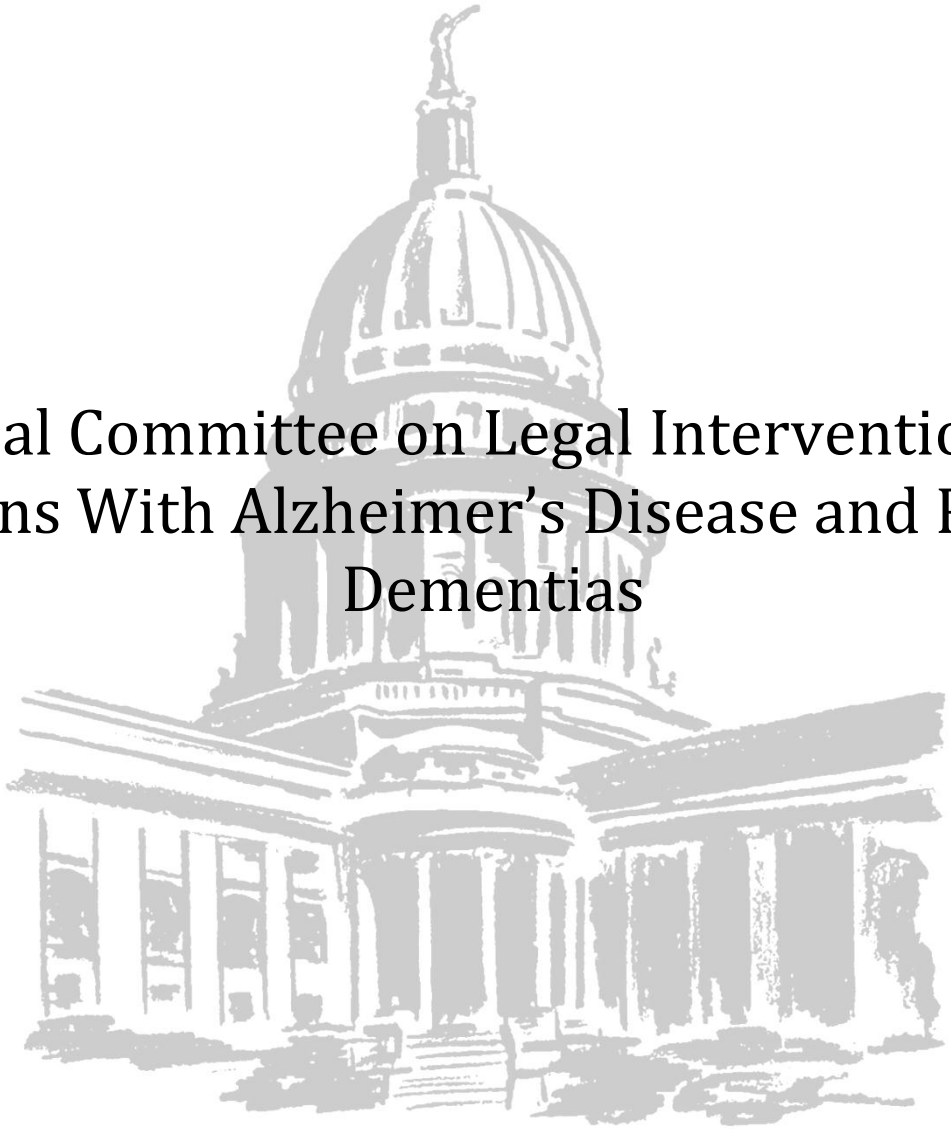
Report to the Joint Legislative Council



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

February 6, 2013

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SPECIAL COMMITTEE ON LEGAL INTERVENTIONS FOR PERSONS WITH ALZHEIMER'S DISEASE AND RELATED DEMENTIAS

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February 6, 2013

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PART I
KEY PROVISIONS OF COMMITTEE RECOMMENDATIONS

The Special Committee on Legal Interventions for Persons With Alzheimer's Disease and Related Dementias recommends the following bill draft to the Joint Legislative Council for introduction in the 2013-14 Session of the Legislature.

WLC: 0061/2, RELATING TO PSYCHIATRIC AND BEHAVIORAL CARE AND TREATMENT FOR INDIVIDUALS WITH DEMENTIA

The draft does all of the following:

- Specifies that individuals with dementia are not subject to emergency detention and involuntary commitment procedures under ch. 51, Stats., the Mental Health Act.
- Creates a new subchapter in ch. 55, Stats., titled "Psychiatric and Behavioral Care and Treatment for Individuals With Dementia", which establishes procedures within the protective placement system for the provision of behavioral and psychiatric evaluation, diagnosis, services and treatment, including involuntary administration of psychotropic medication, to individuals with dementia.
- Requires each county department to identify at least one location as a dementia crisis unit for the purpose of emergency and temporary protective placement for behavioral or psychiatric evaluation, diagnosis, services, or treatment for individuals with dementia.
- Creates procedures within the new subchapter under which individuals with dementia may be protectively placed or transferred to dementia crisis units, in a planned manner or in an emergency situation, for the purpose of behavioral or psychiatric evaluation, diagnosis, services, or treatment.
- Creates a procedure under which involuntary administration of psychotropic medication may be provided as an emergency protective service to an individual with dementia.

OTHER RECOMMENDATIONS

The Special Committee also submitted letters, with recommendations related to the committee's charge, to the following recipients:

- Senator Luther Olsen and Representative Joan Ballweg, Co-Chairs, Joint Legislative Council. The letter was signed by Chair Knodl, on behalf of the Special Committee, to express the committee's support for the proposed redesign of the state's care delivery

systems for individuals with dementia, as set forth in the recommendations provided to the Special Committee by the Department of Health Services (DHS).

- Dennis Smith, Secretary, DHS, and Attorney General J.B. Van Hollen. The letter was signed by Chair Knodl, on behalf of the Special Committee, to request that DHS and the Department of Justice (DOJ) provide clear guidance to educate and inform stakeholders across the state about procedures to be followed for involuntary treatment of individuals with dementia in light of the *Helen E.F.* case and pending changes to chs. 51 and 55, Stats.

PART II
COMMITTEE ACTIVITY

ASSIGNMENT

The Joint Legislative Council established the Special Committee on Legal Interventions for Persons With Alzheimer's Disease and Related Dementias, and appointed the chairperson, by an April 24, 2012 mail ballot. The committee was directed to review and develop legislation to clarify the statutes regarding guardianship, protective placement, involuntary commitment, and involuntary treatment as they apply to vulnerable adults with a dementia diagnosis who may or may not have a co-occurring psychiatric diagnosis.

Membership of the Special Committee was appointed by a May 31, 2012 mail ballot. The final committee membership consisted of two Senators, two Representatives, and 12 public members. A subcommittee was established at the October 18, 2012 meeting of the Special Committee. A list of subcommittee members and members of the Special Committee are included as ***Appendix 3*** to this report.

SUMMARY OF MEETINGS

The Special Committee held five meetings on the following dates:

July 31, 2012
September 12, 2012
October 18, 2012
November 14, 2012
December 17, 2012

The subcommittee held four meetings on the following dates:

November 2, 2012
November 5, 2012
December 5, 2012
December 6, 2012

At the July 31, 2012 meeting, the Special Committee heard invited testimony from several speakers.

Andy Phillips, General Counsel, Wisconsin Counties Association, presented information on behalf of Wisconsin counties regarding how they may be impacted by the *Helen E.F.* case. According to Mr. Phillips, counties are less concerned with the specific underlying condition that may cause a person's behavior, than with the behavior itself and any safety risk that may be posed

by the behavior. Mr. Phillips urged the committee to emphasize practical solutions giving counties the ability to address safety risks presented by challenging behaviors.

Dyann Hafner, Corporation Counsel, Dane County, expressed concern that when challenging behaviors arise, counties may not have practical solutions or interventions at their disposal to address the situation. Ms. Hafner relayed details of a recent situation from another county, in which police refused to initiate an emergency detention under ch. 51, Stats., because they believed the *Helen E.F.* case prevented them from doing so. Ms. Hafner recommended that the committee amend ch. 55, Stats., to make it easier to use and more suitable for emergency situations.

Scott Ethun, Director, Juneau County Human Services, explained that his approach to the decision in *Helen E.F.*, which limited the county's ability to use ch. 51, Stats., is to look elsewhere to find "safe options," which are largely unavailable. Mr. Ethun emphasized the distinction between short-term and long-term care. He gave examples in which an individual is moved to a psychiatric unit and receives psychotropic medication, and is then able to be moved out of the psychiatric unit after two to five days to be managed in the community. This type of "acute" care can be extremely helpful in some situations, but nursing homes are not currently set up to provide it. Mr. Ethun also emphasized the role of adult family homes in providing long-term care for these individuals.

Dr. Sara Coleman, Psychologist, Mobile Crisis Team, and Ramona Williams, Elder Abuse/Adult Protective Services Coordinator, Milwaukee County Behavioral Health Division, suggested changes to chs. 51, 55, and 155, Stats. These include amending ch. 51, Stats., to specify how it applies to patients with dementia, and in cases where ch. 51, Stats., is inappropriate, to create a clear pathway of referral to an appropriate system of emergency care. They suggested several changes to strengthen ch. 55, Stats., for the implementation of emergency protective placement and services. They also suggested changes to ch. 155, Stats., including the vesting of authority in a health care agent acting under a power of attorney for health care to consent to admission to an acute psychiatric inpatient unit or the involuntary administration of psychotropic medication.

