WISCONSIN LEGISLATIVE COUNCIL STAFF MEMORANDUM

Memo No. 1

TO: MEMBERS OF THE SPECIAL COMMITTEE ON REVIEW OF EMERGENCY DETENTION AND ADMISSION OF MINORS UNDER CHAPTER 51

FROM: Laura Rose, Deputy Director, and Richard Sweet, Senior Staff Attorney

RE: Potential Recommendations for the Committee's Consideration in the Areas of Emergency Detention, Treatment of Minors, Involuntary Commitment, and Other Mental Health Issues

DATE: November 8, 2010

This Memo summarizes and briefly discusses potential recommendations for the committee's consideration regarding emergency detention, treatment of minors, involuntary commitment, and other mental health issues. The Memo incorporates suggestions that have been made at previous meetings of the committee or by follow-up correspondence from committee members or others. It includes suggestions that can be dealt with legislatively, either through draft legislation or recommendations to government agencies or Congress. The Memo is intended only as a starting point for discussion, and committee members should feel free to suggest other items that are not included.

EMERGENCY DETENTION

This portion of the Memo discusses potential recommendations related to emergency detentions.

Who May Be Detained

Current statutes provide that a person may be detained if there is cause to believe that he or she is mentally ill, drug dependent, or developmentally disabled and that the person evidences any of the circumstances set forth in four standards specified in the statutes, which state as follows:

> 51.15 **(1)** (a) 1. A substantial probability of physical harm to himself or herself as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm.

2. A substantial probability of physical harm to other persons as manifested by evidence of recent homicidal or other violent behavior on his or her part, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt or threat to do serious physical harm on his or her part.

3. A substantial probability of physical impairment or injury to himself or herself due to impaired judgment, as manifested by evidence of a recent act or omission. The probability of physical impairment or injury is not substantial under this subdivision if reasonable provision for the individual's protection is available in the community and there is a reasonable probability that the individual will avail himself or herself of these services or, in the case of a minor, if the individual is appropriate for services or placement under s. 48.13 (4) or (11) or 938.13 (4). Food, shelter or other care provided to an individual who is substantially incapable of obtaining the care for himself or herself, by any person other than a treatment facility, does not constitute reasonable provision for the individual's protection available in the community under this subdivision.

4. Behavior manifested by a recent act or omission that, due to mental illness or drug dependency, he or she is unable to satisfy basic needs for nourishment, medical care, shelter, or safety without prompt and adequate treatment so that a substantial probability exists that death, serious physical injury, serious physical debilitation, or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for this mental illness or drug dependency. No substantial probability of harm under this subdivision exists if reasonable provision for the individual's treatment and protection is available in the community and there is a reasonable probability that the individual will avail himself or herself of these services, if the individual may be provided protective placement or protective services under ch. 55, or, in the case of a minor, if the individual is appropriate for services or placement under s. 48.13 (4) or (11) or 938.13 (4). The individual's status as a minor does not automatically establish a substantial probability of death, serious physical injury, serious physical debilitation or serious disease under this subdivision. Food, shelter or other care provided to an individual who is substantially incapable of providing the care for himself or herself, by any person other than a treatment facility, does not constitute reasonable provision for the individual's treatment or protection available in the community under this subdivision.

The following suggestions were made regarding who may be detained:

- **Emergency detention should not be used for persons who are seeking voluntary treatment, but only for persons who are high-risk and uncooperative.** If a recommendation such as this is included in the statutes, it would be necessary to describe

those persons who are "high-risk," as opposed to those who meet one of the four standards set forth above.

- **Emergency detention should not be used for persons who have only dementia.** As noted above, the statute applies to persons for whom there is cause to believe that they are mentally ill, drug dependent, or developmentally disabled. The term "developmental disability" is defined in current statutes to specifically exclude dementia. Under s. 51.01 (5) (a), "developmental disability" does not include "…dementia that is primarily caused by degenerative brain disorder." The term "mental illness" is defined to mean "…mental disease to such an extent that a person so afflicted requires care and treatment for his or her own welfare, or the welfare of others, or of the community." Therefore, while the definition of the term "developmental disability" explicitly excludes dementia, the definition of the term "mental illness" does not do so.

Who May Detain

Current statutes provide that a law enforcement officer or a person who may take children or juveniles into custody under ch. 48 or 938, Stats., may take any individual into custody if that person has cause to believe that the individual is mentally ill, drug dependent, or developmentally disabled, and meets one of the four standards set forth above. The person's belief must be based on a specific recent overt act or attempt or threat to act or omission by the individual that is observed by the person or that is reliably reported to the person by any other person.

The following suggestions were made regarding who may detain individuals on an emergency basis:

- **Qualified physicians who have completed a training and certification process should be allowed to initiate emergency detentions in hospital emergency rooms and other medical settings.** In discussing this potential recommendation, the committee might consider who would develop a training program, what the contents of the training program should be, and who would certify physicians to undertake this.

