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AN EVALUATION OF INVOLUNTARY CIVIL COMMITMENT IN MILWAUKEE COUNTY

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FINAL REPORT

Submitted to:

THE PLANNING COUNCIL FOR MENTAL HEALTH AND SOCIAL SERVICES, INC.
and the
SUBCOMMITTEE ON INVOLUNTARY CIVIL COMMITMENT STUDY
TASK FORCE ON HUMAN SERVICES AND THE LAW

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PREFACE

This report represents the results of a nine-month evaluation, beginning in August 1982, of the involuntary civil commitment process in Milwaukee County, Wisconsin. Recognizing that the debate about how society should handle its mentally ill, helpless, and potentially dangerous individuals, is well over 100 years old, that resolution of the problem hardly seems imminent, and that law and practice are never entirely parallel and sometimes not even consistent, this report emphasizes the actual procedures and practices of mental health-legal personnel who participate in involuntary civil commitment proceedings. The goal is to provide practical information, based on both theory and practice, to make the involuntary civil commitment process in Milwaukee County work as fairly, efficiently, and economically as it can.

In this preface we make two types of acknowledgements. Both should assist the reader in evaluating the scope and cogency of our conclusions and recommendations. The first is an acknowledgement of the limitations of this report. The second is an acknowledgement of the host of individuals and groups who assisted us in completing this report and the evaluation upon which it is based.

This report relates only to the involuntary civil commitment of mentally ill adults. It is not meant to be accurate with reference to minors, prisoners, mentally retarded or developmentally disabled persons, alcohol or drug dependent persons, or "sexual offenders" who are alleged to be mentally ill. Some of the report, of course, has obvious relevance to these special populations of people. These populations are subject to special considerations, however, that seriously qualify this report's applicability to them. Also, it should be clear that this report applies only to the process of involuntary civil commitment in Milwaukee County. It is not meant to apply directly to any other parts of Wisconsin. Some parts of the report certainly will generalize beyond Milwaukee County, but generalizations to areas outside of the county must be considered by the reader as fortuitous and not as the specific intention of the authors.

Many references are made in this report to sections of Wisconsin's State Mental Health Act (Wis. Stat. Ann., Chapter 51). The report is not intended as a law review, however. It is aimed primarily at an audience of practitioners and policy makers--mental health and social services personnel, judges, commissioners, attorneys and others involved in the involuntary civil commitment process in Milwaukee County. Interpretations of the State Mental Health Act and case law presented in this report should not be taken as authoritative, whether presented as the interpretation of the authors or of other commentators.

Neither is this report to be taken as a scholarly analysis of broad issues in mental health and the law. It contains relatively few citations to professional literature, although an enormous literature exists that is relevant to this area. To adequately cite the professional literature as it relates to the manifold aspects of this report would have been an enormous task that would have increased the

bulk of this report significantly. The obvious debt to the scholarly work of others in this field is readily acknowleged, however, and will be easy to identify in the pages that follow. No pretense is made that the philosophical and technical ideas raised in this volume are original, and apologies are made to the numerous commentators in Milwaukee County and throughout the country to whom no direct credit is given in the text.

The data upon which this report is based were gathered by the authors from July 1982 to April 1983. Except where specifically noted in the text, the report is accurate up to the time the last data were gathered. Late in February, a "review draft" of this report was sent to those people in Milwaukee County and other parts of Wisconsin who participated directly or indirectly in the study. The authors received review comments in the form of reports from the Task Force on Human Services and the Law and its Subcommittee on Involuntary Commitment Study,[1] a dozen personal letters from individuals in Wisconsin (some of whom represented the views of agencies and reflected the input from staff members of those agencies), and numerous personal telephone calls to the authors. Finally, the authors received review comments during a meeting of the Subcommittee on April 13, 1983, a meeting of the Combined Community Services Board on April 14, 1983, and numerous interviews with members of the mental health-legal community in Milwaukee conducted in connection with another project.[2]

Some of the recommendations appearing in the "review draft" were wholly or partially implemented between the time of our field research and the preparation of the final report, either directly in response to the recommendations or coincidental to them. Although we have amended and revised many of these recommendations, we have not deleted them for two reasons. First, one sign of change in the involuntary civil commitment procedures in Milwaukee County is the rapidity with which and the extent to which this report becomes outdated. The number of recommendations contained in this report that may have in fact been

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[1]Task Force on Human Services and the Law. Minutes of Meeting, March 24, 1983. The Planning Council for Mental Health and Social Services, Inc., Milwaukee, Wisconsin; Lane, L. Report of Subcommitte on Involuntary Civil Commitment study. Memorandum to Task Force on Human Services and the Law. The Planning Council for Mental Health and Social Services, Inc., Milwaukee, Wisconsin, March, 22, 1983.

[2]During the week of April 11, 1983, the authors began field work in Milwaukee County as part of the Least Restrictive Alternative Project. The purpose of this 18-month project, funded by the U.S. Department of Health and Human Services, is to develop a model program for coordinating the effective application of community resources for less restrictive alternatives to involuntary hospitalization in the treatment and care of mentally ill, elderly, and disabled persons. Preliminary to the development of the model program, project staff will assess how commitment courts in Tucson, Los Angeles, Milwaukee, New York City, Chicago, Kansas City, and Williamsburg (Virginia) use community resources in applying the "least restrictive alternative" doctrine.

implemented in the last six months may be a useful gauge for assessing the impact of this report. In performing evaluations and policy analysis, and in making recommendations for change, one implicitly hopes that a report soon will be out of date. It seems that the longer something remains unchanged, the longer a report addressing it remains accurate and the greater the evidence that the report had no impact. We hope, therefore, that this report will soon be outdated. Second, since we did not directly observe and evaluate the implementation of any recommendations, the omission of any recommendations in this final report would make the assumption that full implementation has indeed occurred. We do not wish to make this assumption.

This final report is not without flaws. We conscientiously have tried to accommodate the views expressed by all participants in the evaluation and by reviewers of the "review draft" of this report, whether or not we shared those views. However, we may have inadvertantly misrepresented or omitted some of these views. Although we sincerely hope that the extensive review comments that have been taken into account in the preparation of the final report have minimized these misrepresentations and omissions, we take full responsibility for the content of this report and apologize for any errors that it may contain.

There are many individuals and groups to whom we are indebted for making this report possible. Without them, the evaluation upon which this report is based would not have been done. By naming these individuals and groups we intend not only to acknowledge our debt to them, but also to identify in a general way the major source of our information about the involuntary civil commitment system in Milwaukee County. Although this report has clearly benefited from their contributions and although we sincerely hope that they find agreement with much of what is contained in it, their endorsement of any portion of this report should not be assumed.

A special debt of gratitude is owed Mrs. Helaine Lane, Senior Planner, The Planning Council for Mental Health and Social Services, for her strong support of the project from beginning to end, and for her assistance, both practical and spiritual. A special thanks is also extended to Dr. Esther Howard and her colleagues of the Alliance for the Mentally Ill of Greater Milwaukee. Without Dr. Howard's willingness to act on her belief that this evaluation should be conducted, and her persistence over a period of more than two years, it would never have happened. Finally, we express our deep appreciation to Supervisor Penny E. Poddell and Ms. Janie Lichter, Legislative Research Analyst, of the Milwaukee County Board of Supervisors, whose enthusiasm for the idea of this evaluation and whose hard work on its behalf successfully marshalled the local support necessary to make it a reality.

A special advisory group, the Subcommittee on Involuntary Commitment Study, composed of members of the Task Force on Human Services and the Law, proved to be an extraordinarily informed group of individuals from whom we received invaluable substantive guidance. The Subcommittee helped us define the parameters of the evaluation and the critical study questions, sharpen the goals of the evaluation, and gain

access to many sources of information that we otherwise would have been unable to access. They made it clear that this evaluation was important to them by their unwavering support and assistance. The names and affiliations of Subcommittee members appear below:

JEFF AIKENS, Milwaukee County Institutions and Departments

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THOMAS WINSLOW, Chief, State Fair Park Police

THOMAS K. ZANDER, Executive Director, Legal Aid Society of Milwaukee, Inc.

During the conduct of our evaluation of the involuntary civil commitment system in Milwaukee County, many other individuals helped explain and demonstrate the workings of the system. Some of these people must go unnamed -- the patients, secretaries, clerks, family members, and others who simply acted naturally and allowed us to observe as they played their parts in the system. Individuals who generously gave of their time for personal and group interviews, who contributed indirectly through their writings, and who offered constructive comments and suggestions after reviewing an earlier draft of this report include: Ellen Abrams, Mental Health Association in Milwaukee County; Bruce Berg, Mental Health Emergency Service; Joseph F. Bird, Psychiatic Emergency Service; Harold A. Breier, City of Milwaukee Police Department; Richard Brock, Circuit Court, Probate Division; Julie T. Carpenter, The Milwaukee Foundation; Barbara Cassius, Milwaukee County Mental Health Complex; John Easterday, Milwaukee County Mental Health Complex; David Felger, Milwaukee City Attorney's Office; John Galanis, The Milwaukee Foundation Board; John C. Geilfuss, The Milwaukee Foundation Board; Richard P. Gerhardstein, Milwaukee County Mental Health Complex; Paul Harris, Division of Community Services; Robert E. Holtz, University of Wisconsin Law School; Andrew W. Kane; Marjorie Kelly, Milwaukee Bureau of Community Correction; Robert R. Knoll, Register in Probate; Raymond S. Koziol, Milwaukee County Mental Health Complex; Fred Linder, Office on Aging; Franklin Lotter, House of Corrections; Victor Manian, Chief Judge, First Judicial District; Bonnie Martin, Crisis Intervention Service; Paul Matthews, Milwaukee County Board of Supervisors; Byron A. McBride; Robert J. Miech, Circuit Judge; Barbara Nealon, Milaukee County Mental Health Complex; Eugene Paykel, Department of Social Services; Robert Pietrykowski, Planning Council for Mental Health and Social Services, Inc.; Robert W. Pledl, Office of State Pubic Defender; William J. Shaughnessy, Judge, First Judicial Circuit; Bruce Schmidt, Crisis Intervention Service; John Siefert, Municipal Court Branch 2; Barbara Simmons, Combined Community Services Board; Patrick Sloan, Milwaukee County Mental Health Complex; Stuart Spielman, Office of State Public Defender; John Sternweiss, Office of State Public Defender; Leslie Taylor, Milwaukee County Institutions and Departments; Darold A. Treffert; James W. Wayner, Milwaukee County Institutions and Departments; Marilyn Walczak, Wisconsin Correctional Service; Charlie Worzella, Wisconsin Correctional Service; Leonard W. Ziolkowski, Police Academy and Special Services, City of Milwaukee. We apologize to any individuals whom we have inadvertantly neglected to acknowledge--your contributions are much appreciated.

TABLE OF CONTENTS

Page

PREFACE iii

EXECUTIVE SUMMARY xi

CHAPTER ONE: INTRODUCTION. 1

The Plan and Perspective of the Report. 2

Summary of Involuntary Civil Commitment in Wisconsin. 5
Initiating Involuntary Civil Commitment. 5
Detention or Release Pending Probable Cause Hearing. 7
Probable Cause Hearing 8
Disposition Pending Final Commitment Hearing 9
Prehearing Examination 10
Final Commitment Hearing 10
Placement of Individual Meeting Commitment Hearing 11
Review of Commitment 12

CHAPTER TWO: INITIATING INVOLUNTARY CIVIL COMMITMENT 15

Emergency Detention 15

Non-Emergency Involuntary Commitment. 22

Crisis Intervention Service 27

Other Routes to Involuntary Mental Health Intervention. 32
Voluntary to Involuntary Status. 33
Overlap of the Criminal and Civil Justice Systems. 35
Wisconsin Correctional Service. 35
The Municipal Courts. 41
Conversion to Civil Status of Persons Incompetent to Stand Trial. 43

Gatekeepers 47

CHAPTER THREE: HOSPITAL ADMISSION AND DETENTION. 57

Admission to Milwaukee County Mental Health Complex 57

Prehearing Care and Treatment 59

Initial Mental Health Evaluation. 66

CHAPTER FOUR: NEGOTIATIONS AND SETTLEMENTS OF CASES BEFORE JUDICIAL HEARINGS 71

CHAPTER FIVE: JUDICIAL PROCEEDINGS 81

Probable Cause Hearings 81
Patients' Rights and Priveleges 82
Is There a Need for a Probable Cause Hearing? 83

Prehearing Mental Health Examinations 86

Final Commitment Hearings 87
The Setting and the Participants 87
Counsel for the Respondent 89
The Questions: Committability and Treatment 92
Matters of Law 92
Procedures 93
Burdens of Proof 96
Commitment Criteria 100

Compliance and the Least Restrictive Alternative 102

CHAPTER SIX: COORDINATION OF SERVICES, TRAINING, AND PUBLIC EDUCATION 115

Linkages, Coordination, and Cooperation 115

Training and Education 118

APPENDICES A1

A. Forms Used in the Involuntary Civil Commitment Process in Milwaukee County A1

B. Study Methods B1

AN EVALUATION OF INVOLUNTARY CIVIL COMMITMENT
IN MILWAUKEE COUNTY

FINAL REPORT

EXECUTIVE SUMMARY

Involuntary civil commitment is the legal and psychosocial process whereby an individual alleged to be mentally disordered and dangerous is restrained, cared for, and treated against his or her will, presumably for his or her own good or the good of others. This process has engendered considerable public interest, intense public scrutiny, and heated debate among those in the mental health-legal community in Milwaukee County. Some observers in Milwaukee County have expressed the concern that the views of the various interest groups are so polarized that a balancing of interests and compromise aimed at improving the involuntary civil commitment process is unlikely.

In early July 1982, amid this controversy, Milwaukee's Planning Council for Mental Health and Social Services, Inc. commissioned the Institute for Mental Disability and the Law, National Center for State Courts, of Williamsburg, Virginia to evaluate the involuntary civil commitment process and provide recommendations for solving existing problems and improving the civil commitment process in Milwaukee County. The hope was that the Institute, as an unbiased organization outside of the controversy, might provide the objective view to channel the energies of the polarized groups in Milwaukee County toward compromise, collaboration, and cooperation. This is a summary of recommendations made in the report of that evaluation which began in August 1982 and ended in April 1983.

The topic headings below approximate the chapter headings in the full report. However, for the sake of convenience, the presentation of this summary of recommendations differs from the format of the full report. Some topic headings are unique to this summary and the recommendations under each heading may not be in the chronological order in which they appear in the full text, although each recommendation is numbered as it is in the full report. The page where each recommendation appears in the full report is noted in parentheses following the recommendation in this summary. The reader is encouraged to refer to the full report for complete explanation of each recommendation. Out of context and without supporting commentary, recommendations may be misleading.

Initiating Involuntary Civil Commitment

1. Emergency detention authority under Section 51.15 of the State Mental Health Act should be extended beyond law enforcement officers to a limited and controlled number of designated county officials.(17)

2. (1) The Milwaukee County Institutions and Departments, in conjunction with law enforcement agencies in Milwaukee County, should develop a consistent method for medical examination and clearance of all Chapter 51 emergency and non-emergency detainees before their admittance to Ward 53B. (2) The method(s) developed should not place undue procedural or fiscal burdens on the Milwaukee County Medical Complex, the Milwaukee County Mental Health Center, or law enforcement agencies in Milwaukee County responsible for transporting persons subject to either emergency detention (51.15) or non-emergency detention (51.20). (3) Any change in procedure should be reflected in the policies, staff orientation and training, and operations manuals of effected agencies or units thereof.(26)

3. Police officers should rely on the expertise of Crisis Intervention Service mental health counselors and give great weight to their recommendations about emergency detention under the "basic needs" commitment criterion (the fourth standard).(31)

4. (1) In appropriate cases, facility treatment directors, or their designees, should increase their exercise of the discretionary power provided in Section 51.10(5)(c) to initiate civil commitment proceedings against voluntary patients requesting discharge against medical advice. (2) The Milwaukee County Mental Health Complex should conduct inservice training to familiarize facility directors and their designees in the procedures and consequences of initiating involuntary commitment proceedings against voluntary patients requesting discharge against medical advice.(35)

5. (1) Whenever a social worker of the Wisconsin Correctional Service determines that an arrestee meets Chapter 51 commitment criteria, he or she should recommend at the charging conference that commitment proceedings be initiated and that the district attorney defer charging the arrestee. The social worker should then initiate a three-party petition and should seek a detention order. (2) In determining whether to charge an arrestee or to permit commitment proceedings to be initiated, the district attorney should give great weight to the social worker's recommendations to pursue civil commitment. (3) In cases where the District Attorney's Office seeks civil commitment of an arrestee, the petitioning process should be expedited. The Protective Services Management Team and Corporation Counsel should forego their customary interviews and screenings of petitioners, and facilitate the issuance of a court order to detain the person pursuant to Section 51.20 non-emergency commitment. (4) Whenever the District Attorney's office initiates a three-party petition and advises Corporation Counsel that involuntary hospitalization is the least restrictive treatment

alternative appropriate for the particular arrestee, Corporation Counsel should give great weight to this advice and accept a stipulated settlement only if the examiners appointed pursuant to Section 51.20(9) communicate serious doubts that commitment criteria are met.(39)

6. The Planning Council for Mental Health and Social Services and the Task Force on Human Services and the Law, in conjunction with the municipal courts and the City Attorney's Office, should actively explore alternative methods by which the municipal courts might divert mentally ill defendants to mental health care and treatment. These organizations should encourage the uniform implementation of the alternative which they determine to be the most effective, understandable, and controllable.(43)

Hospital Admission and Detention Procedures

7. To the extent that short-term treatment can be provided to respondents prior to final commitment hearings, and in accordance with Section 51.61(1)(g) and (h) of the State Mental Health Act, respondents in Ward 53B of the Milwaukee County Mental Health Complex should be provided with prompt and adequate treatment appropriate for their conditions, including all available psychological, educational, social, chemical, or somatic techniques designed to bring about rehabilitation.(61)

8. (1) Staff of Ward 53B of the Milwaukee County Mental Health Complex should, in accordance with Section 51.61(1)(g) and (h), override a patient's refusal of treatment in clearly defined emergencies. (2) Ward 53B should have a written policy covering emergency situations in which patients are treated without their informed consent. This policy should be consistent with the written policy governing the use of restraint and isolation required by Section 51.61(1)(i) of the State Mental Health Act. (3) The procedures for emergency treatment of nonconsenting patients should not be so onerous and complex as to compromise needed emergency mental health intervention, but should be simple and efficient.(64)

9. (1) When a patient refuses treatment in non-emergency situations, and when the refused treatment is in the best interest of the patient, Ward 53B staff should, in accordance with Section 51.61(1)(g) and (h), seek a court order permitting treatment without a patient's informed consent. (2) The procedures for securing a court order permitting treatment without the patient's informed consent should not be so complex or onerous that they compromise needed treatment, but should be simple and efficient.(65)

10. Ward 53B staff who conduct the initial mental health evaluation of persons brought to Ward 53B following an emergency detention by law enforcement officers should include in the opening precautionary statement to such persons a notification of the right to remain silent during the interview.(69)

11. Before accepting a person subject to an emergency detention as a voluntary patient, Ward 53B staff should carefully explain to the person the rights and obligations arising from voluntary status. This explanation should include notice that although the person has a right to leave the hospital upon submission of a written request to the staff, the person may, nevertheless, be further detained if the treatment director, or his or her designee, files a statement of emergency detention.(70)

Negotiations and Settlements of Cases Prior to Judicial Hearing

12. (1) The mental health-legal community in Milwaukee County should give their support to the general process of the negotiation and settlement of appropriate involuntary civil commitment cases. (2) The following improvements of the process should be made: (a) information obtained from petitioners and families of respondents should be considered in every negotiated settlement; (b) proposals for negotiated settlements and court-ordered voluntary (COV) agreements should be evaluated more thoroughly, first by corporation counsel, and then by the court; corporation counsel should be provided adequate resources for this purpose; (c) policies and procedures should be developed for monitoring compliance, and responding to cases of noncompliance, with the terms and conditions of negotiated settlements and court-ordered voluntary (COV) agreements; and (d) a system should be established so that current information is readily accessible about community-based, less restrictive facilities and programs and their willingness and capacity to accept involuntary civil commitment cases diverted from inpatient hospitalization.(76)

13. (1) A comprehensive guide to mental health resources in Milwaukee County should be prepared for use by members of the mental health-legal community in Milwaukee County who are involved in the involuntary civil commitment process. (2) This guide should be designed to further the application of the least restrictive alternative doctrine and should include the following information: (a) a complete listing of public, private, non-profit, and voluntary resources, and their locations, serving mentally ill persons; (b) a short description of the type of services offered by each resource listed; (c) a brief history of services, if any, provided to persons involved in involuntary civil commitment proceedings; and (d) the

service capacity of each resource including: (i) staff, (ii) bed capacity, and (iii) fiscal arrangements for clients. (3) The guide should be updated regularly by the Planning Council for Mental Health Services, the Mental Health Association in Milwaukee County, or some other appropriate agency or agencies.(78)

Probable Cause Hearing

14. (1) Ward 53B staff and attorneys before all probable cause hearings should ask respondents if they wish to wear their own clothes at the probable cause hearing. (2) If the respondent wishes to wear street clothes but has no personal clothes to wear, Ward 53B staff should endeavor to secure appropriate street clothing for the respondent.(82)

15. Ward 53B visiting hours should be modified to allow respondents to meet with their family members and friends at the conclusion of the probable cause hearing.(82)

16. Within the framework of the State Mental Health Act probable cause hearing requirements, members of the mental health-legal community in Milwaukee County should strive to achieve a proper, acceptable balance among the complex and competing interests of the respondent, the family, and the state in involuntary civil commitment proceedings. Legislative reform to change the probable cause hearing requirements in Wisconsin is not recommended at this time.(85)

Patients' Compliance with Terms of Least Restrictive Alternative

23. (1) Whenever corporation counsel determines that a respondent may be a proper subject for involuntary treatment less restrictive than hospitalization, yet the respondent may (or is likely to) fail to comply with the terms of a stipulated settlement, corporation counsel should refuse to settle and should proceed to the probable cause hearing. (2) Following a finding of probable cause, if the commissioner presiding at the probable cause hearing determines that treatment less restrictive than hospitalization is appropriate, the commissioner should consider releasing the respondent on the condition that he or she accepts and complies with treatment while the final commitment hearing is pending. (3) The conditional release order should clearly set forth: (a) that probable cause to believe that the respondent is a fit subject for commitment has been found, (b) the types of services and treatment to be provided, including whether the services and treatment are to be provided on an inpatient or outpatient basis, (c) the facility, clinic, or mental health professional which is to provide the services or treatment, (d) that the respondent has been released provided that he or she complies with the conditions of the release, (e) that the

CCSB social worker (or some other "neutral" social worker) should monitor the respondent's participation and progress in the stated treatment program, (f) that if the respondent fails to comply with the stated conditions, noncompliance should be immediately reported to corporation counsel or to the court, (g) that immediate detention and acceleration of the final hearing, or another appropriate remedy, will be imposed following a breach of conditions, and (h) that, in any event, a final commitment hearing shall be held on the date specified in the order unless accelerated. Copies of the order should be given to the parties, the stated treatment providers, and the CCSB social worker. The commissioner should direct the respondent's counsel to explain to his or her client the terms and consequences of the order. (4) The CCSB social worker, under the direction of the court, should notify and confer with the petitioners or any other third parties, other than the treatment provider(s), who may be affected by the conditional release of the respondent. (5) While the final commitment hearing is pending, and following a final commitment order to a treatment alternative less restrictive than hospitalization, the CCSB social worker should monitor the respondent's compliance with ordered treatment terms. If the CCSB social worker discovers that a respondent has violated ordered treatment terms, or if such a violation is reliably reported to the social worker (e.g., by the treatment provider or by a reliable third party), the social worker should immediately report the violation to corporation counsel or to the court. (6)(a) If a respondent has materially violated a conditional release pending final hearing, corporation counsel or the court should request that a law enforcement officer take the respondent into custody and transport him or her to an appropriate inpatient treatment facility. A new detention order should not be required. The final commitment hearing should be accelerated. (b) If a respondent fails to comply with the terms of a final commitment order to a treatment alternative less restrictive than hospitalization, the court, or the treatment provider if so provided by statute or in the commitment order, should take appropriate remedial action as provided in statute or in the commitment order.(110)