Robert Gundermann, Public Policy Director, Alzheimer's and Dementia Alliance of Wisconsin, discussed the need for psychiatric units to be made available for the treatment of persons with dementia. Individuals with dementia who are in facilities that can no longer deal with them would be better served in a "geriatric psych" unit, especially when medication issues arise. Mr. Gundermann discussed the use of psychotropic medications and cautioned against relaxing the standards for administration of such drugs, which, in his opinion, are widely overused. He also advocated increased training and use of techniques for caretakers to avoid the need for detention or placement under ch. 51 or 55, Stats.

Kim Marheine, Ombudsman Services Supervisor, Board on Aging and Long-Term Care, provided information regarding the Wisconsin Long-Term Care Ombudsmen Program, a federally mandated advocacy service for residents of long-term care facilities. Ms. Marheine explained why nursing homes are often not equipped to deal with dementia patients exhibiting challenging behaviors. She described practical and legal challenges facing surrogate decision-makers seeking to consent to treatment on behalf of a patient with dementia. Ms. Marheine stressed that facilities and providers should not be allowed to avoid caring for difficult patients, but should instead be

invested with the tools and training to provide patients with required care and the all-important feeling of having a home.

Carol Wessels, Shareholder, Nelson, Irvings & Waeffler, S.C., Milwaukee and Former Chair, Elder Law Section, State Bar of Wisconsin, stated that "a tsunami is approaching in terms of the growth of Alzheimer's" due to demographic changes in society. She urged the committee to review the *2012 Alzheimer's Facts and Figures* report published by the Alzheimer's Association. Several of the required legal changes, according to Ms. Wessels, concern the use of a power of attorney for health care for advance planning for dementia. Ms. Wessels made a case that involuntary commitment under ch. 51, Stats., is inappropriate for Alzheimer's patients in all cases, because challenging behaviors are communication related, and ch. 51, Stats., does not allow for notice to, or participation by, family members or agents of the individual.

Mark Radmer, Administrator, and Karen Wagner, Director of Social Services, Harbor Haven Health and Rehabilitation, discussed the regulatory environment affecting nursing homes and the difficulties of responding to challenging resident behaviors with limited resources. They explained that successful strategies have been used at their facility, including staff training, use of care plans and assessments, meetings with family members, and use of a 1:1 staff-to-resident ratio, when necessary. They emphasized the need for all parties to remain open to all ideas, and that nursing homes need an option to temporarily relocate residents who are dangerous, provided that the nursing home has done everything possible to prevent this from occurring.

Jerry L. Halverson, M.D., Medical Director for Adult Services, Rogers Memorial Hospital, stated that the goal of the committee should be to ensure that the correct care is delivered to the right patient at the right time. Dr. Halverson discussed reasons that current law presents obstacles to providing treatment for a person with dementia when they have a psychiatric disorder or the dementia itself is causing a behavioral disturbance that can be treated. These individuals may need acute psychiatric treatment, but often do not receive it. He also stated that when treatment in a psychiatric unit is unavailable or inappropriate, for individuals with dementia, it is difficult to find protective placement facilities that will accept them.

Mike Pochowski, Wisconsin Assisted Living Association; Manager, Government Affairs & Legal Operations, Brookdale Senior Living Inc., explained that the *Helen E.F.* decision has resulted in a number of new concerns for long-term care providers. These include concerns that residents will not have access to psychiatric and behavioral services when required and that families may fail to disclose a prospective resident's aggressive behaviors based on a concern that they will not be accepted for admission. Mr. Pochowski suggested that ch. 51, Stats., be amended to allow it to apply to persons with degenerative brain disorders. Mr. Pochowski pointed to Florida's Baker Act as a model that could be used to address these issues.

Dr. Mark Sager, Director, Wisconsin Alzheimer's Institute, University of Wisconsin School of Medicine and Public Health, cited the importance of the committee's work given that demographic trends suggest that the incidence of Alzheimer's Disease and dementia is increasing. He also stressed the need to consider issues from the perspective of the large majority of individuals with dementia who live at home as opposed to in a facility. Dr. Sager expressed his concern that individuals with dementia who also have treatable psychiatric disorders may not get access to

care that is needed to treat those disorders. He discussed ways to encourage behavioral treatments, methods, and training to prevent challenging behaviors from arising, to the extent possible, which may include certifying individuals with specialized training as dementia specialists.

Mary Salzeider, Training Coordinator, Alzheimer's and Dementia Alliance of Wisconsin, explained her work training caregivers to use communication and behavioral techniques to minimize challenging behaviors in patients with Alzheimer's Disease or related dementia. Training in using these techniques must be ongoing, according to Ms. Salzeider, in order to be successful. In addition, she emphasized the need to employ these techniques comprehensively, so that they are used by every caregiver, family member, and facility employee with whom the patient comes in contact.

Cagney Martin, Activity Therapist, and Lori Koeppel, Nursing Home Administrator, North Central Health Care, described their four-year effort to create a specialized dementia care program in their facility, based on a resident-centered model. They described the use of assessment tools, environmental changes, staff hiring decisions, creation of specialized CNA positions, the reduction of the use of antipsychotic medications, and attempts to change the culture of the facility. Outcomes have included a reduction in challenging behaviors and in the use of restraints within the facility. They also described their efforts to reach out to other facilities and programs to support increased use of behavioral approaches to address challenging behaviors. This led to the development of a training program called "Stop Starting It" that has been well received.

Dr. Robert Smith, Past President and Board Member, Wisconsin Association of Medical Directors, stated that in his view, the population that needs help are those patients with acute behavior incidents that require short-term help, with a goal of returning them to the place they were living prior to the acute treatment. The committee should focus its efforts on amending the statutes as needed to ensure that this short-term treatment may be provided to those who need it. Dr. Smith also emphasized that every dementia is unique, and circumstances and support networks are different in every case, so each case must be evaluated on an individual basis. He said that many behavioral interventions are very effective, but they will not be effective in all cases, and a short-term acute care option should be retained as an available tool.

At the September 12, 2012 meeting, the Special Committee heard invited testimony from several speakers and discussed *Memo No. 1, Summary of Recommendations Made to the Special Committee at the July 31, 2012 Meeting.*

Charlie Morgan, Program Supervisor and Grant Cummings, Fiscal Analyst, Legislative Fiscal Bureau presented the information contained in the memorandum to Representative Dan Knodl, Chair, from Grant Cummings, Fiscal Analyst, Legislative Fiscal Bureau, *Use of Chapter 51 and 55 Procedures to Address Challenging Behaviors of Individuals With Alzheimer's Disease and Dementia* (July 24, 2012). Mr. Cummings also provided a handout containing the following information: *Individuals with Dementia Admitted to Public or Private Inpatient Facilities, Calendar Year 2011*, and *Mendota Mental Health Institute Admissions of Civil Patients with Primary Diagnosis of Dementia, by County*.

Mr. Cummings stated that although the statutes require all counties to establish an intake facility for ch. 55, Stats., placements, not all counties have done so. He said that in the course of gathering information for the memorandum, various individuals stated that if an individual is placed in a psychiatric hospital or unit under ch. 51, Stats., it may be difficult to find a long-term care facility that is willing to accept the person as a resident when they are ready for discharge. It was also stated that if a person's initial placement is a psychiatric facility, the individual is subjected to the stress of moving to a new residential setting upon completion of treatment. Concerns were also expressed that if pressure is placed on nursing homes to keep residents in-house even when they exhibit difficult behaviors, nursing homes may be reluctant to accept individuals with dementia for initial placement even if they do not have a history of difficult behavior.

Otis Woods, Division Administrator, and Pat Benish, Program Specialist, Division of Quality Assurance (DQA), DHS, described the duties and activities of DQA in regulating and licensing nursing homes and assisted-living facilities. He discussed the regulations that require a facility to remove a resident if their behavior becomes injurious to themselves or others, and the work DQA has done to promote "person-centered care" in nursing homes. He explained that Wisconsin does not have any special regulations for facilities that serve individuals with dementia. When asked about citations related to challenging behaviors by residents with dementia, Mr. Woods said that DQA staff realizes that these behaviors can be unpredictable, but it is expected that when a resident initially demonstrates this type of behavior, the facility will take appropriate steps such as making changes to the individual's plan of care so that the facility can provide a coordinated response when the behavior recurs. He said DQA is in the process of developing training to be provided to DQA staff in how to evaluate the appropriateness of a facility's response to an individual with Alzheimer's Disease.

Mr. Woods explained that DQA inspects nursing homes for compliance with state regulations and also for compliance with federal regulations on behalf of the federal Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS). He stated that although CMS is not, to the best of his knowledge, currently developing special standards for Alzheimer's facilities, CMS has undertaken some special initiatives for care of people with dementia.

Dr. Molli Rolli, Medical Director, Mendota Mental Health Institute (MMHI), described the services provided to patients with dementia at the specialized geriatric unit at MMHI. She said that the high staffing levels and care provided by occupational and physical therapy staff are crucial to success with this population. She said MMHI is intended for short-term stays to stabilize people and get them back to their normal residential setting. She said that since MMHI is very expensive, counties don't typically send individuals to MMHI unless they truly need the high level of care that MMHI provides. Individuals with dementia typically come to MMHI via a ch. 51, Stats., emergency detention which is converted to a ch. 55, Stats., proceeding at the probable cause hearing. After the conversion, MMHI may hold the individual for up to 30 days, which is typically long enough to provide adequate treatment; however, she suggested allowing the 30 days to be increased, when needed, by allowing for an extension period after judicial review.