- **Psychologists, psychiatrists, and other trained mental health professionals (e.g., psychiatric social workers, psychiatric nurses, and alcohol and other drug abuse or AODA counselors) should be allowed to place individuals on an emergency basis.** The same questions relate to this potential recommendation as relate to the previous potential recommendation. Namely, who would develop the training program, what the contents of the training program should be, and who would certify those persons. Additionally, a question arises as to whether these persons would be allowed to detain on an emergency basis only those individuals who are already in a medical setting.

Screening of Detainees

Current statutes provide that a detainee be transported for detention "…if the county department of community programs in the county in which the individual is taken into custody approves the need for detention, and for evaluation, diagnosis, and treatment…." Testimony at one of the committee's

meetings indicated that in Milwaukee County, the approval for detention comes through use of a treatment director's supplemental statement (TDS), as described below.

The following suggestion was made regarding this screening:

- **The use of the county department of community programs for screening of persons who are detained on an emergency basis should continue after they have been detained.** A question the committee may wish to consider, if it pursues this suggestion, is how the department of community programs would be involved in ongoing screening of the detainee once he or she is in detention.

Uniformity and Quality Standards for Emergency Detention

The following suggestions were made with regard to use of emergency detention in the various counties:

- **The statutory provisions in ch. 51 relating to emergency detention should be applied uniformly throughout the state.** One mechanism for moving toward that goal would be the use of a **statewide ombudsman for emergency detention**. A question that arises is whether such an ombudsman would be used in place of the approval of the county departments of community programs, or be used to supplement the activities of those county departments by providing advice to the counties where requested.

- **A regional mental health system should be adopted for emergency detention. In addition, some of the funding that is currently used for the state's two mental health institutes should be used for smaller, regional emergency detention facilities.** The suggestion was made that the statute dealing with the regional trauma system could be the model for the regional mental health service system. Section 256.25, Stats., requires the Department of Health Services (DHS) to develop and implement a statewide trauma care system, with the advice of the Statewide Trauma Advisory Council. As part of the system, DHS is required to develop regional trauma advisory councils.

- **DHS or the Department of Justice should promulgate rules or best practice guidelines for emergency detention.**

- **The state should create voluntary county-based quality and process measures for emergency detention, similar to quality measures that are used for medical hospitals.** If the committee decides to pursue this recommendation, a state agency, such as DHS, could be required to develop the quality and process measures for emergency detention.

Transportation of Detainees

Current statutes provide that the law enforcement officer or other person authorized to take a person into custody must "…transport the individual, or cause him or her to be transported, for detention…."

The following suggestions were made regarding the transportation of detainees:

- **Eliminate the use of police cars and handcuffs for detainees.** A question arises of whether a provision such as this should be statutory or should be included in the agency rules or best practices guidelines described above.

- **Allow persons other than law enforcement personnel to transport detainees.** Current statutes require law enforcement officers to transport or cause the detainee to be transported. However, this puts the impetus on law enforcement to either provide or arrange for the transportation. If this recommendation is pursued by the committee, a question that arises would be who else would be transporting and what level of training that person would be required to have.

- **Require that law enforcement personnel who detain persons only do so if they have received crisis intervention training.** Questions that arise regarding this potential recommendation are who would provide the training and what would the training involve.

Places Where Detention May Occur

Current statutes provide that detention is to take place in any of the following facilities:

> 51.15 **(2)** … (a) A hospital which is approved by the department as a detention facility or under contract with a county department under s. 51.42 or 51.437, or an approved public treatment facility;
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> (b) A center for the developmentally disabled;
>
> (c) A state treatment facility; or
>
> (d) An approved private treatment facility, if the facility agrees to detain the individual.

The following suggestion was made regarding places where a person may be detained on an emergency basis:

- **The types of facilities that are listed in the statutes in which a person may be detained on an emergency basis should be expanded to include crisis stabilization facilities for minors, residential settings, peer-run respite homes, or crisis resource centers.** If the committee decides to pursue this potential recommendation, it should consider whether to require that any alternative type of setting be certified by a state agency or accredited by a private organization.

Detention Period

Current statutes specify that an individual who is detained on an emergency basis may not be held for a period to exceed 72 hours, excluding Saturdays, Sundays, and legal holidays. In addition, in counties having a population of 500,000 or more (currently only Milwaukee County), the treatment

director of the facility, or his or her designee, must determine within 24 hours whether the individual is to be detained, or to be detained, evaluated, diagnosed, and treated. If the individual is detained, the treatment director or designee may supplement in writing the statement filed by the law enforcement officer or other person.