Social Work Resources

24. (1) A social worker should be assigned to every involuntary civil commitment case to assist the attorneys and the court in identifying the least restrictive, appropriate treatment and care and to monitor respondents' compliance with conditions of negotiated settlements and court orders. (2) The Planning Council for Mental Health and Social Services, Inc. and the Task Force on Human Services and the Law should study the current social work performed under the auspices of CCSB and the State Public Defender's Office in

Milwaukee and recommend the most effective, equitable, efficient, and acceptable administrative and organizational structure to support the social work function.(113)

Final Commitment Hearing

18. (1) The final hearing court should carefully distinguish the two questions which it must address: committability and treatment. To ensure that these questions are considered in proper order, the court should implement a two-phase approach to final commitment hearings. (2) During the first phase, the "committability phase," the court should allow the parties to present evidence concerning only whether the respondent meets Chapter 51 commitment criteria. Evidence concerning the appropriate treatment disposition should be minimized. (3) The second phase, the "treatment phase," should commence immediately after (and only if) the court enters a finding that the respondent is committable. During this phase, the court should require the parties to present evidence concerning the least restrictive treatment alternative appropriate given the respondent's disabling condition.(95)

20. Attorneys representing respondents at final commitment hearings should carefully consider how to cross-examine expert witnesses offered by corporation counsel as proponents for involuntary hospitalization. Important cross-examination concerns might include how the witness reached the conclusion that hospitalization is the least restrictive alternative sufficient given the respondent's disabling condition, and specifically which treatment alternatives the witness investigated and why they were insufficient.(98)

21. (1) In appropriate cases, the final hearing court should commit respondents to treatment programs less restrictive than hospitalization. (2) To ensure that the court is able to make well-informed dispositional decisions, and to ensure that respondents' counsel systematically investigate and present treatment alternatives, whenever a respondent's attorney fails to present alternatives evidence, the court should privately brief the attorney regarding his or her responsibility for investigating and presenting such alternatives.(99)

The Fifth Commitment Standard

22. Although the proposed addition of a fifth standard may merit consideration as a matter of substantive law, legislative reform is not recommended. At the present time, the resources of the mental health-legal community in Milwaukee County should be channeled into improvements of the practices in involuntary civil commitment proceedings under the current State Mental Health Act rather than into seeking improvements by legislative reform.(101)

Linkages, Coordination, and Cooperation

25. (1) In accordance with the powers and duties prescribed in Section 51.42 of the State Mental Health Act, the Combined Community Services Board of Milwaukee County should provide for the integration of the administration of all agencies, services, and facilities involved in the involuntary civil commitment process, including the Probate Division of the Circuit Court, law enforcement agencies, the Protective Services Management Team, Corporation Counsel, the Public Defender's Office, the Legal Aid Society, Ward 53B, the Crisis Intervention Service, Wisconsin Correctional Service, community mental health clinics, and other voluntary, non-profit and public services as may be appropriate. (2) The Combined Community Services Board should establish an advisory board to encourage linkages, coordination, and cooperation among the facilities, services, and agencies listed in paragraph (1). (3) The advisory board should be comprised of representatives of the facilities, services, and agencies in paragraph (1) who are involved in the involuntary civil commitment process. (4) The Task Force on Human Services and the Law should be specifically charged by the Combined Community Services Board with reviewing and facilitating linkages, coordination, and cooperation among the various components of the mental health-legal system involved in the involuntary civil commitment process in Milwaukee County.(117)

Training and Education

17. (1) As prerequisites to initial and continued inclusion on the list of private attorneys who are potential appointees as respondents' counsel, attorneys should be required to participate in an orientation and continuing education program. (2) This program should be a cooperative effort among the components of the legal and mental health community in Milwaukee County. The State Public Defender's Office, the Milwaukee Bar Association, the Probate Court, the Legal Aid Society, or another appropriate entity should coordinate the program. (3) This program should seek to inform attorneys regarding the civil commitment process in Milwaukee County and of their role and function in it.(91)

19. (1) The orientation and continuing education program prerequisite to inclusion on the appointment list of private attorneys should include instruction regarding (a) the statutory mandate concerning the least restrictive alternative, (b) the responsibility of respondent's counsel for exploring less restrictive alternatives and for offering these alternatives to the court, (c) the alternative treatment modalities available in the community, and (d) the procedure of enlisting the assistance of social workers in identifying, exploring and communicating these alternatives. (2) Attorneys

representing respondents in involuntary civil commitment proceedings should explore treatment alternatives less restrictive than hospitalization and should present these alternatives to the final hearing court. Respondents' attorneys are encouraged to enlist the assistance of social workers in identifying, exploring, and communicating less restrictive alternatives.(97)

26. The Mental Health Association in Milwaukee County, the Task Force on Human Services and the Law, the Planning Council for Mental Health and Social Services, the advisory board proposed in Recommendation 25 above, or some other appropriate agency, organization, or group designated by the Milwaukee County Combined Community Services Board, should arrange for the preparation of a set of standard orientation materials to be used by professionals in the mental health-legal network who become involved with involuntary civil commitment proceedings in Milwaukee County.(119)

27. The Mental Health Association in Milwaukee County, the Task Force on Human Services and the Law, the Planning Council for Mental Health and Social Services, the advisory board proposed in Recommendation 25 above, or some other appropriate agency designated by the Milwaukee County Combined Community Services Board, should arrange for periodic continuing education seminars in Milwaukee County to keep professionals who work in the mental health-legal system abreast of relevant developments in mental health and the law.(120)

28. The Mental Health Association in Milwaukee County or some other appropriate agency, organization, or group, should mount a vigorous campaign to educate the Milwaukee County public about the theory and practice of involuntary civil commitment in Milwaukee County.(122)

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CHAPTER ONE

INTRODUCTION

> All those concerned with the involuntary commitment debate should recognize that most proponents of commitment are not unconcerned with the liberty of those effected and that most proponents of legalization or abolishment of commitment are not lacking in compassion or concern for citizens who are disordered and apparently unable to cope successfully in our society. Name calling should cease, and advocates should no longer use unrepresentative cases to support their positions, for such evidence produces both poor social science and unsound bases for sensible public policy. What should be clear is that there is no ideal solution to the personal, family, and social problems associated with mental disorder.[3]

> If the energy that has been devoted to arguing the extremes of the issue [civil commitment] can be channeled into finding creative solutions that accommodate both sides of the debate, a partial swing of the pendulum to a more moderate position ought not be an impossible task. With luck, the process may have already begun.[4]

Involuntary civil commitment is the legal and psychosocial process whereby an individual alleged to be mentally disabled and dangerous is restrained, cared for, and treated against his or her will, presumably for his or her own good or the good of others. This process has engendered considerable public interest, intense public scrutiny, and heated debate among those in the mental health-legal community in Milwaukee County.[5] Some observers in Milwaukee have expressed the concern that the views of the various interest groups in Milwaukee County are so polarized that a balancing of interests and compromise aimed at improving the involuntary civil commitment process seem unlikely.

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[3]Morse, S.J. A preference for liberty: The case against involuntary commitment of the mentally disordered. In C.A.B. Warren, Mental Illness and the Law: The Court of Last Resort. Chicago: University of Chicago Press, 1982, at 71.

[4]Appelbaum, P.S., Civil commitment: Is the pendulum changing direction? Hospital & Community Psychiatry, 1982, 33, 703-704, at 704.

[5]Since the beginning of 1982, Milwaukee's two daily newspapers, The Milwaukee Journal and The Milwaukee Sentinel, have published numerous articles and Milwaukee's broadcast media has aired several editorials pertaining to the involuntary civil commitment process.

In early July 1982, amid this controversy, Milwaukee's Planning Council for Mental Health and Social Services, Inc. commissioned the Institute for Mental Disability and the Law, National Center for State Courts, of Williamsburg, Virginia to evaluate the involuntary civil commitment process and provide recommendations for solving existing problems and improving the civil commitment process in Milwaukee County. The hope was that the Institute, as an unbiased organization outside of the controversy, might provide the objective view to channel the energies of the polarized groups in Milwaukee County toward compromise, collaboration, and cooperation. This is the final report of that evaluation which began in August 1982 and ended in April 1983. The report contains 28 recommendations aimed at improving the involuntary civil commitment process in Milwaukee County. The general theme of the report is suggested by the words of Stephen J. Morse, a California lawyer and psychologist, and Paul S. Appelbaum, a Pennsylvania psychiatrist, quoted in the beginning of this chapter.

This introduction begins with a discussion of the plan and general perspective of the report. This is followed by a summary of the involuntary civil commitment procedures in Wisconsin as contemplated in of the State Mental Health Act.

THE PLAN AND PERSPECTIVE OF THE REPORT

It seems impossible to consider involuntary civil commitment in Milwaukee County, or anywhere else in the country, without confronting fundamental differences of opinion and conflicting attitudes about mental illness and society's proper response. At its simplest, the involuntary civil commitment process will be appreciated to the extent that it can accommodate one of two basic values. First, because of a perceived obvious need for treatment of mentally ill individuals and because a presumed societal responsibility to respond to that need, some people value a process that can readily provide prompt treatment and care, even if treatment and care must be coerced. Second, others value a process to the extent that it can protect individuals from having hospitalization or treatment thrust upon them against their will. For ease of reference, the first of these values will be referred to as the "helping attitude" and the second as the "liberty attitude."

Some people in Milwaukee County and elsewhere hold these attitudes in the extreme. Those who are strongly biased toward the helping attitude may contend that mentally illness is, *per se*, a sufficient reason to treat an individual against his or her will because that person's capacity for voluntary and intelligent decision-making is necessarily impaired. This is not to say, however, that those who subscribe firmly to the helping attitude are unconcerned with the rights of those effected. Indeed, they may maintain a strong orientation toward respecting patients' dignity, minimizing unnecessary restrictions, providing humane and adequate care, and so on. At the other extreme, those who hold the liberty attitude may contend that mental illness does

not exist except as a convenient tool of social control.[6] They view persons as having wide ranges of behavior which society must accommodate without interference. They agree that behavior harmful to others is cause for concern, but argue, however, that it should be handled by the criminal rather than the civil justice system. In other words, mentally disordered persons who have not committed crimes should not be legally distinguishable from normal persons.

Try as one may to balance the helping attitude and the liberty attitude, many situations arise in civil commitment proceedings that bring these two attitudes into sharp conflict. Although the attitudes are not necessarily contradictory, decisions arise where the two may compel contradictory procedures. Disagreements about the effectiveness, efficiency, equity, and public acceptibility of a civil commitment system frequently can be understood by reference to these differing attitudinal perspectives. The best process, we believe, will find ways to accommodate both interests, but conflicts between them are impossible to always avoid, and a failure of compromise may occasionally force a choice between one or the other.

This report is of an evaluation of the effectiveness, efficiency, and equity of, and public satisfaction with the involuntary civil commitment process in Milwaukee County. The perspective taken in the report is suggested by the quotations in the beginning of this chapter. It is a perspective emphasizing balance, compromise, collaboration, and cooperation. The emphasis in the report is squarely on improvement of the everyday practices in the entire involuntary civil commitment process; practices which are often incongruent with state statutes and mental health law theory, and practices that should reflect the best intents of existing law. Recommendations contained in the report are directed primarily at practice, not theory or legal reform, although many of the recommendations are explained with references to substantive and procedural law and legal theory.

The perspective is similar to that taken by the courts as they struggle with striking a balance among important, legitimate, yet conflicting interests. Such balancing in the context of involuntary civil commitment proceedings involves weighing (1) the private, individual interests (e.g., liberty and privacy) that are effected by a particular procedure or judicial action; (2) the interests of family and friends in assuring that the person is given the prompt care and treatment that he or she needs, but may be unwilling and unable to obtain voluntarily (they also may wish to rid themselves of the debilitating burden that the state's failure to intervene on behalf of the individual

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[6]This view, sometimes referred to as a labeling perspective, is propounded by such theorists as Thomas S. Szasz, Thomas J. Scheff, and Alan V. Horwitz. See, generally, Szasz, T.S. <u>The myth of mental illness</u>. New York: Harper, 1961; Scheff, T.J. <u>Being mentally ill: A sociological theory</u>. Chicago: Aldine, 1966; Horwitz, A.V. <u>The social control of mental illness</u>. New York: Academic Press, 1982.

may be causing); and finally, (3) the state's interests in protecting its citizens from mentally ill and dangerous persons, and in taking care of its sick and helpless. Another legitimate interest of the state, related to its obligation to protect its citizenry, is its interest in efficiency and economy, that is, not imposing undue programmatic, fiscal, and administrative burdens by the procedures that it may require as a matter of law. Unfortunately, as suggested by Stephen J. Morse, there is no ideal balance among the competing interests of the individual, the family, and the state.[7] Even within the last 15 years, legal reform, social changes, and shifts in social policy have dramatically altered this balance.

In the final analysis, the decision between individual liberty and state intervention in the lives of allegedly mentally disturbed persons may be based more on values and morals than on fact and logic, and may entail judgments that probably should be made by our lawmakers. Unfortunately, the people in the mental health-legal system charged with the responsibility of deciding between commitment and freedom in individual cases do not have the luxury of waiting for legislative directives. Decisions are being made today and will continue to be made in the absence of final judgments about the state's justification for involuntary commitment, and the patient's interest in the right to treatment, the right to refuse treatment, prompt judicial review, and so forth. Our aim in this report is to help those individuals who must make these difficult decisions on a daily basis. In brief, the perspective in this report, tends to shy away from theory and ultimate questions (e.g., Does the state have any compelling interests in interfering in the lives of mentally ill persons who have not committed crimes?), preferring instead to focus on everyday practice. The report emphasizes action that necessarily needs to strike a balance between competing interests. As one philosopher has quipped, philosophic speculation about problems seems to be abundant at times that do not possess the logical and practical means to solve those problems.

Chapters Two through Five of this report are organized roughly according to the typical chronology of events in the involuntary civil commitment process in Milwaukee County, from the initiation of commitment proceedings, discussed in Chapter Two, through judicial hearings, discussed in Chapter Five. (This chronological order is, of course, inexact. Some events and issues arise in reality in different sequences than are represented in the text. Some issues dealt with in one chapter may have bearing on events and issues discussed in another chapter.) Following the discussion of specific aspects of commitment proceedings, Chapter Six explores the perceived need in Milwaukee County to build linkages, coordination, and cooperation among the various components of the mental health-legal community. This chapter also deals with the issue of training and education of professionals and the public in Milwaukee County. Many (one would hope most) of the standardized forms used in the involuntary civil commitment process in Milwaukee County are reproduced in Appendix A. Finally, a discussion of the methods used to evaluate the involuntary civil commitment process in Milwaukee is presented in Appendix B.

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[7] Morse, _supra_, note 1.

SUMMARY OF INVOLUNTARY CIVIL COMMITMENT IN WISCONSIN

The following is a summary of the involuntary civil commitment process as envisioned in the Wisconsin State Mental Health Act (SMHA).[8] It is presented here for two purposes: (1) to acquaint the reader with the applicable statutory provisions and (2) to lay the groundwork for discussions in several parts of the report indicating that actual practice may conflict with or transcend statutory procedures. This section will focus exclusively on SMHA provisions.[9] Beginning in Chapter Two we will focus on how these provisions have been implemented and transcended in Milwaukee County.

An analysis of the SMHA, allows the involuntary civil commitment process to be summarized in terms of eight steps: (1) initiating involuntary civil commitment; (2) detention or release pending probable cause hearing; (3) probable cause hearing; (4) detention or release pending final commitment hearing; (5) prehearing examination; (6) final commitment hearing; (7) placement of the individual meeting commitment criteria into the least restrictive treatment alternative; and (8) review of the commitment.

Initiating Involuntary Civil Commitment

The involuntary civil commitment process may be initiated in Wisconsin either by the filing of a written petition for examination or by the initiation of emergency detention. A petition must allege that the individual to be examined:

(1) is mentally ill, drug dependent, or developmentally disabled, and is a proper subject for treatment; and

(2) is dangerous because the individual (a) evidences a substantial probability of physical harm to himself or herself as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm; (b) evidences a substantial probability of physical harm to other individuals as manifested by evidence of recent homicidal or other violent behavior, or by evidence that others are placed in reasonable fear of violent behavior or serious physical harm to them, as evidenced by a recent overt act, attempt or threat to do serious physical harm; (c) evidences such impaired judgment, manifested by evidence of

[8]Wis. Stat. Ann., Chapter 51 (1975).

[9]In this section only, citations to specific statutory provisions are not included. Citations will be included in subsequent chapters where the practical significance of these provisions in Milwaukee County is discussed in depth.

a pattern of recent acts or omissions, that there is a substantial probability of physical impairment or injury to himself or herself (the probability is not substantial if reasonable provision for the individual's protection is available in the community); or (d) evidences behavior manifested by recent acts or omissions that, due to mental illness, he or she is unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt and adequate treatment so that a substantial probability exists that death, serious physical injury, serious physical debilitation or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for this mental illness (no substantial probability of harm exists if reasonable provision for the individual's treatment and protection is available in the community).

If an individual is already voluntarily admitted or involuntarily committed immediately before the initiation of the proceedings, the recent overt act, attempt, or threat requirements, may be shown by demonstrating a substantial likelihood, based on the person's treatment record, that if treatment were withdrawn the individual would be a proper subject for commitment. The petition must be signed by three adults, at least one of whom has personal knowledge of the individual's conduct. The petition is filed in the court assigned to exercise probate jurisdiction in the county where the individual is located or in the county of his or her legal residence. The petition must include a clear and concise sworn statement of the facts constituting probable cause to believe the allegations of the petition. When a petition is filed, the court should assure that the individual is represented by adversary counsel. Counsel should be appointed for indigent individuals.[10]

In emergency situations, initiation of involuntary civil commitment may not require the filing of a petition. SMHA prescribes procedures for the emergency detention of an individual whose behavior gives a law enforcement officer "cause to believe" that the individual is mentally ill, drug dependent or developmentally disabled, and evidences a substantial probability of harm to himself or herself or others, or is unable to satisfy his or her basic physical needs. Emergency detention, without a petition signed by three individuals, is justified if the officer's belief is based on a specific recent overt act, attempt or

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[10]According to the Supreme Court of Wisconsin's decision in State ex rel Memmel v. Mundy, 75 Wis. 2d 276, 249 N.W. 2d 573 (1977), counsel appointed in civil commitment proceedings has the same function, duties, and responsibilities as retained counsel in any civil proceeding. This mandatory appointment of adversary counsel at the initiation of commitment proceedings replaces the discretionary appointment of a guardian ad litem at any stage of the proceedings.

threat to act, or omission, made by the individual and observed by or reliably reported to the officer. When a law enforcement officer takes emergency custody of an individual, the officer must sign a statement of emergency detention which details information concerning the recent overt act, attempt or threat to act, or omission upon which the custody-taking is based, and the names of the persons observing or reporting that information. Although the officer need not specify whether the subject individual is mentally ill, developmentally disabled, or drug dependent, the officer must allege that he or she has cause to believe that the individual evidences one or more of these conditions. The statement of emergency detention should be delivered to the detention facility when the subject individual is taken there.

Detention or Release Pending Probable Cause Hearing

Upon filing of a petition, the court reviews the petition to determine whether to issue a detention order. The individual should be detained only if there is "cause to believe" that he or she meets commitment criteria. The statute fails to clearly state under what circumstances the subject individual should be released, or not initially detained, pending the probable cause hearing. If the individual is detained, he or she has a right to a hearing to determine probable cause for commitment within 72 hours after arrival at the facility, excluding Saturdays, Sundays, and legal holidays. If the individual is not detained, the probable cause hearing should be held within a reasonable time.

When a law enforcement officer detains a subject individual pursuant to a detention order, the officer must present the individual with a notice of hearing, a copy of the petition and detention order, a written statement of the criteria under which he or she may be committed, and a written statement of the individual's rights to an attorney, to a jury trial if requested more than 48 hours prior to final hearing, and to a probable cause hearing. If the individual is not detained, the officer must serve these documents on the individual, and orally inform him or her of these rights.

The SMHA specifies certain individuals who must receive notice of all commitment proceedings. These include the individual, his or her counsel, and any other persons whom the court may designate. Notice of the time and place of a hearing must be personally served on the individual and his or her attorney within a reasonable time prior to the probable cause hearing.

A law enforcement officer may take a person into custody pursuant to a detention order, or without such an order if the officer has cause to believe that the person meets the emergency detention criteria articulated above. After an individual is detained by an officer, upon arrival at the detention facility, facility staff should present the documents mentioned above to the individual, and orally inform the individual of his or her rights. The place of detention following a petition or an emergency detention may be a hospital approved by the department or under contract with the county board, an approved

public treatment facility, a mental health institute, a center for the developmentally disabled, a state treatment facility, or an approved private treatment facility if the facility so agrees.

When an individual subject to emergency detention is delivered to a detention facility, the facility director, or his or her designee, must orally and in writing inform the individual of his or her rights. These rights include the right to contact an attorney and a member of the individual's immediate family, the right to appointed counsel (if the individual is indigent), and the right to remain silent (including the right to a warning that any statements made may be used as a basis for commitment). The individual should also receive a copy of the statement of emergency detention.

Within 24 hours after an individual is delivered to a detention facility, the treatment director, or his or her designee, must determine whether the individual will be detained (and treated, if the director or designee advises the individual of the right to refuse treatment and the individual consents to the treatment). The director or designee must release the individual or detain him or her for not more than 72 hours (excluding Saturdays, Sundays, and legal holidays) after delivery of the individual to the facility. If the individual is detained, the director or designee may supplement the law enforcement officer's statement of emergency detention. This supplement should state the belief concerning whether the individual is mentally ill, developmentally disabled, or drug dependent, and may specify information concerning whether the individual should be subject to commitment. The director or designee should promptly file the officer's statement, and any supplement, together with the notice of detention, with the court. This filing has the same effect as the filing of a petition for commitment.

Probable Cause Hearing

A detained individual has a right to a probable cause hearing. This hearing must be held within 72 hours after the individual arrives at the detention facility, excluding Saturdays, Sundays, and legal holidays. The individual or his or her counsel may request a postponement of the hearing not exceeding seven days. If the individual is not detained, the hearing must be held within a reasonable time of the filing of the petition. This hearing, and all other hearings required under SMHA, must conform to the essentials of due process including the rights to an open hearing, to request a closed hearing, to counsel, to present and cross-examine witnesses, and to remain silent. The court may hold the hearing at the detention facility, unless the individual or his or her attorney objects.

If the court determines that no probable cause to believe the allegations exists, the court merely dismisses the proceeding. If the court finds probable cause, however, it should schedule the matter for a final commitment hearing within 14 days from the time of initial detention of the individual (the period may be longer if the individual or his or her counsel requests a jury trial). If the court has previously granted a postponement of the probable cause hearing, the final commitment hearing must be scheduled within 21 days of the initial detention. If the individual has not been detained, the final hearing must be scheduled within 30 days of the probable cause hearing.

The court may determine that no probable cause exists to commit the subject individual, but that probable cause exists to believe that the individual is a fit subject for guardianship and protective placement or services. If the court finds guardianship and protective placement or services to be warranted, the court may appoint a temporary guardian and order emergency protective placement or services.

<u>Disposition Pending Final Commitment Hearing</u>

If probable cause is established, the court may either release or detain the subject individual pending the final commitment hearing. If release is ordered, the individual has a right to receive voluntary treatment services from the community board or from the department. The court may issue an order stating conditions of release. If acceptance of treatment is one of the conditions, the individual may elect to accept the conditions or to submit to detention. The court may specify in the release order what remedial actions may be taken upon breach of stated conditions. The final commitment hearing must be held within 30 days of a release order.

If the court finds that release and voluntary treatment services would be unavailable, unsuitable, or undesirable because of the individual's condition, the court may issue a detention order. Detention may be for 14 days, or for up to 21 days if the court previously granted a postponement of the probable cause hearing. Proper facilities for placement of an individual detained pending final hearing are the same as the facilities mentioned above for placement pending probable cause hearing.