Dr. Rolli said a high level of expertise is needed to determine whether an elderly individual demonstrating challenging behaviors has dementia, another psychiatric diagnosis, or both. She said this diagnosis cannot be made "on the spot" in an emergency situation. Dr. Rolli also said that some individuals with dementia need to be treated with psychotropic medication and better access to mental health assessment and treatment could help avoid the need to transfer some individuals with dementia to MMHI.

Alice Page, JD, MPH, Adult Protective Services and Systems Developer, Bureau of Aging and Disability Resources, Division of Long Term Care, described the activities of the Division of Long-Term Care relevant to individuals with dementia, including the adult protective services system and the adults-at-risk abuse response and reporting system. She explained the role of counties in these systems and how the systems interact. Ms. Page also described the funding and operations of Aging and Disability Resource Centers (ADRCs), which can provide support to family members and caregivers who interact with individuals with dementia who exhibit challenging behaviors. She said a new dementia care specialist position is being created at several ADRCs.

Ms. Page discussed various approaches to addressing challenging behaviors exhibited by individuals with dementia, including person-centered care models, and discussed the risks of using psychotropic medications with this population. She explained the use of Interdisciplinary teams (I-teams) in some counties that plan community responses to situations that put adults at risk of abuse or neglect. She said the I-team approach would be a good model for providing flexibility while ensuring appropriate community responses to the needs of individuals with dementia, particularly in crisis situations.

The committee next discussed the recommendations set forth in Memo No. 1, *Summary of Recommendations Made to the Special Committee at the July 31, 2012 Meeting*, and identified issues they felt should be given priority.

At the October 18, 2012 meeting, the Special Committee heard invited testimony from several speakers, reviewed *Memo No. 2, Selected Federal Regulations and Initiatives Related to Long-Term Care Facilities*, and discussed bill drafts WLC: 0018/1, WLC: 0017/1 and WLC: 0015/P1.

Sergeant John Wallschlaeger, Community Liaison Officer, Crisis Intervention Team Officer, Appleton Police Department, provided an overview of the Crisis Intervention Team (CIT) model implemented by the Appleton Police Department beginning in 2004. Under this model, officers may volunteer to become designated as "CIT officers," and receive additional training in crisis intervention and identifying the signs and symptoms of mental illness. Sergeant Wallschlaeger described how CIT officers respond to an elderly individual in crisis, which involves efforts to de-escalate the situation and minimize use of force, as well as consultation with the appropriate county mental health department. Mr. Wallschlaeger also stated that it would be helpful if DOJ and DHS would send a letter to law enforcement agencies explaining the proper law enforcement procedures to be used in these situations in light of the *Helen E.F.* decision.

Sergeant David A. Coughlin, Racine County Sheriff's Office, provided additional perspective on the CIT model by describing its operation in Racine County. Based on their process of tracking how CIT has affected calls for service. He said commitments are down about 60%. He attributes

this to an ability to de-escalate situations and find placements other than a secure detention facility. When individuals in crisis are transported, the first priority is to have rescue personnel handle the transportation; however, law enforcement will sometimes provide transportation, and use of restraints is sometimes necessary to ensure safety. Sergeant Coughlin also provided a description of the facilities available in Racine County for an individual who has dementia. He indicated that, as far as his office has observed, it is rare for those individuals to be committed under ch. 51, Stats., as opposed to being protectively placed under ch. 55, Stats.

Captain Ron Lueneburg, Rhinelander Police Department, outlined the concerns facing law enforcement agencies in the northern part of the state regarding care for elderly individuals with mental health issues. He noted that resources are more limited in his area of the state. He described some success at gathering stakeholders across several counties to work together and arrive at common understandings and approaches. Captain Lueneburg stated that when challenging behaviors arise, law enforcement is sometimes used as an expedited and convenient solution to the problem. He suggested reforming ch. 51, Stats., to address jurisdictional issues among agencies. When an overt act leads to an emergency detention, agencies in the jurisdiction where the act occurred should be responsible for the investigation, detainment, and transportation associated with the emergency detention. He said that is not the case under the current statute.

Officer Sarah Shimko, Madison Police Department, described her work as part of the mental health liaison team in Madison, and the close working relationship between the team and the county agency, Journey Mental Health. Officer Shimko also discussed the impact of the *Helen E.F.* case in Madison, which has been minimal as far as the police response is concerned. Officer Shimko advocated the making of decisions about appropriate police involvement on a more case-by-case basis. She shared a recent experience with a three-party petition for commitment under ch. 51 that involved an extended hospital wait, where there were minimal safety issues present and, therefore, it was not efficient to devote the amount of police resources that were utilized. Also, in certain cases, rather than using police for transport, it may be more efficient to transport by ambulance or other means.

After the conclusion of the above presentations, Mr. Anam provided an overview of *Memo No. 2*, *Selected Federal Regulations and Initiatives Related to Long-Term Care Facilities*. A brief discussion followed regarding the contents and operation of the federal regulations and corresponding provisions in the Wisconsin Administrative Code.

Mr. Larson provided an overview of WLC: 0018/1, regarding authorization for certain decisions related to dementia care by an agent under a power of attorney for health care. A discussion followed regarding the practical effect of the proposed changes. A subcommittee was formed to meet on a separate date and continue to work through issues in the draft.

Ms. Matthias provided an overview of WLC: 0017/1, which creates alternatives to emergency detention and involuntary commitment under ch. 51, Stats., by creating new protective placement procedures under ch. 55, Stats. A discussion followed regarding provisions related to the facilities that would be designated to provide care to individuals with dementia under ch. 55,

Stats., as well as timelines for placement of an individual with dementia under ch. 55, Stats., and other issues. The committee agreed on several revisions to the language of the draft.

Ms. Matthias provided an overview of WLC: 0015/P1, which creates a procedure under which involuntary administration of psychotropic medication may be provided as an emergency protective service. A discussion followed regarding several issues in the draft.

After conclusion of the discussions, Chair Knodl expanded the scope of the subcommittee to include work on issues identified in all three drafts.

At the November 2, 2012 meeting, the subcommittee discussed bill drafts WLC: 0018/1, relating to authorization of an agent under a power of attorney for health care to make certain decisions related to care and treatment of irreversible dementia and to consent to the admission of the principal to certain facilities and WLC: 0017/2, relating to inpatient psychiatric treatment for individuals with irreversible dementia.

At the November 5, 2012 meeting, the subcommittee discussed bill drafts WLC: 0018/2, relating to authorization of an agent under a power of attorney for health care to make certain decisions related to care and treatment of dementia and to consent to the admission of the principal to certain facilities and WLC: 0017/3, relating to inpatient psychiatric treatment for individuals with dementia.

At the November 14, 2012 meeting, the Special Committee reviewed *Memo No. 3, Physical Separation Requirement in WLC: 0017/4*, and discussed bill drafts WLC: 0018/3, WLC: 0017/4, and WLC: 0015/2.

Mr. Larson described WLC: 0018/3, regarding authorization for certain decisions related to dementia care by an agent under a power of attorney for health care. He explained that the provision regarding involuntary administration of psychotropic medications was removed from the draft at the request of the subcommittee. After a discussion of various additional provisions, it was determined that the subcommittee would further discuss the draft at its next meeting.

Ms. Matthias described WLC: 0017/4, noting the alterations and additions made in response to discussions by the subcommittee. The committee also reviewed the suggestions set forth in *Memo No. 3, Physical Separation Requirement in WLC: 0017/4*, November 12, 2012 (Revised November 13, 2012). There was consensus among the committee members as to several issues in the draft, including the need to prohibit placements of individuals with dementia in facilities that are not equipped to care for this population. The committee discussed other issues including public input in designating care facilities, the separate unit requirement, "aftercare" placement issues, length of initial placements under ch. 55, Stats., transfer of individuals placed under ch. 55, Stats., and medical clearance issues. Staff was instructed to redraft several provisions in the draft.

Ms. Matthias described WLC: 0015/2, relating to involuntary administration of psychotropic medication as a protective service to a person with dementia. A discussion followed regarding the benefits and risks associated with treatment using psychotropic medication.

At the December 5 and 6, 2012 meetings, the subcommittee discussed *Memo No. 4, Issues Pertaining to WLC: 0017/5 and WLC: 0015/3* and *Memo No. 5, Summary of Remaining Issues in*

WLC: 0018/3, and bill drafts WLC: 0018/3, relating to authorization of an agent under a power of attorney for health care to make certain decisions related to care and treatment of dementia, WLC: 0017/5, relating to inpatient psychiatric treatment for individuals with dementia, and WLC: 0015/3, relating to involuntary administration of psychotropic medication as a protective service to a person with dementia.

At the December 17, 2012 meeting, the Special Committee heard invited testimony from DHS and discussed bill drafts WLC: 0061/1 (a consolidation of WLC: 0017/5 and WLC: 0015/3) and WLC: 0018/4.