A 1998 Wisconsin Court of Appeals decision addressed the issue of when the 72-hour period described above begins. In the case of *Matter of Delores M.*, 217 Wis. 2d 69, 577 N.W.2d 371 (Wis. App. 1998), the issue before the court was whether the 72-hour period is triggered when a person taken into custody is transported to a facility other than one designated by the county for purposes of emergency detention. The court of appeals concluded that the time limits established in the emergency detention statute are triggered when a person taken into custody is transported to any of the facilities designated in the statute, regardless of whether the facility is one specifically chosen by the county for receipt of persons who are detained on an emergency basis.

Both the statute dealing with Milwaukee County, and the statute dealing with other counties, require release of a detainee under specified circumstances. Under the statute governing Milwaukee County, if the treatment director or designee of the facility determines that the person is not eligible for involuntary commitment, the treatment director is required to release the individual immediately, unless otherwise authorized by law. In the statute governing the other counties, if the director of the facility, upon the advice of the treatment staff, determines that grounds for detention no longer exist, the director must discharge the detainee.

The following suggestions were made regarding the detention period:

- **Provide for consistency in the use of a TDS by either: (1) eliminating the use of a TDS in Milwaukee County; or (2) requiring use of a TDS in all counties.**

- **Specify that the 24-hour and 72-hour time periods described above do not begin to run while the individual is in a medical facility for treatment of a physical injury.** The committee may wish to specify the types of medical facilities to which the person is taken or what constitutes stabilization of a physical injury for purposes of determining when the time periods described above would begin.

- **Specify that decision-making authority over a detainee is with the physician.** As described above, the treatment director or the director, depending on the county, is required to release the detainee if certain conditions are not met. In pursuing this recommendation, the committee might consider whether that authority should be given to a physician and what other types of decision-making a physician would be involved in with regard to a detainee.

- **Allow a treatment director of a facility to file paperwork to hold a person in the facility if they have acted out during the period of detention, even if the time deadlines for filing a TDS or holding a hearing have been missed.** The Wisconsin Court of Appeals held that a person may not be detained after the 72-hour period has run and no hearing was held, even with the filing of another emergency detention statement. [*Dane County v. Stevenson*, 2009 Wis. App. 84 (2009).]

Other Emergency Detention Issues

The following additional suggestions were made with regard to emergency detention:

- **Require that insurance covers emergency detention, including programs like the Crisis Resource Center in Milwaukee.**

- **Provide training to law enforcement, emergency room personnel, and school personnel regarding emergency detention.** As with other training issues described above, decisions would be needed by the committee as to who might develop a training program, what the contents of the training program should be, and who would certify persons who undertake the training. In addition, the committee might wish to discuss funding issues related to the training.

- **Increase the number of peer support personnel in all settings.** The committee may wish to discuss how this could be undertaken and funded.

- **Require that providers are given sufficient notice of probable cause hearings at which they need to appear.**

- **Review the provisions in ch. DHS 34, Wis. Adm. Code, and enforcement of that chapter.**

MENTAL HEALTH TREATMENT OF MINORS

This portion of the Memo discusses potential recommendations related to mental health treatment of minors.

Awareness of Changes in s. 51.13, Stats.

2005 Wisconsin Act 444 took effect on August 1, 2006. The law made significant changes to the mental health treatment of minors, including:

- Changed current law to provide that if a minor age 14 or older refuses to join with his or her parent on the application for inpatient mental health treatment, a parent or guardian may execute the application on the minor's behalf.

- Eliminated the distinction between admissions of minors for inpatient treatment by a county department or the DHS, and an admission of a minor that does not involve a county department or DHS.

- Provided additional rights to a minor upon admission to an inpatient facility:

  - The right to an independent evaluation, if ordered by the court.

  - The minor's right to be informed about how to contact the state protection and advocacy agency.

- Provided that the requirement for a petition for review of the admission applies to the admission of any minor, whether or not the admission is with the involvement of the county department and DHS.

- Changed the 14-day time limit within which the court must hold a hearing on certain admissions of minors to seven days, exclusion of weekends and holidays, and requires the court to order an independent evaluation of the minor in certain situations.

- Provided that the court shall permit admission after a hearing and a finding by the court that the minor is in need of psychiatric, developmental disability, or AODA services in an inpatient facility; the facility offers treatment appropriate for the minor's needs; and it is the least restrictive treatment consistent with the minor's needs.

- Provided that if a minor age 14 or older is in an inpatient facility for treatment for mental illness or developmental disability, the minor *and* the minor's parent or guardian may request discharge in writing. If the parent or guardian refuses to request discharge, and the facility director states that the minor is in need of psychiatric or developmental disability services, that the facility's treatment is appropriate to the minor's needs, and that inpatient care is the least restrictive treatment consistent with the minor's needs, the minor may not be discharged. However, the minor is entitled to a court hearing in this situation.

- Modified and clarified the review process for outpatient mental health treatment of minors age 14 and older.