During detention, a physician may order the administration of medications and therapies provided that the subject individual has been informed of the right to refuse treatment and has signed a written consent to the treatment. The individual has a right to refuse all treatment except that which is court-ordered or that which is necessary to prevent serious physical harm to the individual or to others. The court may issue an order permitting administration of medication without the individual's consent if prior to such an order the court holds a hearing and determines (1) that the medication will have therapeutic value, (2) that the medication will not unreasonably impair the individual's ability to prepare for or to participate in subsequent legal proceedings, and (3) that probable cause exists to believe that the individual is incompetent to refuse medication. An individual is incompetent to refuse medication if because of mental illness, developmental disability, or alcohol or other drug dependence, the individual is incapable of understanding the advantages and disadvantages of accepting treatment, as well as the alternatives to the particular treatment offered. No medication may be administered to the subject individual unless ordered in writing by a physician. A record of all medications administered to the individual must be kept in the individual's medical file. The director of the treatment facility in which the subject individual is detained, or his or her designee, must file with the court a report of all treatment provided to the individual, along with the written consent of the individual.

Prehearing Examination

After a finding of probable cause to believe the allegations in the petition, the court should appoint two examiners to examine the individual to determine whether he or she meets the commitment criteria and what treatment modalities or facilities might be appropriate. These examiners should be two licensed psychiatrists, one licensed physician and one licensed psychologist, or two licensed physicians (one of whom has specialized training in psychiatry, if such is available), or two physicians. The court should appoint examiners having specialized training appropriate to the needs of the individual. The individual may select one of these examiners if the individual informs the court of his or her selection within 24 hours after the probable cause hearing. The court may deny appointment of the individual's selected examiner, however, if the court determines that the examiner does not meet statutory requirements or is unavailable. The individual, his or her attorney, or any other interested party with court permission, may secure an additional medical or psychological examination, and may offer that examiner's testimony as evidence at hearing.

Prior to the examination, the individual must be informed that his or her statements may be used as a basis for commitment and that he or she has the right to remain silent. This warning establishes a presumption that the individual understands his or her right to remain silent during the examination.

Each examiner must make an independent report to the court concerning the individual's mental condition. If the examiner determines that the subject individual is a proper subject for treatment, the examiner should make recommendations concerning the least restrictive level of treatment appropriate for the individual. On motion of either party, all parties must produce all physicial evidence, including examiner's reports, which they intend to introduce at hearing, so that the other party may inspect, copy, or transcribe the evidence.

Final Commitment Hearing

The final commitment hearing, and all other hearings in the involuntary civil commitment process, must be open to the public, unless the subject individual, or his or her attorney acting with the individual's consent, requests that the hearing be closed. If the hearing is closed, only interested persons, including representatives of service providers, attorneys, and witnesses may be present.

Within a reasonable time prior to the hearing, the petitioner's counsel must notify the subject individual and his or her attorney of persons who may testify in favor of commitment, and of the time and place of the final hearing. The court may designate additional persons who must receive notice of the time and place of the hearing.

At least 48 hours prior to the final hearing, the individual's counsel must be given access to all psychiatric and other reports. At the commitment hearing, the rules of evidence followed in civil actions generally apply. Throughout the proceedings, the court must disregard any "harmless" errors or defects in the pleadings or proceedings, that is, errors or defects which do not affect the substantial rights of either party. The petitioner has the burden of proving all required facts by clear and convincing evidence.

The subject individual has a right to a jury to determine if the allegations in the petition are true. The individual, or his or her counsel if the individual does not object, must demand a jury at least 48 hours prior to the hearing or a jury trial is deemed waived, provided that the individual or his or her counsel has been given notice of the time requirement. After a timely demand for a jury trial, the court must direct that a jury of six people be drawn. If the jury trial demand is made within five days of detention, the final hearing must be held within 14 days of detention. If the demand is made after five days, however, the final hearing must be held 14 days from the date of the demand.

Placement of Individual Meeting Commitment Criteria

If the court determines that the individual does not meet commitment criteria, it has several dispositional alternatives. First, the court may simply dismiss the petition. Second, if the court determines that the individual should not be committed but that guardianship or protective placement or services are warranted, the court may appoint a temporary guardian and order temporary placement or services not to exceed 30 days. Any interested person may then file a petition for permanent guardianship or protective placement or services. A third alternative emerges when a petition is dismissed: the subject individual may voluntarily remain in the detention facility for the time necessary for alternative plans to be made for his or her care.

If the court determines that the individual meets commitment criteria, the court should order commitment to appropriate inpatient care or outpatient treatment. The court should designate the facility or service which is to receive the individual. The community board should arrange for treatment in the least restrictive manner consistent with the individual's needs and the maximum level of inpatient care permitted by the court order. The county board must report to the court concerning the initial treatment plan. The board has the ongoing responsibility to review the individual's needs and to transfer the individual to the least restrictive treatment program consistent with those needs. If the court finds that the subject individual's dangerousness can be controlled by medication on an outpatient basis, the court may condition release upon the individual continuing to take prescribed medication and to report to a particular treatment facility as an outpatient as often as required for evaluation. If the subject individual is a nonresident, or was or is to be transferred from a state correctional facility or jail, commitment to the department should be ordered. An appeal of the court's commitment decision may be taken to the court of appeals by the individual, the individual's guardian, the petitioner, or the public representative.

The initial commitment period may never exceed six months. Each subsequent, consecutive order of commitment may not exceed one year. In one situation, however, the commitment period may not exceed 45 days in any 365-day period. This limit applies if the criterion upon which the commitment is based is the fourth standard for involuntary commitment, namely that due to mental illness, the individual is unable to satisfy his or her own basic needs for nourishment, medical care, shelter or safety.

Proceedings to continue commitment beyond the initial commitment period are initiated when the department or the board having custody of the individual apply for an extension of the commitment. A judicial hearing, conducted in the same manner as the final commitment hearing, is then held to determine whether the subject individual continues to meet commitment criteria. The board or other person seeking continued commitment has the burden of proving that the subject individual is in need of continued commitment.

At any time during a commitment period, the department or the board may transfer an individual committed to it, or admitted to a facility under its supervision or operating under an agreement with it, from one treatment facility to another, or from a treatment facility into the community, if such a transfer is consistent with reasonable medical and clinical judgment. The board should discharge any committed individual when it determines that the individual no longer meets commitment criteria.

Review of Commitment

Treatment staff must periodically reevaluate an involuntarily committed person to determine whether the individual has progressed sufficiently to warrant discharge or transfer to a less restrictive facility. Periodic reevaluations must occur within 30 days after the commitment, within three months after the initial reevaluation, and again thereafter at least once each six months. The findings of these reevaluations must be written in the individual's treatment record. A copy of these findings must be sent to the board having responsibility for the individual and to the committing court.

In addition to these automatic periodic reevaluations, a committed individual may at any time file a petition requesting a reexamination or requesting the court to modify or cancel the commitment order. The petition is filed with the court having jurisdiction in probate matters, either in the county from which the person was committed or in the county in which the person is detained. If a hearing regarding the person's commitment has been held within 30 days of the filing of the petition, no hearing on the petition must be held. If a hearing has been held more than 30 days but less than 120 days from the filing, within 24 hours of the filing, the court must order the appropriate board to complete an examination within seven days. A hearing may then be held in the court's discretion. If no hearing concerning the commitment has been held within 120 days of the filing of a petition for reexamination, a hearing on the petition must be held within 30 days. The hearing on the petition should be conducted according to the standards discussed above

for a judicial hearing pursuant to extension of a commitment. Reexaminations should be conducted in the same manner as were the prehearing examinations. Subsequent reexaminations may be given at any time in the court's discretion; subsequent reexaminations may be compelled after 120 days of the preceding examination. The pendency of an appeal in either the court of appeals or the supreme court does not deprive the circuit court of jurisdiction to conduct reexamination proceedings.

CHAPTER TWO

INITIATING INVOLUNTARY CIVIL COMMITMENT

The Wisconsin State Mental Health Act,[11] like the mental health law in most states, provides for two major means for initiating involuntary civil commitment of a person alleged to be a proper subject for such an action: emergency and non-emergency. The first is characterized, and differentiated from the latter, by the need for <u>immediate</u> mental health intervention, including temporary emergency detention without a judicial order or prior judicial approval. This means of initiating involuntary civil commitment often involves some type of crisis intervention by mental health or law enforcement personnel. Non-emergency procedures require a formal petition to the court requesting mental health examination of the respondent pursuant to involuntary civil commitment. A petition must be signed by three adult persons, at least one of whom has personal knowledge of the behavior of the respondent(51.20(1)(b)). In 1981, according to statistics compiled by the Milwaukee County Office of the Register of Probate, approximately 61 percent of the 699 involuntary commitment proceedings were initiated via the emergency detention route; the remaining 39 percent were non-emergency petitions filed with Milwaukee County's Office of Corporation Counsel.[12]

EMERGENCY DETENTION

Section 51.15(1) of the Wisconsin State Mental Health Act (SMHA) authorizes a law enforcement officer to take an individual into custody if the officer has "cause to believe that such individual is mentally ill, drug dependent or developmentally disabled" and evidences a substantial probability of harm to himself or herself or others, or is "unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt and adequate treatment." The term "law enforcement officer" is defined as "any person who by virtue of the person's office or public employment is vested by law with the duty to maintain public order or to make arrests for crimes while acting within the scope of the person's authority" (51.01(11)). The law enforcement officer's belief that the person is mentally ill and should be subject to temporary emergency detention must be based on "a specific recent overt act, attempt or threat to act or omission made by the individual and observed by or <u>reliably reported to the officer</u>" (51.15(1)(b); emphasis added).

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[11] Wisc. Stat. Ann., Chapter 51 (1975); hereafter, references to the State Mental Health Act will be by section number only.

[12] These statistics do not take into account petitions filed regarding alleged alcohol and other drug abusers, petitions filed for re-examination, and petitions filed for emergency detention through the Office of the Protective Services Management Team under Chapter 55 of the Wisconsin Statutes.

An officer does not necessarily have to witness the behavior warranting emergency detention, but may initiate emergency detention on the basis of reliable information reported by an eyewitness. The officer need only believe that the informant is a reliable source. The officer, in effect, serves as the agent through whom proceedings are initiated. There have been reports that officers in Milwaukee have in the past refused to detain mentally ill persons because they did not actually observe the dangerous behavior themselves.[13] Whether every lawenforcement officer in Milwaukee County is aware of his or her authority to act on the reliable report from an eyewitness, and will in fact do so if the situation should arise, is a question that is far beyond the scope of this report. However, interviews with several police officers and others familiar with police work, suggested that officers are generally aware of their authority in emergency detentions and will refuse to detain a person only if they believe that the person does not meet statutory criteria for emergency detention. Any avoidance or non-enforcement of laws by police officers in Milwaukee did not appear to us to be any more noticeable in Milwaukee than in other cities[14] in which the Institute has conducted studies of involuntary civil commitment.

In practice, according to a representative of Milwaukee's Department of Police, determining "cause to believe" is no different in emergency detentions than in arrests in criminal cases. That is, the officer's response is determined by the allegedly mentally ill person's recent and specific actions which seriously threaten the safety of the person or others. Although we did not speak to this point directly with the police officers we intereviewed, it is probably also influenced by many other factors such as the demands of obedience to superiors, loyalty to colleagues, responsiveness to the community, adherance to operational norms, and personal factors (e.g., mood, work experiences, and the individual officer's attitudes toward mentally ill persons). It is our belief that law enforcement officers' responses to mentally ill persons in Milwaukee are shaped much less by a close tracking of statutory provisions that define what they can or cannot do, than by an exercise of discretion determined by the joint impact of the beliefs contained within an operational style and the assessment of risks and opportunities undertaken in any given situation.[15]

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[13] A dangerous misunderstanding (Editorial). The Milwaukee Journal, March 8, 1982; also, see Gerhardstein, R. P. Panel and additional notes to panel discussion, "The Commitment Laws, Is There A Need For Change? The View from a Mental Health Center." Annual meeting of the Alliance for the Mentally Ill of Wisconsin, Milwaukee, September 25, 1982.

[14] New York, Columbus (Ohio), Winston-Salem (North Carolina, Los Angeles, and Chicago.

[15] Cf., for example, Brown, M. K. Working the street: Police discretion and the dilemnas of reform. New York: Sage, 1981, Chapter 8.

An officer has four basic options when confronting a mentally aberrant person who he or she believes is exhibiting strange or frightening behavior: (1) criminal arrest, (2) emergency detention pursuant to Section 51.15 of SMHA, (3) referral of the "complainants" to the Protective Services Management Team or the Office of Corporation Counsel for filing of a formal petition for examination of the person pursuant to involuntary commitment (51.20); or (4) referral to some other service or facility (e.g., Crisis Intervention Service). The present law, it seems, allows individual officers to exercise discretion, make moral judgments, and react compassionately to situations. We doubt that more rules and regulations for law enforcement officials will silence critics of the exercise of this broad discretion by police in emergency detentions. We suggest that community expectations be brought in line with the realities of police work.

Under the present emergency detention law (51.15), the authority to take an individual into custody is limited to law enforcement officers. Generally speaking, restricting entry into the involuntary civil commitment system by way of emergency detention has considerable merit. The ease or difficulty with which the commitment process can be initiated, and by whom it can be initiated, will largely determine the number and types of cases involved in this process and the extent of involvement. It is not difficult to envision abuse of the civil commitment process if it were easily accessible and viewed as a convenient answer to interpersonal, family, and relatively mild social problems. In our view, however, the emergency detention power can be extended beyond law enforcement personnel to designated mental health personnel to some advantage and without inviting abuse.

RECOMMENDATION 1: EMERGENCY DETENTION AUTHORITY UNDER SECTION 51.15 OF THE STATE MENTAL HEALTH ACT SHOULD BE EXTENDED BEYOND LAW ENFORCEMENT OFFICERS TO A LIMITED AND CONTROLLED NUMBER OF DESIGNATED COUNTY OFFICIALS.

In Los Angeles County, only "designated county personnel," as defined by state and county regulations, may take a person into custody pursuant to emergency detention. The following class of officials, or "gatekeepers," are authorized to take into custody and detain allegedly mentally disordered persons for emergency evaluation and treatment: peace officers, members of the attending staff of an evaluation facility properly designated by Los Angeles County, and members of community mental health centers' mobile crisis or psychiatric emergency teams.[16] The extension of emergency powers in involuntary civil commitment proceedings beyond peace officers to a limited category of persons designated by the county, to our knowledge, has not engendered abuse and improper emergency detentions in Los Angeles County.

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[16] California Welfare and Institutions Code, Section 51.50; see also, Keilitz, I., Fitch, W.L., and McGraw, B.D. Involuntary Civil Commitment in Los Angeles County. Williamsburg, Virginia: National Center for State Courts, 1982 (hereafter Los Angeles).

The restrictions on initiating involuntary civil commitment in emergency situations cut two ways: at the same time that the restrictions make it more difficult to effect improper detention of a person, they often make it quite a formidable (some in Milwaukee would say impossible) task to get much needed care and treatment for a person. We recommend that emergency power in Milwaukee County be extended, following the Los Angeles procedure, beyond law enforcement officers to include the following "gatekeepers": the Crisis Intervention Service and designated members of the attending staff of the Milwaukee County Mental Health Complex and other evaluation facilities (e.g., the Psychiatric Emergency Service) properly designated by the county. Only those categories of persons capable of effecting emergency detention, including conveyance to the Milwaukee County Mental Health Complex, without law enforcement assistance should be empowered to initiate emergency detention.

In its review of this rcommendation,[17] the Subcommittee on Involuntary Commitment Study (hereafter Subcommittee) suggested that any statutory revision required by this recommendation should be worked broadly to allow each county to designate which county officials may have emergency detention authority. One reviewer, representing the Milwaukee County Mental Health Center, suggested that the following staff should have authority to make emergency detention in Milwaukee County should this recommendation become law: members of the psychiatry and psychology staff of the Milwaukee County Mental Health Complex; all outpatient clinic managers; and all members of the staff of the Psychiatric Emergency Service and the Crisis Intervention Service. This reviewer further recommended that any revision of the law should specifically state that emergency detentions by designated county personnel should be made with the assistance of the police whenever necessary.

Similar recommendations to increase the categories of officials authorized to initiate emergency detentions have previously been made in Milwaukee.[18] We generally oppose recommendations to expand the categories of persons empowered to initiate emergency detention to teachers, building inspectors, public health officers, and others who would, of necessity, need to summon law enforcement officers to take into custody and convey the person to the Milwaukee County Mental Health Complex.

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[17] Supra, note 1.

[18] Gerhardstein, R. P., supra, note 10; see also, Background Information Concerning Recommendations Made By Robert McKnight on Status of Mental Health Laws in Wisconsin. The Planning Council for Mental Health and Social Services, Inc. Unpublished memorandum. March 4, 1982.

According to a number of interviewees, limitation of the emergency detention power to only law enforcement officers has engendered some practical difficulties and seemingly senseless impediments to the provision of prompt mental health care. For instance, when an individual with severe mental disturbances arrives at the Psychiatric Emergency Service of the Milwaukee County Mental Health Complex, but refuses voluntary admission, staff of the Psychiatric Emergency Service have several options: (1) release the person; (2) urge relatives or friends, who typically have accompanied the individual, to petition for an examination of the person pursuant to involuntary civil commitment;[19] or (3) attempt to convince one of the institution deputies (a Deputy Sheriff assigned to Milwaukee County's Mental Health Complex and Medical Complex) that the individual is mentally ill and a proper subject for emergency detention. Reportedly, sheriff's deputies assigned to the Milwaukee County Mental Health Complex are reluctant to initiate emergency detention and transport the individual to Ward 53B of the Mental Health Complex solely on the report of Psychiatric Emergency Service staff without having witnessed the behavior of the individual themselves.

The extension of emergency detention powers to designated mental health personnel may balance the present emphasis on observable overt acts or omissions in emergency detention by law enforcement officers with a concern for treatment and care by designated mental health gatekeepers. Our recommendation is not intended to suggest that law enforcement officials presently use solely the "recent overt act or omission" criterion as the basis for emergency action, nor that mental health personnel, when given emergency powers, should use only the care and treatment criterion embodied in the Wisconsin commitment standards. The recommendation, instead, strives for a balance of interests beginning at the earliest stage of the involuntary civil commitment process.

The emergency detention process typically is initiated either by a telephone call from a family member, friend, or acquaintance of the potential respondent, or by direct observation by a law enforcement officer. At the scene, the law enforcement officer makes an initial assessment of possible criminal actions and/or mental disturbance of the individual. According to a manual used in the training of police officers in Milwaukee, a police officer should do the following in the handling of apparently mentally disturbed individuals: protect the public, safeguard his or her own life, and treat the mentally disturbed person as a sick person and not a criminal.[20] According to a representative of Milwaukee's Department of Police, orientation and

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[19]This option can usually only be exercised the following day, at the earliest, due to the distance between the Milwaukee County Mental Health Center and the Milwaukee County Courthouse where petitions must be filed.

[20]<u>How To Recognize and Handle Abnormal People</u>. Arlington, Virginia: National Association for Mental Health, Inc., 1978.

continuing education is provided to police officers in order to assist them in identifying mentally ill persons, understanding the problems involved, and making proper referrals. The handling of mentally disturbed persons is discussed in recruit officer's and in-service instruction in a number of areas of police responsibility including patrol procedures, the handling of domestic violence, investigating suspicious persons, and Wisconsin State Statutes. Individual lesson plans are developed and written using state laws, court opinions, and communications from other agencies.

If a law enforcement officer is unsure whether an emergency detention is proper in a given case, the officer may call the Milwaukee Crisis Intervention Service for assistance in making the determination.[21] Alternatively, the officer refers "complainants" to the Milwaukee County Office of Corporation Councel or the Milwaukee County Department of Social Services to obtain a petition for non-emergency involuntary civil commitment. This latter course of action may be appropriate in situations where the officer does not make a criminal arrest and also fails to find the person a fit subject for emergency detention pursuant to Section 51.15.

In cases where the officer believes that the individual is a proper subject for emergency detention, he or she transports the individual, or arranges for transportation by an ambulance or "paddy wagon," to the Milwaukee County General Hospital Emergency Admitting Center. Once the person is "medically cleared" by staff of the Center, the person is taken to Ward 53B of the Milwaukee County Mental Health Complex. The officer remains with the person in the Emergency Admitting Center during the medical examination by the physician on duty. A standard form, referred to as a "blue sheet" (see Appendix A, pp. 3-4), documenting the medical clearance by the Emergency Center, is given to the officer to take to Ward 53B.[22]

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[21]A discussion of the interaction between law enforcement officers and Crisis Intervention Service counselors appears later in this chapter.

[22]Contrary to a misunderstanding among some mental health-legal personnel in Milwaukee County, the Psychiatric Emergency Service located in the Milwaukee County Medical Complex is not involved, except very rarely, in involuntary civil commitments. The mission of the Psychiatric Emergency Service is crisis intervention, psychiatric assessment, and diagnosis of patients on a voluntary basis. The staff consists of one psychiatrist and three psychiatric social workers; during evening hours, duties are performed by one psychiatric social worker and a psychiatric resident. Two-thirds of the patients of the Psychiatric Emergency Service are self-referred; the remaining one-third are accompanied by relatives or friends at the time of admission. According to a spokesman for the Psychiatric Emergency Service, interactions between staff of the Psychiatric Emergency Service and Ward 53B, the involuntary admission ward of the Mental Health Complex, are infrequent.

In the City of Milwaukee, the investigating officer may not convey the allegedly mentally disturbed individual to the Mental Health Complex but may call for a paddy wagon or ambulance to transport the respondent. According to Milwaukee Police Department policy, the investigating officer usually completes a form requesting and stating the reason for such a conveyance. Investigating officers from law enforcement agencies outside of the City of Milwaukee, in most cases, transport an individual to the Milwaukee County Mental Health Complex themselves.

When a law enforcement officer believes that an individual is mentally disturbed but not sufficiently so to proceed with emergency detention under Section 51.15, the transportation of the person to a facility for temporary emergency care and treatment has posed some problems. Milwaukee City police officers are required to justify and document their reasons for a conveyance request. The Milwaukee Police Department's Form PP-42 (Protective Custody or Transfer of Prisoner for Medical Care) requires that an investigating officer provide reasons for conveyance requests based on four separate provisions in Wisconsin's statutes: (1) protective custody of intoxicated persons (51.45(11)(a)); (2) protective custody of incapacitated persons (51.45(11)(b)); (3) temporary emergency detention for mental health examination (51.15); and (4) the transfer of prisoners in need of medical or hospital care (53.38). If police officers have no basis upon which to pursue emergency detention under Section 51.15, they lack the formal authority to transport an individual to a detention facility, even if the person is in need of some other type of treatment and care. According to a representative of the Milwaukee Police Department, in such cases a referral is made and assistance is sought from the Mental Health Complex or the Crisis Intervention service. Nonetheless, lack of resources may cause a person to be without transportation to a mental health facility.

In Milwaukee County, law enforcement officers taking emergency detention of a person are required to provide "detailed specific information concerning the recent overt act, attempt or threat to act or omission" upon which the emergency detention is based or, alternatively, the names of persons who witnessed the recent overt act, attempt or threat to act, or omission (51.15(4)(a)). The law further requires that the law enforcement officer provide this statement to the staff of the detention facility upon transporting the person to the facility. The filing of this statement with the court, together with any supplemental statement ("Treatment Director's Supplement to Law Enforcement Officers Statement of Detention"; see Appendix A, p. 5) by the examining psychiatrist in Ward 53B, has the same effect as a "three-party" petition for non-emergency involuntary civil commitment.

Milwaukee police officers detail the specific information on which an emergency detention is based by completing a standardized form (Form PE-18, "Statement of Emergency Detention By Law Enforcement Officer"). A properly completed form sets forth the statutory basis for the detention, the names of the person(s) who reliably reported the basis of the detention to the investigating officer (if the detention was not based upon the officer's personal observations) and a narrative description of the events upon which the allegations are based. The form must be signed by the detaining officer and collaborating officer, if

any. A typical statement of emergency detention by a law enforcement officer in the City of Milwaukee included the following observations:

> Attempt to cut her left wrist open, causing minor abrasions to same, with an unknown object. She stated that at the time she is fed up with society and no matter what happens to her today she will try the same thing again when she can. She further stated she is very depressed and wants to end her life.