Kitty Rhoades, Deputy Secretary, DHS; Alex Ignatowski, Legislative Liaison, DHS; and Kevin Bailey, Legal Counsel, DHS, discussed suggestions provided by DHS to the Special Committee on December 13, 2012. Ms. Rhoades applauded the efforts of the Special Committee to tackle difficult and complex issues confronting individuals with dementia who exhibit challenging behaviors. Ms. Rhoades stated that the statutes do not require modification. She said the true underlying issue is the lack of a behavior-specific system of delivering care to individuals in this population. As a result, DHS recommends a major system redesign of the community-based, facility-based, and institutional care delivery systems and capacities for this population, which will require an appropriation of additional state funds.

When asked to provide a specific recommendation regarding WLC: 0061/1, Ms. Rhoades stated that DHS would support modifications to the draft that would add a sunset provision and that would restructure the proposal as a two-year, stop-gap measure. She also said it would be appropriate to include a charge to DHS to complete the proposed two-year system redesign.

Mr. Bailey stated that DHS's opinion is that, under current law, individuals with dementia who exhibit challenging behaviors may still be subject to ch. 51, Stats., after *Helen E.F.*, in that the court left an opening for individuals with dementia to be subject to ch. 51, Stats., with a dual diagnosis.

Ms. Rhoades suggested that confusion created by the *Helen E.F.* decision would be best resolved through an information and education campaign advising stakeholders how to properly interpret the decision.

Ms. Rhoades indicated that DHS was not in favor of taking away the counties' role of designating facilities under the draft and that, beyond the materials already provided, DHS had no additional recommendations regarding the draft to provide.

Ms. Matthias provided an overview of changes recommended by the subcommittee to WLC: 0061/1 (a compilation of WLC: 0017/5 and WLC: 0015/3), relating to psychiatric and behavioral care and treatment for individuals with dementia, since the last full meeting of the Special Committee. A discussion followed regarding those changes and DHS's recommendations to add a sunset provision and a charge to DHS to complete a two-year system redesign of the system.

The committee decided not to add a sunset provision to the draft because it is unlikely that behavioral interventions and treatment in place will ever entirely eliminate the need for a small subset of individuals with dementia to receive short-term care on an involuntary basis in an

inpatient psychiatric facility. Thus, the statutory changes proposed under WLC: 0061/1 will still be needed even if the care system is redesigned as proposed by DHS.

The committee agreed express the Special Committee's support for a system redesign in a letter that could be signed by Chair Knodl on behalf of the committee.

The committee considered other issues in WLC: 0061/1 and instructed staff to change several provisions in the final draft. These included a change to the timeframe for extensions of placements or transfers of individuals with dementia under ch. 55, Stats., as well as other issues.

The committee also agreed to write a letter to DHS and DOJ regarding the education of county stakeholders and law enforcement officers regarding *Helen E.F.* and the pending statutory changes to chs. 51 and 55, Stats., as applied to individuals with dementia.

The committee declined to take up WLC: 0018/4 due to time constraints.

PART III
RECOMMENDATIONS INTRODUCED BY THE JOINT LEGISLATIVE COUNCIL

WLC: 0061/2, RELATING TO PSYCHIATRIC AND BEHAVIORAL CARE AND TREATMENT FOR INDIVIDUALS WITH DEMENTIA

Background

Currently, ch. 51, Stats., establishes the procedures and criteria under which an individual may be detained and involuntarily committed for mental health treatment. The process of initial involuntary detention is referred to as "emergency detention." An individual may be detained or committed under ch. 51, Stats., only if the individual is: (a) mentally ill, drug dependent, or developmentally disabled; (b) a proper subject for treatment; and (c) believed to be dangerous because he or she has exhibited certain behaviors described in the statutes.

Currently, ch. 55, Stats., establishes the procedures and criteria under which an individual may be provided with protective services or protective placement if the individual or others have been placed at risk of harm as a result of the individual's developmental disability, degenerative brain disorder, serious and persistent mental illness, or other like incapacity. Also, if the individual is not under guardianship, an appointment of a guardian must be included in the process.

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. In the case, Helen, an 85-year old woman suffering from Alzheimer's Disease, 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 removed from the nursing home, and eventually the circuit court issued an order for involuntary commitment in a locked psychiatric unit for up to six months, which Helen appealed.

The Wisconsin Supreme Court ultimately held 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, Stats., which would allow for her care in a facility more narrowly tailored to her needs and which would provide her with necessary additional processes and protections.

Description

Overview

The draft specifies that individuals with dementia are not subject to ch. 51, Stats., emergency detention and involuntary commitment procedures. The draft creates procedures within ch. 55, Stats., under which individuals with dementia may be protectively placed or transferred to dementia crisis units, in a planned manner or in an emergency situation, for the purpose of behavioral or psychiatric evaluation, diagnosis, services, or treatment. The draft also specifies that if an individual subject to a conversion is in a ch. 51, Stats., treatment facility at the time of conversion, and the individual has dementia, the individual may continue to be held in that facility only if it is a dementia crisis unit and the unit provides an environment that is appropriate for the individual. The draft also specifies that the corporation counsel of the county in which a conversion from ch. 51 to ch. 55, Stats., occurs must assist in conducting the ch. 55, Stats., proceedings if the subject individual has dementia.

The basic steps and statutory standards for these procedures are described below. For a complete description of the provisions of the draft, see the Prefatory Note for WLC: 0061/2.

County Designation of Dementia Crisis Unit for Emergency and Temporary Protective Placements; County Reports

The draft requires each county department to designate at least one location as a dementia crisis unit for the purpose of emergency and temporary protective placement for behavioral or psychiatric evaluation, diagnosis, services, or treatment of individuals with dementia. The draft requires the county department to solicit information and advice from the public to aid it in carrying out this responsibility. The draft also requires the county department to periodically review and update the designation and to submit a report to DHS each time a designation is made.

The draft requires DHS, by June 30 of each even—numbered year, to submit a report to the Legislature regarding the dementia crisis units designated by counties and the number of petitions filed for emergency protective placement, or temporary transfer of an individual with dementia, to a dementia crisis unit.

IAPM as an Emergency Protective Service for Individuals With Dementia

There is some disagreement as to whether, under current law, involuntary administration of psychotropic medication (IAPM) may be provided as an emergency protective service under current law. The draft creates a procedure under which IAPM may be provided as an emergency protective service to an individual with dementia. Among other requirements, the county department must immediately file a petition for IAPM as a protective service and a probable cause hearing must be held within 72 hours. If the court makes the requisite findings at the probable cause hearing, it may order IAPM to continue to be provided as an emergency protective service for up to 30 days pending the hearing on IAPM as a protective service.

IAPM as a Protective Service for Individuals With Dementia

Under current law, IAPM may be ordered as a protective service under s. 55.14, Stats., which includes procedures linked to standards and findings under ch. 51, Stats. Under current

law, among other requirements, a petition for IAPM as a protective service must include a written statement signed by a physician who has personal knowledge of the individual that provides specific data indicating that the individual's current condition necessitates the use of psychotropic medication.

The draft makes several changes to the procedure for IAPM to an individual with dementia as a protective under s. 55.14, Stats. These include modification of the required standards and findings in order to link them to those existing under ch. 55, Stats., rather than ch. 51, Stats. In addition, the physician statement must state that a physical examination has been conducted and, based on that examination, a physician has determined with reasonable probability that the behavior for which treatment is sought is not caused by a physical condition or illness that could be treated successfully by means other than psychoptropic medication. If the individual resides in a long-term care facility, the facility must first make reasonable efforts to address or accommodate the behavior or condition for which treatment with psychotropic medication is sought.

Emergency Protective Placement of an Individual With Dementia in a Dementia Crisis Unit

Under current law, an individual may be placed in a protective placement facility without a court order if he or she meets the statutory standards for emergency protective placement. The person making the emergency protective placement must file a petition for permanent protective placement, and a probable cause hearing must be held within 72 hours. If probable cause for permanent protective placement is found, the court may order temporary protective placement for up to 30 days pending the final hearing on permanent placement.

Under current law, emergency protective placement may not be made to a unit for the acutely mentally ill, and 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 under s. 51.15 or 51.20, Stats.

The draft creates a new procedure which allows emergency protective placement of an individual with dementia in a dementia crisis unit. Under the procedure, an individual may be taken into custody and transported to a medical facility or a dementia crisis unit if it appears probable that the individual or others have been placed at risk of harm, as a result of the individual's dementia, mental illness, or psychiatric condition and if, in addition, it appears probable that unless the individual is admitted to a dementia crisis unit, 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.

An individual who has been detained, as described above, may be admitted to a dementia crisis unit as an emergency protective placement if both of the following are also true:

(a) A physical examination of the individual has been conducted and a physician has determined with reasonable probability and documented in writing that the behavior is not caused by a physical condition or illness that could be treated safely and appropriately in a setting other than a dementia crisis unit and the physician recommends that the individual be placed in a dementia crisis unit for behavioral or psychiatric evaluation, diagnosis, services, or treatment.

(b) The placement is in an environment that is appropriate for the individual.

A probable cause hearing must be held within 96 hours after the individual is taken into custody for the purpose of emergency protective placement. If the individual is not under guardianship, a petition for guardianship must accompany the petition for protective placement.

If the court finds probable cause to believe that the grounds for emergency protective placement exist, it may order temporary protective placement of the individual in a dementia crisis unit for up to 45 days, pending the hearing on the petition for permanent protective placement.