Testimony provided at the August and October meetings indicated that, in some areas of the state, there is little awareness of the ability of a parent of a minor age 14 or older to obtain treatment for that minor if the minor does not want treatment. In some cases, this lack of awareness has resulted in necessary treatment not being provided that could have prevented harm to a minor.

The following suggestions were made to increase awareness of the changes in 2005 Wisconsin Act 444:

- **Create a separate child and adolescent mental health code.** Sections 51.13 and 51.14, Stats., are currently separate statutory sections that relate solely to mental health treatment for minors. It has been suggested that this would highlight the different mental health needs of children and adolescents. It is possible to create a subchapter within ch. 51, or a separate statutory chapter, that relates specifically to mental health treatment for minors, to further emphasize the differences in obtaining voluntary and involuntary treatment for minors. However, virtually all of the other provisions of ch. 51 also apply to minors, in addition to adults.

- **Rewrite the statutory section [s. 51.13, Stats.] relating to mental health treatment for minors, so that it is more clear and understandable.** Another option that may increase awareness of and compliance with the provisions of s. 51.13, Stats., is to rewrite the statute to make it more clear and understandable.

Application of the Petition Requirement in Wisconsin Act 444 to All Minors

Section 51.13 (4), Stats., requires a petition be filed in court for review of an admission of a minor of any age for treatment for mental illness, alcoholism or drug abuse, or developmental disability. Included in the petition must be a notation of any statement made or conduct demonstrated by the minor in the presence of the director or staff of the facility indicating that inpatient treatment is against the wishes of the minor.

Testimony provided at the August 31, 2010 meeting indicated that in one Wisconsin county, in a six-month period from late 2006 to early 2007, 103 petitions were filed, and 60 of these were for children under age 14.

Because under s. 51.14 (4) (d), Stats., an admission of a minor under age 14 (and of a minor age 14 or older who jointly petitions for admission with the minor's parent) will be approved where there is a showing that the minor needs treatment and the facility provides appropriate treatment in the least restrictive manner consistent with the minor's needs, some have questioned the need for the petition requirement in these situations. Comments have been made that this petition requirement is a hardship for treatment facilities.

The following suggestions were made to change the statute requiring that a petition be filed for all admissions:

- **Eliminate the need to file a petition for review of an admission of a minor under age 14 for treatment of mental illness, alcoholism or drug abuse, or developmental disability.** A parent who has legal custody, or the minor's guardian, must consent to admission for inpatient treatment for mental illness or developmental disability of a minor under age 14. [s. 51.13 (1) (a), Stats.] Such a minor must be informed of his or her rights upon admission. In addition, if the application for admission notes a minor's unwillingness to be admitted, despite the minor's age, the court must order an independent evaluation of the minor and hold a hearing to review the admission.

  Since parents have the authority to consent to inpatient admission for minors under age 14 without the minor joining in the petition, it has been recommended that the petition and hearing requirements in current law for minors under age 14 are superfluous, and should be eliminated. In addition, it has been suggested that the petition requirement is inappropriate, given that most younger minors have not yet developed the ability to make their own decisions regarding mental health treatment.

- **Eliminate the need to file a petition for a minor age 14 to 17 who is voluntarily participating in inpatient treatment for mental illness.** It has been suggested that if a minor age 14 or over is voluntarily seeking treatment, the requirement to file a petition for review of the voluntary admission is superfluous. In addition, a minor age 14 or older may request discharge at any time. If the request is denied, s. 51.13 (7), Stats., sets forth a procedure for determining the continued appropriateness of the admission. Therefore, the minor's rights are protected if the minor changes his or her mind about the inpatient treatment.

- **Establish a medical review process, rather than a legal review, to provide appropriate procedural safeguards to minors.** It has been suggested that medical personnel, rather than courts, have more expertise to evaluate the need for, and appropriateness of, mental health treatment for minors.

Refusal of Some Facilities to Treat Older Minors Who Do Not Consent to Treatment

Prior to the passage of Wisconsin Act 444, there was a distinction between admission of minors by a county department and those admitted without involvement of a county department. For admission through a board or the department, the facility's treatment director had to file a petition in court for review of the admission. Private admissions did not require a petition. However, minors age 14 and older had the right to be discharged from a private facility within 48 hours of their request. Wisconsin Act 444 eliminated the distinction between admissions of minors for inpatient treatment by a county department or DHS and an admission of a minor that does not involve a county department or DHS.

Testimony at the August 31 meeting of the committee asserted that some private treatment facilities have enacted internal policies that are more consistent with the law prior to Wisconsin Act 444 and that they are, by policy, refusing to treat minors age 14 and older who do not consent to treatment, regardless of the parents' wishes.