In the City of Milwaukee, law enforcement officers are required to complete the statement of emergency detention in quadruplicate. The original and two copies of the form accompany the respondent to the Mental Health Complex. The fourth copy is forwarded to the Medical Section of the Milwaukee Police Department. While Milwaukee County law enforcement officers outside of the City of Milwaukee do not use the same printed form for their statement of emergency detention, they use a printed form similar in all essential components to that used by city police (see Appendix A, p. 6).

Once the allegedly mentally disturbed person is "medically cleared" by the Milwaukee County General Hospital Emergency Admitting Center and is transported by the detaining officer to Ward 53B of the Milwaukee County Mental Health Complex, the procedures pursuant to involuntary civil commitment via by the emergency detention route (51.15) and the non-emergency, petition route (51.20), are, except for some minor differences, the same.

NON-EMERGENCY INVOLUNTARY COMMITMENT

Wisconsin, like most states,[23] allows a more deliberate process of involuntary civil commitment to be initiated in non-emergency cases. Section 51.20 of the State Mental Health Act allows any person to file a petition alleging that a person is a proper subject for involuntary civil commitment and, further, requesting that the court order the person to be examined and that a hearing be held to determine whether the person should be committed. A "petition for examination" must be signed by three adult persons, at least one of whom has "personal knowledge of the conduct" of the individual who is the subject of the petition (51.20(b)). The form, "Petition for Examination" (see Appendix A, p. 7), formally invoking the jurisdiction of the court, lists the criteria for involuntary civil commitment as they are set forth in the State Mental Health Act.[24]

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[23]Institute on Mental Disability and the Law. Provisional Substantive and Procedural Guidelines for Involuntary Civil Commitment. Williamsburg, Virginia: National Center for State Courts, 1982 (hereafter Institute).

[24]The preprinted form, "Petition For Examination" (Appendix A, p. 7), contains an error that appears to have resulted from an incorrect transcription of Section 51.20 of the Wisconsin State Mental Health Act. The second sentence of paragraph (c), referring to the exception provided when less restrictive alternatives are available, should not contain the word "not" in the last phrase. This phrase should read "...if the individual is appropriate for placement under s. 55.06." This error was

The petition serves as a formal allegation by three persons (the petitioners) that another person (the respondent) is a proper subject for commitment. From a legal perspective, the petition constitutes the basis to establish "probable cause" to believe that the respondent requires commitment and should be involuntarily detained pending judicial hearing.

The petition process is almost always initiated by a telephone call to the Office of the Protective Service Management Team (PSMT) located on the lower floor of the Milwaukee County Courthouse. Callers may be, or may be referred by, law enforcement officers, members of the Crisis Intervention Service, mental health or social service personnel, attorneys, or other persons or agencies in the community. The PSMT intake worker answering a call, typically queries a caller about the respondent's present mental condition, behavior, and prior mental health history.

First and foremost, the intake worker determines whether an emergency exists. If there is an emergency, a caller is referred to the police or to the Crisis Intervention Service.[25] If no emergency appears to exist, a caller may be referred to the nearest community mental health center or some other agency or facility (e.g., the Wisconsin Correctional Service or the Human Service Triangle). Alternatively, staff of the PSMT may pursue with a caller the possibility of filing a petition for protective placement and services under Chapter 55 of the SMHA or, as a last resort, involuntary civil commitment (51.20). (See the following section in this chapter for a discussion of the PSMT's screening and diversion in collaboration with the Crisis Intervention Service.) If the latter option is pursued, a caller is

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brought to the attention of the Office of Corporation Counsel and the Office of the Protective Service Management Team by the authors on December 16, 1982. In several other respects, the preprinted form does not accurately transcribe Section 51.20. Although these inaccuracies may not be "errors" and may be immaterial in view of Wisconsin's harmless error rule (51.20(10)(c)), they should be modified: (1) in paragraph "1.", line 3, the words "believed to be" should be deleted (see 51.20(1)(a)1.); (2) in paragraph "2.", the words "and evidences one or more of the following" should be deleted and replaced by (continued)"because the subject" (see 51.20(1)(a)2.) [this change will require adding the word "Evidences" at the beginning of paragraph "2.(b)"]; (3) in paragraph "2.(b)", line 6, "such" should be replaced by "do" (see 51.20(1)(a)2.b.); (4) in paragraph "2.(c)", lines 2, 5, and 10, the word "very" should be deleted (see 51.20(1)(a)2.c.); and in paragraph "2.(e)", lines 3 and 4, "the requirements of specific recent overt acts, attempts or threats" should be deleted and replaced by "the requirements of a recent overt act, attempt or threat" (see 51.20(1)(am)). Also, "2.(e)" omits the last sentence of 51.20(1)(am), which probably should be included. We would suggest a careful review and revision of the petition form.

[25] See the discussion regarding the Crisis Intervention Service immediately following this section.

provided with a description of the "three-party" petition process and is asked to provide the PSMT with basic information such as his or her name, telephone number, and the name and location of the potential respondent. Finally, an appointment is made for all three potential petitioners to complete a three-party petition in the PSMT office. All three potential petitioners must be present to execute the petition; otherwise, the PSMT will not initiate the petition process. Appointments are usually scheduled promptly, depending mostly upon the potential petitioners' ability to travel to the PSMT office to complete the petition.

At the time of the appointment, the PSMT intake worker interviews all three petitioners and obtains the necessary information to complete a proper petition (i.e., specific dates when the respondent's behavior occurred, identities of observers, and specific facts which might constitute probable cause to believe the allegations in the petition (51.20(1)(c)). According to a member of the PSMT, few petition requests are rejected once three petitioners have been interviewed, although some potential petitioners require more extensive questioning by the interviewer to extract the detailed, specific information required by the SMHA.

Once a three-party petition has been completed to the satisfaction of the PSMT, the petitioners take the petition to Milwaukee County's Office of Corporation Counsel located on the third floor of the courthouse, where they are sworn and sign the petition (see Appendix A, p. 8, for the standardized form signed by petitioners). In accordance with the SMHA (51.20(4)), corporation counsel represents the "interests of the public" and has the responsibility to approve or disapprove petitions submitted to him. In reviewing a petition, corporation counsel may speak to one or more of the petitioners, usually by telephone. Extensive communication about a petition between corporation counsel and the PSMT, once a petition reaches the corporation counsel, is rare.

The petitioning process, up to this point, is sequential and usually not iterative. Once corporation counsel has completed his review of the petition and is convinced that involuntary commitment is warranted, he files the original petition and sworn affidavit with the clerk of the Circuit Court who time-stamps and dates the petition, prepares all the necessary papers related to the action (i.e., a "hearing data sheet," an unsigned judicial order of detention, notices of rights and service, and the original petition and sworn affidavit), and submits the petition to the circuit judge of the Probate Division. In accordance with the SMHA, Section 51.20(2), a circuit court judge reviews the petition and determines whether a detention order should be issued. Although the subject of a petition may remain free pending probable cause hearing, a detention order is almost always issued.

The Circuit Court Clerk then prepares the necessary papers and notifies the Sheriff's Department to take the individual into custody. With some minimal information about the individual to be detained provided by the PSMT (e.g., whereabouts, appearance, likelihood of

violence), members of the Process Service Division of the Sheriff's Department take the respondent into custody (see 51.20(2)). When taking the respondent into custody, they must present the individual with a notice of hearing (see Appendix A, p. 9), a copy of the petition and detention order, a copy of the criteria under which he or she may be committed, and a written statement of the individual's rights (51.20(2)). If the judge does not issue a detention order, the other documents must be served on the individual, and he or she must be orally informed of his or her rights (51.20(2)).

In contrast to the procedures for temporary emergency detention followed by law enforcement personnel in Milwaukee County, members of the Sheriff's Department's Process Service Division do not first transport a person taken into custody subject to non-emergency detention to the Milwaukee County General Hospital Emergency Admitting Center for "medical clearance" but, instead, transport the person directly to Ward 53B of the Mental Health Center. This inconsistency in custody-taking procedures conceivably may be justified by differences in the needs for medical clearance between emergency detainees and non-emergency detainees. That is, since the custody and detention of a person subject to a three-party petition does not constitute, by definition, an emergency situation, medical examination and clearance by the Milwaukee County General Hospital Emergency Admitting Center may not be warranted. Furthermore, because most of the non-emergency detentions are made during working hours when a psychiatrist on Ward 53B of the Mental Health Center is likely to be present to conduct a physical examination of the detainee, transporting the detainee to the Emergency Admitting Center first may be unnecessary.

These justifications, adduced by the authors, were not supported by personnel of Ward 53B. Although conceding that most non-emergency admittees to Ward 53B are in good shape physically, one interviewee stated that the lack of resources and personnel to conduct physical examinations and the need for consistency of procedures dictate that all respondents be "medically cleared" by the Milwaukee County General Hospital Emergency Admitting Center before being admitted to Ward 53B. This interviewee suggested that the difference in medical clearance procedures may not be due to a policy based upon acknowledged differences between the medical needs of emergency and non-emergency detainees, but rather it may be based upon the fact that the official court order (see Appendix A, p. 10) requires that the sheriff's deputies taking a person into custody pursuant to Chapter 51.20 shall take the person to Ward 53B of the Milwaukee County Mental Health Center. The order does not specifically require the sheriff's deputies to transport the person to the Milwaukee County General Hospital Emergency Admitting Center for medical examination and clearance.

One psychologist noted that there is sometimes a wait of hours for non-emergency medical evaluation at the Emergency Admitting Center. Such a long waiting time, he stated, is not only a misuse of the detaining officer's time, but adds to the stress on the detained individual. He recommended that a less stressful means of conducting medical examinations be found, whether the physical examination is performed at the Emergency Admitting Center or Ward 53B.

RECOMMENDATION 2: (1) THE MILWAUKEE COUNTY INSTITUTIONS AND DEPARTMENTS, IN CONJUNCTION WITH LAW ENFORCEMENT AGENCIES IN MILWAUKEE COUNTY, SHOULD DEVELOP A CONSISTENT METHOD FOR MEDICAL EXAMINATION AND CLEARANCE OF ALL CHAPTER 51 EMERGENCY AND NON-EMERGENCY DETAINEES BEFORE THEIR ADMITTANCE TO WARD 53B.

(2) THE METHOD(S) DEVELOPED SHOULD NOT PLACE UNDUE PROCEDURAL OR FISCAL BURDENS ON THE MILWAUKEE COUNTY MEDICAL COMPLEX, THE MILWAUKEE COUNTY MENTAL HEALTH CENTER, OR LAW ENFORCEMENT AGENCIES IN MILWAUKEE COUNTY RESPONSIBLE FOR TRANSPORTING PERSONS SUBJECT TO EITHER EMERGENCY DETENTION (51.15) OR NON-EMERGENCY DETENTION (51.20).

(3) ANY CHANGE IN PROCEDURE SHOULD BE REFLECTED IN THE POLICIES, STAFF ORIENTATION AND TRAINING, AND OPERATIONS MANUALS OF EFFECTED AGENCIES OR UNITS THEREOF.

This recommendation does not articulate a method for medical examination and clearance of detainees before their admittance to Ward 53B, but leaves the development of such a method to the affected agencies. Thus, this recommendation differs from the recommendation made in the review draft of this report that all persons subject to either emergency detention or non-emergency detention should first be transported by law enforcement officers to the Milwaukee County General Hospital Emergency Admitting Center before being transported and admitted to Ward 53B of the Milwaukee County Mental Health Center. Although reviewers of the earlier recommendation expressed considerable feeling that there may be a more efficient way of conducting medical examinations of non-emergency detainees, most reviewers that commented on this recommendation expressed their concern that transporting persons subject to non-emergency detention to the Emergency Admitting Center would involve prohibitive costs. One reviewer noted that all patients at the Mental Health Complex receive a complete physical examination within 24 hours of admission. He reported that in 1982 the Mental Health Center had 1,725 non-emergency voluntary admissions. His major concerns were that if each of these admittees first had to be transported to the Medical Complex, there could be additional costs related to transportation of admittees, that extra waiting-time would be required of the detaining law enforcement officer while the individual completes the medical examination, and that extra staff resources may be required to perform the medical examinations. While any requirement for first transporting to the medical complex persons subject to non-emergency involuntary detention would not include the voluntary patients alluded to by the reviewer and, in comparison, would affect only a relatively small

number of involuntary patients,,[26] the concerns about costs expressed by this and other reviewers should not go unheeded. As we have indicated earlier, it is our belief that in carrying out its duties and responsibilities in the involuntary civil commitment process, the state has the obligation to not impose undue programmatic, fiscal, and administrative burdens by any procedures that may be required.

CRISIS INTERVENTION SERVICE[27]

The Crisis Intervention Service (CIS) is a Milwaukee County agency which provides emergency services and counseling to persons who are experiencing crises related to mental health, family conflicts, alcoholism or other drug abuse, and emergency social service needs. CIS maintains a 24-hour hotline and 24-hour mobile teams for these purposes. At the time of our research in Milwaukee, CIS employed seven full-time and one half-time staff including two with masters degrees in psychology, two nurses, and four with masters degrees in social work (one of whom worked half time). The primary function of CIS is under Chapter 55 (the Protective Services Law) of the Wisconsin Statutes. According to a

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[26]In 1981, 699 involuntary commitment proceedings were initiated in Milwaukee County. Of this total, 39 percent were non-emergency detainees (see supra, note 12). This subgroup, or about 273 individuals in 1981, would be affected by any change in the manner that involuntary detainees are provided medical clearance. This group is obviously smaller than and does not overlap, at least initially, with the large group of voluntary patients referred to by the reviewer.

[27]The Crisis Intervention Service, perhaps more than any other Milwaukee County agency involved with involuntary civil commitment, has undergone extensive organizational and administrative changes since the dissemination of the review draft of this report in late February 1983.

> The Crisis Intervention Hotline, the Mobile Outreach, and the Psychiatric Emergency Service have combined to form the Mental Health Emergency Service. William I. Gore, the newly appointed administrator and his administrative assistant, Bruce Berg, are in the process of restructuring the service in order to provide maximum service despite limited resources of budget and staff. Ten full time employees and one part-time employee divide their time between the walk-in service, the Hotline, and the Mobile Outreach Service, as demand requires. The mobile unit is available Monday through Friday and is busiest between the hours of 10 a.m. and 10 p.m. .... [T]he Hotline will continue to provide 24-hour emergency counseling and aid. ("Three in One Emergency Services Merge." The AMI, April 1983, 3.)

(continued)

representative of CIS, CIS effected ninety-seven percent of the approximately 60 emergency detentions occurring in 1981 under Chapter 55.[28]

CIS also performs important functions under both the emergency and non-emergency procedures of the SMHA. Pursuant to the non-emergency procedures (51.20), CIS often does screening for the Protective Services Management Team (PSMT) to evaluate whether a three-party petition is appropriate. Although this screening of individuals potentially subject to three-party petitions is not required by the SMHA, it provides a means for diverting individuals away from the commitment process when the screening evaluation warrants such diversion.

According to a representative of PSMT, a three-party petition is the last resort. When the PSMT intake worker receives a telephone call from a person seeking a three-party petition, the intake worker questions the person to determine what actions have been taken (e.g., by the allegedly mentally ill person's family) to mitigate the condition or circumstances prompting the telephone call. If the intake worker determines that the caller or the disturbed person's family has taken action to mitigate the situation with no or minimal success, the intake worker will schedule an appointment for the caller and two other adult persons to come to the PSMT office to fill out forms pursuant to a three-party petition. If mitigating action has not been taken, however, the intake worker may call CIS or the Wisconsin Correctional Service, for example, to get assistance. Often the intake worker will telephone CIS while the caller is still connected and simply transfer the caller to CIS.

The CIS mental health counselor then continues the telephone screening. Reportedly, an average call received by CIS takes about 20 minutes and includes assessment, negotiating a care plan, and referring the caller to a treatment facility or agency.[29] In many cases such

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Because this section of the report deals primarily with practices of the Crisis Intervention Service and not with administrative and organizational structure, it retains its relevance to current policies and practices.

[28]The remainder were accomplished by the Protective Services Management Team. According to statistics compiled by Milwaukee County's Register in Probate, a total of 56 emergency detention were effected under the Protective Services Law during 1981. This can be compared with a total of 425 emergency detentions under Chapter 51. It should be noted that Chapter 55 does not specify who specifically should be authorized by the CCSB to take persons into protective custody. Sheriffs, police officers, firemen, and guardians may also perform that function (55.06).

[29]This characterization of incoming calls includes not only those received as referrals from the PSMT, but also includes all incoming calls received as referrals or directly from individuals experiencing crises.

telephone intervention is all that is required to assist the caller in resolving the crisis situation. Other situations, however, require face-to-face intervention. One psychologist, who has frequently been appointed as an examiner in involuntary civil commitment matters and is familiar with the work of CIS, noted that this type of screening by CIS appropriately places an emphasis upon persuasion rather than coersion to get candidates for involuntary commitment to become voluntary patients. He expressed the opinion that more individuals would be diverted from the commitment process prior to the prehearing examination if more such emphasis was placed upon counseling and persuasion.

When on-site intervention is warranted, CIS mental health counselors work in teams of two. Reportedly, because crisis situations are often unpredictable (e.g., a team may be confronted with violent behavior), CIS counselors very rarely work alone. Mobile crisis intervention team members are required to hold a master's degree in a mental health discipline or a bachelor's degree in nursing with three years of psychiatric experience. Although telephone intervention by CIS extends from Milwaukee County to the counties of Washington, Ozaukee, and Waukesha, the mobile catchment area is limited to Milwaukee County. CIS teams travel to intervention locations in one of two passenger cars leased for that purpose. Each car is equipped with a telephone to allow continued contact with a caller when the situation demands it.

CIS Mobile Teams continue their screening and intervention on site by administering a standardized, three-part assessment of the subject individual (see Appendix A, pp. 11-16, "Milwaukee County Crisis Intervention Services, Assessment and History"). The three areas of assessment are the biological, psychological, and social factors. In making these assessments, mobile teams use an eleven-page, standardized form which they fill out either on site or when they return to their office. The biological assessment includes review of the person's chief medical complaint (if any), his or her medical history, his or her general appearance, and his or her bodily systems (e.g., neurological, pulmonary, cardiovascular). The psychological assessment includes review of such areas as behavior, orientation, judgement, suicide risk, potential danger to others, and alcohol or drug abuse. The social assessment includes inquiry into such areas as the person's age, marital status, ethnicity, education, type of employment, income, social support system, family conflicts, and involvement with the criminal justice system. The Mobile Teams complete the three-part assessment in all but extreme circumstances.

Based on this assessment, the mental health counselors form diagnostic impressions and determine the treatment route or routes they deem optimal and should be pursued. If the counselors determine that Chapter 51 commitment criteria are met, they may refer the case back to the PSMT for a three-party petition or may contact the police regarding emergency detention of the person. According to one representative of CIS, the only circumstances in which a mobile team would call the police expressly pursuant to a Chapter 51 emergency detention is one in which a

potential exists for a drug overdose.[30] Reportedly, approximately 60 percent of all the cases handled by CIS in 1981 resulted in crisis counseling or referral to outpatient services. An additional 31 percent of CIS clients were hospitalized; of these, 23 percent were voluntary admissions and eight percent were involuntary admissions.[31]

Although most of the instances in which CIS and the police work cooperatively are initiated by police, such interaction may also be initiated by a CIS counselor. When a CIS mobile team encounters an individual who is violent or has a weapon, CIS counselors will almost always call for police assistance. CIS counselors generally are not experienced or trained in handling violent individuals. When contacted, police come to the scene and provide assistance. The police may provide consultation or assistance in controlling the violent individual. Such situations may lead to a criminal arrest or to a Chapter 51 emergency detention.

Whenever CIS counselors become involved in Chapter 51.15 emergency detentions, they work in conjunction with police officers. Reportedly, police and CIS counselors work together in about 20 percent of all CIS mobile cases. When police officers encounter an individual whom they believe may need mental health care, if they are uncertain whether the individual is mentally ill and should be detained, the police may call CIS for assistance in determining whether the individual meets emergency detention criteria. CIS may provide consultation by telephone or on location. Because Section 51.15 of the SMHA authorizes only law enforcement officers to take an individual into custody pursuant to involuntary civil commitment, the police make the final decision concerning whether the individual will be detained. Thus, if a CIS counselor determines that emergency detention criteria are met, he or she can only recommend that the police take custody of the subject individual.

Reportedly, police officers generally follow CIS counselors' recommendations. However, police officers sometimes disagree with CIS determinations that the "fourth standard," or what has been called the "basic needs" criterion, is met and refuse to take custody of the individual. The fourth standard requires that the law enforcement officer have cause to believe that the subject individual is mentally ill, drug dependent, or developmentally disabled, and is "unable to satisfy basic needs for nourishment, medical care, shelter or safety

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[30]However, CIS does become involved in other types of cases when law enforcement officers initiate the call to CIS. CIS may also call the police for assistance in handling violent individuals. The interaction between CIS and the police is discussed in more detail below.

[31]These figures do not differentiate the involuntary hospitalizations pursuant to Chapter 51 (the Mental Health Act) and Chapter 55 (the Protective Services Law).

without prompt and adequate treatment so that a substantial probability exists that death, serious physical injury, serious physical debilitation or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for his mental illness" (51.20(1)(a)2.c.).[32] One CIS counselor we interviewed said she was unable to recall any occasion that a police officer agreed to detain an individual when CIS recommended emergency detention based on the fourth standard. Although our research suggested that police officers in Milwaukee generally will take a person into custody if they have cause to believe that he or she meets commitment criteria, the comments of CIS counselors whom we interviewed suggest that the "basic needs" criterion is not always used in Milwaukee as contemplated by lawmakers.

Although the CIS interviewees were generally pleased with the cooperative efforts of the police, they suggested that the police could further the treatment needs of allegedly mentally disturbed persons by being more willing to take custody of persons meeting the "basic needs" criterion. They suggested that the reluctance of the police to apply the criterion may be attributable to two factors: (1) police officers prefer to personally observe dangerous acts or omissions rather than to rely on the reports of informants, and (2) police officers are frustrated because many persons detained on the basis of this fourth standard are later diverted from involuntary commitment.

As stated earlier, the present law allows individual police officers broad discretion in making emergency detentions. It is beyond the scope of our evaluation of the involuntary civil commitment process in Milwaukee County to ascertain and dictate how every police officer in Milwaukee County exercises that discretion. However, without expressing a judgment about how strictly Milwaukee law enforcement officers apply the statutory emergency detention criteria, and notwithstanding the recommendation made earlier to expand the emergency detention power under Chapter 51.15, we make the following recommendation.

> RECOMMENDATION 3: POLICE OFFICERS SHOULD RELY ON THE EXPERTISE OF CRISIS INTERVENTION SERVICE MENTAL HEALTH COUNSELORS AND GIVE GREAT WEIGHT TO THEIR RECOMMENDATIONS ABOUT EMERGENCY DETENTION UNDER THE "BASIC NEEDS" COMMITMENT CRITERION.

Reportedly, when the CIS counselors believe that a subject individual meets emergency detention criteria but the police decide not to take custody of the person, CIS refers the case to the PSMT for a three-party petition to initiate non-emergency commitment of the person. Although in most cases it would be permissible for a CIS counselor to sign a three-party petition as one of the petitioners, CIS counselors do not act as petitioners. Rather, CIS counselors urge the allegedly

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[32]This fourth commitment criterion was added to the three previous criteria by revision of the SMHA in July 1980. It was intended to loosen the statutory commitment standards and strike a balance between making commitment too hard and too easy. Cf., Friedrich, C. E. Lawmakers fine tune commitment law. The Milwaukee Journal, July 6, 1980.

mentally ill person's family or other witnesses to PSMT to sign as petitioners. If requested by Corporation Counsel, however, CIS counselors will testify at judicial hearings.

Generally, cooperation between CIS and police appear praiseworthy. Some people we interviewed, however, stated that CIS presently does not, or is unable to , provide complete on-site intervention 24 hours a day as advertised.[33] A representative of CIS stated that recent budget cuts and reductions in staff have rendered it impossible for CIS to respond to about 25 percent of incoming calls requiring mobile intervention. He stated that CIS originally had 20 staff members but that because the community was then unaware of the availability of CIS, there was insufficient demand for such a large staff. Now, with reduced staff and increased community awareness of CIS, CIS is unable to respond to the demand for its services. Others have acknowledged these resource limitations but suggest that even within these constraints CIS is not operating to full capacity. One interviewee stated that CIS is "too selective" with incoming calls.