The county in which the original order for protective placement of the individual was issued is responsible for transportation of the individual to any facility to which placement of the individual is ordered upon discharge of the individual from the dementia crisis unit.

The hearing on the petition for permanent protective placement must be held within 45 days after the emergency protective placement. The court may order permanent protective placement in a protective placement facility, but not a dementia crisis unit. If continued temporary placement in the dementia crisis unit is desired, a petition for extension of the order for temporary placement must be filed prior to the hearing on the petition for permanent protective placement. If the court orders permanent protective placement of the individual, the hearing on the petition for extension is held immediately after that order is issued. If the court does not order permanent protective placement of the individual, the petition for extension must be dismissed. The court may order an extension for a period of not more than 60 days.

Temporary placement in the dementia crisis unit may be extended in subsequent increments of no more than 60 days each. In each case, a hearing is required, and the court may order an extension of the temporary placement if grounds exist for continued placement of the individual, as specified in the draft.

Temporary Transfer of a Protectively Placed Individual With Dementia to a Dementia Crisis Unit

Under current law, an individual under a protective placement order may not be transferred to any facility for which commitment procedures are required under ch. 51, Stats.

The draft authorizes a court to order the transfer of an individual with dementia who is under a protective placement order to a dementia crisis unit for behavioral or psychiatric evaluation, diagnosis, services, or treatment, for a period not to exceed 45 days if the grounds specified in the draft exist, as described below.

A petition for transfer of an individual with dementia who is under a protective placement order to a dementia crisis unit must allege all of the following:

- That the individual has engaged in behavior that creates a substantial risk of serious physical harm to himself or herself or others as manifested by recent acts or omissions.
- A physician who has personal knowledge of the individual has conducted a physical examination of the individual within the past seven days and has determined that the behavior is not caused by a physical condition or illness that could be treated safely and

appropriately in a setting other than a dementia crisis unit and that the individual's behavior or condition may be improved by transfer to a dementia crisis unit.

- Unless the individual is temporarily transferred to a dementia crisis unit for behavioral or psychiatric evaluation, diagnosis, services, or treatment, the individual will incur a substantial probability of being subject to a change in permanent placement to a more restrictive setting due to the inability of the current placement facility to provide for the safety of the individual or others due to the behavior of the individual. The substantial probability must be manifested by evidence as provided in the draft.
- The protective placement facility has made reasonable efforts to address or accommodate the behavior or condition for which behavioral or psychiatric evaluation, diagnosis, services, or treatment in a dementia crisis unit is sought. These steps must be documented in the individual's plan of care before an individual may be transported to a dementia crisis unit.
- The protective placement facility has prepared detailed documentation of the behaviors or condition of the individual that necessitate inpatient behavioral or psychiatric evaluation, diagnosis, services, or treatment, including detailed information regarding efforts to address or accommodate the individual's behavior.
- The protective placement facility has a plan in place for the orderly return of the individual upon discharge from the dementia crisis unit, which specifies the conditions under which the individual will be readmitted to the facility. If the protective placement facility has determined that readmission of the individual to the facility upon discharge from the dementia crisis unit is not in the best interests of the individual, the facility must provide the court with specific factual information supporting this conclusion.

The written consent of the individual's guardian and the county department are required in order to carry out a transfer to a dementia crisis unit, except in the case of an emergency transfer.

The court must hold a hearing within 72 hours after the filing of a petition for transfer. If the court finds that the statutory standards have been met, it may order the transfer of the individual to a dementia crisis unit for a period not to exceed 45 days.

The county in which the original order for protective placement of the individual was issued is responsible for transportation of the individual to any facility to which placement of the individual is ordered upon discharge of the individual from the dementia crisis unit.

Extension of Temporary Transfer to a Dementia Crisis Unit

The order for temporary transfer to a dementia crisis unit may be extended beyond the initial 45-day period of transfer if certain requirements specified in the statute are met. A petition for extension must be filed before expiration of the order for temporary placement. At a hearing on the petition for extension, the petitioner must prove allegations similar to those required at the probable cause hearing. The court may order an extension for a period of not more than 60 days.

Subsequent Extensions of Temporary Transfer to a Dementia Crisis Unit

Temporary transfer to a dementia crisis unit may be extended in subsequent increments of no more than 60 days each. In each case, a hearing is required, and the court may issue an order extending the temporary placement for an additional period of up to 60 days, if grounds for continued temporary transfer exist.

Emergency Transfer of Placement of an Individual With Dementia to Dementia Crisis Unit; Probable Cause Hearing; Order

If an emergency makes it impossible to file a petition prior to transfer of an individual to a dementia crisis unit or to obtain the prior written consent of the guardian, an individual may be transferred without the prior written consent of the guardian and without a prior court order. Identification of the specific facts and circumstances of the emergency must be included in the petition, which must be filed immediately upon transfer. At the probable cause hearing, in addition to the other factors to be considered, the court must consider whether there is probable cause to believe the allegation of an emergency.

When an individual with dementia is placed or remains in a dementia crisis unit under any of the new procedures created in the draft, the individual has a right to refuse medication and treatment, except as provided in an order for involuntary administration of psychotropic medication or in a situation in which medication or treatment is necessary to prevent serious physical harm to the individual or others. The individual must be advised of these rights by the director of the dementia crisis unit.

APPENDIX 1

COMMITTEE AND JOINT LEGISLATIVE COUNCIL VOTES

One draft was recommended by the Special Committee on Legal Interventions for Persons With Alzheimer's Disease and Related Dementias to the Joint Legislative Council for introduction in the 2013-14 Session of the Legislature. In addition, the Special Committee approved two letters to be prepared and delivered on its behalf (included as ***Appendix 5*** to this report).

SPECIAL COMMITTEE VOTES

The Special Committee voted on the draft and letters as follows:

- WLC: 0061/2, relating psychiatric and behavioral care and treatment for individuals with dementia, passed by a vote of Ayes, 15 (Reps. Knodl and Bernard Shaber; Sens. Kedzie and Wirch; and Public Members Bottum-Jones, Cauley, Hlavacek, Koeppl, Lightfoot, Mueller, Plachecki, Purtell, Reed, Robbins, and Rosso); Noes, 0; and Not Voting, 1 (Public Member Hanrahan).
- Letter to Senator Olsen and Representative Joan Ballweg, Co-Chairs, Joint Legislative Council, passed by a vote of Ayes, 14 (Reps. Knodl and Bernard Shaber; Sen. Wirch; and Public Members Bottum-Jones, Cauley, Hlavacek, Koeppl, Lightfoot, Mueller, Plachecki, Purtell, Reed, Robbins, and Rosso); Noes, 1 (Sen. Kedzie); and Not Voting, 1 (Public Member Hanrahan).
- Letter to Dennis Smith, Secretary, DHS, and Attorney General J.B. Van Hollen, passed by a vote of Ayes, 16 (Reps. Knodl and Bernard Shaber; Sens. Kedzie and Wirch; and Public Members Bottum-Jones, Cauley, Hanrahan, Hlavacek, Koeppl, Lightfoot, Mueller, Plachecki, Purtell, Reed, Robbins, and Rosso); and Noes, 0.

APPENDIX 2

JOINT LEGISLATIVE COUNCIL

SENATE MEMBERS

LUTHER OLSEN, Co-Chair
1023 Thomas Street
Ripon, WI 54971

ALBERTA DARLING
1325 West Dean Road
River Hills, WI 53217

PAUL FARROW
Room 3 South
State Capitol

SCOTT FITZGERALD
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JOE LEIBHAM
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MARK MILLER
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Monona, WI 53716

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Unit 501, Madison, WI 53703

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CORY MASON
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Racine, WI 53405

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Whitefish Bay, WI 53217

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5535 Grandview Drive
Greendale, WI 53129

SCOTT SUDER
102 South 4th Avenue
Abbotsford, WI 54405

ROBIN VOS
960 Rock Ridge Road
Burlington, WI 53105

This 22-member committee consists of the majority and minority party leadership of both houses of the Legislature, the co-chairs and ranking minority members of the Joint Committee on Finance, and 5 Senators and 5 Representatives appointed as are members of standing committees.

Terry C. Anderson, Director, Legislative Council Staff
1 East Main Street, Suite 401, P.O. Box 2536, Madison, Wisconsin 53701-2536

APPENDIX 3

COMMITTEE LISTS

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

Chair Dan Knodl, Representative
N101 W14475 Ridgefield Ct.
Germantown, WI 53022

Vice-Chair Penny Bernard Schaber, Representative
815 E. Washington St.
Appleton, WI 54911

Suzanne Bottum-Jones, Director
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Director Jefferson County Human Services
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Madison, WI 53703-2865

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Alzheimer's Association of Southestern Wisconsin
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Tom Reed, Assistant State Public Defender
State Public Defender -- Milwaukee Trial Office
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Neal Kedzie, Senator
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Assisted Living Franciscan Villa
3601 S. Chicago Ave.
South Milwaukee, WI 53172

Robert Lightfoot II, Attorney
Reinhart Boerner Van Deuren, S.C.
22 E. Mifflin St., Ste. 600
Madison, WI 53703

Robert Wirch, Senator
3007 Springbrook Rd.
Pleasant Prairie, WI 53158

STUDY ASSIGNMENT: The Special Committee is directed to review and develop legislation to clarify the statutes regarding guardianship, protective placement, involuntary commitment, and involuntary treatment as they apply to vulnerable adults with a dementia diagnosis who may or may not have a co-occurring psychiatric diagnosis.