The following suggestion was made regarding the alleged refusal of private facilities to follow current law relating to admission of minors for treatment:

- **Clarify the statutes to provide that private admissions of minors are subject to the provisions that minors age 14 and older can be admitted if the parent petitions for admission, a review is held to review the minor's refusal, and a court orders the minor into treatment in spite of the minor's refusal.** Some of the suggestions made to further this recommendation would include developing and providing education programs for hospitals regarding ch. 51 requirements, to make mental health laws more understandable and workable for hospitals. In addition, the previous recommendations to create a separate children's mental health code, or to rewrite s. 51.13, Stats., to increase its clarity, could improve private hospital compliance with the laws relating to admission of minors who are age 14 and older.

Short-Term Admissions Issues

A minor may be admitted to an inpatient treatment facility without following the review procedures for diagnosis and evaluation or for dental, medical, or psychiatric services, for no longer than 12 days. A minor's parent or guardian must execute the application for short-term admission. However, if the minor is age 14 or older, the minor must join in the application if it is for mental health or developmental disability services or treatment. If the minor refuses to do so, then the parent or guardian may do so. In that case, the review procedures outlined above apply, and the facility's treatment director must file a petition for review of the short-term admission.

An application for short-term admission must be reviewed by the facility's treatment director, who may approve it only if the treatment director determines that the admission provides the least

restrictive means of providing the diagnosis or evaluation, or provision of dental, medical, or psychiatric services.

The minor must be released at the end of the 12-day period unless a regular application for admission has been filed. Only one short-term admission under this procedure may be made every 120 days. [s. 51.13 (6), Stats.]

Testimony at the August 31 meeting indicated that some children are discharged shortly before the 12-day limit, in order to avoid the requirement to file a petition.

The following suggestions were made regarding the petition requirement:

- **Eliminate the petition requirement at the expiration of the 12-day time period if the admission was voluntary on the part of the minor and the parent.** If the committee adopts the previous recommendations to eliminate the petition requirement for children under age 14, and for minors age 14 to 17 who are voluntarily admitted, this would obviate the need to eliminate the petition requirement at the expiration of the 12-day period in the case of voluntary admissions.

- **Eliminate the statute that provides for no more than one short-term (up to 12 days) admission every 120 days.**

INVOLUNTARY COMMITMENT

Current statutes provide for commitment of a person who: (1) is mentally ill, drug dependent, or developmentally disabled; (2) is a proper subject for treatment; and (3) meets one of the five standards of dangerousness set forth in the statutes. Those standards are as follows:

> 51.20 **(1)** (a) 2. The individual is dangerous because he or she does any of the following:
>
> a. Evidences a substantial probability of physical harm to himself or herself as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm.
>
> b. Evidences a substantial probability of physical harm to other individuals as manifested by evidence of recent homicidal or other violent behavior, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt or threat to do serious physical harm. In this subd. 2. b., if the petition is filed under a court order under s. 938.30 (5) (c) 1. or (d) 1., a finding by the court exercising jurisdiction under chs. 48 and 938 that the juvenile committed the act or acts alleged in the petition under s. 938.12 or 938.13 (12) may be used to prove that the juvenile exhibited recent homicidal or other violent behavior or committed a recent overt act, attempt or threat to do serious physical harm.

c. Evidences such impaired judgment, manifested by evidence of a pattern of recent acts or omissions, that there is a substantial probability of physical impairment or injury to himself or herself. The probability of physical impairment or injury is not substantial under this subd. 2. c. if reasonable provision for the subject individual's protection is available in the community and there is a reasonable probability that the individual will avail himself or herself of these services, if the individual may be provided protective placement or protective services under ch. 55, or, in the case of a minor, if the individual is appropriate for services or placement under s. 48.13 (4) or (11) or 938.13 (4). The subject individual's status as a minor does not automatically establish a substantial probability of physical impairment or injury under this subd. 2. c. Food, shelter or other care provided to an individual who is substantially incapable of obtaining the care for himself or herself, by a person other than a treatment facility, does not constitute reasonable provision for the subject individual's protection available in the community under this subd. 2. c.

d. Evidences behavior manifested by recent acts or omissions that, due to mental illness, he or she is unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt and adequate treatment so that a substantial probability exists that death, serious physical injury, serious physical debilitation, or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for this mental illness. No substantial probability of harm under this subd. 2. d. exists if reasonable provision for the individual's treatment and protection is available in the community and there is a reasonable probability that the individual will avail himself or herself of these services, if the individual may be provided protective placement or protective services under ch. 55, or, in the case of a minor, if the individual is appropriate for services or placement under s. 48.13 (4) or (11) or 938.13 (4). The individual's status as a minor does not automatically establish a substantial probability of death, serious physical injury, serious physical debilitation or serious disease under this subd. 2. d. Food, shelter or other care provided to an individual who is substantially incapable of obtaining the care for himself or herself, by any person other than a treatment facility, does not constitute reasonable provision for the individual's treatment or protection available in the community under this subd. 2. d.

e. For an individual, other than an individual who is alleged to be drug dependent or developmentally disabled, after the advantages and disadvantages of and alternatives to accepting a particular medication or treatment have been explained to him or her and because of mental illness, evidences either incapability of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives, or substantial incapability of applying an understanding of

