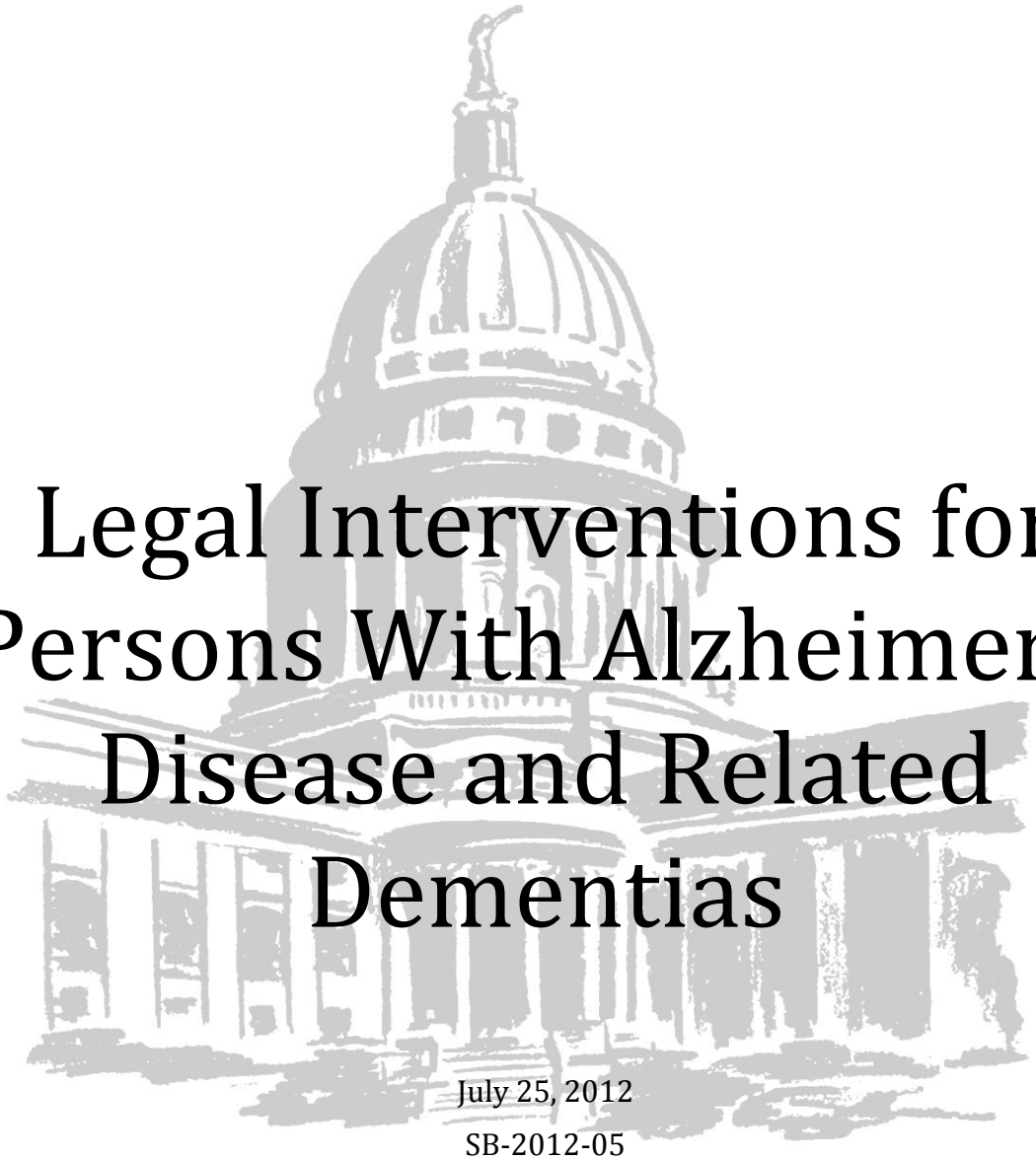
Staff Brief



Legal Interventions for Persons With Alzheimer's Disease and Related Dementias

July 25, 2012

SB-2012-05

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INTRODUCTION

This Staff Brief describes Wisconsin law that is relevant to the discussion of legal interventions for persons with Alzheimer's Disease and related dementias. A person with Alzheimer's Disease or a related dementia may exhibit difficult, disruptive, or challenging behaviors, as described by the Alzheimer's Challenging Behaviors Task Force in its report, "Handcuffed," released in December, 2010. In these situations, certain legal processes and mechanisms ranging from guardianship to involuntary detention, commitment, and protective placement or services may come into play.

The immediate backdrop of the Staff Brief is the Wisconsin Supreme Court's holding in *Fond du Lac County v. Helen E.F.*, 2012 WI 50, in which the Court examined legal avenues for the involuntary care of a person with Alzheimer's Disease. In the *Helen E.F.* case, the Court examined:

- Procedures under ch. 51, Stats., for involuntary commitment for treatment, which may be preceded by an emergency detention under appropriate circumstances.
- Procedures under ch. 55, Stats., for protective services and placement, which may be preceded by emergency and temporary protective services and placement under appropriate circumstances.

This Staff Brief explains the different procedures required and outcomes available under these chapters, as well as the rationale underlying the Court's ultimate conclusion in *Helen E.F.* that a patient with Alzheimer's Disease (who does not have any other qualifying illness) is more appropriately treated under the provisions provided in ch. 55 than those in ch. 51. Also included in the Staff Brief is an in-depth look at statutory procedures for both voluntary and involuntary administration of psychotropic medication under chs. 51 and 55, and a summary of statutes and regulations related to nursing home care that may be relevant to the work of the committee.

This Staff Brief is divided into the following parts:

- ***Part I*** provides a description of *In the Matter of the Mental Commitment of Helen E.F.*, 2012 WI 50.
- ***Part II*** describes portions of chs. 51 and 55, Stats., that may be most relevant to the care and treatment of persons with Alzheimer's Disease and related dementias.
- ***Part III*** describes statutory provisions related to the administration of psychotropic medication on both a voluntary and involuntary basis.
- ***Part IV*** briefly describes statutes and regulations related to nursing home care that are particularly relevant to the care of individuals with Alzheimer's Disease and related dementias.

This Staff Brief was prepared by Mary Matthias, Senior Staff Attorney, and Brian Larson, Staff Attorney.

PART I – THE *HELEN E.F.* CASE

In Fond du Lac County v. Helen E.F., 2012 WI 50, issued on May 18, 2012, the Wisconsin Supreme Court held that a person with Alzheimer's Disease who does not also have a "ch. 51 qualifying illness" is more appropriately treated under the provisions in ch. 55, Stats., than those in ch. 51, Stats., and therefore, may not be involuntarily committed under ch. 51, Stats.

BACKGROUND

Helen, an 85 year-old woman suffering from Alzheimer's Disease, with symptoms including progressive dementia and memory loss, had lived in a nursing home in Fond du Lac for six years. She began to exhibit agitated and aggressive behavior, including striking out at caregivers and refusing meals and medication. She was transported to a hospital emergency room, where the behavior persisted, and was then placed, by a police officer, in the hospital's behavioral health unit under an emergency detention pursuant to s. 51.15, Stats. Fond du Lac County then initiated a proceeding under ch. 51, Stats., to have Helen involuntarily committed for treatment.

At the probable cause hearing held three days later, the court commissioner found that no probable cause existed to proceed under ch. 51. The commissioner converted the ch. 51 petition to a petition for protective placement under ch. 55, Stats., and issued an order for a temporary guardianship and a temporary protective placement, valid for 30 days.

On the day that the order expired, the county filed a second petition for involuntary commitment under ch. 51. At the probable cause hearing on that petition, the county stated that at the time of the original petition, it was thought that Helen's behavior was due to a urinary tract infection, but since that condition had been treated, and the behavior continued, it now appeared that the behavior was a product of Helen's dementia. A psychiatrist who had been treating Helen stated that although cognitive deterioration is not treatable, the "psychiatric complications" of Helen's dementia--agitation, aggressiveness, and combativeness--could be treated with medications that have some calming effects. The court found sufficient probable cause to proceed with the involuntary commitment.

At the final commitment hearing, another psychiatrist stated that dementia is not considered to be a treatable mental disorder, but rather is a progressive mental defect that is not treatable. He stated that the behavioral disturbances resulting from dementia are subject to treatment with medications to address impulsivity, agitation, and physical combativeness. The psychiatrist also testified that in his opinion, Helen posed a risk of harm to herself and others. The court issued an order for involuntary commitment in a locked psychiatric unit for up to six months, which Helen appealed.

COURT OF APPEALS

The Court of Appeals determined that Helen was not a proper subject for commitment or treatment under ch. 51, Stats., because Alzheimer's Disease is not a qualifying mental condition

under that chapter. The Court of Appeals analyzed the text of the statutes that delineate the applicability of chs. 51 and 55 and concluded that degenerative brain disorders, such as Alzheimer's Disease, are specifically excluded from coverage by ch. 51 and included within the authority of ch. 55. The Court of Appeals also stated that since *rehabilitation* is the purpose of ch. 51, as set forth in the statement of legislative policy in s. 50.001, Stats., the treatment of an Alzheimer's Disease patient under that chapter is inappropriate because an individual with Alzheimer's Disease cannot be rehabilitated.

SUPREME COURT

The Wisconsin Supreme Court agreed with the Court of Appeals. The Court stated that because Helen was not medically capable of rehabilitation, as is required by ch. 51, Stats., she could not be involuntarily committed under that chapter. Since her disability was likely to be permanent, the Court found her to be a proper subject for protective placement and services under ch. 55, which would allow for her care in a facility more narrowly tailored to her needs and which would provide her necessary additional process and protection.

In reaching its decision, the Court noted that the Legislature had created two separate and distinct avenues by which counties may provide medical placement and services to persons in need, along with strict rules and boundaries governing such placements and services. These rules and boundaries, it said, are based on the principle of placing the least possible restriction on the personal liberty and due process rights of the person served. Thus, they require counties to commit or place individuals in institutions in accordance with the individual's specific situation.