16 MEMBERS: 2 Representatives; 2 Senators; and 12 Public Members.

LEGISLATIVE COUNCIL STAFF: Mary Matthias, Senior Staff Attorney; Brian Larson, Staff Attorney; and Tracey Young, Support Staff.

Subcommittee of the Special Committee on Legal Interventions for Persons With Alzheimer's Disease and Related Dementias

Vice-Chair Penny Bernard Schaber, Representative
815 E. Washington St.
Appleton, WI 54911

Suzanne Bottum-Jones, Director
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Chrystal Rosso, Vice President
Assisted Living Franciscan Villa
3601 S. Chicago Ave.
South Milwaukee, WI 53172

STUDY ASSIGNMENT: The subcommittee is directed to review and develop recommended changes to drafts under consideration by the Special Committee.

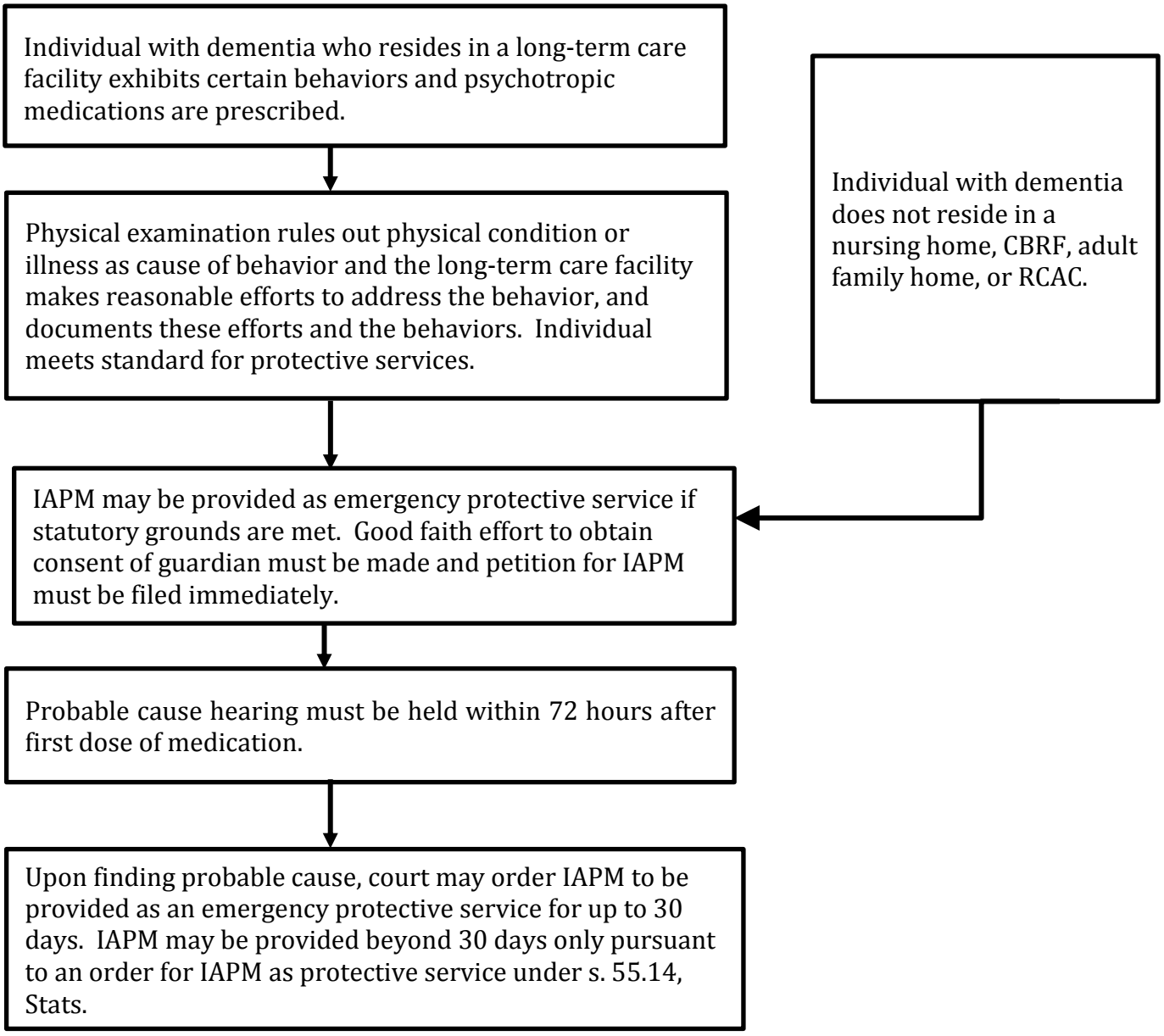
10 MEMBERS: 1 Representative; and 9 Public Members.

LEGISLATIVE COUNCIL STAFF: Mary Matthias, Senior Staff Attorney; Brian Larson, Staff Attorney; and Tracey Young, Support Staff.

APPENDIX 4

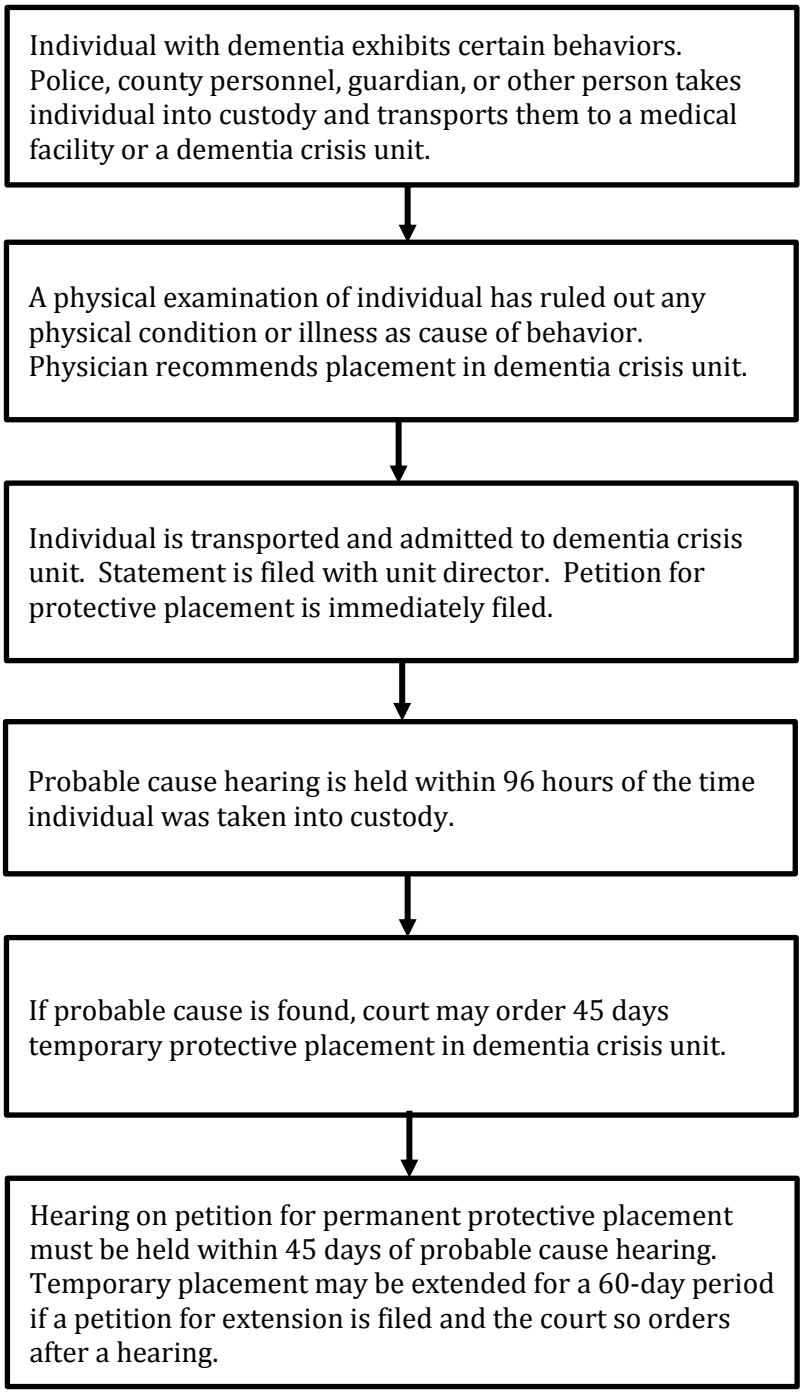
Basic Steps in Involuntary Administration of Psychotropic Medication (IAPM) to an Individual With Dementia as an Emergency Protective Service Under WLC: 0061/2

Under current law, IAPM may be provided as a protective service pursuant to s. 55.14, Stats. Current statutes do not set forth specific procedures to be followed for IAPM as an emergency protective service.