> the advantages, disadvantages, and alternatives to his or her mental illness in order to make an informed choice as to whether to accept or refuse medication or treatment; and evidences a substantial probability, as demonstrated by both the individual's treatment history and his or her recent acts or omissions, that the individual needs care or treatment to prevent further disability or deterioration and a substantial probability that he or she will, if left untreated, lack services necessary for his or her health or safety and suffer severe mental, emotional, or physical harm that will result in the loss of the individual's ability to function independently in the community or the loss of cognitive or volitional control over his or her thoughts or actions. The probability of suffering severe mental, emotional, or physical harm is not substantial under this subd. 2. e. if reasonable provision for the individual's care or treatment is available in the community and there is a reasonable probability that the individual will avail himself or herself of these services or if the individual may be provided protective placement or protective services under ch. 55. Food, shelter, or other care that is provided to an individual who is substantially incapable of obtaining food, shelter, or other care for himself or herself by any person other than a treatment facility does not constitute reasonable provision for the individual's care or treatment in the community under this subd. 2. e. The individual's status as a minor does not automatically establish a substantial probability of suffering severe mental, emotional, or physical harm under this subd. 2. e.

Generally, the first commitment order may not exceed six months, and all subsequent consecutive commitment orders may not exceed one year. However, a commitment under the fourth standard of dangerousness above may not exceed 45 days in any 365-day period. In addition, after the 30th day after a commitment order based on the fifth standard of dangerousness above, the person may be treated only on an outpatient basis. However, if the person committed based on the fifth standard of dangerousness violates a condition of treatment established by the court or by a county department, that person may be transferred to an inpatient facility or an inpatient treatment program for a period not to exceed 30 days. [s. 51.20 (13) (g) 1., 2., and 2d., Stats.]

Current statutes also provide that if a person is an inmate of a state prison, the petition for involuntary commitment may allege that the inmate is mentally ill, is a proper subject for treatment, and is in need of treatment. The petition must allege that appropriate less restrictive forms of treatment have been attempted and have been unsuccessful and must include a description of the less restrictive forms of treatment. The petition must also allege that the person has been fully informed about his or her treatment needs, the mental health services available, and his or her rights under ch. 51, Stats. The person must have an opportunity to discuss his or her needs, the services available, and his or her rights with a physician or psychologist. The petition must include a statement by a physician or psychologist of a state prison and a statement by a physician or psychologist of a state treatment facility attesting that: (1) the inmate needs inpatient treatment at a state treatment facility because appropriate treatment is not available in the prison; or (2) the inmate’s treatment needs can be met on an outpatient basis in the prison. A commitment under this paragraph may not continue beyond the inmate’s date of release on parole or extended supervision.

For persons who are involuntarily committed, including persons committed who are inmates of state prisons, 21 days prior to the expiration of the period of commitment, DHS or the county department to which the person is committed must file an evaluation of the person and a recommendation regarding recommitment with the committing court. A copy of the evaluation and recommendation must be provided to the person's counsel and the corporation counsel. Upon application for extension of a commitment, the court must proceed under the statutes relating to hearings and disposition. If the court determines that the person is a proper subject for commitment and satisfies other specified requirements, it must order judgment to that effect and continue the commitment. The burden of proof is on the county department or other person seeking commitment to establish evidence that the person is in need of continued commitment.

The following suggestions were made regarding involuntary commitment:

- **Eliminate the requirement that commitments of persons in state prisons may not extend beyond the inmate's date of release on parole or extended supervision.**

- **Eliminate the provision that states that commitments ordered under the fourth standard of dangerousness may not continue longer than 45 days in any 365-day period.**

- **Modify the introductory paragraph that precedes the five standards of dangerousness to clarify that the fourth standard of dangerousness applies only to persons who are mentally ill, not persons who are drug dependent or developmentally disabled.** The text of the fourth standard makes clear that it is limited just to persons with mental illness, but the introductory language applies to persons who are mentally ill, drug dependent, developmentally disabled (other than for persons committed under the fifth standard of dangerousness, which is also limited to persons with mental illness). [s. 51.20 (1) (a) 1., Stats.]

- **Modify the provision in the statutes dealing with privileged communications between specified health care providers and patients to substitute references to "commitment" for "hospitalization."** Current statutes provide that a patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made or information obtained or disseminated for purposes of diagnosis or treatment of the patient. The providers covered are physicians, registered nurses, chiropractors, psychologists, social workers, marriage and family therapists, and professional counselors. However, the statutes provide that there is no privilege regarding communications and information relevant to an issue in proceedings to "hospitalize" the patient for mental illness and other specified proceedings.