Achieving a balance between the resources available to CIS and the need in the community for emergency intervention will require additional observation and inquiry. As noted earlier, presently CIS has detention power only under the Protective Services Law (Chapter 55) but not under the SMHA (Chapter 51). Extending CIS' detention power to encompass emergency detentions under the SMHA, as recommended, should not substantially change the character of CIS intervention, but probably will necessitate increased CIS resources. These additional resource requirements should be offset, however, by a decrease in the demands on police resources, particularly by a decrease in the number of situations in which CIS and the police must work together in effecting an emergency detention.

OTHER ROUTES TO INVOLUNTARY MENTAL HEALTH INTERVENTION

Legal reform of involuntary civil commitment in Wisconsin and throughout the country has caused burdens of proof, evidentiary procedures, and the adversary process to approach the rigor of criminal proceedings. Too often this rigorous adversarial approach has proven unworkable, requiring complex and onerous procedures, and demanding excessive resources and time of the mental health-legal system. The laws, policies, and practices of involuntary civil commitment are shaped by subtle influences both from within and without the commitment process. As one observer has recently noted, "if one aspect of mental health law is tinkered or tampered with, pressures are likely to mount that will push towards certain types of tinkering or tampering with other aspects of mental health law or practice."[34]

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[33]See "Guide to Mental Health Resources in Milwaukee County" compiled by Mental Health Association in Milwaukee County, Patient Services Committee. Revised 1982.

[34]Wexler, D.B. Mental health law: Major issues. New York: Plenum, 1981, at 2.

If civil commitment laws are tightened such that the initiation of involuntary commitment proceedings along the emergency and non-emergency routes discussed above becomes more difficult, it is likely that some people who may have been civilly committed under looser laws will find other routes into the mental health system. Some of these routes may be by way of the criminal courts. Evidence exists, for example, that criminal commitment for incompetence to stand trial may be commonly used as an alternative to civil commitment in states, such as Wisconsin, with particularly stringent commitment laws.[35] Also, as we have observed in Milwaukee, "voluntary" participation in a mental health treatment program may be made a condition of bail for mentally disturbed persons charged with minor offenses.

In this section, we will discuss routes leading to involuntary mental health intervention other than the emergency and non-emergency procedures discussed earlier. Although we did not have the opportunity to study some of these areas as thoroughly as we would have liked, we will discuss the interelationships between criminal commitment and civil commitment in Milwaukee County. We will conclude this section by highlighting some serious public safety problems in the handling of mentally adherrant individuals who have committed violant acts but are not readily accommodated by either the criminal or civil justice systems.

Voluntary to Involuntary Status

Section 51.10(5) of the SMHA prescribes a procedure by which a voluntary patient in an inpatient treatment facility may, under specified circumstances, become subject to involuntary civil commitment proceedings. When a person is admitted to a hospital as a voluntary inpatient, the person must be informed of this possibility (51.10(5)(a)). Commitment proceedings may be initiated by the treatment director, or his or her designee, when a voluntary patient submits to hospital staff a written request for discharge against medical advice (51.10(5)(a)). Following such a request the patient must be released unless the treatment director takes affirmative action (see 51.10(5)(c)). The patient may be detained if the treatment director has reason to believe that the patient is "dangerous" as defined in 51.20(1)(a)2. or (am). To detain the patient, the treatment director must file a statement of emergency detention under 51.15 before the end of the court's next business day (51.10(5)(c)) (see Appendix A, "Treatment Director's Statement of Emergency Detention", pp. 17-18). Prior to filing of this statement, the patient may be detained only long enough for the hospital staff to evaluate the patient's condition and file the statement (51.20(5)(c)). Once the statement is filed, the

[35]See e.g., Dickey, W. Incompetency and the non-dangerous mentally ill client. Criminal Law Bulletin, 1980, 16, 22-40; also, generally Wexler, D.B. The structure of civil commitment: Patterns, pressures, and interactions in mental health legislation. Law and Human Behavior, 1983, 7 (1), 1-18.

patient may be detained pursuant to 51.15 emergency procedures (51.10(5)(c)). A probable cause hearing must be held within 72 hours of the initial request for discharge (51.10(5)(c)).

The statute allows the treatment director considerable discretion in determining whether to initiate commitment proceedings against a voluntary patient requesting discharge against medical advice. The treatment director need not believe that the patient meets the relatively strict commitment criteria contained in 51.20(1)(a). The discretion permitted to the treatment director is broader than that which law enforcement officers may exercise in detaining persons under 51.15 emergency procedures. There is no specific statutory requirement that the treatment director believe the patient to be mentally ill, drug dependent, or developmentally disabled (as under 51.15(1)(a) and 51.20(a)(a)1.) or that he or she believe that the patient is <u>at that time</u> a proper subject for involuntary treatment (as under 51.20(1)(a)1.). The "dangerousness" requirement included in 51.20 commitment criteria is also relaxed for purposes of a treatment director's emergency detention. In particular, Section 51.20(1)(am) relaxes the standard by stating that the "recent overt act(s) or omission(s)" requirement may be satisfied by "a subtantial likelihood, based on the subject individual's treatment record, that the individual would be a proper subject for commitment if treatment were withdrawn." If a voluntary patient has been in a hospital for not more than 30 days prior to the commencement of proceedings, the recent act(s) or omission(s) requirement may be met by showing an act(s) or omission(s) which occurred immediately prior to admission (51.20(1)(am)). This provision appears to contemplate that if a patient has been in the hospital more than 30 days, no overt act(s) or omission(s) would be required. Only a potential for such an act(s) or omission(s) if treatment were withdrawn would be required.

As a practical matter, it is unlikely that a treatment director would detain a voluntary patient if he or she did not believe that the patient had a mental disability and was a proper subject for treatment. Indeed, the second paragraph of the Treatment Director's Statement of Emergency Detention (see Appendix A, p. 17) goes beyond statutory requirements and states that the signer of the petition is of the opinion that the patient is mentally ill, drug dependent or developmentally disabled, and is a proper subject for involuntary treatment. Despite the broad discretion which the SMHA allows treatment directors, and notwithstanding the often-heard charge that involuntary hospitalization is too difficult in Milwaukee County,[36] this discretion is rarely exercised by treatment directors in Milwaukee County. Although hospital staff may encourage a patient to remain in the hospital, treating physicians rarely use a "treatment director's hold." One psychiatrist commented that facility treatment directors do not exercise their authority to "hold" voluntary patients requesting discharge against medical advice because it is so difficult to do so. He added that the procedure is an "exercise in futility" and that one "almost has to be an attorney to get the job done."

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[36]See e.g., Libman, R. Commitment law can deny needed help. <u>The Milwaukee Journal</u>, January 6, 1983.

Contrary to the belief of some in Milwaukee, a treatment director's hold is not used following a "court-ordered voluntary" stipulation (see Chapter Four). Under such a stipulated settlement, a patient relinquishes his or her right to be discharged against medical advice. If the patient fails to cooperate with the treatment program under such a stipulation, the proper remedy is for hospital staff to notify corporation counsel who, in turn, will schedule a final commitment hearing within 14 days.[37] Thus the treatment director's hold procedures apply only to voluntary patients who do not have voluntary status by virtue of such stipulation. A treatment director's hold is, thus, a distinct route into involuntary mental health treatment. The relaxed dangerousness requirement makes this route a relatively efficacious route into involuntary treatment, and one which should not be overlooked.

> RECOMMENDATION 4: (1) IN APPROPRIATE CASES, FACILITY TREATMENT DIRECTORS, OR THEIR DESIGNEES, SHOULD INCREASE THEIR EXERCISE OF THE DISCRETIONARY POWER PROVIDED IN SECTION 51.10(5)(c) TO INITIATE CIVIL COMMITMENT PROCEEDINGS AGAINST VOLUNTARY PATIENTS REQUESTING DISCHARGE AGAINST MEDICAL ADVICE.
>
> (2) THE MILWAUKEE COUNTY MENTAL HEALTH COMPLEX SHOULD CONDUCT INSERVICE TRAINING TO FAMILIARIZE FACILITY DIRECTORS AND THEIR DESIGNEES IN THE PROCEDURES AND CONSEQUENCES OF INITIATING INVOLUNTARY COMMITMENT PROCEEDINGS AGAINST VOLUNTARY PATIENTS REQUESTING DISCHARGE AGAINST MEDICAL ADVICE.

Overlap of the Criminal and Civil Justice Systems

Wisconsin Correctional Service. The concern has frequently been voiced in Milwaukee County[38] and elsewhere throughout the country[39] that many people in need of mental health treatment find their way into the criminal justice system. When this happens, a mentally ill person may end up in jail rather than in a treatment program. The Wisconsin Correctional Service (WCS) has established screening and treatment-planning programs designed to intervene in the criminal justice system and to guide or divert mentally ill and developmentally disabled arrestees to the treatment and care they need.

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[37] See Appendix A, p. 19, for the form used for stipulation of a "court-ordered voluntary" admission. Chapter Four explores in some detail this type of stipulation settlement of cases.

[38] See Zahn, M. and Patrinos, D. Mentally ill behind bars. Milwaukee Sentinel. (A special reprint of articles which appeared in August 1981); more recently, see Libman, supra, note 28.

[39] See Bonovitz, J. C. and Guy, E. G. Impact of restrictive civil commitment procedures on a prison psychiatric service. American Journal of Psychiatry, 1979, 136, 1045-1048.

One WCS program, funded in part by United Way of Milwaukee, seeks to identify and divert mentally ill arrestees from jail toward mental health intervention prior to and during the "charging conference" at the Milwaukee County Office of District Attorney. This unit, referred to as "DA-MHU," began functioning in January 1982, and is staffed by two social workers who screen possibly mentally ill arrestees immediately after they are brought to the district attorney's office by police officers. All persons arrested in Milwaukee's 12 precincts for alleged offenses against the State must be brought to the district attorney's office to be formally charged with a crime.[40] The WCS social worker or "screeners" do not interview all arrestees but rather only those who come to their attention as possibly mentally ill.

Reportedly, whether the WCS screeners will interview a particular arrestee is determined by several factors. First, the arresting police officer(s) is provided a small card on which the arresting officer notes whether the arrestee evidences or has any history of mental disorder, or whether the officer has any other information indicating that the arrestee may be a medical or suicidal risk. This "screening card" provides a simple mechanism to immediately detect persons who may be mentally ill. Second, the WCS social workers monitor the incoming arrestees to look for familiar names and for individuals apprehended for offenses typical of mentally ill people. The social workers conduct this monitoring by reviewing four clipboards on which the names and offenses are recorded. The four clipboards are labeled "felony," "misdemeanor," "traffic offense," or "domestic violence." WCS has compiled a complete list of charges against arrestees interviewed by the DA-MHU during eight months in 1982. The list indicates that the majority of arrestees interviewed by the DA-MHU face charges for misdemeanor offenses. The most prevalent offenses include disorderly conduct, battery, shoplifting, and damage to property. The third way the WCS social workers determine whether to interview particular arrestees is by referrals from staff of the district attorney's office and, to a lesser extent, from public defenders or other defense attorneys, or from other concerned individuals (e.g., a probation agent, a relative of the arrestee, or the arrestee him or herself).

Once it is determined that an arrestee may have a mental health problem, a DA-MHU social worker interviews the person. This interview may typically last for ten minutes to one hour, or as long as the district attorney is preparing for the charging conference. During the interview, the social worker determines the nature of any present mental health problem and develops a strategy for mental health intervention to discuss at the charging conference (see Appendix A, p. 20 for the DA-MHU screening form).

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[40]On occasion a police officer may not bring an arrestee to the district attorney' office if the arrestee is violent or unmanageable. Presumably, the police take such arrestees directly to jail.

Whether an arrestee is charged with a crime or is diverted to the mental health system is determined at the charging conference. During the conference the arresting police officer relates to the district attorney the circumstances leading to the arrest. Witnesses to the alleged criminal conduct may also present their stories. Following the factual inquiry, the WCS social worker who interviewed the arrestee presents the treatment plan developed in the initial interview. Reportedly, approximately one-third of the arrestees referred to DA-MHU are not prosecuted in lieu of participation in a treatment program recommended by the social workers. Typically, if the district attorney does not charge an arrestee for whom a WCS social worker has recommended mental health care and treatment, the district attorney will hold the case open and send the arrestee to participate in the proposed program. Participation in the care and treatment program is made more likely when the district attorney makes compliance with the conditions of such a program a condition of bail. WCS monitors the arrestees participation in the program to ensure compliance. The district attorney eventually may drop the case against the arrestee.

If an arrestee has a severe mental health problem, WCS may pursue non-emergency commitment by means of a three-party petition as an alternative to a criminal charge against the arrestee. The witnesses to the arrestee's alleged criminal conduct are usually present at the charging conference and may sign as petitioners. Generally, however, if an arrestee's condition is not appropriate for outpatient treatment, or if he or she won't accept the conditional treatment, the person is criminally charged rather than civilly committed. Interviewees from the district attorney's office and from WCS told us that such arrestees usually are not diverted from the district attorney's office to involuntary civil commitment because, under certain circumstances, charging a person is perceived as a more effective and efficient means of getting the arrestee needed treatment. Interviewees expressed concerns that people who enter the involuntary civil commitment process often end up in voluntary treatment programs in which participation is inadequately monitored. (The concern about compliance with the terms of outpatient or voluntary treatment and care is discussed in detail in Chapter Five.) Charging an individual and requiring mental health treatment as a condition of bail was viewed as more effective than involuntary civil commitment. When bail is conditioned on compliance with a treatment program, the WCS, which monitors compliance, has the leverage to ensure that an arrestee, in fact, cooperates and participates in the treatment program. Reportedly, because of this leverage that the bail condition provides, this procedure works more effectively than a "court-ordered voluntary" resulting from a stipulated settlement (see Chapter Four). A bail condition for arrestees may be a more effective mechanism for ensuring the needed treatment in those cases that the arrestees would not be involuntarily committed if referred for a three-party petition.

A problem remains, however, with regard to those arrestees who are appropriate for civil commitment under Chapter 51. It is these people who are the primary subject of the often-voiced concern that mentally ill people are finding their way into jail rather than into

treatment.[41] For these persons outpatient treatment is not enough, claimed several of the interviewees. Nor is it likely that jail time and punishment for a crime (typically involving nuisances and lesser offenses) serve to change or deter their criminal or aberrant behavior. Thus, these individuals should be diverted from the criminal justice system to involuntary civil commitment. Accomplishing this diversion will require cooperation among the district attorney's office, the DA-MHU social workers, and the Corporation Counsel's office. In the next few paragraphs, we will suggest a scenario for such a cooperative effort.

When a DA-MHU social worker suspects that an arrestee may be a proper subject for involuntary civil commitment, the social worker would conduct an extensive mental health asessment of the arrestee. One social worker we interviewed stated that, on occasion, time demands of the initial interview of an arrestee require the social workers to make treatment recommendations in the charging conference based primarily on "impressions" formed about the arrestee's condition. Whenever a social worker suspects that commitment may be proper, the screener should request that the district attorney allow more time prior to the charging conference so that a more extensive mental health evaluation can be conducted. The social worker should focus the interview on determining whether the arrestee meets Chapter 51 commitment criteria. If the social worker determines that commitment would be inappropriate, he or she should proceed to the charging conference and recommend an appropriate treatment plan. On the other hand, if the social worker determines that the arrestee is a fit subject for commitment, the social worker should recommend that commitment proceedings be initiated and that the district attorney defer charging the arrestee. Although the final decision concerning whether to charge an arrestee rests with the district attorney, the district attorney should give great weight to a social worker's recommendation to pursue commitment in these exigent cases.

When the district attorney defers charging in order that civil commitment can be pursued, the DA-MHU social worker should have the witnesses who are present sign a three-party petition as petitioners. Because Section 51.20(1)(b) requires only that one petitioner have personal knowledge of the conduct of the subject individual, the DA-MHU social workers could sign as petitioners if other petitioners are not readily available. Because an arrestee who is subject to a three-party petition is already in custody following a criminal arrest, to permit continuity of custody, the social worker would immediately seek a detention order under Section 51.20(1). When the DA-MHU social workers have determined that any treatment short of involuntary hospitalization would be insufficient for a particular arrestee, they should so inform corporation counsel. Corporation counsel should give this advice great weight and consider a stipulated settlement only if the examining physician or psychologist appointed pursuant to Section 51.20(9) expresses doubts that commitment criteria are met.

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[41] _Supra_, notes 36, 38, and 39.

Because the district attorney and social workers have already reviewed the case of an arrestee determined to be a fit candidate for involuntary civil commitment, a review approximating the social and legal review given by the Protective Services Management Team and corporation counsel, we recommend an expedited petitioning process for cases originating from the District Attorney's Office and WCS. This expedited process should alleviate the concern of one district attorney who complained that, even when civil commitment might otherwise be preferred, he often avoided this route to mental health intervention largely due to the length of time required and the cumbersome nature of the 51.20 petitioning process.

RECOMMENDATION 5: (1) WHENEVER A SOCIAL WORKER OF THE WISCONSIN CORRECTIONAL SERVICE DETERMINES THAT AN ARRESTEE MEETS CHAPTER 51 COMMITMENT CRITERIA, HE OR SHE SHOULD RECOMMEND AT THE CHARGING CONFERENCE THAT INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS BE INITIATED AND THAT THE DISTRICT ATTORNEY DEFER CRIMINALLY CHARGING THE ARRESTEE. THE SOCIAL WORKER SHOULD THEN INITIATE A THREE-PARTY PETITION AND SHOULD SEEK A DETENTION ORDER.

(2) IN DETERMINING WHETHER TO CHARGE AN ARRESTEE OR TO PERMIT CIVIL COMMITMENT PROCEEDINGS TO BE INITIATED, THE DISTRICT ATTORNEY SHOULD GIVE GREAT WEIGHT TO THE SOCIAL WORKER'S RECOMMENDATIONS TO PURSUE CIVIL COMMITMENT.

(3) IN CASES WHERE THE DISTRICT ATTORNEY'S OFFICE SEEKS CIVIL COMMITMENT OF AN ARRESTEE, THE PETITIONING PROCESS SHOULD BE EXPEDITED. THE PROTECTIVE SERVICES MANAGEMENT TEAM AND CORPORATION COUNSEL SHOULD FOREGO THEIR CUSTOMARY INTERVIEWS AND SCREENINGS OF PETITIONERS AND FACILITATE THE ISSUANCE OF A COURT ORDER TO DETAIN THE PERSON PURSUANT TO SECTION 51.20 NON-EMERGENCY COMMITMENT.

(4) WHENEVER THE DISTRICT ATTORNEY'S OFFICE INITIATES A THREE-PARTY PETITION AND ADVISES CORPORATION COUNSEL THAT INVOLUNTARY HOSPITALIZATION IS THE LEAST RESTRICTIVE TREATMENT ALTERNATIVE APPROPRIATE FOR THE PARTICULAR ARRESTEE, CORPORATION COUNSEL SHOULD GIVE GREAT WEIGHT TO THIS ADVICE AND ACCEPT A STIPULATED SETTLEMENT ONLY IF THE EXAMINERS APPOINTED PURSUANT TO SECTION 51.20(9) COMMUNICATE SERIOUS DOUBTS THAT COMMITMENT CRITERIA ARE MET.

At least two reviewers objected to this recommendation in its draft form. The strongest objection was raised by a public defender who objected to the draft recommendation because, in his view, it limited corporation counsel's exercise of prosecutorial discretion in a manner that might violate the code of professional responsibility which requires a prosecutor to exercise such discretion without third-party intervention. We do not share the view that this recommendation necessarily limits the prosecutorial discretion of corporation counsel. While it may, indeed, be unethical for corporation counsel to allow himself to be governed by the advice of a WCS social worker and the district attorney in these cases, we do not recommend that corporation counsel be bound to their advice. We recommend simply that corporation counsel be highly attentive to this advice just as he is attentive to the PSMT staff's recommendations regarding the merits of a three-party petition.

The greatest concern expressed regarding the draft recommendation was that an expedited three-party petition process initiated by the district attorney's office may inappropriately limit corporation counsel's ability or willingness to accept negotiated settlements of cases. We do not share this concern. The intent of the recommendation, already shown to be at least initially workable in practice,[41] is to facilitate the conversion of appropriate misdemeanor criminal cases to civil commitment cases by avoiding unnecessarily time-consuming, complex repetition of the social and legal review of a three-party petition. Although the question may be answerable only by empirical research, it is our opinion that the recommended expedited petition process should not adversely affect the disposition and settlement of these cases.

Although there was general agreement with the basic intent of Recommendation 5, several reviewers of the draft recommendation pointed out that using 51.15 emergency detention procedures for persons brought to the District Attorney's Office may be simpler and less time consuming than the three-party petition process and therefore preferable. Emergency detention procedures may, indeed, be preferable in some cases. Whether emergency procedures will work in a given case will depend upon whether the law enforcement officer who originally detained and transported the arrestee to the District Attorney's Office is willing to exercise the 51.15 detention power.

In any case in which the DA-MHU social workers and district attorneys do not pursue commitment in lieu of criminal prosecution, a bail condition seems to be an effective means of increasing the likelihood that a mentally ill arrestee receives treatment and care he or she needs. Reportedly, the DA-MHU social workers have recently begun going to the intake court to make bail motions recommending release with treatment conditions. Whenever a treatment program might be helpful to an arrestee, the social workers request that the district attorney agree to recommend the program to the judicial officer presiding at the arrestee's initial court appearance. Reportedly, these bail motions have

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[41] Task Force on Human Services and the Law, supra, note 1 at 3.

signficantly increased the number of arrestees whom the DA-MHU has been successful in getting into treatment and care programs.

According to a representative of WCS, the DA-MHU social workers currently identify about 60 individuals a month who are brought to the district attorney's office under criminal arrest, and who are in need of mental health treatment. Over half of these people participate in some type of treatment program whether or not they are actually charged. WCS monitors each arrestee's participation in the agreed upon treatment program to ensure the arrestee's progress and compliance with a bail condition, if applicable. The clinic to which arrestees are most frequently referred for outpatient treatment is the WCS Outpatient Clinic located in the City of Milwaukee. It employes five social workers and three nurses; two physicians work at the clinic three times weekly for four to six hours. The clinic provides such services as securing housing for clients in the community, and securing social security or welfare income, as well as the more conventional mental health intervention including psychiatric evaluation, psychotherapy, medication monitoring, and support groups. Many clients are required to come to the clinic daily to receive a daily income allowance and medication. Reportedly, conditioning payment of a patient's daily income allowance on the patient's taking his or her medication is the reason that many patients return to the clinic daily; it provides WCS with leverage to ensure that patients comply with a treatment program. Finally, WCS refers patients to other community programs for treatment services which the Outpatient Clinic does not provide.

The Municipal Courts. Municipal courts in Wisconsin have no statutory authority to directly order mentally ill persons into mental health treatment. The power to order involuntary treatment is reserved to the circuit courts (see 51.20(1)(c)). According to many persons we interviewed, however, the municipal courts are sometimes confronted with people who have violated municipal ordinances but show signs of mental disabilities. One interviewee stated that such persons appear in municipal court approximately four times each day.[42] Because municipal court judges have no formal authority to order treatment and care, they must resort to informal measures. One interviewee said that very often a judge will take no affirmative steps to ensure that an apparently mentally ill defendant receives treatment and care, but will only refrain from imposing a jail sentence as a contempt sanction if he or she fails to pay the imposed fine. Apparently, the reluctance of the municipal courts to impose jail sentences on defendants who appear mentally disordered may be at least partially motivated by the desire to avoid recurrences of unfortunate past incidents involving mentally disordered

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[42]"[Municipal Judge]Siefert said that there are five or six persons in need of mental observation who are brought into court each day;" see Fauber, Jr. Special tape aims at law on commitment. The Milwaukee Sentinel, August 31, 1979.

persons left uncared for and unattended in jail.[43]

When judges do take affirmative action, it might take one of several forms. A judge may simply suspend the sentence imposed and recommend that the defendant seek treatment, perhaps coupled with a stern warning of dire consequences if the recommendation is not taken. A judge might take a more direct approach, however, and order the arresting officers to make out a statement of emergency detention pursuant to involuntary civil commitment. This approach has led to problems. If the officers have not observed actions on the defendant's part which demonstrate a substantial probability of harm occurring, the officers may choose not to make out the emergency detention form (see the discussion of police officer's discretion in emergency detention in the beginning of this chapter). When this occurs, a confrontation between the judge and the officers is likely. A judge might also refer the case to the Protective Services Management Team for a three-party petition. It is unclear whether the judge would then become a petitioner on the three-party petition. A final manner in which municipal judges have dealt with the problems of mentally disturbed defendants in their court is to refer them to the District Attorney's Office for screening by the WCS mental health unit. This may be accomplished by use of a state charge, such as disorderly conduct, against the defendant.