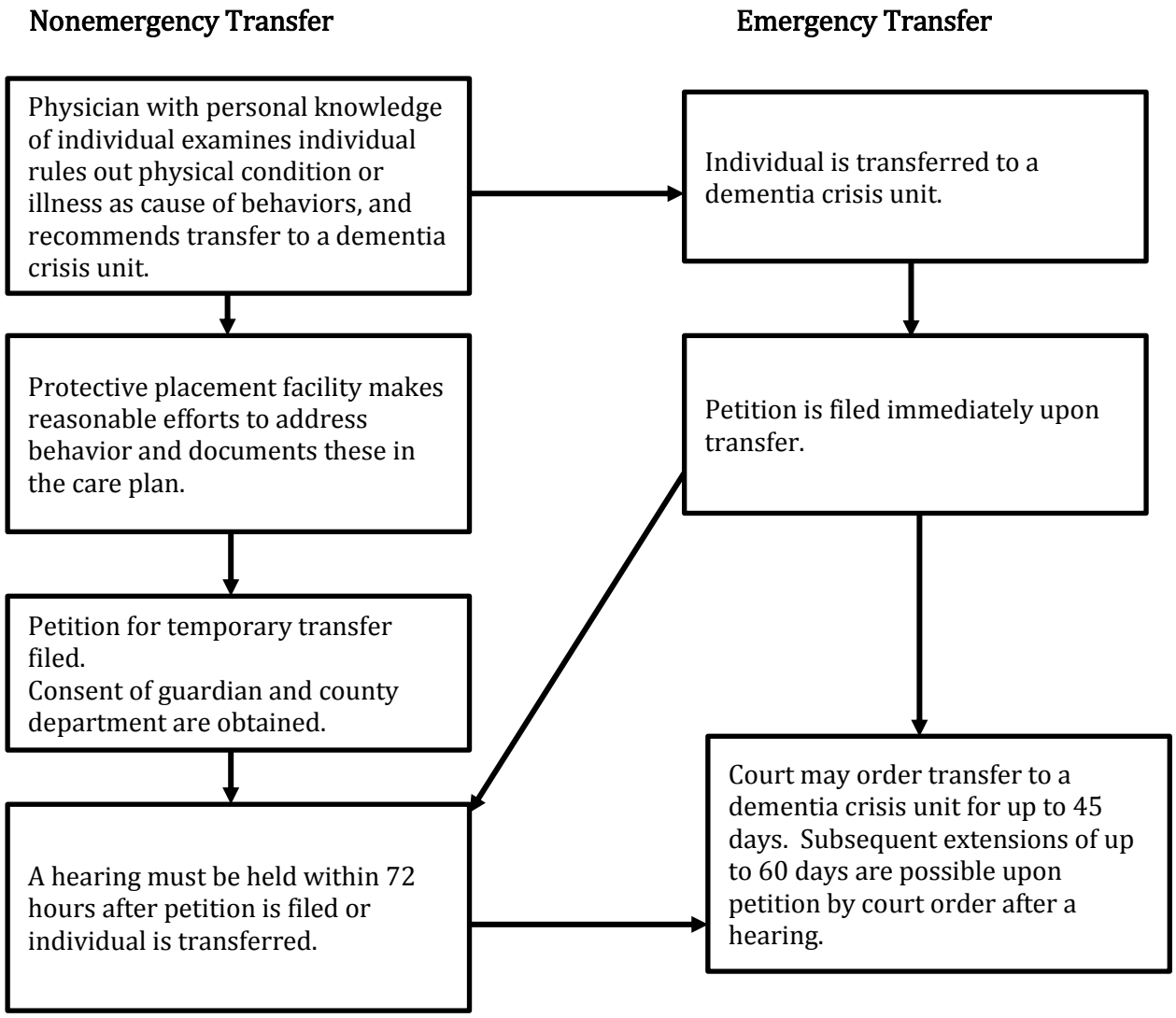
Basic Steps for Emergency Protective Placement of an Individual With Dementia in a Dementia Crisis Unit Under WLC: 0061/2

Under the draft, the procedures shown below generally replace the use of ch. 51, Stats., emergency detention and involuntary commitment for individuals with dementia who are in need of psychiatric or behavioral care or treatment and who are not already subject to a protective placement order under ch. 55, Stats.



Basic Steps in Procedure for Transfer of a Protectively Placed Individual With Dementia to a Dementia Crisis Unit Under WLC: 0061/2

Under the draft, the procedures shown below generally replace ch. 51, Stats., emergency detention and involuntary commitment procedures in situations in which an individual with dementia, who has already been protectively placed under ch. 55, Stats., engages in behavior that poses a threat to the safety of the individual or other residents or staff of the protective placement facility.



OTHER RECOMMENDATIONS

State of Wisconsin
JOINT LEGISLATIVE COUNCIL

Co-Chairs
LUTHER OLSEN
Senator

JOAN BALLWEG
Representative

LEGISLATIVE COUNCIL STAFF
Terry C. Anderson
Director
Laura D. Rose
Deputy Director

January 28, 2013

Senator Luther Olsen, Co-Chair
Joint Legislative Council
Room 319 South
State Capitol
Madison, WI 53707

Representative Joan Ballweg, Co-Chair
Joint Legislative Council
Room 210 North
State Capitol
Madison, WI 53707

Re: Support for the Department of Health Services' proposed system redesign of care delivery systems for individuals with dementia.

Dear Co-Chairs Olsen and Ballweg:

On behalf of the Special Committee on Legal Interventions for Persons with Alzheimer's Disease and Related Dementias, I write to express the Special Committee's support for the proposed redesign of the state's care delivery systems for individuals with dementia, as set forth in the recommendations provided to the Special Committee by the Department of Health Services (DHS). For your reference, I have enclosed with this letter a copy of the full set of recommendations from DHS, which DHS submitted to the Special Committee in reaction to WLC: 0061/1, an earlier version of WLC: 0061/2, relating to psychiatric and behavioral care and treatment for individuals with dementia. The portions of DHS's recommendations that include the system redesign endorsed by this letter are found on pages 4 and 5, particularly in the final seven bullet points on page 5. [1]

In its recommendations, DHS calls for a redesign of the care delivery systems and capacities for persons with dementia, within two years, to maintain individuals in their current placements with adequate treatment and supports, until such time as their behavior warrants an alternative placement. DHS states that the goals of redesigning the system include reducing the unnecessary use of psychotropic medications for persons with dementia and addressing the lack of appropriate community-based, facility-based delivery systems and capacities to provide services to individuals with dementia.

The Special Committee received the enclosed recommendations only several days prior to its last scheduled meeting. Due to time constraints, the Special Committee was unable to revise its draft legislation to incorporate DHS's proposal for a system redesign. In addition, as

[1] Several other aspects of DHS's proposal are not supported by the Special Committee. This letter of support pertains only to the portions of the DHS recommendation relating to a system redesign.

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noted in its memorandum to the Special Committee, the system redesign contemplated by DHS will require substantial funding. The Special Committee understood that it was not within the committee's charge to forward a proposal of this magnitude to the Legislature, and thus it focused on pragmatic, revenue-neutral solutions, with the acknowledgement that the system does not currently have the capacity to adequately serve the dementia population.

The draft legislation developed by the Special Committee, WLC: 0061/2, is in harmony with DHS's proposed dementia care system redesign. The procedures created by the draft will ensure access to psychiatric care for individuals with dementia both in the dementia care system as it currently exists and as it is proposed to be redesigned in the future by DHS.

The individual members of the Special Committee note and appreciate DHS's willingness to include stakeholders in the redesign process. Although the Special Committee has completed its work, the individual members will remain engaged. They look forward to future discussions with representatives from DHS and from the Legislature to ensure implementation of DHS's recommendations and to continue to develop solutions to the complex issues raised by challenging behaviors in individuals with dementia and Alzheimer's Disease.

In closing, the Special Committee urges the Joint Legislative Council to approve WLC: 0061/2, relating to psychiatric and behavioral care and treatment for individuals with dementia. In addition, it is hoped that the Legislature will take action to implement DHS's proposed system redesign of the state's care delivery systems for individuals with dementia.

Sincerely,

Representative Dan Knodl, Chair
Special Committee on Legal Interventions for Persons with Alzheimer's Disease and Related Dementias

DK:jr:tr

Enclosure

State of Wisconsin
JOINT LEGISLATIVE COUNCIL

Co-Chairs
LUTHER OLSEN
Senator

JOAN BALLWEG
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LEGISLATIVE COUNCIL STAFF
Terry C. Anderson
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January 28, 2013

Secretary Dennis Smith
Department of Health Services
1 W. Wilson St.
Madison, WI 53703

Attorney General J.B. Van Hollen
Risser Justice Center
17 W. Main St.
Madison, WI 53703

Re: Guidance for law enforcement and county human services personnel regarding involuntary psychiatric treatment of individuals with dementia.

Dear Secretary Smith and Attorney General Van Hollen:

I write on behalf of the Special Committee on Legal Interventions for Persons With Alzheimer's Disease and Related Dementias to request that your agencies provide clear guidance to educate and inform stakeholders across the state about procedures to be followed for involuntary treatment of individuals with dementia. At a minimum, this information should be provided to county human services departments and law enforcement personnel. This should occur as soon as possible, with an eye toward practical options that may be implemented until the Legislature provides a more permanent solution based in statute.