OTHER MENTAL HEALTH ISSUES

Medical Assistance Eligibility for Inmates

Section 49.47 (6) (c) 3., Stats., provides that Medical Assistance (MA) benefits shall not include any payment with respect to care or services for an individual who is an inmate of a public institution, except as a patient in a medical institution or a resident in an intermediate care facility.

The federal Center for Medicare and Medicaid Services, in a letter issued in 2004, encouraged states not to terminate eligibility for individuals who are inmates of public institutions or residents of an institution for mental disease based solely on their status as inmates or residents. Instead, states should establish a process under which an eligible inmate or resident is placed in a suspended status so that the state does not claim federal financial participation for services the individual receives, but the person remains eligible for MA (assuming the person continues to meet all applicable eligibility requirements). Once discharge from the facility is anticipated, the state should take whatever steps are necessary to ensure that an eligible individual is placed in payment status so that he or she can begin receiving MA-covered services immediately upon leaving the facility. If an individual is not already eligible for MA prior to discharge from the facility, but has filed an application for MA, the state should take whatever steps are necessary to ensure that the application is processed in a timely manner so that the individual can receive MA-covered services upon discharge from the facility.

The following suggestion was made to provide continuity of medical care to individuals who are released from prison:

- **Suspend, rather than terminate, MA eligibility for someone who enters a correctional facility.** This suggestion would require the amendment of state statutes and administrative rules to allow inmates to retain MA eligibility while incarcerated.

- **Retain current law but institute an expedited MA application process 30 days prior to their release from custody, so that MA would be in place upon release.**

Sharing of Information About Mentally Ill Individuals

Current state and federal laws mandate confidentiality of patient information for individuals receiving mental health and other health care treatment. Federal law, under the Health Insurance Portability and Accountability Act (P.L. 104-191) authorizes limited disclosure of protected health information to law enforcement personnel in specific situations (see 45 C.F.R. s. 164.512). State law, under s. 51.30 (4), Stats., requires confidentiality of treatment records for persons receiving mental health services.

Testimony to the committee suggested that the importance of preserving client confidentiality must be weighed against crisis responders' need for background information about persons with mental illness who are in need of assistance. Testimony stated that clarifying the types of information that can be shared with crisis responders and under what circumstances is an important and necessary refinement of confidentiality and information-sharing protocols.

The following suggestion was made regarding sharing of information between crisis responders:

- **Send a letter to Wisconsin's Congressional delegation recommending changes to federal privacy regulations to allow more sharing of information between providers who are treating the same patient.**

County Community Programs Board Representation

Under s. 51.42 (4), Stats., in a single-county department of community programs, the county community programs board must be composed of not less than nine nor more than 15 persons of

recognized ability and demonstrated interest in the problems of the mentally ill, developmentally disabled, alcoholic or drug dependent persons and shall have representation from the interest groups of the mentally ill, the developmentally disabled, and persons with alcoholism and drug dependency. At least one member appointed to a county community programs board must be a consumer of services, or a consumer's family member. No more than five members may be appointed from the county board of supervisors.

In a multi-county department of community programs, the county community programs board must be composed of 11 members with three additional members for each county in a multi-county department of community programs in excess of two. Appointments must be made by the county boards of supervisors of the counties in a multi-county department of community programs in a manner acceptable to the counties in the multi-county department of community programs and shall have representation from the interest group of the mentally ill, the developmentally disabled, and persons with alcoholism and drug dependency. At least one member appointed to a county community programs board must be a consumer of services, or a consumer's family member. Each of the counties in the multi-county department of community programs may appoint to the county community programs board not more than three members from its county board of supervisors.

The following suggestion was made regarding county community programs board representation:

- **In order to foster intra-county collaboration between county agencies, law enforcement, and hospitals and to ensure the best outcomes for mental health consumers, require hospitals and law enforcement to be represented on county community programs boards established under s. 51.42.** Although current law does not preclude appointing law enforcement personnel or hospital representatives to s. 51.42 boards, this suggestion would require that these entities be specifically required to be represented on the boards.

MA Reimbursement

Currently, the MA program reimburses psychiatrists $96.16 for a psychiatric diagnostic interview examination. Subsequent visits for pharmacologic management, which run 15 to 20 minutes, are reimbursed at $32.00. Psychotherapy visits are reimbursed at $40.46 for 20 to 30 minutes of individual psychotherapy, and $96.16 for 45 to 50 minutes of psychotherapy. Reimbursement rates for psychiatrists were increased 20% in the 2007-09 biennial budget.

The following suggestion has been made to increase access to psychiatrists for persons on MA:

- **Increase the MA reimbursement rate for psychiatrists.** However, DHS notes that the rate increase for psychiatrists has not had a substantial impact on access to psychiatric services. This is likely due to a significant statewide shortage of psychiatrists.

Partnerships With Federally Qualified Health Centers

Wisconsin has 17 federally qualified health centers (FQHCs). DHS reimburses FQHCs for 100% of their reasonable costs of providing services to MA recipients. In 2007-08, DHS expended

approximately $74.6 million (all funds) to reimburse FQHCs for the services they provided to MA recipients.