To determine which chapter, 51 or 55, was appropriate for Helen, the Court analyzed the purpose of each chapter, the corresponding criteria and procedures established to achieve those purposes, and the options for placement available under each chapter. The Court concluded that ch. 55 better balanced Helen's interest in liberty with the county's interests in protecting the public and providing Helen with care. This was because ch. 55 is more narrowly tailored to her condition and provided her with additional procedural protections to ensure the appropriateness of her placement. The Court identified three specific features of ch. 55 which, described below, make that chapter, rather than ch. 51, appropriate for providing treatment to Alzheimer's Disease patients.

Placement Options

The Court noted that both chapters require balancing the individual's liberty with the safety of the public by requiring counties to make placements with the least possible restriction on personal liberty and to provide the least restrictive treatment alternative appropriate to an individual's needs. The Court found that ch. 55 better balances the individual's interest in liberty with the county's interests because, under ch. 51, a person may be placed in any mental health unit without additional finding by the circuit court. In contrast, under ch. 55, an individual may not be placed in a unit for the acutely mentally ill. Thus, ch. 55 is more narrowly tailored to Helen's specific condition and provides her with additional process to ensure the appropriateness of the facility in which she is placed.

Guardian Ad Litem

The second feature of ch. 55 that, according to the Court, makes it more appropriate for persons with Alzheimer's Disease is that it requires the appointment of a guardian ad litem (GAL), while ch. 51 does not. The Court wrote that individuals subject to ch. 55 "need an additional advocate for their best interests, given that ch. 55 is focused on the provision of long-term care to individuals with incurable conditions." The Court explained that the GAL would have been helpful in providing a recommendation to the court regarding Helen's need for protective services. With regard to psychotropic medications in particular, the Court noted that they were a critical component of Helen's care, and stated as follows:

> In short, the GAL would have provided the court with advice as to Helen's best interest regarding psychotropic medication throughout the pendency - and continuance - of the protective placement under ch. 55. Such advice would have given the court valuable assistance in overseeing Helen's care with particular sensitivity to her unique needs. Because the County utilized ch. 51, however, the court was forced to act without that helpful assistance.

Rehabilitation Versus Long-Term Care

The final consideration in the Court's analysis was whether Helen was in need of long-term care or short-term treatment and rehabilitation. The Court wrote that in order to be a proper subject for treatment pursuant to an involuntary commitment under ch. 51, an individual must be capable of "rehabilitation." If the person will be in need of long-term care because their condition is permanent or likely to be permanent, ch. 55 is to be used. The Court discussed two earlier decisions [*Athans*[1] and *C.J.*[2]] in which the Court of Appeals analyzed whether persons suffering from chronic paranoid schizophrenia were proper subjects for treatment under ch. 51. The Supreme Court adopted a "fact-based test" used by the Court of Appeals in those cases for determining whether an individual is capable of rehabilitation which can be paraphrased as follows:

> If treatment will maximize the individual functioning and maintenance of the subject, but not help in controlling or improving their disorder, then the subject individual does not have rehabilitative potential, and is not a proper subject for treatment. However, if treatment will go beyond controlling activity and will go to controlling the disorder and its symptoms, then the subject individual has rehabilitative potential, and is a proper subject for treatment.

Applying the test, the Court found that Helen was not a proper subject for treatment under ch. 51 because Alzheimer's Disease is incurable and untreatable. The Court stated that medical

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[1] *Milwaukee County Combined Community Services Board v. Athans*, 107 Wis. 2d 331 (Ct. App. 1982).

[2] *C.J. v. State*, 120 Wis. 2d 355 (Ct. App. 1984).

techniques can maximize functioning and maintenance of an individual with Alzheimer's Disease but cannot rehabilitate them within the meaning of ch. 51.

The Court acknowledged that certain symptoms associated with Alzheimer's Disease, such as anxiety and aggression, may be ameliorated by psychotropic medication. However, this was not sufficient to justify treatment under ch. 51 because of the uncontroverted evidence that the underlying disorder, Alzheimer's Disease, as well as the vast majority of its symptoms, do not respond to treatment techniques designed to bring about rehabilitation.

The Court did not rule on whether an individual who has a ch. 51 qualifying illness in addition to Alzheimer's Disease may be involuntarily committed under ch. 51. Instead the Court, like the Court of Appeals, determined to "leave for another day the question of what is proper under the law when a person has a duel [sic] diagnosis" of Alzheimer's Disease and a ch. 51 qualifying illness.

PART II – RELEVANT PORTIONS OF CHS. 51 AND 55, STATS.

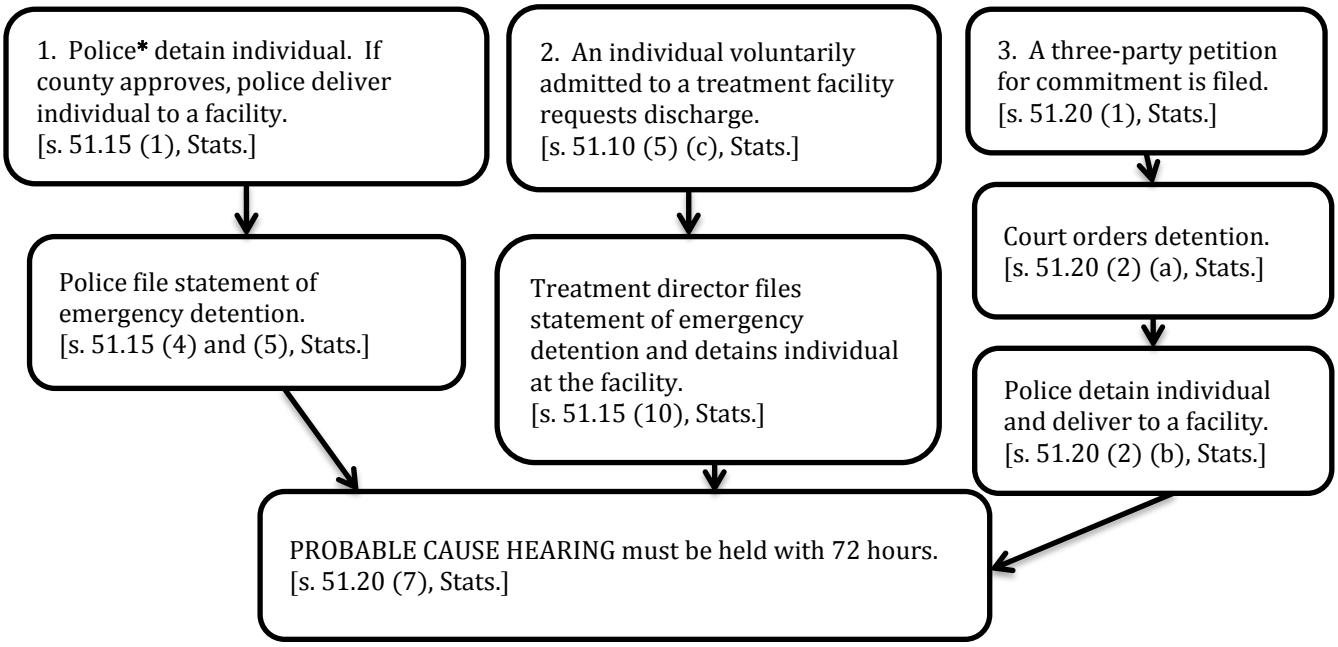
This Part of the Staff Brief describes provisions of chs. 51 and 55 that may be relevant to the care and treatment of persons with Alzheimer's Disease and related dementias. Note, that as discussed in Part I, the *Helen E.F.* case calls into question whether persons with Alzheimer's Disease and related dementias may be treated under ch. 51, Stats., and if so, under what circumstances.

This description is intended to provide a general understanding of the statutory processes and criteria most relevant to the committee's charge. It does not describe all the details of the relevant statutes. The statutory provisions described are the following:

- The provisions of ch. 51 that provide for *emergency detention*, including a chart illustrating the basic procedures.
- The provisions of ch. 51 that provide for *involuntary commitment and treatment*, including a chart illustrating the basic procedures.
- The provisions of ch. 55 that establish the procedures and criteria for *emergency and temporary protective services and placement*, including a chart illustrating the basic procedures.
- The provisions of ch. 55 that establish the procedures and criteria for standard *protective services and placement*, including a chart illustrating the basic procedures.

EMERGENCY DETENTION UNDER CH. 51, STATS.

CHART A: BASIC STEPS IN EMERGENCY DETENTION



* The statutes authorize any law enforcement officer to carry out the duties of "police" shown in the chart.

Chapter 51, Stats., establishes the procedures and criteria under which an individual who is mentally ill, drug dependent, or developmentally disabled may be involuntarily detained and subsequently committed for treatment.

The process of initial involuntary detention is referred to as "emergency detention." The basic steps in the emergency detention process, up to the point of the probable cause hearing, are set forth in Chart A, above, and described in greater detail below.

Under emergency detention process, an individual may be detained only if they meet all of the conditions for detention. These are as follows: (a) the individual is mentally ill, drug dependent, or developmentally disabled; (b) the individual is a proper subject for treatment; and (c) the individual is believed to be dangerous because he or she has exhibited any of the following behavior:

- Behavior demonstrating a substantial probability of physical harm to self or others, such as threats, suicide attempts, or violent behavior.
- Behavior demonstrating a substantial probability of physical impairment or injury to self from impaired judgment.
- Behavior demonstrating that, due to mental illness or drug dependency, the individual cannot satisfy his or her own basic needs of medical care, shelter, or safety, which will

cause imminent death, injury, debilitation, or disease without prompt treatment. [s. 51.15 (1) (a) and (b), Stats.]

In all cases, a probable cause hearing must be held within 72 hours, and the emergency detention may not be continued after the hearing unless the court finds probable cause to believe the individual meets the standards for commitment under ch. 51, Stats., made in connection with the detention. [s. 51.20 (7) (a) and (e), Stats.]