The Joint Legislative Council created the Special Committee in response to the Wisconsin Supreme Court's decision in *Fond du Lac County v. Helen E.F.*, 2012 WI 50. In that case, the Court stated that involuntary psychiatric care of a person with Alzheimer's Disease is more appropriately provided under the provisions of ch. 55 than those of ch. 51. The Joint Legislative Council directed the Special Committee to review and develop legislation to clarify the application of these statutes to vulnerable adults with dementia.

Accordingly, the Special Committee has developed draft legislation addressing the issue. The proposal, which has been forwarded to the Joint Legislative Council for review, would create provisions in ch. 55 to allow for appropriate involuntary psychiatric care of a person with Alzheimer's Disease under that chapter, as opposed to ch. 51. However, the Special Committee is aware that the Legislature may take several months or longer to act on the proposed legislation.

The Special Committee believes that immediate action is required by DHS and DOJ to clarify the application of chs. 51 and 55 until such time as legislation is enacted. This action is needed because there is a significant confusion among county officials, law enforcement, and

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other stakeholders across the state regarding current options and best practices for involuntary treatment of individuals with dementia after *Helen E.F.* This includes confusion over:

- Whether emergency detention procedures under current ch. 51 remain an option for individuals with dementia who may have a co-occurring psychiatric diagnosis.
- Criteria that may be used by law enforcement and county agencies in determining how to respond when an individual who appears to have dementia exhibits behavior that poses a threat to the health and safety of the individual or others.

In your guidance clarifying the application of chs. 51 and 55, Stats., the Special Committee strongly encourages you to conform as closely as possible to the principles embodied in the Special Committee's recommendations to the Joint Legislative Council. These include the promotion of treatment in place, minimization of trauma for elderly individuals with dementia, and provision of environmentally appropriate placements for involuntary psychiatric treatment of individuals with dementia to the extent possible.

Since the time that *Helen E.F.* was decided, confusion over the application of chs. 51 and 55, Stats., has resulted in a tragic lack of access to necessary care for some vulnerable individuals with dementia for whom the care would otherwise be available. We urge DHS and DOJ to take immediate action to ensure that this does not continue to occur.

Sincerely,

Representative Dan Knodl, Chair
Special Committee on Legal Interventions
for Persons with Alzheimer's Disease and Related Dementias

DK:tr

APPENDIX 6

COMMITTEE MATERIALS LIST

[Copies of documents are available at www.legis.wisconsin.gov/lc

December 17, 2012 Meeting	Notice	Agenda	Audio	Minutes
• Article, *Nonpharmacologic Management of Behavioral Symptoms in Dementia,* JAMA, November 21, 2012 - Volume 308, No. 19, submitted at the request of Public Member Tom Hlavacek. The article is available at: http://bit.ly/KenPopeNonPharmDementiaInterventions. • Draft Report, Psychotropic Medications Work Group as part of the Alzheimer's Challenging Behaviors Task Force. It was submitted for distribution by Public Member Tom Hlavacek. (Please note this is a draft report, and not intended for wide circulation.) • Letter, from Shel Gross, Chair, Wisconsin Council on Mental Health (December 2, 2012).				
December 5 and 6, 2012 Meetings of the Subcommittee	**Notice**			
• Memo No. 4, *Issues Pertaining to WLC: 0017/5 and WLC: 0015/3* (November 30, 12). ○ Attachment • Memo No. 5, *Summary of Remaining Issues in WLC: 0018/3*. • WLC: 0015/3, relating to involuntary administration of psychotropic medication as a protective service to a person with dementia. • WLC: 0017/5, relating to inpatient psychiatric treatment for individuals with dementia.				
November 14, 2012 Meeting	**Notice**	**Agenda**	**Audio**	**Minutes**
• WLC: 0015/2, relating to involuntary administration of psychotropic medication as a protective service to a person with dementia. • WLC: 0017/4, relating to inpatient psychiatric treatment for individuals with dementia. • WLC: 0018/3, relating to authorization of an agent under a power of attorney for health care to make certain decisions related to care and treatment of dementia. • Memo No. 3, *Physical Separation Requirement in WLC: 0017/4,* November 12, 2012 (Revised November 13, 2012). • Memorandum, to Dan Knodl, Chair and Penny Bernard Schaber, Vice Chair, Special Committee on Legal Interventions for Persons with Alzheimer's Disease and Related Dementias, from Rob Gundermann, Alzheimer's and Dementia Alliance of Wisconsin (November 12, 2012). • Memorandum, to Rep. Dan Knodl, Chair and Rep. Penny Bernard Schaber, Vice Chair, and Members of the Special Committee on Legal Interventions for Persons with Alzheimer's Disease and Related Dementias, from Robert Kellerman, Executive Director, Greater Wisconsin Agency on Aging Resources, and Spokesperson, Wisconsin Aging Network (November 12, 2012). • Memorandum, distributed at the request of Kristine Beck, Administrative Specialist, Disability Rights Wisconsin. • Proposals, submitted by Matthew Stanford, Vice President, Policy and Regulatory Affairs Associate Counsel Wisconsin Hospital Association, Inc. • Questions Regarding bill drafts submitted by Matthew Stanford, Vice President, Policy and Regulatory Affairs Associate Counsel Wisconsin Hospital Association, Inc.				

- Suggestions, submitted by Public Member Tom Hlavacek (November 12, 2012).

November 5, 2012 Meeting of the Subcommittee	Notice

- WLC: 0017/3, relating to inpatient psychiatric treatment for individuals with dementia.
- WLC: 0018/2, relating to authorization of an agent under a power of attorney for health care to make certain decisions related to care and treatment of dementia and to consent to the admission of the principal to certain facilities.

November 2, 2012 Meeting of the Subcommittee	Notice

- WLC: 0017/2, relating to inpatient psychiatric treatment for individuals with irreversible dementia.

October 18, 2012 Meeting	Notice	Agenda	Audio/Video	Minutes

- Memo No. 2, *Selected Federal Regulations and Initiatives Related to Long-Term Care Facilities* (October 12, 2012).
- WLC: 0015/P1, relating to involuntary administration of psychotropic medication to a person with irreversible dementia.
- WLC: 0017/1, relating to inpatient psychiatric treatment for individuals with irreversible dementia.
- WLC: 0018/1, relating to authorization of an agent under a power of attorney for health care to make certain decisions related to care and treatment of irreversible dementia and to consent to the admission of the principal to certain facilities.

September 12, 2012 Meeting	Notice	Agenda	Audio/Video	Minutes

- Memo No. 1, *Summary of Recommendations Made to the Special Committee at the July 31, 2012 Meeting* (September 6, 2012).
- Handout, Grant Cummings, Fiscal Analyst, Legislative Fiscal Bureau.
- Handout, Linda Harris, Division Administrator, Division of Mental Health and Substance Abuse Services, Mendota Mental Health Institute, Department of Health Services.
- Testimony, submitted by Alice Page, Adult Protective Services and Systems Developer, Bureau of Aging and Disability Resources, Division of Long Term Care, Department of Health Services.
- Other materials distributed by Alice Page:
  - Handout, *Treatment of patients with dementia at Mendota Mental Health Institute*.
  - Map, *Percent of the Population Age 65+ 2010.*
  - Map, *Percent of the Population Age 65+ 2035.*
- Testimony, submitted by Otis L. Woods, Division Administrator for the Division of Quality Assurance, Department of Health Services.

July 31, 2012 Meeting	Notice	Agenda	Audio/Video	Minutes

- Staff Brief 2012-05, Legal Interventions for Persons With Alzheimer's Disease and Related Dementias (July 25, 2012).
- Memorandum to Representative Dan Knodl, Chair, from Grant Cummings, Fiscal Analyst, Legislative Fiscal Bureau, *Use of Chapter 51 and 55 Procedures to Address Challenging Behaviors of Individuals With Alzheimer's Disease and Dementia* (July 24, 2012).
- Presentation, by Dyann Hafner, Assistant Corporation Counsel for Dane County.
- Materials presented by Dr. Sara Coleman, Psychologist, Mobile Crisis Team, Milwaukee County

Behavioral Health Division:
  - Flowchart, *Emergency Detention Process - PROPOSED.*
  - Flowchart, *Emergency Detention Process - CURRENT.*
  - Proposed Chapter 51 Wording Update.
  - Proposed Chapter 51 Amendment.
- Testimony, submitted by Carol J. Wessels, Attorney, Nelson, Irvings & Waeffler, S.C.
- Testimony, submitted by Mike Pochowski, Wisconsin Assisted Living Association; Manager. Government Affairs and Legal Operations, Brookdale Senior Living Inc.
- Testimony, submitted by Rob Gundermann, Alzheimer's and Dementia Alliance of Wisconsin.
- Testimony, submitted by Kim Marheine, Ombudsman Program Supervisor; Board of Aging and Long-Term Care.
- Testimony, submitted by Mark Radmer, Nursing Home Administrator and Karen Wagner, Director of Social Services, Harbor Haven Health and Rehabilitation, Fond du Lac County.
- Testimony, submitted by Dr. Robert P. Smith, Past President and Board Member, Wisconsin Association of Medical Directors.
- Testimony, submitted by Scott A. Ethun, Director, Juneau County Department of Human Services.
- Testimony, submitted by Cagney Martin, Activity Therapist and Lori Koeppel, Nursing Home Administrator, North Central Health Care.
- Memo, submitted by Matthew Standord, Vice President Policy and Regulatory Affairs, Associate General Counsel, Wisconsin Hospital Association.