Several additional solutions to this problem have been proposed. One is that rather than suspension of sentence and treatment recommendations, the judge should actually condition the suspension of sentence on the defendant accepting treatment. If the defendant failed to accept treatment, the suspension would be revoked. Checks on the defendant's participation in treatment might be conducted in much the same way as a probation officer supervises a person placed on probation by a criminal court. Another proposal is to place a mental health screening unit in the City Attorney's Office similar to that which WCS currently has in the District Attorney's Office. Finally, it has been proposed that the SMHA be amended to give municipal court judges dispositional powers such as emergency detention powers. This last proposal has received little support. Opponents have stated that because municipal court judges in Wisconsin are not statutorially required to have legal training, they may be unqualified to make such detention decisions. They have argued that municipal judges in Milwaukee do not have the authority to impose jail sentences (except as a contempt sanction), and should not be granted emergency detention power. One municipal judge, who reviewed this section in draft form, noted that whether or not municipal judges have the authority to impose jail sentences may be a "distinction without a difference" in practice. He stated that any jail time imposed by any municipal judges is, technically speaking, for "failure to pay a forfeiture." He contended, however, that despite this technicality hundreds of persons are in the House of Correction each day on sentences from the Milwaukee Municipal Court.

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[43]See Zahn and Patrinos, _supra_, note 30.

The possibility of an expedited three-party petition process similar to that recommended for the District Attorney's Office above should be considered. A municipal court judge who has witnessed aberrant behavior by a defendent in the courtroom should consider executing a three-party petition by personally signing as a petitioner. The remaining two petitioners might be police officers or members of the Protective Services Management Team.

It has been suggested that the frequency with which apparently mentally ill persons appear in the municipal courts might be greatly reduced by the cooperative efforts of CIS and the police. Such cooperative efforts undoubtedly have already resulted in persons being diverted to mental health treatment before even reaching the municipal court. We recommend that such efforts be continued and increased. This recommendation does not, however, address directly the problem of helping mentally ill individuals who do end up in municipal court.

It is apparent that the municipal courts in Milwaukee County represent a gate through which mentally ill persons can enter the mental health delivery system. No uniform, understandable, or controllable procedure has emerged, however, to divert such people to treatment. This problem must be acknowledged and dealt with. Provision for referral of mentally ill defendants to treatment is the minimum that is required. Once these people have come to the threshold of the mental health-judicial system, they should not be turned back into the streets. Precisely how these people should be diverted to mental health treatment is a matter that will require further study. The logistics and ramifications of the alternative solutions listed above should be considered.

> <u>RECOMMENDATION 6</u>: THE PLANNING COUNCIL FOR MENTAL HEALTH AND SOCIAL SERVICES AND THE TASK FORCE ON HUMAN SERVICES AND THE LAW, IN CONJUNCTION WITH THE MUNICIPAL COURTS AND THE CITY ATTORNEY'S OFFICE, SHOULD ACTIVELY EXPLORE ALTERNATIVE METHODS BY WHICH THE MUNICIPAL COURTS MIGHT DIVERT MENTALLY ILL DEFENDANTS TO MENTAL HEALTH CARE AND TREATMENT. THESE ORGANIZATIONS SHOULD ENCOURAGE THE UNIFORM IMPLEMENTATION OF THE ALTERNATIVE WHICH THEY DETERMINE TO BE THE MOST EFFECTIVE, UNDERSTANDABLE, AND CONTROLLABLE.

The implementation of this recommendation may require the crossing of jurisdictional lines between the City and County of Milwaukee. In this regard, one reviewer of the draft of this recommendation, questioned whether County dollars may be appropriately spent for developing programs which are outside the jurisdiction of the County.

<u>Conversion to Civil Status of Persons Incompetent to Stand Trial.</u> We predict that the message alluded to in the beginning of this section--that nothing is unmixed within the involuntary civil commitment process, and within the field of mental health law in general--

will be heard more often in the near future. The swift, vigorous, and professional outcry following the aquittal and civil commitment in the case of John Hinckley, Jr. may already indicate a widespread recognition of the important interrelationships between criminal and civil proceedings. The perception of public safety and public confidence in the administration of justice is at stake in making the elements of mental health law, policy, and procedures not only fair to the public and the accused, but also logically consistent with each other.

It is for these reasons that we call attention to the precarious and makeshift nature of the security provisions under both Chapter 51 and Chapter 55 applicable to persons who have been charged with but not convicted of violent crimes because they have been determined to be permanently incompetent to stand criminal trial. Unlike the persons, discussed earlier, who may have committed minor offenses and are diverted from criminal proceedings by WCS, these persons have been involved in sex offenses, arson, and homicides and pose a real threat to public safety in Milwaukee. They are persons who easily meet almost any standards of dangerousness, but who fail to meet the commitment criteria of Chapter 51 because they are "untreatable." Although the number of mentally ill persons in Milwaukee County who fit into this category is relatively small, the justice system's failure to adequately deal with this category of persons would, in our opinion, constitute a major setback for the mental health-legal community in Milwaukee County.

One reviewer of the draft of this report regretably acknowledged that we were not commissioned to directly study the public safety problem in committing and otherwise restraining violent mentally ill persons that may have been involved in criminal proceedings. The reviewer, nonetheless, recommended that the special problem of "conversion of a criminal incompetent to civil status" be given consideration in this report. Given that we share this reviewer's concern regarding the seriousness of this problem, but recognizing that we have not studied this problem thoroughly enough in Milwaukee County to describe the problem in any great detail or to offer solutions, we have decided to reproduce the very thoughtful and detailed comments of this reviewer.

> There is a potentially explosive problem in both the criminal commitment and the involuntary civil commitment procedures. It concerns protection of the community from chronically mentally ill persons with tendencies to commit sexual assault, arson, homicide and other crimes of violence. These persons present a special problem both to the legal system and the hospital system.
>
> Within the legal system there is a question as to whether such persons belong under Chapter 51 (treatable involuntary commitment) or Chapter 55 (protective placement) and the additional legal problem (which also may be a philosophical problem) as to whether and how long they can be committed.

Within the hospital system, there is the ever present expectation that such persons have to be isolated from other patients and specially watched because of their tendency toward seriously disruptive conduct. The total problem is additionally complicated if these persons are diagnosed as "unlikely to become competent" or "untreatable." The ordinary scenario is for these persons to commit a serious crime, usually a felony. They are arrested and brought to court. Early in the court proceedings, the issue of their competence to stand trial is raised. Wisconsin Statutes sec. 971.13(1) is invoked to the effect that "no person who lacks substantial mental capacity to understand the proceedings or to assist in his or her own defense may be tried, convicted or sentenced for the commission of an offense so long as the incapacity endures." A competency examination is then ordered under Wisconsin Statutes sec. 971.14 and if the court determines, following the examination, that the defendant is not competent, the defendant can be committed to the custody of the Department of Health and Social Services for a period not to exceed 18 months, or the maximum sentence for the most serious offense charged, whichever is less.

The very longest that such a person can be held, rapist or petty thief, is 18 months. An additional and complicating provision requires the court to discharge the defendant from this commitment if "it is unlikely that the defendant will become competent within the commitment period." The discharge is hinged on the theory that "we have no right to hold a person we can never bring to trial."

On a finding of "untreatability," the defendant is either released or held briefly so that proceedings for civil commitment under Chapter 51 or Chapter 55 can be instituted.

The conversion to civil commitment is usually begun by an emergency order and immediately a question arises: Is the defendant eligible for processing under Chapter 51?

If the defendant is deemed to be treatable, which means that he has probably completed 18 months in the criminal commitment system, the legal problem is not so great. Section 51.20 can be invoked without difficulty and the defendant committed for a reasonable period of time. The problem for the hospital system, however, has now begun.

Under Sec. 51.20 the commitment is to an acute treatment ward, and the defendant becomes disruptive to other patients. In Milwaukee County there is no totally adequate "detention-type," acute ward for such a disruptive person. The only alternative, besides constant vigilance and attention, is transfer to the Winnebago Mental Health Institute. Transfer to the state poses a serious budget problem because the county is liable for all costs of civil commitment and the Winnebago commitment charge against Milwaukee County carries a very high daily rate. Solution of the hospitalization problem for the treatable, criminally ill defendent in Milwaukee County requires either a facility for isolation of such persons or a better cost arrangement with the State of Wisconsin.

For the "untreatable," criminally inclined, chronically mentally ill person, the same hospitalization problem exists. The legal and procedural problems for the "untreatable" are much greater than for the "treatable." Under Milwaukee County interpretation, and indeed a strict reading of the definition of treatment [51.01(17], untreatable persons cannot be committed under Chapter 51.

The only way to protect the public, therefore, is utilization of Chapter 55, the Wisconsin protective service system. Chapter 55 in its declaration of policy is intended to protect the person, not the public. It is basically designed for the infirmities of aging, chronic mental illness, mental retardation, and other developmental disabilities. Primarily it provides "care and custody." Whether or not, philosophically, the kind of potentially serious and untreatable offender we are describing belongs within this secton, that's the only place this person fits by strict statutory interpretation.

The Chapter 55 special legal problem is that insufficient time deadlines are available to hold the person until a commitment order can be obtained. Three to six months are ordinarily required for guardianship and protective placement under Chapter 55, particularly if the commitment is contested.

Emergency placement under sec. 55.06(11) is only authorized if "it appears probable that an individual will suffer irreparable injury or death." A knowingly false statement is punishable by a $5,000 fine or 5 years' imprisonment. As a result of this difficulty in holding a potentially serious, but untreatable offender under Chapter 55, the county engages in the legal fiction of always bringing the case under Chapter 51 which has a 30-day holding provision. Then an attempt is made to stipulate or work out the Chapter 55 placement while the person is being held under Chapter 51.

Needless to say, this is a makeshift system for holding very dangerous people. It appears that some statutory improvement is necessary. One solution might be expanding the definition of treatability under Chapter 51. Another solution might be providing a holding period under Chapter 55.[44]

GATEKEEPERS

After reviewing recommendations contained in this chapter, several reviewers suggested that we highlight in this report recommendatons and guidelines previously made by Institute staff regarding "gatekeepers" in the involuntary civil commitment process. Because of this interest in the "gatekeeper" concept, we have excerpted, at length with relatively few revisions, the following guidelines and accompanying text from Provisional Substantive and Procedural Guidelines for Involuntary Civil Commitment,[45] a nationally oriented document published by the Institute in 1982. We have not adapted the following excerpts for specific application in Milwaukee. Although these materials should be generally useful in the commitment process in Milwaukee County, certain aspects may need refinement to jibe with the demands of law and practice in Milwaukee.

> Prehearing matters may have more bearing on the equity, effectiveness, and efficiency of a commitment system, and on the public's satisfaction with the system, than the events at any other stage in the commitment process. Systems that provide for a prompt, reliable, and thorough screening procedure, and a diversion of cases at the earliest stages, protect both the liberty interests of the respondents, and the pocketbook of the taxpayer. The guidelines in this chapter suggest that

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44 John, H., Deputy District Attorney, Milwaukee County Office of District Attorney. Personal communication, April 14, 1983. (Quoted by permission)

45 See, Institute, supra, note 23, at Part II, Chapters One and Three.

involuntary civil commitment prehearing matters are an important aspect of the process, that the prehearing process is malleable without legislative reform, that responsibility for its implementation is diffused, and, most importantly, that the courts (i.e., judges, court administrators, and managers) should take this initial stage of commitment into their purview and should take shared responsibility for its monitoring and regulation.

Commitment Routes, Detours, and Diversions

GUIDELINE II-A. (1) REGARDLESS OF THE COMMITMENT ROUTE -- EMERGENCY, JUDICIAL, NON-JUDICIAL, OR GUARDIANSHIP -- ENTRY INTO THE MENTAL HEALTH-JUDICIAL SYSTEM SHOULD BE MONITORED AND REGULATED BY AUTHORIZED "GATEKEEPERS" AT DESIGNATED "PORTALS" IN THE COMMUNITY. THESE GATEKEEPERS SHOULD BE EMPOWERED AND QUALIFIED TO INITIATE INVOLUNTARY CIVIL COMMITMENT ALONG ITS VARIOUS ROUTES OR TO DIVERT CASES TO LESS RESTRICTIVE ALTERNATIVES.

(2) COMMUNITY PORTALS, SERVING AS SCREENING AGENCIES WITHIN THE COMMUNITY, SHOULD REVIEW AND INVESTIGATE APPLICATIONS FOR INVOLUNTARY COMMITMENT, AND, IF APPROPRIATE, SHOULD DIVERT CASES TO LESS RESTRICTIVE TREATMENT ALTERNATIVES (AS PRESCRIBED IN GUIDELINES II-S THROUGH II-U). SCREENING REPORTS SHOULD BE FILED WITH THE COURT.

GUIDELINE II-B. JUDGES, COURT ADMINISTRATORS, AND COURT MANAGERS SHOULD INFLUENCE THE POLICIES OF PORTAL AGENCIES (E.G., POLICE DEPARTMENTS, SHERIFF'S DEPARTMENTS, MENTAL HEALTH DEPARTMENTS, COMMUNITY MENTAL HEALTH AGENCIES, AND HOSPITALS) TO FOSTER A UNIFORM, UNDERSTANDABLE, AND CONTROLLABLE PROCEDURE FOR INITIATING AND SCREENING INVOLUNTARY COMMITMENT CASES.

GUIDELINE II-C. THE COURT SHOULD REVIEW, MONITOR, AND REGULATE, THE ACCESS TO THE MENTAL HEALTH-JUDICIAL SYSTEM BY THE VARIOUS INVOLUNTARY CIVIL COMMITMENT ROUTES.

GUIDELINE II-D. JUDGES AND ATTORNEYS SHOULD BE THOROUGHLY FAMILIAR WITH THE METHODS AND OPERATIONS OF THE COMMUNITY PORTALS AND GATEKEEPERS REGULATING INVOLUNTARY CIVIL COMMITMENT CASES.

Comment

In most jurisdictions, the practices in the initial stages of the commitment process evolved in the absence of rigorous reviews of their equity, efficiency, and effectiveness, except for occasional reviews by the federal judiciary. The administration of agency linkages and cooperation, and the

management of resources from various units of the mental health-judicial systems, have been largely left to expediency. In Chicago, Los Angeles, and New York City, for example, although non-emergency routes are provided by statute, access to involuntary commitment is usually limited to the emergency route. Because non-emergency routes are expensive, time-consuming, and burdensome to an already strained system, their use is discouraged by court personnel and mental health practitioners. Because the emergency route is the quickest way to get someone into the hospital, with the least amount of red tape, it is likely that many persons involuntarily hospitalized via this route are not the emergency cases envisioned by legislators.

Guidelines II-A through II-D propose that the courts take control of the initiation process. The arrangements of community portals for entry into the mental health-judicial system are malleable. Without legislative reform, the courts can regulate the gatekeeper's practices in the initial stages of commitment. Typically, several units of the mental health-judicial system are involved in initiating involuntary civil commitment: law enforcement agencies, community mental health centers, hospitals, and courts. Responsibility for a particular case shifts back and forth from one unit to another as a case proceeds through the system, until it settles largely with a court during judicial hearing. The courts are in the best position to effect cooperation among agencies, thereby achieving the maximum design and fair implementation of community portals and gatekeepers.

The identification and configuration of community portals, and the precise confluence of cases through those portals, should be locally determined. In Arizona and occasionally in North Carolina (see Involuntary Civil Commitment in Winston-Salem, p. 32 (1982); hereafter Winston-Salem), peace officers confer with hospital staff by telephone before proceeding toward detention and involuntary hospitalization of a person whom they have apprehended, and, thereby divert inappropriate cases from hospitalization. In Columbus, Ohio, a mental health review unit of the probate court works cooperatively with hospitals and local community mental health centers to funnel all involuntary civil commitment cases through the community centers for review and screening (see Part VII, Chapter Two). In nearby Dayton, Ohio, a court liaison, employed by the court but located in a community mental health center, screens all petitions for involuntary civil commitment, diverting many cases from forced hospitalization. Finally, in Los Angeles, mobile psychiatric emergency teams -- consisting of community mental health workers and the police -- serve as gatekeepers to the mental health-judicial system.

At a minimum the arrangement of community portals and methods of gatekeepers should:

(a) Be visible, accessible, and manageable by the courts, working in cooperation with agencies involved in the initial stages of the commitment process;

(b) be monitored, if not regulated, by the courts;

(c) provide all legal safeguards mandated by statutes;

(d) be an extension or an adaptation of existing service delivery systems now accessible to the public (e.g., community mental health centers or court clinics);

(e) provide prompt access to mental health facilities without undue delays in emergency treatment and care;

(f) provide fair, prompt, and reliable decisionmaking about involuntary hospitalization and diversion alternatives;

(g) facilitate diversion of the maximum number of cases from involuntary hospitalization and the mental health-judicial system;

(h) be fair, effective, and efficient; and finally,

(i) avoid onerous complexity.

The Gatekeepers

GUIDELINE II-E. (1) GATEKEEPERS SHOULD BE MENTAL HEALTH PROFESSIONALS, OR COURT PERSONNEL WORKING IN COOPERATION WITH MENTAL HEALTH PROFESSIONALS, EXPERIENCED IN THE DIAGNOSIS OF MENTAL ILLNESS AND FACILE IN APPLYING THE LEGAL, PSYCHOLOGICAL, AND SOCIAL CONSTRUCTS USED IN MAKING DECISIONS CONCERNING DETENTION PURSUANT TO INVOLUNTARY HOSPITALIZATION, RELEASE, AND ALL INTERMEDIATE ALTERNATIVES.

(2) GATEKEEPERS SHALL SERVE AS SCREENERS, OR WORK IN CLOSE COOPERATION WITH SCREENERS, TO CAUSE REVIEW AND INVESTIGATION OF COMMITMENT APPLICATIONS, AND THE SCREENING AND DIVERSION OF CASES FROM COMPULSORY HOSPITALIZATION AS DESCRIBED IN GUIDELINES II-S THROUGH II-U.

GUIDELINE II-F. GATEKEEPERS SHOULD HAVE THE AUTHORITY TO ORDER INVOLUNTARY DETENTION AND TO REQUEST AMBULANCE OR POLICE ASSISTANCE FOR TRANSPORTING RESPONDENTS TO AND FROM APPROPRIATE MENTAL HEALTH FACILITIES.

Comment

The decision by mental health personnel or police to initiate the involuntary civil commitment process, in most jurisdictions, invariably causes an individual some curtailment of liberty, loss of rights, and stigma of being labeled "mentally ill." Thorough mental health screening and evaluation, and judicial review of a case before detention and forced hospitalization, has remained a matter of theory. "The majority of courts addressing the issue of whether there is a right to a probable-cause hearing in civil commitment proceedings, implicitly acknowledge the need for a hearing before a non-emergency admission is made, but primarily address the arguments for or against a prompt probable-cause hearing soon after the initial detention" (*Mental Disability Law Reporter*, 5(4), 290 (1981); emphasis added).

The decisions regarding entry into the mental health-judicial system entail more than determining whether the psychological criteria for involuntary civil commitment, as defined by statutes, have been met in particular cases. Good decisions are based on knowledge of conditions in state institutions, availability of less restrictive alternatives for particular classes of persons (*e.g.*, gravely disabled, those harmless to others, elderly persons), and the budgetary restraints on the units of the mental health-judicial system likely to be involved in the case. They also entail a good understanding of linking the courts and other units of the mental health-judicial system in cooperative strategies.

Qualifications appropriate for a gatekeeper may trace the qualifications of a "mental health review officer," as proposed in a suggested statute on civil commitment presented in 1977 by the Mental Health Law Project in Washington, D.C.:

> "Mental health review officer" means a person designated as such by [the county mental health authority or human rights committee] who was actively engaged in the treatment and diagnosis of mental disorders during at least two of the three years immediately preceding such designation and who is:
>
> (a) a psychiatrist;
>
> (b) a psychologist with a doctoral degree from an accredited clinical program and such experience in the treatment and diagnosis of serious mental disorders as is required under rules and regulations adopted by the Commissioner; or

(c) in counties in which sufficient persons having the qualifications required under the preceding subsections (a) and (b) are, with the approval of the Commissioner, found to be unavailable, a person with the following qualifications who has such experience in the treatment and diagnosis of serious mental disorder as is required under regulations adopted by the Commissioner:

(i) an earned graduate degree in psychology from an accredited clinical program;

(ii) a social worker with an earned graduate degree in social work with field training in a psychiatric facility from an accredited program; or

(iii) a registered nurse with a graduate degree in psychiatric nursing from an accredited program.

The "mental health review officer" is a mental health professional, preferably independent of evaluation and treatment facilities, whose functions include the screening of petitions for evaluation and various preliminary or short-term determinations in the course of commitment proceedings, evaluation and treatment. A provision to avoid conflict-of-interest situations in individual situations is included in the definition. (Suggested statute on civil commitment. Mental Disability Law Reporter, 2(1), 132, 134 (1977)).

Guidelines II-E and II-F suggest the identification of gatekeepers that function on the threshold of involuntary civil commitment much as judges function during hearings later in the commitment process. They should be knowledgeable and talented individuals, capable of making, and empowered to implement, decisions about release, involuntary confinement, and all the options between those extremes, in the context of legal requirements, mental health practices, social values, and resource allocations from various sources within the mental health-judicial system. Given these demands on gatekeepers, teams comprised of two or more individuals from different parts of the system may need to function cooperatively to do the job.

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GUIDELINE II-R. APPLICATIONS TO GATEKEEPERS SHOULD BE READILY AVAILABLE AT DESIGNATED PORTALS AND MAY BE EXECUTED BY ANY ADULT PERSON WITH THE ASSISTANCE OF GATEKEEPERS. A SINGLE PREPRINTED FORM SHOULD BE USED FOR ALL COMMITMENT APPLICATIONS, REGARDLESS OF THE ROUTE TAKEN.

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Screening and Diversion of Cases

GUIDELINE II-S. WHEN A COMMUNITY PORTAL RECEIVES A REQUEST FOR AN APPLICATION FOR INVOLUNTARY COMMITMENT, A GATEKEEPER SHALL: (a) IMMEDIATELY DETERMINE WHETHER TO PURSUE COMMITMENT PROCEEDINGS, OR TO ADVISE THE APPLICANT TO SEEK ALTERNATIVES TO COMPULSORY HOSPITALIZATION; (b) IF SUCH ALTERNATIVES ARE NOT PURSUED BY THE APPLICANT, ASSIST THE APPLICANT IN COMPLETING THE APPLICATION FOR INVOLUNTARY COMMITMENT; AND, (c) PREPARE FOR A REVIEW AND INVESTIGATION, OF THE APPLICATION, AND SCREENING OF THE CASE.

GUIDELINE II-T. (1) WHEN A COMMUNITY PORTAL RECEIVES AN APPLICATION, AND A GATEKEEPER DETERMINES THAT INVOLUNTARY COMMITMENT PROCEEDINGS SHOULD BE INITIATED PURSUANT TO GUIDELINE II-S, PARAGRAPH (a), THE GATEKEEPER SHALL CAUSE AN INVESTIGATION AND REVIEW OF THE APPLICATION, AND POSSIBLE SCREENING AND DIVERSION OF THE RESPONDENT FROM COMPULSORY HOSPITALIZATION, TO BE COMPLETED BY THE END OF THE SECOND DAY AFTER RECEIPT OF THE APPLICATION.

(2) INVESTIGATION AND REVIEW OF THE APPLICATION SHALL INCLUDE THE FOLLOWING: (a) REVIEW AND ASSESSMENT OF THE RELIABILITY AND CREDIBILITY OF ALL FACTUAL INFORMATION CONTAINED IN THE WRITTEN APPLICATION AS PRESCRIBED IN GUIDELINE II-Q, PARAGRAPHS (a) THROUGH (c); AND, (b) INTERVIEWS OF THE APPLICANT AND AVAILABLE WITNESSES WHO HAVE KNOWLEDGE OF THE RESPONDENT THROUGH PERSONAL INFORMATION.