Emergency Detention Initiated By Law Enforcement

A common scenario under which an emergency detention process begins is when a person is taken into custody by a law enforcement officer and the officer transports the person to a detention facility. This may occur because the officer has observed the person's behavior in public, possibly in response to a 911 call, or because someone familiar with the individual, such as a family member or the staff of a nursing home, has called law enforcement to request their assistance with an individual. The law enforcement officer may take the person into custody based on the officer's observation of the person's recent behavior or based upon a reliable report of their behavior from another person. [s. 51.15 (1) (a), (an), and (b), Stats.]

The county department of community programs in the county in which the individual was taken into custody (the county department) must be contacted. (The statutes do not specify who is responsible for contacting the county department.) If the county department approves the need for detention, the law enforcement officer takes the person, or arranges for the person to be taken, to a facility for detention. Upon arrival at the facility, the individual is deemed to be in the custody of the facility. [s. 51.15 (2) and (3), Stats.]

The facilities that may be used for detention are:

- A hospital which is approved by the Department of Health Services (DHS), as a detention facility or under contract with a county department under s. 51.42 or 51.437, or an approved public treatment facility.
- A center for the developmentally disabled.
- A state treatment facility.
- A private treatment facility approved by DHS if the facility agrees to detain the individual. [s. 51.15 (2) (a) to (d), Stats.]

The law enforcement officer must sign a statement of emergency detention and the officer or other person must file the statement of emergency detention with, or deliver it to, the detention facility at the time of admission. [s. 51.15 (4) (a) and (5), Stats.]

In all counties other than Milwaukee County, the officer or other person must file the statement of emergency detention with the court immediately after filing it with the facility. In Milwaukee County, the facility treatment director or designee must make a determination as to whether the person should be detained, may supplement the statement of emergency detention, and must then file it with the court. [s. 51.15 (4) (b) and (5), Stats.]

The filing of the statement of emergency detention has the same effect as a petition for commitment under s. 51.20.

The director and staff of the facility may evaluate, diagnose, and treat the individual during detention, if the individual consents. The individual has a right to refuse medication and treatment unless the medication or treatment is necessary to prevent serious physical harm to the individual or to others. If, upon the advice of the treatment staff, the director of the facility determines that the grounds for detention no longer exist, he or she must discharge the individual. [ss. 51.15 (4) (b), (5) and (8) and 51.61 (1) (g) 1., Stats.]

A probable cause hearing must be held within 72 hours after the individual arrives at the facility, excluding Saturdays, Sundays, and legal holidays. [s. 51.20 (7), Stats.]

Emergency Detention Initiated by the Treatment Director of a Treatment Facility

The emergency detention process may also begin when a patient who has been admitted to a treatment facility, and is there on a voluntary basis, attempts to leave the facility and is detained by the facility personnel.

The statutes provide that any patient or resident voluntarily admitted to an inpatient treatment facility must be discharged on request, unless the treatment director or designee has reason to believe that the patient or resident meets the conditions for emergency detention. If these conditions exist, the individual may be detained until the treatment director or designee signs a statement of emergency detention and files it with the court. The statement must be filed by the end of the next day in which the court transacts business. After the statement is filed, the individual may be detained until the probable cause hearing. A probable cause hearing must be held within 72 hours after the individual's request for discharge, excluding Saturdays, Sundays and legal holidays. [ss. 51.10 (5) (c) and 51.15 (10), Stats.]

Emergency Detention Initiated by a Three-Party Petition for Examination

The third way the emergency detention of an individual may begin is with the filing of a "three-party" petition for examination. This type of petition must be signed by three people, at least one of whom has personal knowledge of the conduct of the individual. The petition must contain allegations that the individual meets the conditions for detention. [s. 51.20 (1) (a) and (b), Stats.]

When the petition is filed, the Court must review it to determine whether an order for detention should be issued. [s. 51.20 (2) (a), Stats.]

If the court issues an order of detention, a law enforcement officer must detain the individual and take them to one of the following facilities:

- A hospital that is approved by DHS as a detention facility or under contract with a county department, or an approved public treatment facility.
- A mental health institute.
- A center for the developmentally disabled.

- A state treatment facility.
- A private treatment facility, approved by DHS, if the facility agrees to detain the individual. [s. 51.20 (2) (d), Stats.]

Probable Cause Hearing

A hearing must be held within 72 hours to determine whether there is probable cause to believe the individual meets the standards for involuntary commitment. (If the court does not order detention of the individual, the individual may nevertheless be subject to involuntary commitment, as described below.)

INVOLUNTARY COMMITMENT FOR TREATMENT UNDER CH. 51, STATS.

Chart B (on the following page) shows the basic steps in the process for involuntary commitment, under ch. 51, Stats., of an individual who was subject to emergency detention under any of the three scenarios described above.

Chart B picks up the process where Chart A ends, which is at the conclusion of the probable cause hearing following an emergency detention. It is also possible for the involuntary commitment process to occur without an emergency detention taking place. This would result if a three-party petition for examination were filed under s. 51.20 (1), Stats., as shown in Box 3 of Chart A, and upon review of the petition, the Court did not order detention of the individual pending the probable cause hearing. In this case, the Court must hold the probable cause hearing within a "reasonable time" after the petition is filed, and the commitment process proceeds, as described below, depending on the outcome of the probable cause hearing.

Probable Cause for Commitment is Found

If the court finds probable cause does exist to believe the person meets the standards for commitment, it may release the person pending the final hearing on the petition for commitment or order detention of the person until the time of the final hearing. [s. 51.20 (8) (a), Stats.]

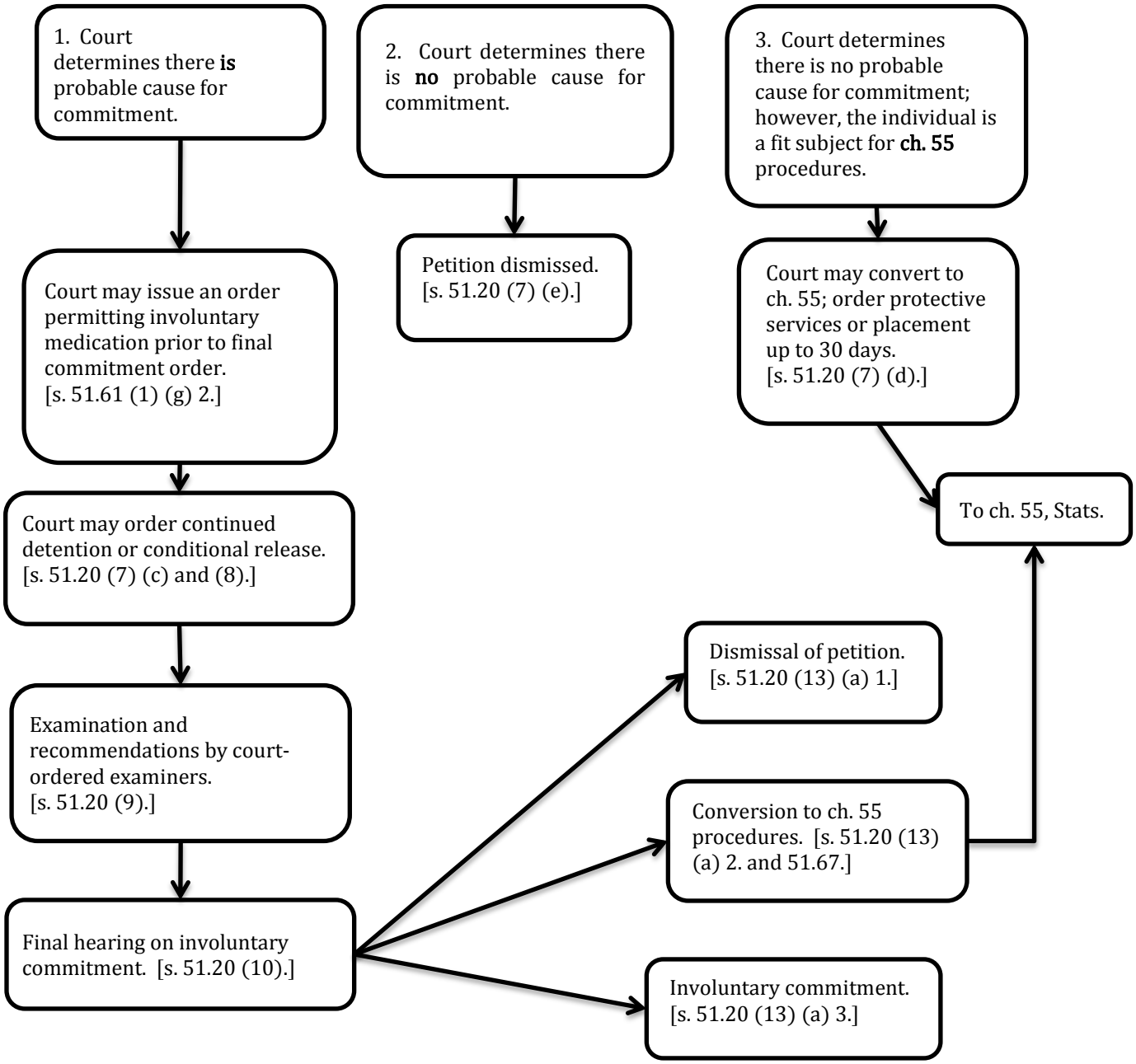
Probable Cause is Not Found

If the court determines that probable cause does not exist to believe the person meets the standards for commitment, or to convert the petition to a ch. 55 petition, as described below, it must dismiss the petition. [s. 51.20 (7) (e), Stats.]

Probable Cause is Not Found; Conversion to Ch. 55

If the court determines, after hearing, that there is probable cause to believe that the subject individual is a fit subject for guardianship and protective placement or services, the court may appoint a temporary guardian and order temporary protective placement or services under ch. 55 for a period not to exceed 30 days, and must proceed as if a petition had been made for guardianship and protective placement or services.

