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Chapter 51 committee
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Issues that need to be addressed:

1. Reducing numbers of ED's
2. Reducing liability fears
3. ED's as a tool for engagement
4. Reducing use of handcuffs
5. Reducing involvement of law enforcement
6. When in danger, the right to be emergently detained
7. Appropriate increase of Treatment Director detention
8. Limited emergency medicine physician authority; EMTALA reminder
9. Sunset of the 24-hour ED & TDS
10. Amending *Delores M.*

1. **Reducing numbers of emergency detentions (ED).** If not read from the beginning, Chapter 51 appears to allow for emergently detaining any individual with an appropriate diagnosis and high risk, not taking into account the many people that meet these two criteria but are willing and able participants in treatment and do not need to be ED'd. Chapter 51's lead paragraphs clearly recommend "…the least restrictive treatment alternative appropriate to their needs…" [51.001(1)]; and: "To protect personal liberties, no person who can be treated adequately outside of a hospital, institution or other inpatient facility may be involuntarily treated in such a facility." [51.001(2)] But readers may be unaware that voluntary hospitalization is a less restrictive alternative than an ED, and anyone reading about emergency detention in 51.15 would not see language reiterating the basic principle of "least restrictiveness" enunciated in the opening lines of Chapter 51. It would be very helpful for 51.15 to open with this, and to specifically to limit the use of involuntary evaluation or treatment to those

individuals who decline help or whose cooperation and engagement are not certain enough given their level of risk. The recently enacted, new requirement of getting approval for an emergency detention before it is written does afford some of this protection. However, training levels vary around the state, and Chapter 51 would be strengthened by an explicit statement that a) it *should not* be invoked for persons who are voluntary enough given their level of risk, and b) it *should* be invoked only when it is the least restrictive means of ensuring that a person at significant risk receive appropriate psychiatric care.

2. **Reducing liability fears when not recommending (or when discontinuing) an emergency detention.** A litigious environment in this country fosters excessive fears about liability, resulting sometimes in overly defensive medicine and law enforcement practices. Section 51.15(11) on liability clearly protects the evaluator who makes an ED decision in good faith, yet many evaluators continue to err too far on the side of safety. 51.51 (11) could help them by referencing the contemporary view that acceptance of some risk is the necessary price of successful treatment.

3. **Emergency detentions are best viewed as a temporary tool for engagement and should be discontinued as soon as they have served their purpose.** In most cases, emergency detentions can only ensure safety in the short term; if the individual's cooperation and collaboration are not obtained, they are temporary measures at best. In cases where the crisis is only time-limited, that is all that

may be necessary: to keep a person safe until an emotional storm blows over. But the problems of most people who become high risk and need emergency detention are severe and persistent, and in these cases the more important function of an ED is to engage a person in treatment. In fact, it is a common occurrence for someone to be taken involuntarily to a hospital, only to have him end up signing in voluntarily and asking for his doctor's help. A good outcome like this is made more likely when the whole process of an ED is non-punitive, engaging and as inoffensive as possible. One might also say, that coercive policy is best which coerces least. Chapter 51 could articulate the view that involuntary commitments should be as brief as possible, and that failing to discontinue a person's involuntary status once it has served its purpose begins to defeat that purpose. Currently, many law enforcement and some inexperienced treatment professionals feel they are doing something wrong by discontinuing an emergency detention before the 72-hour mark (or 24-hour mark in Milwaukee). Chapter 51 can correct this common misconception.

4. **Reducing use of handcuffs with emergency detentions.** The use of handcuffs is a significant problem in our state. Chapter 51 might explicitly make the following points: a) most individuals with mental health problems are not predatory or impulsively combative. Handcuffs are not needed for most emergency detentions, and their use should **not** be routine; b) Handcuffs should only be used for individuals who are volatile or aggressive or who are simultaneously on a criminal police hold; c) The unnecessary use of handcuffs creates hostility,

thereby increasing danger to law enforcement and caregivers, not decreasing it; d) Many non-violent individuals with mental health problems are trauma victims who will be re-traumatized by handcuffing; e) Unnecessary handcuffing increases distrust of authority figures, including treatment providers, thereby damaging the treatment alliance and increasing recidivism.