(3) SCREENING SHALL INCLUDE A PERSONAL INTERVIEW WITH THE RESPONDENT WHEREUPON A DETERMINATION IS MADE TO PURSUE INVOLUNTARY CIVIL COMMITMENT OR TO DIVERT THE RESPONDENT TO LESS RESTRICTIVE TREATMENT AND CARE. THE INTERVIEW SHALL BE CONDUCTED AT A COMMUNITY PORTAL AT A SPECIFIC TIME AND DATE OR, IF THE RESPONDENT IS UNWILLING OR UNABLE TO COME TO THE PORTAL, AT THE RESIDENCE OR OTHER LOCATION OF THE RESPONDENT OR, IF A PERSONAL FACE-TO-FACE INTERVIEW CANNOT BE ARRANGED WITHIN THE PRESCRIBED TIME LIMITS, THE INTERVIEW MAY BE CONDUCTED BY TELEPHONE. THE INTERVIEW SHALL INCLUDE: (a) GIVING THE RESPONDENT A COPY OF THE COMPLETED APPLICATION AND AN ORAL EXPLANATION OF THE

NATURE, PURPOSE, AND POSSIBLE CONSEQUENCES OF THE INTERVIEW; (b) WRITTEN NOTICE AND ORAL EXPLANATION OF ALL RIGHTS PRESCRIBED BY LAW, AND AN OFFER OF ASSISTANCE TO THE RESPONDENT TO REALIZE THOSE RIGHTS; AND, (c) MENTAL HEALTH SERVICES SUCH AS CRISIS INTERVENTION, COUNSELING, MENTAL HEALTH THERAPY, AND OTHER PSYCHIATRIC, WELFARE, PSYCHOLOGICAL, AND LEGAL SERVICES AIMED AT AVOIDING UNNECESSARY AND INAPPROPRIATE COMPULSORY HOSPITALIZATION AND PROVIDING CARE AND TREATMENT IN THE LEAST RESTRICTIVE SETTING.

GUIDELINE II-U. (1) AT THE COMPLETION OF THE INVESTIGATION, REVIEW, AND SCREENING, THE GATEKEEPER SHALL DETERMINE WHETHER TO PURSUE COMMITMENT PROCEEDINGS, TO DIVERT THE CASE TO SOME ALTERNATIVE TREATMENT OR CARE, OR TO TERMINATE ANY FURTHER ACTIONS IN THE CASE.

(2) IF THE GATEKEEPER DETERMINES THAT THE RESPONDENT MEETS THE COMMITMENT CRITERIA AND THAT THE RESPONDENT CANNOT BE SERVED IN A SETTING LESS RESTRICTIVE THAN THAT PROVIDED BY COMPULSORY HOSPITALIZATION WITHOUT GIVING RISE TO IMMEDIATE AND SUBSTANTIAL RISKS TO THE RESPONDENT OR OTHERS, THE GATEKEEPER SHOULD CAUSE THE RESPONDENT TO BE TAKEN TO A MENTAL HEALTH FACILITY PURSUANT TO INVOLUNTARY COMMITMENT.

GUIDELINE II-V. (1) THE GATEKEEPER SHALL CAUSE A REPORT OF THE REVIEW, INVESTIGATION, AND SCREENING PURSUANT TO GUIDELINE II-T, TO BE SUBMITTED TO THE COURT WITH THE APPLICATION FOR INVOLUNTARY CIVIL COMMITMENT NO LATER THAN THREE DAYS AFTER RECEIPT OF THE APPLICATION.

. . .

Comment

Guidelines II-S through II-V encourage the accomplishment of reviewing, investigating, and screening, of mental health cases before a respondent is taken into custody pursuant to involuntary civil commitment. In all cases, gatekeepers must cause a review and investigation of the application for involuntary civil commitment, and must accomplish a screening, to avoid unnecessary detention and compulsory hospitalization when (1) there are inadequate grounds to believe that the respondent presents a likelihood of serious harm to self or others as a result of mental disorder, and (2) when there are less restrictive alternatives for care and treatment available to the respondent. The review, investigation, and screening should be completed prior to custody-taking and detention, unless a gatekeeper or a peace officer, upon consultation with a gatekeeper, determines that immediate detention is necessary to prevent serious harm to the respondent or others. In such

emergency cases, at least telephone contact and consultation between a gatekeeper and a peace officer should establish the necessity for immediate detention. Even in such emergency cases, however, the filing of an application for involuntary commitment, and investigation, review, and screening, should occur after detention as prescribed in Guidelines II-P through II-V.

The screening guidelines in this section propose that all requests and actions pursuant to involuntary civil commitment be funneled through community portals. The development of mechanisms for screening, investigation, and review of cases before a formal judicial hearing takes place, must be achieved by a cooperative effort involving mental health practitioners, court personnel, and to a lesser extent, law enforcement officials. Review and investigation of cases, and screening and diversion of respondents from compulsory hospitalization, serve the interests of the respondent, the applicant or petitioner, the court, and the taxpayer. The respondent's interests are met by the avoidance of unnecessary detention and involuntary hospitalization, as well as his or her interest in access to less restrictive mental health care and treatment. The applicant or petitioner's interests are served by providing immediate support and assistance for a person whom he or she believes is incapable of caring for him or herself, and by providing an education resource during a time of crisis. The courts and the community are served by a more efficient and economical allocation of resources.

CHAPTER THREE

HOSPITAL ADMISSION AND DETENTION

ADMISSION TO MILWAUKEE COUNTY MENTAL HEALTH COMPLEX

Ward 53B, or Sunny Sands, as it is sometimes called, is a secure unit of the Milwaukee County Mental Health Complex. Ward staff provide theraputic detention and psychotropic medication to respondents involuntarily detained under the authority of the emergency (51.15) and non-emergency (51.20) provisions of the SMHA. Only involuntarily detained respondents awaiting a final determination of their legal status are placed in Ward 53B. This includes respondents awaiting a probable cause hearing, held within 72 hours of hospital admission, and respondents who have had a probable cause hearing and are awaiting a final commitment hearing. (This latter category includes only those respondents who are awaiting final hearings but who have refused treatment. Presently, according to one Ward 53B psychiatrist, those persons who accept treatment while they are awaiting final hearing are transferred to one of the treatment wards in the Mental Health Complex. This point is discussed later in this chapter.) Ward 53B has the bed-capacity for 24 patients. At the time of one of our visits to Ward 53B (November 17, 1982), the ward had seven patients, two awaiting probable cause hearings and five awaiting their final commitment hearings. According to ward staff, the daily census on Ward 53B ranges from 7 to 14, only rarely reaching capacity.[46]

Reportedly, the purpose of Ward 53B is not primarily to provide treatment, but rather to provide therapeutic restraint of respondents awaiting the determination of their legal status. Although staff do observe and interact with patients, the only formal treatment provided is psychotropic medication. An exception noted by an examining psychologist who reviewed the draft of this chapter, is the provision of occupational therapy occasionally conducted in a group setting with Ward 53B patients. Generally, individual, group, occupational, and recreational therapies, ground passes, and other mental health interventions provided on the treatment wards of the Milwaukee County Mental Health Complex are not provided to the patients on Ward 53B.

An individual subject to an emergency detention is delivered to Ward 53B at the Milwaukee County Mental Health Complex by the law enforcement officer(s) who intially took the person into custody (see Chapter Two). The officer and the detained person are met at the door of Ward 53B by a staff physician, intern, resident, or ward nurse. If the person is taken into custody and transported to Ward 53B by police officers pursuant to an emergency detention, the admitting staff receives the police officer's statement of emergency detention and the "blue

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[46]In the winter, according to Ward 53B staff, the daily census increases to approximatey 12-14 patients. However, in our latest conversation with Ward 53B staff on April 20, 1983, the daily census had reached 28.

sheet" (see Appendix A, pp. 3-4) documenting the medical clearance by the Emergency Center. Upon arrival at Ward 53B, the person is considered to be in the custody of the facility (51.15(3)). However, detaining officers typically remain with the respondent until emergency medical or behavioral problems are controlled. According to a spokesman of the Milwaukee Police Department, officers transporting respondents to Ward 53B may sometimes object to excessive time spent waiting and assisting Ward 53B staff in the admission process but recognize the necessity of their assistance.

Section 51.15(9) requires that a detention facility director, or his or her designee, orally and in writing, inform a detained person of his or her rights when the person arrives at the facility. These rights include the right to contact an attorney and a member of the detainee's immediate family, the right to appointed counsel if the individual is indigent, and the right to remain silent including that the individual's statements may be used as a basis for commitment. The detainee should also receive a copy of the statement of emergency detention. In accordance with these provisions in the law, upon admission to Ward 53B respondents are interviewed by a member of the Ward 53B staff, orally informed of their legal rights, and provided with a set of written materials setting forth those legal rights. Following the notification of rights, the respondent is asked to sign and date several forms contained in the written materials provided to acknowledge the oral and written notification of rights (see Appendix A, pp. 25-28). The person providing the notification of rights then signs an affidavit of service (see Appendix A, p. 29) certifying that the respondent was informed of his or her rights. Finally, the respondent is asked to authorize the Milwaukee Mental Health Complex to acknowledge his or her presence in Ward 53B to parties that may be personally interested in the respondent's whereabouts. A standardized consent form is used for this purpose (see Appendix A, p. 30). The respondent is also asked to sign a consent form directing that persons named by the respondent be given notice in the event of his or her imminent discharge from Ward 53B (see Appendix A, p. 31).[47]

A respondent is subjected to a number of procedures as part of his or her admission to Ward 53B. A nurse interviews the respondent and conducts a mental status and physical examination. He or she takes the respondent's temperature, pulse rate, respiration rate, and blood pressure. The information acquired is documented on a series of standardized forms (see Appendix A, pp. 32-33). Also a nursing

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[47]Procedures for notification of involuntary detention, scheduled hearings, and legal rights in non-emergency hospitalizations are not conducted by Ward 53B staff at the time of admission, but rather by the Sheriff's Deputies at the time the person is taken into custody (see Chapter Two).

assistant assists the respondent to take a shower or bath if desired or needed. The nursing assistant also conducts a body check which includes weight measurements. All respondents have a chest x-ray, a blood analysis, and a complete physical examination, usually within 24 hours of admissions. Each admittee is provided a wrist band with his or her name and a hospital number for identification purposes. Finally the respondent is assigned a bed, shown around 53B, and introduced to the staff.

Respondents are usually provided hospital clothes to wear while on Ward 53B. If a respondent desires to wear his or her own clothes, a right provided by the State Mental Health Act (51.61(1)(q)), Ward 53B staff ask that the respondent sign a form assuming responsibility for the clothes. According to Ward 53B staff, this procedure was instituted because of a problem with missing and stolen personal clothes on the ward.

There is a registered nurse, usually a licensed practical nurse, on duty on Ward 53B at all times. Nursing assistants on each shift include both males and females. All nursing staff wear name tags identifying themselves, though most wear street clothes instead of uniforms. Physicians are available or on call at all times.

PREHEARING CARE AND TREATMENT

The State Mental Health Act defines treatment as "those psychological, educational, social, chemical, medical or somatic techniques designed to bring about rehabilitation of a mentally ill, alcoholic, drug dependent, or developmentally disabled person" (51.01(17)). Respondents detained in Ward 53B awaiting probable cause hearings or final commitment hearings have the right to refuse all treatment except when treatment is ordered by the court after a judicial hearing and a determination of the respondent's incompetency to make treatment decisions, or when medication or treatment is necessary to prevent serious physical harm to the respondent or to others (51.15(8); 51.20(8)(c); 51.61(g) and (h)). A respondent may consent to treatment, but only after he or she has been informed of the right to refuse treatment and has signed a written consent to such treatment (51.20(8)). A report of all treatment provided shall be filed with the court (51.20(8)(c) and 51.15(8)).

In Milwaukee County, like many other places throughout the country,[48] strong conflicting interests are at stake in treatment and care before a full judicial review. On the one hand, when a respondent is first admitted to Ward 53B, a judicial review has not yet determined that the respondent meets Wisconsin's involuntary civil commitment criteria. The respondent may, in fact, have been wrongly detained. On the other hand, the respondent's deteriorating mental condition and aberrant behavior may seriously threaten not only his or her own safety, but that of others in the hospital. Although not often openly acknowledged, the factors of economy, efficiency, and administrative convenience are also probably considered in attempting to balance conflicting interests in treatment before full judicial review.

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[48]See, Institute, supra, note 23, at II-39.

As mentioned earlier, respondents on Ward 53B receive little in the way of treatment "designed to bring about rehabilitation" except for the administration of psychotropic medication after a respondent has consented to such treatment. Respondents are infrequently given medication without informed consent, usually by means of intramuscular injection, but only when they are deemed dangerous to themselves or others. To the best of our knowledge, judicial hearings to determine competency to refuse medication and court orders permitting medication to be administered without consent are rare.

A patient in Ward 53B has a qualified right to refuse treatment. The intent of the law is clear: to protect the individual's right to make informed choices about treatment and care, and to prevent abusive, improper, capricious, or arbitrary treatment. The law allows the individual's choice to be overriden, however, in an emergency or after a due process proceeding. The qualification is intended, it appears, to allow treatment to be administered when absolutely necessary. No one we interviewed in Milwaukee opposed the fundamental values inherent in this part of the law. The complaint in Milwaukee, and elsewhere,[49] is that the procedures to implement the law do not work and that they compromise needed treatment.

Concern about treatment and care provided in Ward 53B voiced by those we interviewed focused on two related but separable issues. The first issue is the adequacy of care and treatment provided to the patients on Ward 53B in general. The second issue is more specific: under what circumstances and by what procedures is a patient's choice overriden and treatment given without the patient's consent? These two issues were often mixed when discussed by interviewees. Other people commenting about the treatment and care provided to detained patients awaiting final determinations of their legal status in Ward 53B have also mixed these issues. Comments that the Medical Director of the Milwaukee County Mental Health Complex made about Ward 53B at a recent conference on Wisconsin's commitment laws are illustrative:

> The present system holds the patient wihout treatment for up to fourteen days, and occasionally even longer due to legal adjournments. Thus the hospital becomes a jail (but without security capability I might add). During this waiting period without treatment, the patients are very angry and frustrated, both by their illness and because they are detained. The staff must frequently resort to physical restraints during this period when treatment is postponed, and this leads to more physical interaction between the staff and patients and more frequent injury, especially of the

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[49]"Too often the adversary process has produced paper victories which require solutions that are so complex or onerous that they are never implemented." Hickman, F. J., Resnick, P. J., and Olson, K. B. Right to refuse psychotropic medication: An interdisciplinary proposal. Mental Disability Law Reporter, 1982, 6 (2), 122-130, at 123.

staff. More staff time is needed to provide this type of control and supervision of agitated patients who are refusing medication. Also, staff time in this context is money; this extra staffing requirement raises the expense of detaining these patients.

Secondly, from a more personal viewpoint, consider the effect of the frustration of the treatment process on the mental health professional. The background of the nurse, the social worker, the psychologist and psychiatrist is one of training and experience in helping, curing as far as possible, and relieving anxiety and suffering. In a setting where treatment is forbidden, these staff are reduced instead to controlling behavior, often through the use of physical restraint or force. When faced with this additional level of physical violence and psychologial tension they become more preoccupied with their own safety and tend to become defensive toward patients rather than open and empathetic, supportive, and healing. Staff burnout in such emergency care situation is always higher than in areas without these stresses and burnout is exaggerated needlessly by the prolonged period of waiting for treatment to begin.[50]

Nothing in the SMHA requires "facilities for detention" (51.15(2)) to be mere reception centers, holding areas or "jails" for detained patients. Staff of Ward 53B may, if they so choose, provide appropriate treatment and care without statutory contraints (except for especially intrusive procedures such as psychosurgery; see 51.61(k)) _if_ the patient consents. Thus, for one group of patients (i.e., those who consent to treatment) included in the Ward 53B patient population, Ward 53B could provide a setting for timely, needed care. Such a setting should be developed.

> _RECOMMENDATION 7_: TO THE EXTENT THAT SHORT-TERM TREATMENT CAN BE PROVIDED TO RESPONDENTS PRIOR TO FINAL COMMITMENT HEARINGS, AND IN ACCORDANCE WITH SECTION 51.61(1)(g) AND (h) OF THE STATE MENTAL HEALTH ACT, RESPONDENTS IN WARD 53B OF THE MILWAUKEE COUNTY MENTAL HEALTH COMPLEX SHOULD BE PROVIDED WITH PROMPT AND ADEQUATE TREATMENT APPROPRIATE FOR THEIR CONDITIONS, INCLUDING ALL AVAILABLE PSYCHOLOGICAL, EDUCATIONAL, SOCIAL, CHEMICAL, OR SOMATIC TECHNIQUES DESIGNED TO BRING ABOUT REHABILITATION.

Reviewers of this recommendation in its draft form expressed differing opinions regarding whether there are presently significant numbers of persons who are not provided treatment in Ward 53B consistent with Recommendation 7.[51] One reviewer indicated that the Mental Health

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[50]Gerhardstein R. P., _supra_ note 13, at 5.

[51]See Task Force on Human Services and the Law, _supra_, note 1, at 4.

Complex accepted this recommendation as a general principle but disagreed with the implication that the Mental Health Complex is not providing sufficient treatment on Ward 53B. To the best of our knowledge, the disagreement among reviewers about the treatment policies and practices on Ward 53B may have been largely due to changes instituted in recent months (i.e., since the distribution of the review draft of this final report). As suggested in the beginning of this chapter, the present policy is to move patients from Ward 53B into treatment wards very quickly. According to a Ward 53B psychiatrist with whom we spoke in late April 1983, respondents detained pending the final commitment hearing are moved to treatment wards if they do not refuse the recommended program of treatment and care. The minority of respondents awaiting final hearing who do refuse treatment (approximately 10% of the Ward 53B detainees) remain in Ward 53B. Heretofore, apparently all Chapter 51 detainees who were awaiting the final determination of their legal status were placed in Ward 53B, and not moved to the treatment wards in the Mental Health Complex, regardless of their willingness to accept treatment and care. Because of this apparently newly-instituted change consistent with the recommendation, Recommendation 7 is limited to (1) all Ward 53B detainees who are waiting the short period of time until a probable cause hearing and (2) those respondents who refuse accepted treatment and are awaiting a final commitment hearing.

Notwithstanding, changes in policies and practices instituted within the last six months, Recommendation 7 remains worthy of consideration, though the problem to which it draws attention is clearly not as pressing as it was six months ago. Consistent with our general approach of not deleting recommendations and commentary because procedural changes have been instituted in Milwaukee County since our on-site research (see PREFACE), we have kept Recommendation 7 intact and made only minor revisions in the remaining commentary supporting this recommendation.

Recommendation 7 addresses the first issue raised earlier--the general adequacy of treatment and care provided to the patients on Ward 53B. Respondents may be in Ward 53B for up to 14 days awaiting a final commitment hearing (or 21 days if the court has granted a postponement of the probable cause hearing; see 51.20(7)). At least as recently as six months ago, the only form of treatment that respondents received was the administration of psychotropic medication and custodial care.[52] Ward 53B is considered by some as a reception center and temporary holding area.[53] Group and individual therapies, occupational and recreational

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[52]We do not use the term custodial care in any pejorative sense. To the contrary, in connection with Ward 53B it refers to the provision of food and a safe, comfortable, and friendly environment. Ward 53B is an excellent care facility. Staff appeared to perform their duties competently. In view of the increasing number of homeless, helpless, and mentally ill persons endangered on the streets of the Nation's cities, custodial care as provided in Ward 53B has considerable value.

[53]Gerhardstein, R.P., supra, note 10, at 1 and 5; also, see booklet entitled "For Your Information: 5.3.B" given to Ward 53B admittees.

therapies, and other types of treatment and rehabilitation encompassed by the statutory definition of treatment (see 51.01(17)) are provided only on the five treatment wards of the Milwaukee County Mental Health Complex.[54] Broadening the function of Ward 53B to include short term treatment and care beyond medication would not only meet the concerns that Ward 53B is little more than reception center for preventive detention, but would also bring the Ward 53B admission and detention procedures in line with statutory intents. As mentioned earlier, the SMHA permits treatment of consenting respondents who are awaiting final commitment hearing.[55] Much more importantly, Section 51.61(1)(f) provides for treatment as a matter of right: "Each patient shall ... have a right to receive prompt and adequate treatment, rehabilitation and educational services appropriate for his or her condition."

Restricting the treatment of Ward 53B patients to administration of medication, as a matter of policy, cannot be justified by the relatively short time patients are detained in Ward 53B. Of course, for some patients medication and temporary custodial care in Ward 53B are appropriate. Others, however, may be released shortly after arrival with little or no mental health intervention. For those staying on Ward 53B for more than a day or two, anything short of "prompt and adequate treatment, rehabilitation, and educational services appropriate for his or her condition" cannot be justified.

The second, more specific issue--care and treatment of Ward 53B detainees who refuse psychotropic drugs--is more problematic. It is probably this issue upon which Dr. Gerhardstein focused his remarks quoted above. No doubt, the violent and abusive patient who refuses treatment poses significant difficulties for Ward 53B. However, according to estimates made by Ward 53B staff, only one out of ten patients detained on Ward 53B refuse administration of psychotropic drugs.[56] While we do not minimize the great burdens and strains these

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[54]Exceptions are made for a small, special category of patients in Ward 53B who are awaiting transfer to the treatment wards of Milwaukee County Hospital as voluntary patients or whose request for voluntary addmission to one of the treatment wards has been rejected by the ward treatment director. According to a Ward 53B psychiatrist, these "volunteer" patients will be provided with some treatment and care, other than medication, similar to that provided patients on the five treatment wards.

[55]See Sections 51.15(2) and (8), 51.20(8)(c), and 51.61(1)(g) and (h). (The reference in Section 51.15(2) to subsection (6) appears to be a typographical error; the reference, we believe, should be to subsection (8) regarding treatment.)

[56]This estimate is consistent with at least one study that found that less than 10 percent of hospitalized patients refused medication in a manner that interfered with treatment. (See Appelbaum, P.S., and Gutheil, T.G. Drug refusal: A study of psychiatric inpatients. <u>American Journal of Psychiatry</u>, 1980, <u>137</u>, 340-346; see also (continued)

uncooperative patients place on Ward 53B staff and resources, we do not feel that this small minority should dictate the overall treatment policy of Ward 53B.[57] The rights and welfare of the majority of 53B detainees who consent to treatment seem to require a treatment policy consistent with the above recommendation. Further, and more to the point of the second issue, even as to patients who do not give their consent to treatment, if the refused treatment is clearly in the patient's best interests Ward 53B staff should follow the procedures provided in the SMHA to override the patient's choice. For various reasons, the statutory provisions for overriding the patient's choice to refuse treatment in clearly defined emergencies or after due process proceedings seem not to be used in Milwaukee as they were intended.

> RECOMMENDATION 8: (1) STAFF OF WARD 53B OF THE MILWAUKEE COUNTY MENTAL HEALTH COMPLEX SHOULD, IN ACCORDANCE WITH SECTION 51.61(1)(g) AND (h), OVERRIDE A PATIENT'S REFUSAL OF TREATMENT IN CLEARLY DEFINED EMERGENCIES.
>
> (2) WARD 53B SHOULD HAVE A WRITTEN POLICY COVERING EMERGENCY SITUATIONS IN WHICH PATIENTS ARE TREATED WITHOUT THEIR INFORMED CONSENT. THIS POLICY SHOULD BE CONSISTENT WITH THE WRITTEN POLICY GOVERNING THE USE OF RESTRAINT AND ISOLATION REQUIRED BY SECTION 51.61(1)(i) OF THE STATE MENTAL HEALTH ACT.
>
> (3) THE PROCEDURES FOR EMERGENCY TREATMENT OF NONCONSENTING PATIENTS SHOULD NOT BE SO ONEROUS

White, M.D., and White, C.A. Involuntarily committed patients' constitutional right to refuse treatment: A challenge to psychology. American Psychologist, 1981, 36, (9), 953-962 ("It is inconceivable that great numbers of committed individuals or their guardians will refuse legitimate psychological assistance with the problems that caused the individual to be confined" (P.959)). We do not mean to minimize the disruptive effect that even a few patients who refuse medication may cause. One mental health professional reports the result of a pertinent study in Massachusetts as follows: "[W]e found that 20% of our refusing sample refused treatment in a way that seriously impaired their own treatment (one of this group committed suicide shortly after the study) and that the disruption effect on the milieu caused by this group significantly interferred with the treatment of other patients, as well as with the right of those patients to a safe, orderly, and therapeutic environment -- a right that is all too often scanted in discussion of RTRT [right to refuse treatment]." Gutheil, T.G. More on the right the refuse treatment. American Psychologist, 1982, 37 (8), 974-975.