CHART B: INVOLUNTARY COMMITMENT FOLLOWING EMERGENCY DETENTION UNDER CH. 51, STATS.



Involuntary Administration of Medication Prior to Trial

If probable cause is found, then at or after the probable cause hearing, but prior to the final commitment order, upon the motion of any interested person, the court must hold a hearing to determine whether to order the involuntary administration of medication to the individual until the time of the hearing or trial. (The court may also hold a hearing in this issue on its own motion.)

The court may issue the order if it finds probable cause to believe that the individual is not competent to refuse medication or treatment (as described on the following page), the medication or treatment will have therapeutic value, and will not unreasonably impair the ability of the individual to prepare for or participate in subsequent legal proceedings.

The order is valid for the period between the date of its issuance and the date of the final order of commitment, unless the court dismisses the petition for commitment or specifies a shorter period of validity. [s. 51.61 (1) (g) 2., Stats.]

Examination by Court-Ordered Examiners

The court must appoint two medical professionals with specified training or credentials to personally observe and examine the individual and provide specified written reports and recommendations to the court prior to the final hearing or trial on commitment.

If requested by the individual, the individual's attorney, or any other interested party with court permission, the individual has a right to secure an additional medical or psychological examination and to offer the evaluator's personal testimony as evidence at the hearing. [s. 51.20 (9) (a), Stats.]

Final Hearing on Petition for Involuntary Commitment; Order for Commitment

If an individual is detained after the probable cause hearing, the court must hold a final hearing on the petition for commitment within 14 days from the time of detention. [s. 51.20 (7) (c), Stats.]

If an individual is not detained after the probable cause hearing, the court must hold a final hearing on the petition for petition for commitment within 30 days of the probable cause hearing. [s. 51.20 (7) (c), Stats.]

If requested by the individual, a jury trial must be held. [s. 51.20 (11), Stats.]

After the hearing or trial, if the court finds that commitment of the individual is not warranted, the court may either dismiss the petition or take steps to facilitate the provision of protective placement or services to the individual. [ss. 51.20 (13) (a) 2. and 51.67, Stats.]

If the court finds that the allegations on the petition were proven, the court must order commitment of the individual to the care and custody of the appropriate county department. If inpatient care is not required, the court must order commitment to outpatient treatment under care of the county department. The court must designate the facility or service that is to receive the subject individual into the mental health system. [s. 51.20 (13) (a) 3. and (c) 1., Stats.]

An initial commitment order may be for a period of up to six months; subsequent commitments of the individual may be for a period of up to one year. [s. 51.20 (13) (g) 1., Stats.]

Administration of Medication or Treatment Without Consent After Commitment

A person who has been committed under ch. 51 has the right to exercise informed consent with regard to all medication and treatment unless the court determines the person is not competent to refuse medication and treatment, or in a situation in which the medication or treatment is necessary to prevent serious physical harm to the patient or to others. [s. 51.61 (1) (g) 3., Stats.]

Following a final commitment order, a court may, upon motion, hold a hearing to determine whether the individual is competent to refuse medication or treatment. The court may not issue an order authorizing medication or treatment without consent unless it receives a statement signed by a licensed physician that asserts that the subject individual needs medication or treatment and that the individual is not competent to refuse medication or treatment, based on an examination of the individual by a licensed physician. [s. 51.61 (1) (g) 3., Stats.][3]

An individual is not competent to refuse medication or treatment if, because of mental illness, developmental disability, alcoholism, or drug dependence, and after the advantages and disadvantages of and alternatives to accepting the particular medication or treatment have been explained to the individual, one of the following is true:

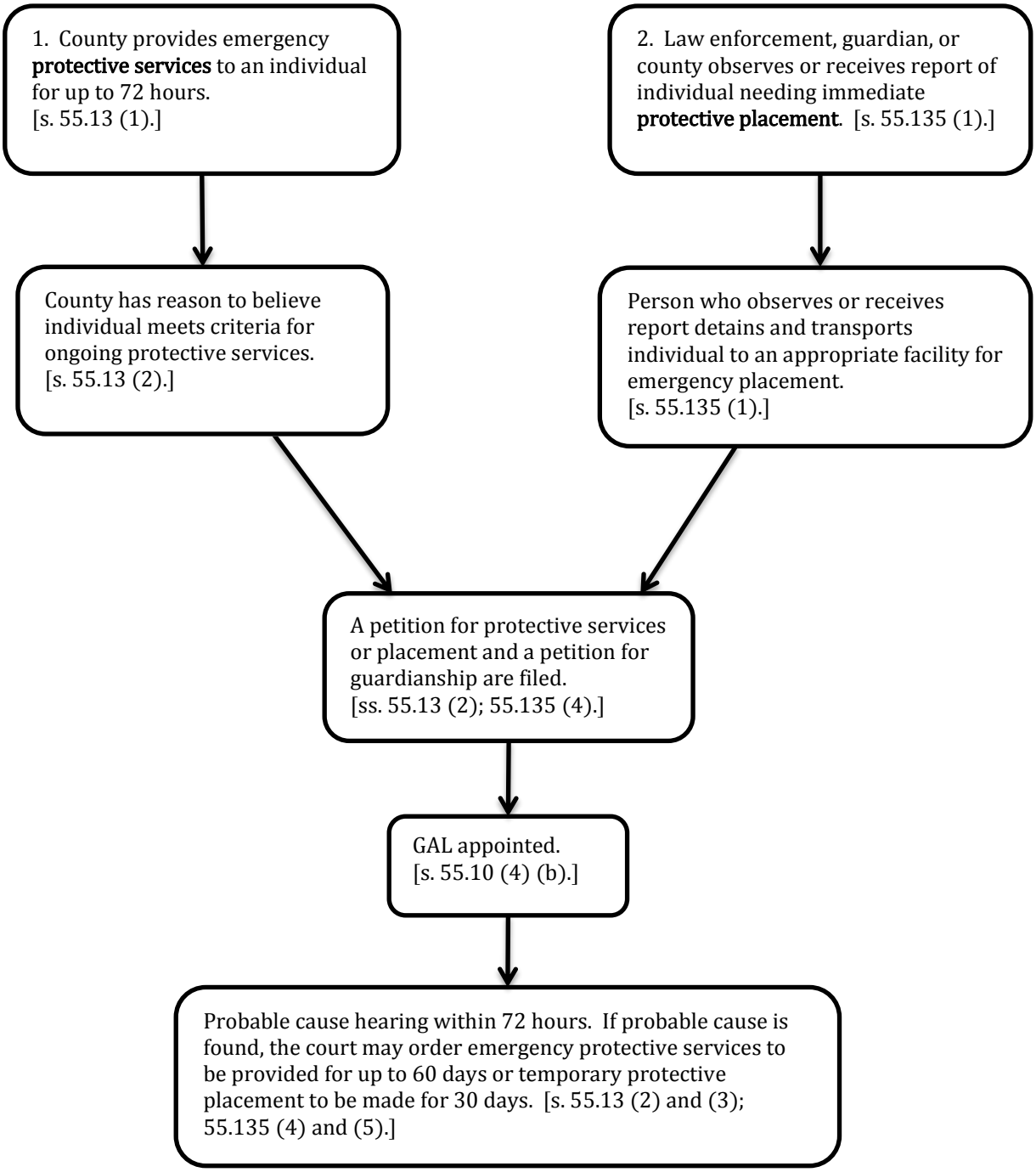
- The individual is incapable of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives.
- The individual is substantially incapable of applying an understanding of the advantages, disadvantages, and alternatives to his or her mental illness, developmental disability, alcoholism, or drug dependence in order to make an informed choice as to whether to accept or refuse medication or treatment. [s. 51.61 (1) (g) 4., Stats.]

EMERGENCY AND TEMPORARY PROTECTIVE SERVICES AND PLACEMENT

The basic steps in the process for ordering emergency and temporary protective services and placement are set forth in Chart C, on the following page, and described in greater detail below.

[3] The statutes require the court to issue an order permitting medication or treatment without consent for any person who is found to meet the commitment standard under s. 51.20 (1) (a) 2. e., Stats., and is committed.

CHART C: EMERGENCY PROTECTIVE SERVICES EMERGENCY AND TEMPORARY PROTECTIVE PLACEMENT UNDER CH. 55, STATS.



Emergency Protective Services

Emergency protective services may be provided for up to 72 hours when there is reason to believe that, if the emergency protective services are not provided, the individual entitled to the services or others will incur a substantial risk of serious physical harm. Involuntary administration of psychotropic medications may be provided as an emergency protective service. [ss. 55.13 (1) and 55.14 (10), Stats.]

If the county department or agency with which it contracts under s. 55.02 (2) (hereafter referred to as "county department"), that is providing emergency protective services to an individual has reason to believe that the individual meets the criteria for protective services, the county department or agency may file a petition for protective services. If a petition is filed, a preliminary hearing must be held within 72 hours, excluding Saturdays, Sundays, and legal holidays, to establish probable cause that the criteria for provision of protective services are present. If the individual is not under guardianship, a petition for guardianship shall accompany the petition for protective services. [s. 55.13 (2), Stats.]

If the court finds probable cause exists, it may order emergency protective services to continue to be provided for up to 60 days pending the hearing on protective services under s. 55.10. [s. 55.13 (3), Stats.]

Emergency and Temporary Protective Placement

A sheriff, police officer, fire fighter, guardian, or representative of a county department may take an individual into custody and transport them to an appropriate medical or protective placement facility for emergency protective placement if all of the following are true:

- It appears probable that an individual is so totally incapable of providing for his or her own care or custody that if he or she is not immediately placed, a substantial risk of serious physical harm to the individual or others will occur.
- The individual's inability to provide for his or her own care is a result of developmental disability, degenerative brain disorder, serious and persistent mental illness, or other like incapacity.
- The person making the emergency protective placement either personally observed the individual's behavior, or received a reliable report of the behavior from a person who identified himself or herself to the person making the emergency protective placement.