5. **Reducing involvement of law enforcement.** Police should retain ED authority and continue to exercise it when they are first responders or when the use of force is required. When they are first responders, they are closer to the evidence supporting the use of detention, and they should continue to write the ED in those cases. But if an individual needing emergency detention is with a mental health professional and is not dangerous or combative, there should be no reason for law enforcement to get involved. Some police officers have outstanding mental health skills, but some of them do not, and the unnecessary involvement of law enforcement has the potential to alienate patients from treatment in some of the same ways as handcuffs. Currently, we authorize certified mental health practitioners to approve ED's that police write. Why shouldn't we allow them to initiate an appropriate detention themselves, as authorized practitioners do in other states? Proper oversight could be achieved by having each case reviewed in real time by a psychiatrist or psychologist. Transportation of the ED'd individual needing care in other states is by ambulance, not police. Law enforcement is only called in for difficult situations, as when the use of force is required.

6. **When in danger, having a legal right to be emergently detained.** Chapter 51 might need to clarify this point, because professionals who advocate for this right are as much patient advocates as professionals who advocate for the right to refuse treatment. When an individual is not thinking clearly and his illness causes dangerousness or inability to care for self, he has a right to expect that competent law enforcement officers and professionals will protect him. In fact, he can come back later and seek legal recourse if they do not. In an attempt to make commitment proceedings less adversarial and more collaborative, Chapter 51 should clarify that individuals in our society have both the right to refuse treatment and the right to receive it involuntarily in defined emergency situations, and that protecting one right sometimes involves temporarily denying the other. Some patient advocates misconstrue Chapter 51 to be based solely on the principle that, under certain circumstances, society has a right to control the individual. But this is the lesser of Chapter 51's purposes, and treatment approaches based on it do not fare well as a rule. It must be appreciated that competent treating professionals routinely weigh both the legal criteria and the clinical merits of voluntary versus involuntary treatment. They uphold a person's right to refuse treatment, on both moral and clinical grounds, and they gladly lift an unneeded emergency detention or steer worried family and friends or other parties asking for commitment toward more effective interventions. Unfortunately, when a commitment proceeding must go to court, the expert in favor of commitment is portrayed as being against his patient, not for him. This is inaccurate. He is possibly against what the patient is currently asking for, but his

willingness to state his opinion about the need for life-saving treatment is an act of advocacy. Given the premium placed on engaging troubled and skeptical patients, better wording in Chapter 51 might help with this. It is true that legal proceedings such as these are by definition an adversarial process. But reframing the debate in some way might be able to make them more collaborative and could make it less likely that the person in need of treatment would perceive his "advocate" defender as neglectful or his clinical provider as his adversary.

7. **Appropriate increase of Treatment Director authority to detain.** Currently, Chapter 51 requires authorized mental health clinicians to approve ED's written by police. Above (#5), it is suggested that these clinicians have ED authority without involvement of police. Currently, Chapter 51 also allows doctors to exercise emergency detention authority without police when working in a psychiatric hospital or psychiatric inpatient unit. (Their non-doctor "designees" also have this power). Doctors do this by writing what is referred to as a Treatment Director's Affidavit or "TDA". Clearly, doctors' training and judgment does not leave them when they leave the psychiatric hospital to practice in another setting, such as an office or a medical ward, yet Chapter 51 prohibits them from filling out a TDA in these places. This is illogical, and, in fact, most states do allow psychiatrists and psychologists to initiate a mental health hold in any setting. For example, Illinois allows for it, provided there is a second opinion done within 72 hours. If a mid-level mental health practitioner in Wisconsin has the authority to advise a police officer on ED's, it is hard to argue that

psychiatrists and psychologists are incapable of handling the same authority. To guard against inexpert use by doctors unaccustomed to evaluating patients with elevated risk, and to guard against private practitioners who might misuse ED authority to over-utilize state and county facilities, it would be advisable to establish a uniform process of appropriate training, certification and swearing in.

8. **Limited emergency medicine (EM) physician authority to detain.** Our committee heard testimony on both sides of this issue. Some EM physicians are quite experienced with psychiatric emergencies, and some are overly risk averse. There are several approaches to consider: 1) offer EM physicians the same specific Chapter 51 training and certification that we would offer to treatment directors not working in a psychiatric facility or not county-based. 2) Offer them ED authority with the same proviso as there is with police that the ED be approved by county mental health. This would work best if we also require county mental health to have a doctorate-level clinical director on call to review cases that were in dispute. 3) Give emergency physicians limited authority to transport a voluntary person needing and requesting hospitalization to a psychiatric facility. This addition would really help to cut down on emergency detentions. EM physicians are all in favor of voluntary admissions in appropriate situations, but a continual concern they express around the country is, what if the person changes his mind after being discharged from the emergency department? What if he won't refuse to sign in once he arrives at the hospital or get out of the car before he gets there? Giving emergency doctors this limited authority would

not only reduce unnecessary ED's, it would also reduce patients' waiting time for a psychiatric hospital bed: it is generally easier to find a hospital to accept a person if he has not been ED'd and been incorrectly labeled as involuntary and, by implication, uncooperative. (Incidentally, EM physicians are on occasion also afraid to refer a voluntary person for a voluntary psychiatric hospitalization because they think the person can sign out after he signs in. Appropriate training reassures them that once a person is admitted, the treatment director can use the TDA if the individual is in danger and requesting to leave against medical advice.

