNTY MENTAL HEALTH COURT
TREATMENT CONDITIONS/TERMS OF PARTICIPATION

1. I understand and agree that being honest and truthful is important for my recovery and my success in the Mental Health Court (MHC). Not being truthful with any member of my treatment team or MHC team could be subject to consequences or termination from the program.

2. I have received the Outagamie County Mental health Court Notice of Representation and understand my rights regarding representation in Mental Health Court.

3. I have received and, knowingly, signed the waiver of ex-parte contact with the Presiding Treatment Court Judge

4. For the purposes of regular Mental Health Court review hearings, I agree to waive my right to have my attorney of record present. I understand that my case may be discussed without my attorney or prosecutor present.

5. If I do not complete MHC or am terminated from the MHC, my case will be referred back to the criminal justice court. I understand that if I enter this program and fail to complete it, I may be ineligible from future participation in this program.

6. I have at least 24 months of Department of Corrections (DOC) supervision left or agree to extend my supervision to 24 months.

7. I understand that what is discussed at Mental Health Court review hearings is part of an open court record and may be disclosed to other participants in treatment court and observers of treatment court, including, but not limited to, members of the public and/or media.

8. I understand that, as the MHC program accepts funding from state and federal grants, my information may be released to state and federal programs for the purpose of grant reporting.

9. I understand and agree that I will be assessed a program fee for participating in the MHC and am responsible for notifying the MHC coordinator of any changes to my income immediately.

10. I will keep ALL appointments with members of my treatment team and will appear in court when scheduled.

11. I will cooperate with all therapy as requested, and once enrolled in a program, I agree to attend all sessions/appointments and will not terminate treatment or programming early without prior approval from the MHC team.

12. I agree to attend an approved pro-social group/activity as directed by the MHC team.

13. I understand that participating in Mental Health Court requires me to be drug and alcohol free at all times. I will not possess drugs or alcohol or drug or alcohol paraphernalia. I will not associate with people who use or possess drugs or alcohol, nor will I be present while drugs or alcohol are being used or consumed by others.

14. I will not enter establishments that primarily serve alcohol, nor will I enter the bar area of any restaurant or other facility.

15. I will not obtain or take any controlled substances not prescribed to me. I will not buy or sell any controlled substances.

16. I will not abuse prescribed or over-the-counter medications, use illegal intoxicants, stimulants, herbal treatments, or mood altering substances.

17. I will not drink alcoholic beverages, including non-alcoholic imitations.

18. As part of my recovery it is important that I remain free from all addictive behaviors, including gambling. I will not enter a gambling facility, nor participate in gambling of any kind.

19. I understand and agree that I may need to participate in drug or alcohol treatment and I will need to provide urine samples when asked by treatment providers and by the MHC team.

20. I will take all medications as prescribed, and will have all my providers complete a Physician's Note for any new medication I am prescribed.

21. I agree to keep the MHC Team advised of my current address and phone number at all times. I understand that my place of residence is subject to MHC approval. I will not leave Outagamie, Winnebago, or Calumet County areas without prior approval from my DOC Agent and the MHC Team.

22. I understand that my property is subject to search by DOC, if my phone is confiscated and has been wiped clean, this will be considered a violation. I am not to delete messages or phone logs from my phone.

23. I will let my case-manager, and MHC know about any medical services I receive outside of my mental health services, including prescribed medications. I will sign a Release of Information (ROI) as the MHC case manager will require, allowing for communication between treatment providers.

24. I understand and agree that a Representative Payee may be appointed initially for benefit income. I understand that I may be asked to participate in budgeting and money management services that will be provided by the MHC case manager.

25. I will participate in vocational programming that may include, but is not limited to competitive employment, supportive employment, community service or other, as directed by my MHC case manager and the MHC team.

26. I will be required to participate in Moral Reconation Therapy (MRT). Moral Reconation therapy is a program that has been shown to reduce the likelihood that I will commit another crime and will give me tools I can use to live a crime free life. Moral Reconation therapy groups will be held once a week.