The person making the emergency protective placement must prepare a statement at the time of detention providing specific factual information concerning the person's observations or reports made to the person and the basis for emergency placement. The statement must be filed with the director of the facility and with any petition for protective placement or services. [s. 55.135 (1), Stats.]

When an individual is detained through this process, a petition for protective services or placement must be filed by the person making the emergency protective placement. A preliminary hearing must be held within 72 hours, excluding Saturdays, Sundays and legal holidays, to establish probable cause to believe the grounds for protective placement exist. If the

person is not under guardianship, a petition for guardianship must accompany the protective placement petition. In the event that protective placement is not appropriate, the court may elect to treat a petition for protective placement as a petition for commitment under s. 51.20 or 51.45 (13). [s. 55.135 (4), Stats.]

Upon finding probable cause, the court may order temporary protective placement up to 30 days pending the hearing for a permanent protective placement, or the court may order such protective services as may be required. [s. 55.135 (5), Stats.]

A law enforcement agency, fire department, or county department must designate at least one employee authorized to take an individual into custody for emergency protective placement. This employer must attend the in-service training on emergency detention and emergency protective placement offered by a county department of community programs if one is offered. [s. 55.135 (6), Stats.]

NON-EMERGENCY PROTECTIVE SERVICES AND PLACEMENT

The basic steps in the protective services and placement process that take place on a non-emergency basis are described in greater detail and set forth in Chart D, below.

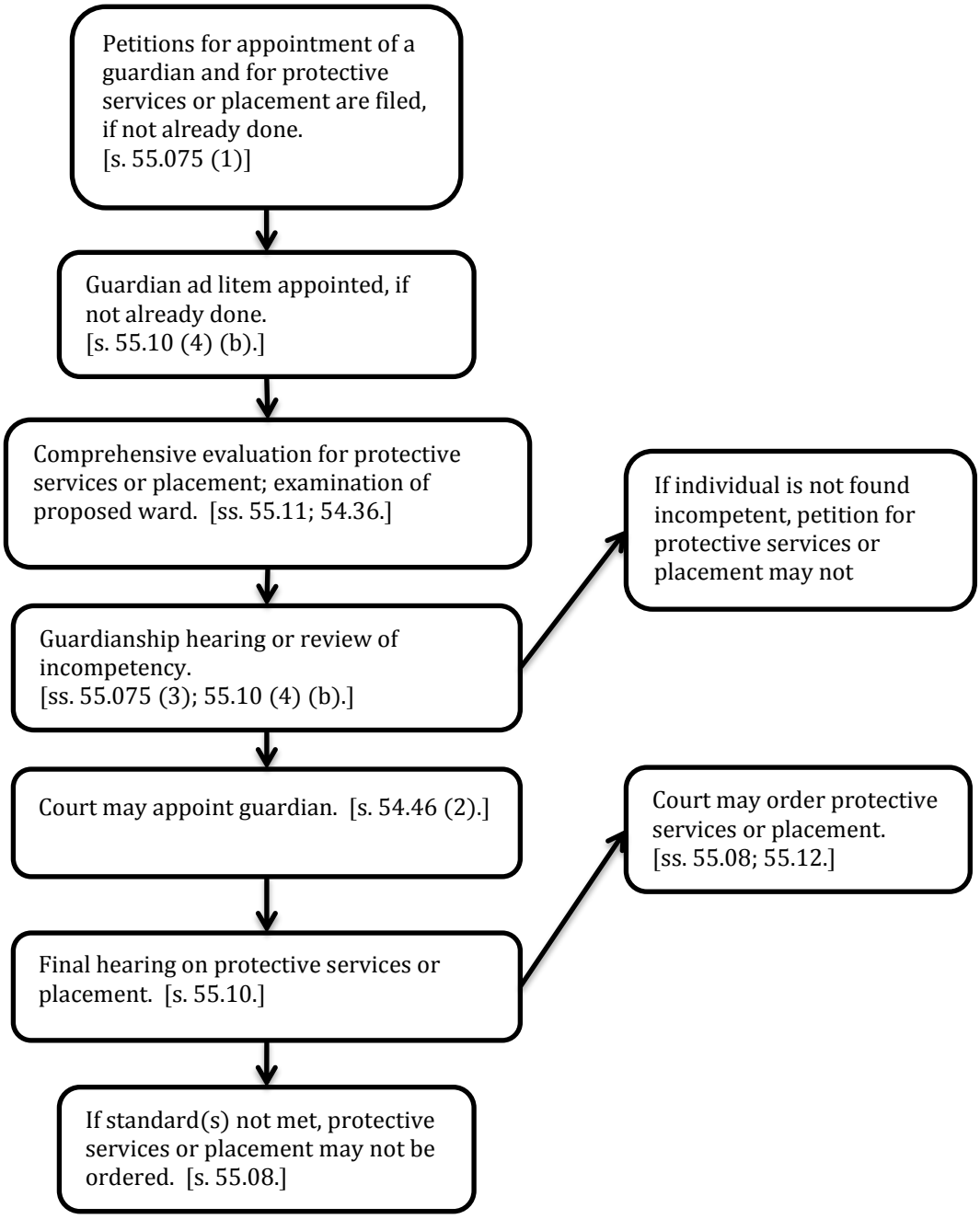
Standards for Protective Services or Protective Placement

Protective Placement

A court may order protective placement for an adult individual who meets all of the following standards:

- The individual has a primary need for residential care and custody.
- The individual has been determined to be incompetent by a circuit court.
- As a result of developmental disability, degenerative brain disorder, serious and persistent mental illness, or other like incapacities, the individual is so totally incapable of providing for his or her own care or custody as to create a substantial risk of serious harm to himself or herself or others. Serious harm may be evidenced by overt acts or acts of omission.
- The individual has a disability that is permanent or likely to be permanent. [s. 55.08 (1), Stats.]

CHART D: PROTECTIVE SERVICES AND PLACEMENT UNDER CH. 55, STATS.



Protective Services

A court may order protective services for an adult individual who meets all of the following standards:

- The individual has been determined to be incompetent by a circuit court.
- As a result of developmental disability, degenerative brain disorder, serious and persistent mental illness, or other like incapacities, the individual will incur a substantial risk of physical harm or deterioration or will present a substantial risk of physical harm to others if protective services are not provided. [s. 55.08 (2), Stats.]

Types of Services or Placement That May be Ordered

The services that may be provided as protective services are:

- Outreach.
- Identification of individuals in need of services.
- Counseling and referral for services.
- Coordination of services for individuals.
- Tracking and follow-up.
- Social services.
- Case management.
- Legal counseling or referral.
- Guardianship referral.
- Diagnostic evaluation.
- Any services that, when provided to an individual with developmental disabilities, degenerative brain disorder, serious and persistent mental illness, or other like incapacity, keep the individual safe from abuse, financial exploitation, neglect, or self-neglect, or prevent the individual from experiencing deterioration, or from inflicting harm on himself or herself or another person. [s. 55.01 (6r), Stats.]

Protective placement of an adult generally may be made to a nursing home, public medical institution, center for the developmentally disabled under certain circumstances, or to other "appropriate facilities," but may not be made to a unit for the acutely mentally ill.

No individual who is subject to an order for protective placement or services may be involuntarily transferred to, detained in, or committed to a treatment facility for care except by following the procedures and meeting the criteria set forth in ch. 51, Stats. Protective placement in a locked unit requires a specific finding of the court as to the need for the action. [s. 51.12 (2), Stats.]

Who May Petition For Protective Placement or Services

The department, the county department, a guardian, or an interested person may file a petition for appointment of a guardian and for protective services or protective placement for an individual. [s. 55.075 (1), Stats.]

Petition For Guardianship; Review Of Incompetency

A petition for guardianship must be heard prior to ordering protective placement or protective services. If the individual was adjudicated incompetent more than 12 months earlier, the court must review the finding of incompetency. [s. 55.075 (3), Stats.]

Guardian Ad Litem

The court must appoint an attorney to serve as GAL for any person who is subject to a petition for protective services or placement.

The GAL must be an advocate for the best interests of the individual as to guardianship, protective placement, and protective services. The GAL must function independently, in the same manner as an attorney for a party to the action, and must consider, but is not bound by, the wishes of the individual or the positions of others as to the best interests of the individual. The GAL has none of the rights or duties of a guardian. [s. 54.40 (3), Stats.]

A GAL must, among other things, do all of the following:

- Interview the individual and explain the contents of the petition, the applicable hearing procedure, the right to counsel, and the right to request or continue a limited guardianship.
- Advise the individual, both orally and in writing, of that person's rights to be present at the hearing, to a jury trial, to an appeal, to counsel, and to an independent medical or psychological examination on the issue of competency, at county expense if the person is indigent.
- Interview the proposed guardian, the proposed standby guardian, if any, and any other person seeking appointment as guardian and report to the court concerning the suitability of each individual interviewed to serve as guardian.
- Review any power of attorney for health care under ch. 155, any durable power of attorney under ch. 244 executed by the individual, and any other advance planning for financial and health care decision-making in which the individual had engaged and interviewed any agent appointed by the individual under any of these documents.
- Report to the court concerning whether or not the individual’s advance planning is adequate to preclude the need for guardianship.
- Request that the court order additional medical, psychological, or other evaluation, if necessary.
- If applicable, inform the court and petitioner's attorney or, if none, the petitioner that the individual objects to a finding of incompetency, the present or proposed placement,

or the recommendation of the GAL as to the proposed ward's or ward's best interests or that the proposed ward's or ward's position on these matters is ambiguous. If the GAL recommends that the hearing be held in a place other than a courtroom, the GAL shall provide the information under this paragraph as soon as possible.

- If individual requests representation by counsel, inform the court and the petitioner or the petitioner's counsel, if any.
- Attend all court proceedings related to the guardianship and protective services or placement.
- Present evidence concerning the best interests of the individual, if necessary.
- Report to the court on any matter that the court requests.