The federal Health Resources and Services Agency began an initiative in 2005 to expand behavioral health services in FQHCs. Newly established FQHCs were required to offer behavioral health services and existing FQHCs could apply for expansion grants to add these services.

An example of an expanded partnership with community mental health services and FQHCs is in Outagamie County, Wisconsin. In 2009, the Fox Cities Community Health Center and the Outagamie County Department of Health and Human Services began discussing a partnership that would increase mental health services availability; increase access for MA patients; and begin integration of mental health into primary care. The implementation of this project has resulted in an increase in the number of consumers receiving county-based mental health services in Outagamie County, and the project will be continued and expanded into neighboring counties.

The following suggestion was made relating to FQHCs:

- **Provide incentives to expand partnerships with FQHCs.** The State of Wisconsin could encourage FQHCs to expand their services to incorporate or expand behavioral health services and could also encourage county mental health agencies to create referral agreements with FQHCs that serve their counties.

Isolation and Restraint

Section 51.61 (1) (i) 1., Stats., provides that each patient shall:

> …have a right to be free from physical restraint and isolation except for emergency situations or when isolation or restraint is a part of a treatment program. Isolation or restraint may be used only when less restrictive measures are ineffective or not feasible and shall be used for the shortest time possible. When a patient is placed in isolation or restraint, his or her status shall be reviewed once every 30 minutes. Each facility shall have a written policy covering the use of restraint or isolation that ensures that the dignity of the individual is protected, that the safety of the individual is ensured, and that there is regular, frequent monitoring by trained staff to care for bodily needs as may be required.
>
> Isolation or restraint may be used for emergency situations only when it is likely that the patient may physically harm himself or herself or others. The treatment director shall specifically designate physicians who are authorized to order isolation or restraint, and shall specifically designate licensed psychologists who are authorized to order isolation. If the treatment director is not a physician, the medical director shall make the designation. In the case of a center for the developmentally disabled, use shall be authorized by the director of the center. The authorization for emergency use of isolation or restraint shall be in writing, except that isolation or restraint may be authorized in emergencies for not more than

> one hour, after which time an appropriate order in writing shall be obtained from the physician or licensed psychologist designated by the director, in the case of isolation, or the physician so designated in the case of restraint. Emergency isolation or restraint may not be continued for more than 24 hours without a new written order.
>
> Isolation may be used as part of a treatment program if it is part of a written treatment plan, and the rights specified in this subsection are provided to the patient. The use of isolation as a part of a treatment plan shall be explained to the patient and to his or her guardian, if any, by the person who provides the treatment. A treatment plan that incorporates isolation shall be evaluated at least once every 2 weeks.
>
> Patients who have a recent history of physical aggression may be restrained during transport to or from the facility. Persons who are committed or transferred under s. 51.35 (3) or 51.37 or under ch. 971 or 975, or who are detained or committed under ch. 980, and who, while under this status, are transferred to a hospital, as defined in s. 50.33 (2), for medical care may be isolated for security reasons within locked facilities in the hospital. Patients who are committed or transferred under s. 51.35 (3) or 51.37 or under ch. 971 or 975, or who are detained or committed under ch. 980, may be restrained for security reasons during transport to or from the facility.

The following suggestion was made with regard to the isolation and restraint statute:

- **Update the isolation and restraint statutes.** The current statute on isolations and restraints was created in Chapter 430, Laws of 1975. The committee could conduct a review of the statute's provisions to ensure that modern practices regarding isolation and restraint are reflected in the law.

Power of Attorney for Mental Health

Under current ch. 155, Stats., a power of attorney for health care may be used to designate a health care agent to make health care decisions, including mental health care decisions. However, such a document may not be used to authorize inpatient treatment, and may not be used to authorize experimental mental health research, psychosurgery, electroconvulsive treatment, or drastic mental health treatment procedures. In addition, a power of attorney for health care is easy to revoke. Revocation methods include tearing or otherwise destroying the document or verbally expressing the intent to revoke in the presence of two witnesses.

Approximately half the states have enacted some form of power of attorney for mental health, also known as "psychiatric advance directive," which would allow an individual to execute a document providing advance authorization for inpatient mental health treatment, administration of specific types of psychotropic medications, electroconvulsive treatment, and similar mental health treatment.

The following suggestion has been made with regard to a power of attorney for mental health:

- **Create a statute authorizing advance directives for mental health care and treatment.** In creating such a statute, some of the issues that may be considered include whether time limits on inpatient hospitalizations and other treatment should be imposed; permitting advance mental health directives only when mental illness is persistent; authorizing treatments that are likely to be successful, based on the patient's past experience if possible; and requiring execution of an advance directive only when the person is symptom-free.

LR:RNS:wu