27. I understand that I may be asked to participate in a specific type of housing program and I agree to follow all of the rules of any housing program I am asked to participate in.

28. I will not obtain or change address or employment without the approval of the MHC team. I will also keep the team up-to-date with any phone number or address changes.

29. I will identify to the MHC team, all persons with whom I have regular contact, and/or whom I anticipate having regular contact with, including but not limited to, friendships, social relationships (romantic or otherwise), family relationships, co-workers, neighbors, sponsors, roommates, proposed roommates, and 12-step or other treatment program associations, throughout the entire period I am in the program.

30. I understand and agree that at any given time in the program, the Mental Health Court (MHC) team has the right to investigate any and all relationships, contact or associations, and require that I discontinue, or limit any relationships, contacts or associations as explained by the MHC team, as a condition of my further participation in the program.

31. I agree to follow all the rules of probation and any and all rules crafted by the Mental Health Court for my treatment.

Outagamie County Department of Health and Human Services
Authorization for Release and Exchange of Health Information

1. _____ _____
Client Name Date of Birth

_____
Street Address City, State, Zip Code

2. AUTHORIZES: Outagamie County Department of Health and Human Services, 320 S. Walnut Street, Appleton, WI 54911 to release protected health information to and receive from:

Outagamie County Mental Health Court Team
Name of Health Care Provider/Plan/Other

_____
Street Address City, State, Zip Code

I authorize the above named agencies/individuals to communicate and exchange written and/or verbal information regarding treatment. I release the above named agencies/individuals from all legal responsibilities that may arise from this act. A uniform charge for reproduction will be assessed. I understand the sub-units of the department, which are subject to HIPAA, may exchange confidential information about a client and with any treatment providers who have a services contract with the department if such information is necessary to enable an employee or service provider to do his or her job, or to enable the department to coordinate services for the client.

Date(s) of Service(s): _____ to _____

3. INFORMATION TO BE RELEASED:

PHI			Non-PHI
☑ ____ Diagnosis	☑ ____ Psychological Evaluations		☐ ____ Child Abuse/Neglect Reports
☑ ____ Discharge report	☑ ____ Treatment/Care Plan		☑ ____ Financial Information
☐ ____ Guardianship records	☑ ____ Substance Abuse Assmnt/Diag		☑ ____ Residential Records
☑ ____ History and Physical	☑ ____ Substance Abuse Dischg Summ		☑ ____ School Academic Records
☐ ____ HIV/AIDS status	☑ ____ Substance Abuse Progress Notes		☑ ____ School Attendance Records
☐ ____ Immunizations	☑ ____ Sustance Abuse Treatment		☑ ____ School Behavior Records
☑ ____ Intake/Initial Assessment	☐ ____ X-Ray/Ultrasound Report		☑ ____ School Pupil Service Records
☑ ____ Laboratory results	☐ ____ Pick Up Medications		☑ ____ Vocational Records
☑ ____ Test Results	☐ ____ Check On Appointments		☑ ____ Law Enforcement Records
☑ ____ Progress Notes	☑ ____ Discuss Case Specifics		☑ ____ Court Records
☑ ____ Psychiatric Records/Notes			☑ ____ Other – Specify any information needed to coordinate services

In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

✓ Mental Health	_____ Developmental Disabilities
✓ Alcoholism	✓ Drug Abuse
_____ HIV/AIDS	_____ Sexually Transmitted Diseases
_____ Other (specify): _____	

4. PURPOSE OF DISCLOSURE: (Check applicable categories)

✓ Further Medical Care	_____ Personal
_____ Insurance Eligibility/Benefits	_____ Changing Physicians
_____ Legal Investigation or Action	_____ Other (Specify): _____

5. I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

6. Your Rights with Respect to this Authorization:

- **Right to Inspect or Copy the Health Information to Be Used or Disclosed.** I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Privacy Officer at the Department of Health and Human Services, 410 S. Walnut Street, Appleton, Wisconsin, 54911.