Another reason to consider expanding the Treatment Director detention authority was summed up in compelling public testimony about tragic consequences due to delaying emergency detention. Just as EM physicians' judgment may be influenced in favor of emergency detention by concerns about malpractice action, so too can county mental health clinicians' judgment be influenced away from emergency detention by concerns that their county may have to pay for any hospitalization that they approve.

EMTALA: EM physicians are sometimes under the misconception that they cannot provide involuntary emergency treatment in the ER without an emergency detention. They may be unaware that the federal Emergency Medical Treatment and Active Labor Act (EMTALA) gives them this authority. EMTALA requires that EM physicians evaluate and stabilize all emergency medical conditions, including emergency psychiatric conditions. This provides EM doctors with the legal protection they need; by referencing

EMTALA, Chapter 51 could help to eliminate ED's that are written just for the sake of emergency treatment.

9. **Sunset the 24-hour ED & Treatment Director Supplement ("TDS").** [This issue pertains only to counties with a population of 500,000 or greater: Milwaukee, and soon, Dane, pop. 491,357 (2009 figure)]. There are three good reasons to sunset the 24-hour ED & TDS, which public testimony did not adequately address. First, the need for them have been replaced and superseded by the new requirement that ED's be evaluated and approved before they are written. Second, hospitals now have internal regulations requiring doctors to evaluate patients within the first 24 hours, rendering the relevance of the TDS moot in routine cases. Third, in a significant minority of cases, the 24-hour ED & TDS can impose an unreasonable burden on the patient or endanger patient safety. This was not the intent of the law, but in actual practice this is what happens. Consider the stories (altered to protect confidentiality) of Ms. A, Mr. B, and Mr. C:

   A) *Routine medical clearance*: Ms. A, a 42 year-old teacher, takes an overdose and is rushed to an emergency department. She is successfully stabilized medically, but regrets that her suicide attempt failed and intends to try again. She declines the offer of voluntary psychiatric hospitalization and is ED'd. She has commercial insurance and the emergency physician would like to transfer her to a hospital in her HMO network, but the private hospital cannot take her till her ED is extended with a TDS. Only County psychiatrists and psychologists can do this, but it must be done in person, and their availability to cover all of Milwaukee County around the

clock is limited. As a result, more often than not, Ms. A has to be transferred to PCS just to have a TDS placed on her, after which she can be transferred from PCS to a private hospital. Between the transfer to PCS (which requires doctor-to-doctor and nurse-to-nurse transfer calls), the evaluation in PCS, the telephone referral to the private hospital, the second set of doctor-to-doctor and nurse-to-nurse transfer calls, then finally the transport to a private facility, this process can take all day. If Ms. A was ED'd in the evening, she will be kept up all night and may not make it to the network private hospital till morning. This unfairly burdens her and uses up valuable police and mental health resources. If her emergency detention was a 72-hour detention like it is in all other counties in Wisconsin (and the rest of the country), she could have been transferred directly to a private hospital. As mentioned, concerns about her not having her detention reviewed within 24 hours are addressed by internal hospital procedures requiring that a psychiatric evaluation occur within 24 hours.

B) *Waiting list case*: Consider a similar clinical scenario, but for a 28 year-old painter, Mr. B. He is taken to an ER for an overdose. A clinical assessment reveals sever depression and the need for hospitalization. He declines and is ED'd. His insurance directs him to a network hospital, and he must be TDS'd first, only this time the Mental Health Complex and its emergency room (PCS) are at capacity and on diversion. Cases referred to