If a guardian has been appointed for an individual who is the subject of a petition for court-ordered protective placement or protective services, the GAL must interview the guardian. The GAL must be present at all hearings if the individual sought to be protected does not have full legal counsel, unless excused by the court. [s. 55.10 (4) (b), Stats.]

Comprehensive Evaluation

Before ordering protective placement or protective services for any individual, the court must require a comprehensive evaluation of the individual sought to be protected, if such an evaluation has not already been made. The county must cooperate with the court in securing available resources to determine the need for protective placement or services. The evaluation must include at least the following information:

- The address of the place where the individual is residing and any person or agency who is providing services to the individual.
- A resume of any professional treatment and services provided to the individual by the department in connection with the problem creating the need for protective placement or protective services.
- A medical, psychological, social, vocational, and educational evaluation and review, if necessary, and any recommendations for or against maintenance of partial legal rights by the individual. The evaluation and review must include recommendations for the individual's placement that are consistent with the statutory factors that must be considered in making placements, described below. [s. 55.11 (1), Stats.]

If requested by the individual sought to be protected, or anyone on the individual's behalf, the individual sought to be protected has the right, at his or her own expense, or, if indigent, at the expense of the county where the petition is filed, to secure an independent comprehensive evaluation if one has not already been made. The individual, or anyone on the individual's behalf, may present a report of this evaluation, or the evaluator's personal testimony, as evidence at the hearing. [s. 55.11 (2), Stats.]

Order for Protective Services or Protective Placement

If the court, after hearing, finds that the standards for protective services or protective placement have been met, it must order the county department to provide protective placement or protective services to the individual. [ss. 55.08 and 55.12 (1), Stats.]

The county department must provide protective placement or protective services in the least restrictive environment and in the least restrictive manner consistent with the needs of the individual to be protected and with the resources of the county department. [s. 55.12 (3), Stats.]

The county department must consider all of the following in providing protective placement or protective services:

- The needs of the individual to be protected for health, social, or rehabilitative services.
- The level of supervision needed.
- The reasonableness of the placement or services given the cost and the actual benefits in the level of functioning to be realized by the individual.
- The limits of available state and federal funds and of county funds required to be appropriated to match state funds.
- The reasonableness of the protective placement or protective services given the number or projected number of individuals who will need protective placement or protective services and given the limited funds available. [s. 55.12 (4), Stats.]

Annual Review of Order for Protective Placement

An order for protective placement must be reviewed annually by the court, following specific procedures set forth in statute. The court may order continuation of the protective placement only if it finds that the individual continues to meet the standards for protective placement and the placement is in the least restrictive environment, as required by statute. If the placement is not in the least restrictive environment, the individual must be transferred to an appropriate placement. If the individual no longer meets the standards for protective placement, the placement must be terminated. In addition, a petition for termination of a protective placement may be filed at any time. [ss. 55.17 and 55.18, Stats.]

PART III – ADMINISTRATION OF PSYCHOTROPIC MEDICATION TO PERSONS WITH ALZHEIMER'S DISEASE AND RELATED DEMENTIAS

This Part of the Staff Brief discusses an individual's legal right to consent to or refuse psychotropic medication and the court's authority to authorize its administration to an individual without the individual's consent.

VOLUNTARY ADMINISTRATION OF PSYCHOTROPIC MEDICATION

Informed Consent

If a person is competent to make health decisions, they may consent on their own behalf to the administration of medical treatments and medications, including psychotropic medication. Chapter 55 recognizes this by authorizing DHS (or a county health department or agency contracting with a county health department) to provide protective services, which may include psychotropic medication, on a voluntary basis when "[a]n individual who needs or believes he or she needs protective services requests the services." [s. 55.05 (2) (a), Stats.]

Before medical treatments and medications, including psychotropic medication, may be voluntarily administered to an individual, the individual must give his or her informed consent to the treatment or medication. [s. 448.30, Stats.; *Johnson v. Kokemoor*, 199 Wis. 2d 615, 628-31 (1996).] Under Wisconsin's general informed consent statute, a physician obtaining informed consent has a duty to provide the patient with the information necessary to assess the significant potential risks associated with the treatment under the circumstances. The physician must take into consideration the patient's ability to understand the information, and is not required to disclose information to a patient who is incapable of consenting. [s. Med. 18.03, Wis. Adm. Code; s. 448.30 (6), Stats.]

If an individual lacks capacity to provide informed consent, it may be provided, under certain circumstances, by an agent under an activated health care power of attorney or a guardian with appropriate authority under the court order creating the guardianship, as described below.

In addition, as discussed in Part IV, below, additional consent requirements apply if certain psychotropic medications are given to a resident of a nursing home.

Consent Via Health Care Power of Attorney

A power of attorney for health care (POAHC) is a written document that allows an individual (or "principal") to designate another individual to make health care decisions on behalf of the principal in the event that he or she lacks capacity to make health care decisions on his or her own in the future. This individual is referred to as the health care agent (or "agent"). The agent must make health care decisions in good faith consistently with the desires of the principal,

to the extent of any specific directive from the principal or to the extent the principal's desires are known. This is sometimes referred to as a *substitute judgment* standard, because the agent must discern the principal's desires and substitute the principal's judgment for his or her own.

Among other requirements, a POAHC must be dated and signed by the principal in the presence of two witnesses. [s. 155.10, Stats.] Also, unless otherwise specified in the POAHC, before a POAHC becomes effective, or "activated," a finding of incapacity must be made by two physicians, or one physician and one licensed psychologist, who personally examine the principal and sign a statement specifying that the principal has incapacity. [s. 155.05 (2), Stats.] "Incapacity" means the inability to receive and evaluate information effectively or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions. [s. 155.01 (8), Stats.] A POAHC may always be revoked by a principal who does not lack capacity to do so. [s. 155.40 (1), Stats.]

An agent acting under an activated POAHC may request and consent to the voluntary provision of psychotropic medication on behalf of the principal. This may occur outside the framework of the protective service system, or it may occur as a voluntary protective service under ch. 55. [ss. 55.05 (2) (b) and 155.20 (5), Stats.]

In cases where a principal opposes the medication, the ability of an agent to act is limited. Under the statute, a health care agent must "act in good faith consistently with the desires of the principal as expressed in the power of attorney for health care instrument *or as otherwise specifically directed by the principal to the health care agent at any time*" (emphasis added). [s. 155.20 (5), Stats.] That is, notwithstanding the general expression of authority in the POAHC instrument, the agent may not take actions that contradict the specific directions of the principal made at a later time. In a case where a principal opposes the receipt of psychotropic medication, one or more decision-makers (such as the hospital or the agent) may conclude that the agent does not have the ability to consent to the medication, because it would conflict with a specific direction from the principal, and therefore may refuse to honor the POAHC.

If it is concluded that a health care agent does not have the authority to consent to medication on behalf of a principal in a specific circumstance, and no other voluntary form of consent is available, then the medication cannot be administered except by involuntary means. Procedures for involuntary administration of psychotropic medication are discussed below.

It is also worth noting that a health care agent is not authorized to request or consent to all types of treatment, even if a principal is not protesting. A health care agent may not consent to experimental mental health research; psychosurgery; electroconvulsive treatment, or drastic mental health procedures. [s. 155.20 (3), Stats.] Also, a health care agent may not authorize inpatient treatment at an institution for mental diseases or a state or private facility providing treatment for mental illness. [s. 155.20 (2), Stats.]

Consent Via Guardianship

A guardianship is a legal mechanism governed by ch. 54, Stats., in which a guardian of the person may be appointed to exercise the legal rights of a person judicially determined to be incapacitated (a "ward"). The guardian must make health care decisions on behalf of the ward

with "such diligence and prudence as an ordinarily prudent man exercises in his own affairs" and must act "loyally in the best interests" of the ward. [*King v. First Nat'l Bank of Kenosha (In re Guardianship of Bose)*, 39 Wis. 2d 80, 88 (1968); *In re Guardianship of Nelson*, 21 Wis. 2d 24, 32 (1963).] This is sometimes referred to as a *best interests* standard, because the guardian must discern what is in the ward's best interests and act accordingly.

When a guardian is appointed for a person who is a principal under an activated POAHC, the powers of the health care agent remain in effect unless the court revokes the POAHC or limits the authority of the health care agent under the terms of the POAHC. [s. 54.46 (2) (b), Stats.] If the POAHC remains in effect and is not limited by the court, then the guardian may not make health care decisions for the ward that can be made by the health care agent. If the POAHC is revoked or limited by the court, then the guardian may make health care decisions for the ward to the extent of the POAHC's revocation or limitation.

A guardian may request and consent to the voluntary provision of psychotropic medication on behalf of a ward. This may occur outside the framework of the protective service system, or it may occur as a voluntary protective service under ch. 55. [ss. 54.25 (2) (d) 2. ab. and 55.05 (2) (b), Stats.] However, before a guardian may give informed consent to the voluntary receipt of psychotropic medication, the guardian must make "a good faith attempt" to discuss the voluntary receipt of the medication with the ward, and the guardian may only give consent if the ward does not protest. [s. 54.25 (2) (d) 2. ab., Stats.]

If the ward protests the administration of psychotropic medication, then the guardian's authority is limited. When this occurs, the guardian may consent to the administration of psychotropic medication only under a court order authorizing the guardian to consent to involuntary administration of psychotropic medication under s. 55.14, Stats. [ss. 54.25 (2) (d) 2. ac., and 55.14, Stats.] This procedure is described in greater detail below.

INVOLUNTARY ADMINISTRATION OF PSYCHOTROPIC MEDICATION

This section of the Staff Brief identifies the circumstances under which psychotropic medications may be administered involuntarily to an individual who is opposed to administration of the medication.

A guardian may not consent to the involuntary administration of psychotropic medications to their ward unless they are specially authorized to do so in a court order issued under s. 55.14, Stats., as described below. [s. 54.25 (2) (d) 2. ab., Stats.]

As described above in the discussion of consent to voluntary administration of psychotropic medications, the authority of an agent acting under an activated POAHC to consent to the involuntary administration of psychotropic medications to their principal may be limited when the principal is protesting.