- **Right to Receive Copy of This Authorization.** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

- **Right to Refuse to Sign this Authorization.** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above, whom I am authorizing to use and/or disclose my information, may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

- **Right to Withdraw this Authorization.** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawl, I may contact the manager of the division through which I am seeking or receiving services, or the Privacy Officer at the Department of Health and Human Services, 410 S. Walnut Street, Appleton, WI 54911. I am aware that my withdrawl will not be effective as to use and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made based upon this authorization.

7. **Disclosure of Direct or Indirect Payment Received by Any Person or Organization Authorized to Use or Disclose my Health Information.** I understand that Outagamie County Department of Health and Human Services will not be receiving any direct or indirect payment in connection with the use or disclosure of my health information.

8. **Expiration Date:** This authorization is good until the following date(s):_____
Or event(s) (specify event) Completion of Mental Health Court

9. **Not to the Patient and Receiving Agency:** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CRF Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CRF Part 2. A general authorization or the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature: _____ Date: _____

If signed by person other than client, state relationship and authority to do so.

Client Name: _____

Client is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Custodial Parent ☐ Authorized Legal Representative
☐ Legal Guardian ☐ Power of Attorney for Health Care
☐ Executor of Estate of Deceased

A PHOTOCOPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL.

2/14/2017

OUTAGAMIE COUNTY
TREATMENT COURTS REFERRAL

Treatment Court Applying For:

- ☐ Drug and Alcohol Treatment Court
- ☐ Branch 2 Treatment Court
- ☐ Mental Health Court
- ☐ Veterans Treatment Court

Form Completed by:_____

Phone Number:_____

Referral Date:_____

Outagamie County Resident: ☐ Yes ☐ No

Applicant Name:	Telephone #:	DOB:	Address:
Employment Status:	Last 4 digits of SSN:	Race/Ethnicity:	Referral Source:
Gender Identity:	Language:	COMPAS Score:	Number of Children:
Level of Education:	Insurance/VA Healthcare:	Marital Status:	Housing Type:

Current/Pending Charges and Case Number:	For ATRs- Current Conviction:
Next Scheduled Court Date: Branch:	Type of Hearing (pre-trial, trial, sentencing, etc.):
Current AODA/Mental Health Treatment:	Diagnosis AODA and/or Mental Health:
Previous Participation in Treatment/Diversion Court: ☐ Yes ☐ No Location:	Supervision Status: Agent:
Previous AODA Assessment: ☐ Yes ☐ No Date Completed: Agency:	Served in the US Armed Forces, National Guard, or Reserves: ☐ Yes ☐ No Dates Served: Branch: Discharge:

OUTAGAMIE COUNTY
TREATMENT COURTS REFERRAL

Criminal History

DATE	OFFENSE	LOCATION	DISPOSITION

Reason for Referral (pending charges, term of probation, ATR) and explanation of how and why criminal behavior is related to diagnosis:
Observable Characteristics of Mental Illness/Distress/AODA:
Previous Drug or Alcohol Treatment (i.e. detox, residential, outpatient, etc.):
Previous Mental Health Treatment (i.e. hospitalization, residential, outpatient, etc):
General Health Issues/Concerns or Service Connected Disability:

OUTAGAMIE COUNTY
TREATMENT COURTS REFERRAL

To be filled out by the applicant:

1. Why do you want to join Treatment Court?

2. What goals would you like to accomplish while in Treatment Court?

3. What are you willing to do to accomplish the above goals?

WAIVER OF EX PARTE CONTACT
WITH TREATMENT COURT JUDGE

I understand that prior to my acceptance into a treatment court program, a team of professionals, including the presiding treatment court judge (s), will meet to discuss my case and determine if I am appropriate for participation.

I am making a decision to permit that contact and allow communications between the treatment court team and the Judge without myself or my attorney present.

Further, if I am accepted into a treatment court program, the treatment court team, including the Judge, will meet to discuss my progress. Decisions regarding programming and other recommendations will arise out of these discussions. I understand that these discussions will occur without either myself or an attorney representing me present.

_____

Participant Signature Date

_____

Witness Date