it are placed on a waiting list. Patients in Mr. B's position are usually made to wait hours and hours in the emergency department. A county mental health practitioner on the Mobile Team will see Mr. B within the first 24 hours, but that person is usually not a doctor and is not qualified or authorized to write a TDS. If Mr. B waits longer than 24 hours, his emergency detention expires. A valid TDS is no longer possible, and the opportunity to be transferred to a private hospital is lost. Once the Mental Health Complex goes off diversion and waiting list status, the court does allow a transfer, and Mr. B will go through the slow and cumbersome transfer process to the County's PCS that Ms. A went through. Upon arrival, a psychiatrist will see him within an hour or two to determine if he needs hospitalization. If not, he goes home. If so, a private hospital will not accept him because of his flawed legal status, but the court allows for his admission to the Mental Health Complex on the expired ED/invalid TDS until he goes to his probable cause hearing in 72 hours. At that point, the ED/TDS is dismissed and Mr. B is allowed to leave the hospital, better or not, unless he has revealed the seriousness of his illness to the inpatient doctor. If he has, and if he still declines treatment, a TDA may be placed on him at this time. As in Ms A's case, if Mr. B's emergency detention were valid for 72 hours, his long waiting process could have been avoided. The TDS-type evaluation would occur routinely at the private hospital within 24 hours, as required by internal hospital policy. Unlike Ms. A's case, however, even under the current system of a 24-hour ED, Mr. B has

lost his chance to be routed to PCS in time for a valid TDS and referral back out to a private hospital. Paradoxically, the longer ED time of 72 hours reduces the delay of treatment.

C) For Mr. C, see below.

10. **Amend *Delores M.*** [*Delores M.* is the 1998 court ruling that starts the clock on an emergency detention when an individual is taken to any treatment facility, including a medical hospital. Prior to 1998, the clock started when the person arrived at the psychiatric facility]. By itself, and especially taken together with the 24-hour ED & TDS requirement, *Delores M.* has unforeseen and unintended consequences that are potentially devastating. Consider this Milwaukee case: Mr. C, a 19 year-old young man with schizophrenia, is caught molesting the 10 year-old friend of his sister. Afraid of jail and what it might hold in store for him, he attempts suicide by gunshot wound to the head, but survives. He is ED'd and hospitalized in a coma. A doctor from the County goes to the hospital in time to do the Treatment Director Supplement. While in a coma, Mr. C is evaluated and has his rights read to him. However, a postponement of the probable cause hearing in three days is denied, he misses the hearing, and his ED/TDS is dismissed for failing to be produced in court. Two weeks later, he awakens from his coma and is medically cleared for transfer to a psychiatric hospital. However, his legal status is now voluntary. He says he doesn't have any problems and he doesn't want treatment. Whether he is at high risk for suicide or sexual assault, Mr. C must be released. If the police had waited till he was awake and medically cleared before ED'ing him, the dangerous acts

that took place more than a week ago could not be used as the basis of an ED. In the current scenario, the police may be called to re-ED him, but if Mr. C hides his problems and psychopathology the same restriction on using dangerous events older than a week as evidence applies. As with Mr. B (#9 B), had Mr. C not been TDS'd, Milwaukee courts would have allowed his transfer to the Mental Health Complex on his expired ED. The court would also allow a doctor at the Mental Health Complex to fill out a TDS and admit him to the hospital, knowing that when he went to his probable cause hearing, the ED/TDS would be summarily dismissed and he would again be free to go. The inpatient doctor treating Mr. C would have the option at that point of filling out a TDA (Treatment Director's Affidavit), but only if Mr. C had not concealed his mental illness during those three days in the hospital. The suicide attempt and sexual assault as evidence of dangerousness are not admissible in court both because they were attached to the dismissed ED and because they are older than a week.

Clearly, although it is carefully written, *Delores M.* does something other than what it was intended to do, which is to protect due process and eliminate open-ended commitment of a person who is able to receive psychiatric evaluation and treatment at the same time that he is being medically cleared for illness or injury in a medical hospital. In some cases, this is a very good thing: a person might be ready for outpatient follow-up after his medical hospitalization is completed. But *Delores M.* doesn't take into account the possibility that the patient may be unconscious or not well enough medically to participate in his psychiatric care, and it doesn't take into

account the vast difference of psychiatric programming in a medical hospital versus a psychiatric hospital. In a medical hospital, a patient is fortunate if can see a psychiatric or mental health consultant once or twice. Many hospitals don't even offer that. In comparison, in a psychiatric hospital there are psychiatric nurses, family therapists, group therapists, psychologists, and psychiatrists present every day, and each day would offer some evaluation and treatment.

Delores M. is extremely problematic in its current form. A reasonable modification protecting both the right to refuse treatment and the right to receive emergency treatment would be to start the clock on the emergency detention when the individual is medically cleared, but if medical stabilization occupied more than 72 hours, then require that the individual be evaluated at the medical hospital for appropriateness of emergency detention face-to-face within 24 hours of being pronounced medically stable, before a transfer to a psychiatric facility is effected.

JB
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