Involuntary Administration of Psychotropic Medications in Emergency Situations

As discussed above, Wisconsin law generally requires a physician to obtain informed consent to all treatment, including psychotropic medications, that they provide to any person.

However, informed consent is not required in "emergencies where failure to provide treatment would be more harmful to the patient than treatment." [s. 448.30 (5), Stats.] The statute does not specifically address whether it authorizes a physician to provide treatment not only without consent, but also against the wishes of the patient.

Psychotropic medications that have not been ordered by a court may be administered to a "patient" against their wishes in a situation in which the medication is necessary to prevent serious physical harm to the patient or to others. In this context, "patient" means a person receiving services for mental illness developmental disabilities, alcoholism, or drug dependency, including a person subject to emergency detention or involuntary commitment. [s. 51.61 (1) (intro) and (g)1., Stats.]

Involuntary Administration of Psychotropic Medications Pursuant to a Medication Order Under Ch. 51

The statutes do not contain any procedure for obtaining a court order for administration of psychotropic medications without consent during the period of emergency detention, prior to the probable cause hearing. However, as discussed above, psychotropic medications may be administered without consent to an individual who is under emergency detention if the medication is necessary to prevent serious physical harm to the patient or others. [s. 51.15 (8) and 51.61 (1) (g) 1., Stats.]

At or after the hearing to determine probable cause for commitment but prior to the final commitment order, a court may order administration of psychotropic medications without consent to an individual who is the subject of a petition for commitment under ch. 51 if the court holds a hearing and determines that there is probable cause to believe the individual is not competent to refuse medication and that the treatment will have therapeutic value and will not unreasonably impair the ability of the individual to prepare for or participate in subsequent legal proceedings. [s. 51.61 (1) (g) 2. and 3., Stats.]

Following a final order for commitment, the court may hold a hearing to determine whether to order the administration of medication to the individual without the individual's consent. The court may hold a hearing on its own motion, or, if any interested person makes a motion requesting a hearing, it must hold a hearing on the issue within 10 days of request. A report, if any, on which the motion is based must accompany the motion and must include a statement signed by a licensed physician that asserts that the subject individual needs medication or treatment and that the individual is not competent to refuse medication or treatment, based on an examination of the individual by a licensed physician. If the court determines that the individual is not competent to refuse medication or treatment, it may issue the order.

An individual is not competent to refuse medication or treatment if, because of mental illness, developmental disability, alcoholism, or drug dependence, and after the advantages and disadvantages of and alternatives to accepting the particular medication or treatment have been explained to the individual, one of the following is true:

- The individual is incapable of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives.

- The individual is substantially incapable of applying an understanding of the advantages, disadvantages, and alternatives to his or her mental illness, developmental disability, alcoholism, or drug dependence in order to make an informed choice as to whether to accept or refuse medication or treatment. [s. 51.61 (1) (g) 3., Stats.]

Following a final commitment order for an individual who is determined to meet the commitment standard under s. 51.20 (1) (a) 2. e., Stats., the court *must* issue an order permitting medication or treatment to be administered to the individual regardless of his or her consent. Section 51.20 (1) (a) 2. e., Stats., is commonly referred to as the "fifth standard" for involuntary commitment and applies only to individuals who are mentally ill. [s. 51.61 (1) (g) 3m., Stats.]

Involuntary Administration of Psychotropic Medications as an Emergency Protective Service

As discussed above, psychotropic medications may be administered to an individual without consent as an emergency protective service. Emergency protective services may be provided for up to 72 hours when there is reason to believe that if the emergency protective services are not provided, the individual entitled to the services, or others, will incur a substantial risk of serious physical harm. [s. 55.13 (1), Stats.]

If a petition for protective services is filed, and the court finds probable cause that the person meets the criteria for protective services, the court may order that emergency protective services, including administration of psychotropic medications without consent, be provided until the time of the hearing, up to a maximum of 60 additional days. Emergency protective services may not be provided during the period, if any, between the end of the initial 72-hour period and the probable cause hearing on the petition for protective services. A petition for guardianship must accompany the petition for protective services. [s. 55.13 (1), (2), and (3), Stats.]

Involuntary Administration of Psychotropic Medications as a Protective Service

A court may authorize a guardian to consent to the involuntary administration of psychotropic medications to the ward as a protective service under s. 55.14, Stats. A guardian may not consent to involuntary administration of psychotropic medications on behalf of the ward under any other situation.

"Involuntary administration of psychotropic medication" means any of the following:

- Placing psychotropic medication in an individual's food or drink with knowledge that the individual protests receipt of the psychotropic medication.
- Forcibly restraining an individual to enable administration of psychotropic medication.
- Requiring an individual to take psychotropic medication as a condition of receiving privileges or benefits. [s. 55.14 (1) (a), Stats.]

A person is considered to be protesting against taking medication if they make more than one discernible negative response, other than mere silence, to the offer of, recommendation for, or other proffering of voluntary receipt of psychotropic medication. "Protest" does not mean a

discernible negative response to a proposed method of administration of the psychotropic medication. [s. 54.25 (2) (d) 2.ab and 55.14 (1) (c), Stats.]

The general requirements for obtaining an order for involuntary administration of psychotropic medications as a protective service are as follows.

A petition for involuntary administration of psychotropic medications must be filed, and must contain all of the allegations required for a standard petition for protective services and, in addition, must allege that all of the following are true:

- A physician has prescribed psychotropic medication for the individual.
- The individual is not competent to refuse psychotropic medication. An individual is not competent to refuse psychotropic medication if, as a result of developmental disability, degenerative brain disorder, serious and persistent mental illness, and after the advantages and disadvantages of and alternatives to accepting the particular psychotropic medication have been explained to the individual, one of the following is true:
    - The individual is incapable of expressing an understanding of the advantages and disadvantages of accepting treatment and the alternatives to accepting treatment.
    - The individual is substantially incapable of applying an understanding of the advantages, disadvantages, and alternatives to his or her condition in order to make an informed choice as to whether to accept or refuse psychotropic medication. [s. 55.14 (b), Stats.]
- The individual has refused to take the psychotropic medication voluntarily or attempting to administer psychotropic medication to the individual voluntarily is not feasible or is not in the best interests of the individual. The petition must state the reasons, if known, for the individual's refusal to take the medication voluntarily and evidence showing that a reasonable number of attempts to administer the medication voluntarily using appropriate interventions have been unsuccessful.
- The condition for which the medication has been prescribed is likely to be improved by the medication and the individual is likely to respond positively to the medication.
- Unless psychotropic medication is administered involuntarily, the individual will incur a substantial probability of physical harm, impairment, injury, or debilitation or will present a substantial probability of physical harm to others, which must be shown by specific evidence. [s. 55.14 (3), Stats.]

The petition must include the written statement of a physician who has personal knowledge of the individual regarding the appropriate use of psychotropic medication for the individual's condition and specific data that indicates that the individual's current condition necessitates the use of psychotropic medication. [s. 55.14 (4), Stats.]

The GAL must report to the court whether the allegations in the petition are true, and whether involuntary administration of psychotropic medication is in the best interests of the individual. [s. 55.14 (5), Stats.]

The court may issue an order authorizing the individual's guardian to consent to involuntary administration of psychotropic medication to the individual and may order involuntary administration of psychotropic medication to the individual as a protective service, with the guardian's consent, if the court or jury finds by clear and convincing evidence that the allegations in the petition are true, psychotropic medication is necessary for treating the individual's condition, and all other requirements for ordering protective services have been met.

An order for involuntary administration of psychotropic medication as a protective service must do all of the following:

- Direct the development of a treatment plan for the individual, including a plan for the involuntary administration of psychotropic medication as ordered by the individual's treating physician. If the individual resides in a nursing home or hospital, the hospital must develop the treatment plan. If the individual resides elsewhere, the nursing home or county department must develop the treatment plan. The treatment plan must be approved by the guardian and reviewed and approved by the court. If the court approves the plan, the court must order the county department to ensure that psychotropic medication is administered in accordance with the plan.
- Order the individual to comply with the treatment plan, and specify the methods of involuntary administration of psychotropic medication to which the guardian may consent. An order authorizing the forcible restraint of an individual shall require a registered nurse, licensed practical nurse, physician, or physician's assistant to be present at all times that psychotropic medication is administered in this manner and must require the person or facility using forcible restraint to maintain records stating the date of each administration, the medication administered, and the method of forcible restraint utilized. [s. 55.14 (8), Stats.]

PART IV – NURSING HOME REGULATIONS RELEVANT TO THE CARE OF PEOPLE WITH ALZHEIMER'S DISEASE AND RELATED DEMENTIAS

Wisconsin law defines, "nursing home" as a place where five or more persons who are not related to the operator or administrator reside, receive care or treatment and, because of their mental or physical condition, require access to 24-hour nursing services, including limited nursing care, intermediate level nursing care, and skilled nursing services. "Nursing home" does not include any of the following:

- A convent or facility owned or operated exclusively by and for members of a religious order that provides reception and care or treatment of an individual.
- A hospice that directly provides inpatient care.
- A residential care apartment complex. [s. 50.01 (3), Stats.]

A nursing home must designate itself as either an intermediate care or skilled care facility, and must adhere to the requirements applicable to that type of facility. [s. DHS 132.14 (1), Wis. Adm. Code.]

All nursing homes in Wisconsin must be licensed by DHS and comply with the applicable requirements of ch. 50, Stats., and ch. DHS 132, Wis. Adm. Code. [s. 50.03, Stats.] Federally certified nursing homes (those that participate in the federal Medicare or Medicaid programs) are also subject to the federal regulations, most notably those set forth in 42 CFR 483.

This Part of the Staff Brief describes provisions of ch. 50, Stats., and ch. DHS 132, Wis. Adm. Code, that may be of particular relevance to the work of the committee. Specifically, it describes provisions relating to the following:

- Admission and retention of residents requiring certain care levels.
- Admission and retention of abusive residents.
- Transfer or discharge of a resident from a nursing home.
- The use of chemical and physical restraints.
- Housing residents in locked units.
- Administration of medications.
- The requirement that a nursing home obtain written informed consent before administering certain psychotropic medications to residents.
- The requirement that a nursing home report the death of a resident related to the use of a psychotropic medication or physical restraint.

Admission and Retention of Residents Requiring Certain Care Levels

A nursing home may not admit or retain persons who require services which the nursing home does not provide or make available. No person who requires care greater than that which the facility is licensed to provide may be admitted to or retained in the nursing home. No resident whose condition changes to require care greater than that which the nursing home is licensed to provide may be retained in the nursing home. [s. DHS 132.51 (1) (b) and (2) (a), Wis. Adm. Code.]

Admission and Retention of Abusive Residents

A nursing home may not admit or retain residents who are known to be destructive of property, self-destructive, disturbing or abusive to other residents, or suicidal unless the facility has and uses sufficient resources to appropriately manage and care for them.

"Abusive" describes a resident whose behavior involves any single or repeated act of force, violence, harassment, deprivation, or mental pressure which does or reasonably could cause physical pain or injury to another resident, or mental anguish or fear in another resident. [s. DHS 132.51 (2) (c), Wis. Adm. Code.]

Transfer or Discharge of a Resident From a Nursing Home

A nursing home may not discharge a resident or transfer them to another a facility, except under one of the following circumstances:

- Upon the request or with the informed consent of the resident or guardian.
- For nonpayment of charges, following reasonable opportunity to pay any deficiency.
- If the resident requires care other than that which the nursing home is licensed to provide.
- If the resident requires care which the nursing home does not provide and is not required to provide.
- For medical reasons as ordered by a physician.
- In case of a medical emergency or disaster.
- If the health, safety, or welfare of the resident or other residents is endangered, as documented in the resident's clinical record.
- If the resident does not need nursing home care.
- If the short-term care period for which the resident was admitted has expired.
- As otherwise permitted by law.

Except for transfers or discharges for nonpayment or in a medical emergency, no resident may be involuntarily transferred or discharged unless an alternative placement is arranged for the resident. The resident must be given reasonable advance notice of any planned transfer or discharge and an explanation of the need for and alternatives to the transfer or discharge except when there is a medical emergency. The nursing home, agency, program, or person to which the

resident is transferred must have accepted the resident for transfer in advance of the transfer, except in a medical emergency.

The nursing home must provide the resident at least 30 days notice of an involuntary transfer or discharge, and must hold a planning conference at least 14 days before the transfer or discharge. These requirements do not apply if the continued presence of the resident endangers the health, safety, or welfare of the resident or other residents.

A resident may appeal an involuntary transfer or discharge following specified procedures set forth in the regulations. Appeal is made to the DHS Bureau of Quality Assurance. The appeal procedures do not apply if the continued presence of the resident poses a danger to the health, safety or welfare of the resident or other residents.

Every nursing home must have in effect a transfer agreement with one or more hospitals under which inpatient hospital care or other hospital services are available promptly to the nursing home's residents when needed. Each intermediate care nursing home must also have in effect a transfer agreement with one or more skilled care facilities.

[s. DHS 132.53, Wis. Adm. Code.]

Use of Chemical and Physical Restraints

Every nursing home resident has the right to be free from mental and physical abuse, and be free from chemical and physical restraints except as authorized in writing by a physician, physician assistant, or advanced practice nurse prescriber for a specified and limited period of time and documented in the resident's medical record. (The Wisconsin Administrative Code provides that physical or chemical restraints may be applied or administered only on the written order of a physician.) The order must indicate the resident's name, the reason for restraint, and the period during which the restraint is to be applied. Physical restraints must be of a type which can be removed promptly in an emergency, and must be the least restrictive type appropriate to the resident. Nursing personnel must check a physically restrained resident as necessary, but at least every two hours, to see that the resident's personal needs are met and to change the resident's position.

"Physical restraints" includes, but is not limited to, any article, device, or garment that interferes with the free movement of the resident and that the resident is unable to remove easily, and confinement in a locked room. "Chemical restraints" is not defined.

Physical restraints may be used in an emergency when necessary to protect the resident from injury to himself or herself or others or to property. However, authorization for continuing use of the physical restraints must be secured from a physician, physician assistant, or advanced practice nurse prescriber within 12 hours. Any use of physical restraints must be noted in the resident's medical records. [s. 50.09 (1) (k), Stats., and s. DHS 132.60 (6), Wis. Adm. Code.]

Housing Residents in Locked Units

Wisconsin law generally prohibits a nursing home from housing a resident in a locked unit. A locked unit means a ward, wing, or room which is designated as a protective environment and is secured in a manner that prevents a resident from leaving the unit at will. A physical restraint

applied to the body is not a locked unit. A facility locked for purposes of security is not a locked unit, provided that residents may exit at will.

Physical or chemical restraints or repeated use of emergency restraints, as described below, may not be used to circumvent this restriction. Placement in a locked unit must be based on the determination that the placement is the least restrictive environment consistent with the needs of the person.

A resident may be housed in a locked unit if the resident has provided a written, signed consent, given without duress and the resident is capable of understanding the nature of the locked unit, the circumstances of his or her condition, and the meaning of the consent to be given. The consent may be revoked by the resident at any time. Consent is effective only for 90 days from the date of the consent, unless revoked earlier.

A resident may be housed in a locked unit without consent if the resident is subject to a protective placement order and either: (a) the court that issued the order made a specific finding of the need for a locked unit; or (b) the resident is transferred to a locked unit following the transfer procedures set forth in s. 55.15, Stats., governing transfers of persons who have been protectively placed.

A resident may also be housed in a locked unit without consent in an emergency, if necessary to protect the resident or others from injury or to protect property, provided the nursing home immediately attempts to notify the physician for instructions. A physician's order for the confinement must be obtained within 12 hours. No resident may be confined for more than an additional 72 hours under order of the physician. [s. DHS 132.33, Wis. Adm. Code.]

Administration of Medications

Medications may be administered only as ordered by an authorized prescriber subject to the resident's right to refuse them. No medication, treatment, or changes in medication or treatment may be administered to a resident without an authorized prescriber's written order which must be filed in the resident's clinical record.

Oral orders must be immediately written, signed, and dated by the nurse, pharmacist, or therapist on the prescriber's order sheet, and must be countersigned by the prescriber and filed in the resident's clinical record within 10 days of the order.

Medication may only be administered by a nurse or other person licensed to prescribe and administer medications, or a person who has completed training in a drug administration course approved by DHS. [s. DHS 132.60 (5), Wis. Adm. Code.]

Reports of Deaths Related To Psychotropic Medication or Use of Restraints

A nursing home must report to DHS the death of any resident if there is reasonable cause to believe that the death was related to the use of a physical restraint or an antipsychotic, antidepressant, lithium carbonate, or a tranquilizer. The nursing home must make the report within 24 hours of the death.

"Physical restraint" for the purpose of this provision includes the use of a locked room, a device, or garment that interferes with an individual's freedom of movement and that the individual is unable to remove easily or restraint by a facility staff member of a resident by use of physical force. [s. 50.04 (2t) (b) 1., Stats.]

Informed Consent for Administration of Certain Psychotropic Medications

When certain psychotropic medications are given to a nursing home resident who has a degenerative brain disorder, the statutes require that a special procedure be followed to obtain informed consent. The procedure applies to any of the following psychotropic medications that have a Food and Drug Administration (FDA)-mandated "boxed warning:" antipsychotic, an antidepressant, lithium carbonate, or a tranquilizer. A boxed warning is a type of warning that the FDA may require pharmaceutical companies to include on the label of a dangerous medication; it provides critical information for the prescriber, including any restrictions on distribution or use. [s. 50.08 (1) (d), (2) and (3), Stats., and 21 CFR 201.57.]

A physician, advanced nurse practitioner, or physician's assistant who prescribes a psychotropic medication described above to a nursing home resident who has a degenerative brain disorder must notify the nursing home that the prescribed medication has a boxed warning. [s. 50.08 (2), Stats.]

Prior to the administration of a psychotropic medication described above, the nursing home must obtain written informed consent on a form provided by DHS. The informed consent may be provided by the resident or, if he or she is incapacitated, by a guardian or health care agent. The standards to which a guardian or health care agent must adhere in making this decision are outlined in Part III of this Staff Brief. Also, as described above, if the resident opposes the administration of psychotropic medication, the authority of a guardian or a health care agent to consent to psychotropic medication is limited.

The written informed consent required for administration of the psychotropic medications listed above is valid for the period specified in the written consent, or until 15 months after the date the written consent was made, whichever is shorter. [s. 50.08 (3) (e), Stats.] A resident, guardian, or health care agent may withdraw the consent in writing at any time. [s. 50.08 (3) (f), Stats.]

The written consent described above is not required if the prescription was written or reauthorized while the resident was off the nursing home's premises. [s. 50.08 (3m), Stats.]

The statutes contain an exception for emergency situations. Written consent is not required when all of the following apply:

- The resident is not the subject of a court order to administer psychotropic medications under s. 55.14, Stats.
- There is an emergency in which a resident is at significant risk of physical or emotional harm or the resident puts others at significant risk of physical harm and in which time and distance preclude obtaining written informed consent before administering psychotropic medication.

- A physician has determined that the resident or others will be harmed if the psychotropic medication is not administered before written informed consent is obtained.

If the emergency exception applies, before the nursing home administers the psychotropic medication, it must obtain the oral consent of the resident or, if he or she is incapacitated, a guardian or health care agent. If the nursing home is able to obtain oral consent, the nursing home may administer the psychotropic medication for up to 10 days, at which time no more medication may be given until written consent has been obtained. If the resident is incapacitated and the nursing home has made a good faith effort to obtain the oral consent of guardian or health care agent, but has been unable to contact such person, the nursing home may administer the psychotropic medication for up to 24 hours before oral or written consent is obtained. [s. 50.08 (4), Stats.]