[57] In all fairness to those who have criticized the policies and procedures of Ward 53B, according to several interviewees, far more 53B patients awaiting final commitment hearings refused treatment in the past than have 53B patients after the arrival of the current key staff.

AND COMPLEX AS TO COMPROMISE NEEDED EMERGENCY MENTAL HEALTH INTERVENTION, BUT SHOULD BE SIMPLE AND EFFICIENT.

One representative of the Milwaukee County Mental Health Complex who reviewed this recommendation in its draft form commented that the Mental Health Complex is, indeed, using medication in spite of a patient's refusal when a clear emergency exists. Further, he stated that the Mental Health Complex has also trained staff to anticipate emergency situations and begin treatment and care before a "potentially dangerous situation erupts."

The intent of Recommendation 8 is not to suggest that we either observed or infer abuses by Ward 53B staff of the emergency provision to override patients' refusal of treatment, or that Ward 53B never acted in accordance with this recommendation. We did not observe, nor were we told about, any abuses. Instead, the recommendation is intended to encourage use of the emergency treatment procedure in clearly defined situations in accordance with Sections 51.61(1)(g) and (h) of the SMHA. Any failure of Ward 53B staff to override a patient's refusal in emergency situations, when they are of the firm opinion that the refused treatment is in the best interest of the patient,[58] is, we believe, contrary to Wisconsin law and good mental health practice. Given the relatively small proportion of Ward 53B detainees who refuse treatment, and given the polarization of the mental health-legal community in Milwaukee, this recommendation may be less important to the day-to-day operations of Ward 53B than to public perception and confidence in the fairness and propriety of procedures employed in 53B. This also may be true regarding the next recommendation addressing the procedures for overriding treatment refusals in non-emergency cases.

RECOMMENDATION 9: (1) WHEN A PATIENT REFUSES TREATMENT IN NON-EMERGENCY SITUATIONS, AND WHEN THE REFUSED TREATMENT IS IN THE BEST INTEREST OF THE PATIENT, WARD 53B STAFF SHOULD, IN ACCORDANCE WITH SECTION 51.61(1)(g) and (h), SEEK A COURT ORDER PERMITTING TREATMENT WITHOUT A PATIENT'S INFORMED CONSENT.

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[58]At least five factors should be considered in deciding whether forced treatment is in the best interest of the patient: (1) whether the patient poses a threat of "serious physical harm" to himself or herself, other patients, or staff; (2) the patient's capacity to make informed choices about treatment; (3) the patient's reasons for refusing treatment; (4) the availability of less restrictive or less intrusive treatment or care; and (5) the likelihood of benefit and the risks of side effects of the proposed treatment. These factors are part of a model procedure agreed to by the attorneys for plaintiffs and State of Ohio as a means of regulating treatment refusals in Ohio's maximum security hospital in Lima and implementing the decision in Davis v. Hubbard, 506 F. Supp. 915 (N.D. Ohio 1980); see Hickman, Resnick, and Olson, supra, note 49, at 122.

(2) THE PROCEDURES FOR SECURING A COURT ORDER PERMITTING TREATMENT WITHOUT THE PATIENT'S INFORMED CONSENT SHOULD NOT BE SO COMPLEX OR ONEROUS THAT THEY COMPROMISE NEEDED TREATMENT, BUT SHOULD BE SIMPLE AND EFFICIENT.

Staff of Ward 53B have four possible responses to treatment refusals: (1) overriding treatment refusals in clearly defined emergencies, as permitted in Section 51.61(1)(g) and (h) of the State Mental Health Act; (2) overriding treatment refusals through a judicial hearing, adjudication of patients' incompetency to make treatment decisions, and a court order permitting such treatment, as prescribed by the same section of the law; (3) restraining and isolating of the patient in acordance with Section 51.61(1)(i); and (4) simply coping with the patient's refusal, as well as possible, until the final determination of his or her legal status. It is our perception that response (4), above, is the most frequent response of Ward 53B staff to the approximately 10% of Ward 53B detainees who refuse medication. This response has engendered the type of frustration reflected in the comments of the mental health official quoted earlier. According to Ward 53B staff whom we interviewed, no court orders for regarding treatment refusals have been sought in the last two years. We submit that a policy encouraging responses (1) and (2), above, in accordance with the last two recommendations, would do much to instill greater public confidence in the treatment and care provided patients in Ward 53B.

Although the procedures for securing a court order permitting treatment without informed consent (see 51.61(1)(g) and (h)) may appear complex and onerous, they need not be. Given the fact that only one out of ten patients in Ward 53B refuse treatment, and that some of the treatment refusals can be accommodated by Ward 53B staff without threat to the safety and welfare of patients and staff, no more than one adversarial hearing to determine "probable cause to believe that the individual is not competent to refuse medication" (51.61(1)(g)) may need to be held every week or two. Furthermore, a significant portion of these hearings can be combined with the required probable cause hearings which are held within 72 hours of admission to Ward 53B (probable cause hearings are conveniently held in a conference room on Ward 53B; see Chapter Five).[59]

INITIAL MENTAL HEALTH EVALUATION

Within 24 hours after an individual is delivered to a detention facility, the treatment director, or his or her designee, must determine whether the individual should remain in detention (51.15(4)(b)). Staff of Ward 53B routinely conduct a mental health evaluation of incoming detainees to determine if detention beyond 24 hours is warranted. If a detainee arrives at 53B during the night, a psychiatric resident on call

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[59]We suggest that any attempts to regulate treatment refusals by Ward 53B patients, whether or not to implement the above recommendations, be made with consideration of the interdisciplinary proposal put forth by Hickman, Resnick, and Olson; <u>supra</u>, note 38.

does an initial assessment of him or her. In rare cases the resident may release the person immediately or the next morning. Generally, however, the staff psychiatrist reevaluates such persons the following day.

Detainees who arrive during the day and those remaining after night arrival are generally evaluated by a staff psychiatrist and a social worker. These evaluations are conducted in an interview room near the nurses' station on the ward. We were permitted to observe two intial evaluations which 53B staff told us were representative of typical evaluations.

At the beginning of each evaluation, the staff psychiatrist told the patient being interviewed that his or her statements during the interview were not confidential, that they would be noted on the patient's chart and could be used in a court hearing. The interview that followed was relatively informal.

The interviewer first read the police report to the patient, asked the patient what he or she thought should now happen to him or her, told the patient what might occur later, and advised the patient about voluntary admission and outpatient treatment. In one instance an interviewer called a relative of the patient to ask how the relative thought the patient might fare in outpatient treatment. After the patient agreed to weekly outpatient counseling, the staff psychiatrist released the patient. The other patient, who had been a patient at the Mental Health Complex before, agreed to voluntary inpatient treatment. The patient signed a form giving consent to voluntary treatment.

Reportedly, about 75 percent of patients who have previously been at the Mental Health Center agree to request voluntary admission status.[60] About half of the remaining 25 percent agree to a "14-day voluntary pending" arrangement.[61] Under this arrangment, a person who has been admitted to Ward 53B pursuant to emergency (51.15) or non-emergency (51.20) hospitalization, may elect to become a voluntary patient with restrictions. Practially speaking, the person signs into the hospital for 14 days but cannot sign out during that period. The patient has 14 days to prove his or her suitability for voluntary rather than involuntary treatment. The treatment director must approve of the voluntary admission within this time. The civil commitment proceedings are suspended until the end of the 14-day period or until the treating physician enters on the patient's chart that the patient is unsuitable for voluntary treatment. At the end of 14 days, the patient becomes a voluntary patient and the civil commitment proceeding is dismissed.

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[60]We have no statistics indicating the frequency with which first-time patients agree to voluntary admission during the initial mental health evaluation.

[61]This procedure is apparently based on Section 51.10(6) of the State Mental Health Act. See Appendix for form entitled "Non-voluntary Admission Case Suspension Agreement."

However, if the treating physician determines at any time during the 14 days that the patient is unsuitable for voluntary treatment, the physician may so note on the patient's chart. Such a chart entry begins the running of the remaining 48 hours during which a probable cause hearing is required.[62] A hearing is usually held on the next day.

If the staff psychiatrist and social worker determine during the initial evaluation that a patient should be further detained pursuant to involuntary commitment, the staff psychiatrist completes a "Treatment Director's Supplement" (TDS) (see Appendix A, p. 5). A TDS is authorized but not required by Section 51.15(4)(b) of the SMHA. It is intended to supplement the statement of emergency detention given by the police officer who detained the person. The TDS should contain a statement indicating whether the patient is believed to be mentally ill, developmentally disabled or drug dependent, if the police officer did not so state in the original statement. The person filling out the TDS may also include any other information concerning why he or she believes that the patient meets commitment criteria. Section 51.15(4)(b) requires that the treatment director, or his or her designee, promptly file with the probate court the original statement of emergency detention and any supplement. The filing of these statements and of a notification of detention have the same effect as a three-party petition under nonemergency procedures of Section 51.10. To carry out this procedure on Ward 53B, the staff psychiatrist gives the completed forms to a court liaison officer employed by the Mental Health Complex who, in turn, forwards them to the Commissioner in Probate, the Corporation Counsel, and the public defender or other defense counsel.

Both our observations and the comments of persons we interviewed in Milwaukee County indicate that the staff of Ward 53B are solicitous to both the treatment needs and the legal rights of detainees whom police officers bring to the ward. The admissions procedure discussed above appears to be effective in directing incoming patients to optimal types of treatment. In two respects, however, 53B staff may be more solicitous of incoming patients' legal interests. The first matter concerns advising a patient of his or her right to remain silent at the beginning of the initial evaluation. As mentioned above, the Ward 53B staff psychiatrist conducting the evaluations we observed told each patient that his or her statements were not confidential, that they would be entered into the patient's chart, and that they could be used in a court hearing. This precautionary statement may be sufficient in many cases, but should preferably include notice to the patient of his or her right to remain silent during the interview. Although strictly construed Section 51.15(9) would require notification of right only at the time the

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[62] The probable cause hearing is required within 72 hour, excluding weekends and legal holidays, of the time a detainee arrives at the Mental Health Complex (51.15(4)(b)). The 48-hour period mentioned in the text is that portion of this 72 hours which remains after the initial 24-hour period during which the treatment director must determine whether detention should be continued.

patient initially arrives at the ward, because the initial interview is the instance at which the right to remain silent becomes most significant to a patient, it is important that the patient be reminded of that right.

> RECOMMENDATION 10: WARD 53B STAFF WHO CONDUCT THE INITIAL MENTAL HEALTH EVALUATION OF PERSONS BROUGHT TO WARD 53B FOLLOWING AN EMERGENCY DETENTION BY LAW ENFORCEMENT OFFICERS SHOULD INCLUDE IN THE OPENING PRECAUTIONARY STATEMENT TO SUCH PERSONS A NOTIFICATION OF THE RIGHT TO REMAIN SILENT DURING THE INTERVIEW.

Including such a notification is but a small departure from the current procedure. It is, however, an important step. Most state statutes do not require examiners to disclose to a patient the purpose, nature, and consequences of the examination process in involuntary civil commitment proceedings; nor do they require that detained patients be informed of their right to remain silent during examinations.[63] Wisconsin, however, is one of the few states that requires that detained patients be informed of their right to remain silent.[64] Even though statute does not expressly require that this notice be given at the beginning of the initial interview, it is important that this be done because, as mentioned above, this interview is the point at which exercise of the right may become most crucial to the patient. Furthermore, on the basis of professional ethics, at the beginning of every examination a patient should be informed not only that his or her statements may later be made public and serve as a basis for involuntary hospitalization, but also that the patient has a right to prevent his or her statements from becoming public by declining to talk in the first instance. It has been our experience in studying civil commitment procedures in other parts of the country that, when such notice is given, few patients refuse to talk as a matter of legal right. Nevertheless, notice is important to those patients who would exercise the right.

The second way in which 53B staff may be more solicitous of incoming patients' rights arises also in the context of the initial mental health evaluation. As mentioned earlier in this chapter, one patient involved in an initial evaluation which we observed signed a form consenting to voluntary, inpatient treatment. Prior to having the patient sign the form, staff advised the patient to stay in the hospital voluntarily but did not inform the patient of the rights and obligations of a voluntary patient. The SMHA requires that a patient be so informed except if the patient "applies for admission in writing" (51.10(4m)(a)). We question whether, as a matter of policy, a person subject to an

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[63] See Institute, _supra_, note 23, at II-46.

[64] See State Mental Health Act, Section 51.15(9). Also, the provision concerning the psychiatric examination of patients after the probable cause hearing (51.20(9)) expressly requires that examiners, prior to the examination, inform patients of their right to remain silent.

emergency detention who merely signs a form (which, as in the case we observed, the patient had not read) should be considered to have applied for admission in writing. A better policy would be to orally and in writing explain to each detained person the significance of accepting voluntary, inpatient status. A person who has been taken into custody and brought to the hospital by police officers presumably against his or her will, may perceive signing voluntary as a way of escaping from his or her "captors." Particularly if the person has been an inpatient before, the patient may know that he or she as a voluntary patient would have a right to leave the hospital. Because being a voluntary patient is a legal status as well as a treatment status, before assuming that status each detained person should understand its consequences, to the extent that any mental disability that he or she may have would allow.

> RECOMMENDATION 11: BEFORE ACCEPTING A PERSON SUBJECT TO AN EMERGENCY DETENTION AS A VOLUNTARY PATIENT, WARD 53B STAFF SHOULD CAREFULLY EXPLAIN TO THE PERSON THE RIGHTS AND OBLIGATIONS ARISING FROM VOLUNTARY STATUS. THIS EXPLANATION SHOULD INCLUDE NOTICE THAT ALTHOUGH THE PERSON HAS A RIGHT TO LEAVE THE HOSPITAL UPON SUBMISSION OF A WRITTEN REQUEST TO THE STAFF, THE PERSON MAY, NEVERTHELESS, BE FURTHER DETAINED IF THE TREATMENT DIRECTOR, OR HIS OR HER DESIGNEE, FILES A STATEMENT OF EMERGENCY DETENTION.

Section 51.10(5)(a) requires that at the time of admission to the hospital as a voluntary inpatient a person be informed orally and in writing (1) of his or her right to leave the hospital upon submission of a written request, and (2) that he or she may be further detained even after a request for discharge if the treatment director files a statement of emergency detention. Thus, at a minimum, the Ward 53B staff should so inform detained persons during the initial evaluation prior to accepting a voluntary admission. Requiring staff to give this explanation to detained persons does not improperly cast them in the role of counsel for the detainee. Rather, requiring staff to give this explanation merely recognizes the logistics of the situation. The decision whether to further detain a person must be made within 24 hours after the person arrives at the ward. Because the detention decision is made at the initial evaluation, explaining the consequences of voluntary status at that time seems appropriate.[65]

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[65]In addition to Ward 53B staff explaining these matters to detainees, to ensure that each patient has knowingly and voluntarily accepted voluntary status, it would be appropriate for an attorney to later meet with patients who accept voluntary status during the initial mental health evaluation. Because diversion from involuntary civil commitment proceedings during the initial evaluation bypasses judicial involvement in the matter, this additional check may be warranted.

CHAPTER FOUR

NEGOTIATIONS AND SETTLEMENTS OF CASES BEFORE JUDICIAL HEARING

A few years ago, representation by the State Public Defender's Office in Milwaukee was characterized by the frequent use of legal motions to challenge irregularities in commitment proceedings, especially technical defects in statements of emergency detention or three-party petitions. Almost 27 percent of the cases in which respondents were represented by the State Public Defender's Office prior to May 1979 resulted in "technical" dismissals.[66] Critics charged that most of these dismissals would have resulted in involuntary hospitalization had the court reached the merits of the case, an allegation denied by at least one public defender.[67] Today, perhaps due to corrections of technical defects in the petition process, implementation of a "harmless error" rule (see 51.20(10)(c)), or a "mellowing" of the public defenders in Milwaukee over time (as suggested by one probate court commissioner), the character of the legal representation by the State Public Defender's Office and of the Legal Aid Society of Milwaukee, Inc., is quite different.

The representation provided respondents today by attorneys of Milwaukee's Office of the State Public Defender and the Legal Aid Society of Milwaukee, Inc. is characterized by negotiation and settlement of cases, and by a de-emphasis on confrontation in court. A litigious approach has given way to a conciliatory approach. Central to this change are the controversial[68] tactics of "negotiated settlements," or "stipulated settlements," which respondent's attorneys use to divert their clients from involuntary hospitalization to outpatient or voluntary inpatient treatment. Approximately 25 to 60 percent of all involuntary civil commitment cases in Milwaukee County are diverted by means of these tactics.[69]

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[66]Zander, T. K. The mental commitment law as a scapegoat: The real problem is not with the mental commitment law, but with the lack of community-based mental health services. Report to Milwaukee County Board's Advisory Committee on Mental Commitment Standards and Procedures, August 1979.

[67]*Id.*, at 13.

[68]See Libman, *supra*, note 36; also Bernstein, N. Alternatives running out for patients. The Milwaukee Journal, December 1982.

[69]Precise statistics on the number of cases in which the probable cause hearing was postponed and the case was held open by means of a stipulated settlement were difficult to acquire. The estimate of 20-50 percent is based on statistics compiled by the Wisconsin Correctional Service for July 1, 1981 through July 30, 1982, statistics for 1981 "mental inquiries" compiled by the Clerk of the Circuit Court, and by the estimates of various interviewees in Milwaukee.

Once a respondent is held in Ward 53B of the Milwaukee County Mental Health Complex following an emergency detention or a three-party petition, his or her attorney can pursue several alternatives less restrictive than hospitalization, other than outright release, following dismissal of the case at probable cause hearing: (1) conversion to voluntary admission status as provided by Section 51.10(4m)(b) (implied voluntary) or 51.10(6) ("regular" voluntary); (2) "court-ordered voluntary" (COV) agreements; or (3) outpatient treatment by way of stipulated settlement of the case. A respondent who fails to indicate a desire to leave the Mental Health Complex but who refuses or is unable to sign an application for admission is presumed to consent to admission and may be held for up to seven days as a voluntary patient (see 51.10(4m)(b)). Thus, a patient's consent to voluntary treatment for up to seven days may be implied from his or her presense at Ward 53B coupled with his or her inability to express a decision regarding treatment. This "implied voluntary" disposition, in effect, maintains the status quo. Voluntary admission may also be accomplished by a Ward 53B detainee signing an application (see form entitled "Non-Voluntary Case Suspension Agreement," Appendix A, p. 35) for voluntary admission. This application is subject to the approval of the director of the 51.42 Combined Community Services Board and the treatment director of the facility. If the voluntary admission is approved, which is usually the case, the commissioner or judge dismisses the involuntary civil commitment proceedings (see 51.10(6)).

The court-ordered voluntary agreements (COV) and stipulated settlements, which have spawned much debate among members of the mental health-legal community in Milwaukee County,[70] are relatively new procedures that are not expressly prescribed by the SMHA. Both procedures entail the postponment of either the probable cause hearing or the final commitment hearing for as long as ninety days. The SMHA contains no specific provision for a respondent's waiver of the statutorily prescribed hearing schedules or for an adjournment of the official proceedings any longer than seven days. Reportedly, the procedures evolved from discussions several years ago between corporation counsel, public defenders, and the court. Acceptance of the innovative procedures resulted from the perceived need for a mechanism for better application of the least restrictive alternative doctrine, which provides the policy foundation for the Wisconsin State Mental Health Act (see 51.001; also see the discussion of the least restrictive alternative doctrine in Chapter Five in this report).

In 1979, one public defender involved in the discussions that gave birth to these new procedures characterized this need as follows:

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[70]See, supra, note 68. Also, a small part of the controvery regarding COV agreements may have resulted from the choice of the inherenty inconsistent label used to refer to these agreements. An agreement cannot be "court-ordered" and "voluntary" at the same time. We would suggest an alternative label, such as "stipulated voluntary."

> In the context of civil commitment, this [the application of the least restrictive alternative doctrine] means, for example, that if outpatient treatment would be _adequate_ to ameliorate the individual's mental illness or dangerousness, involuntary inpatient treatment cannot be imposed even if it is clinically preferrable for the individual. Obviously, this principle and policy favors the use of community-based treatment, including outpatient treatment, halfway house placement, and transitional housing. Unfortunately, Milwaukee County's mental health system has not caught up to this legislative policy, and is still largely institution-oriented.[71]

A stipulated settlement results from relatively unstructured conferences and negotiations between the attorney representing the respondent and the corporation counsel. These conferences and negotiations generally occur prior to the probable cause hearing and are not formally part of that hearing. The parties negotiate, agree to the arrangements, and then pursue an adjournment of the probable cause hearing for a specified period of time. During that time period, the respondent should participate in the treatment program stipulated in the agreement. At the conclusion of that time period, the matter is dismissed unless the corporation counsel requests that the case be reopened due to his belief that the respondent did not comply with the conditions of the stipulated settlement.

The matter may be held open for as little as three or four days (although such a short postponement is rare) to ascertain if the terms of the agreement are acceptable, or for as long as ninety (90) days. Typical conditions of the agreements include outpatient administration of psychotropic drugs, psychotherapy, vocational rehabilitation, day care, placement in a group home or board-and-care facility, social services such as General Assistance or supplementary security income, food stamps, "meals-on-wheels," homemaker services, and other conditions peculiar to the case (e.g., no uninvited contacts with neighbors and other designated individuals). At the time of the originally scheduled probable cause hearing, the stipulated agreement is presented to the court and is usually adopted by the commissioner as the order of the court (see form entitled "Stipulation," Appendix A, p. 36). Serious questioning and rejection of the stipulated agreement by the probate court commissioner is infrequent. One interviewee stated, however, that the court commissioners "will not let bad stipulated agreements slip by." This interviewee's opinion was confirmed in our discussions with probate court commissioners and others familiar with their performance at probable cause hearings. One commissioner we interviewed, however, said that he could recall only two occasions on which he did not approve the settlement; these two settlements were approved, however, by the final

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[71] Zander, T., _supra_, note 66, at 20.

hearing court. Precise statistics on the frequency of court commissioners' objections to and rejections of stipulated agreements are, unfortunately, not available.

Under the conditions of a COV agreement, judicial proceedings may be adjourned for up to six months or until such time as one of the following occurs: (a) the respondent's counsel notifies the court that his or her client wishes the case to be set for judicial hearing, or (b) staff of the Milwaukee County Mental Health Complex determine that the respondent is no longer a proper subject for inpatient hospitalization and notify the court to that effect, in which case the pending involuntary commitment petition is dismissed. The conditions of the COV are ordered by the court subject to the approval of the treatment staff. The resulting "voluntary" admission is for the purpose of treatment and, under the agreement, the respondent agrees to cooperate with the treatment staff. Conditional release of the respondent is possible under the COV agreement but the case may be reopened if the respondent does not cooperate with the conditions of the release (see the standardized form for a COV agreement and court order in Appendix A, p. 19).

As mentioned earlier, the consultations, conferences, and negotiations among the parties in the case, mental health personnel familiar with the respondent, petitioners, and family members are unstructured and informal. Typically, public defenders or attorneys for the Legal Aid Society representing the respondent construct the elements of the proposed settlement after talking to the respondent (usually the evening before the scheduled probable cause hearing), staff of Ward 53B of the Milwaukee County Mental Health Complex (e.g., psychiatrists, nurses, and attendants), social workers affiliated with the two public defender programs in Milwaukee, and, although less frequently, family members and petitioners. The operational question for the respondent's counsel in formulating the terms of the settlement, according to one public defender, is "What does my client want that the court will accept?" In other words, counsel's task is to translate the expressed wishes of the respondent into legal actions, options, and conditions acceptable to the court.

In formulating the elements of a proposed settlement, the respondent's counsel usually seeks and considers information gained about the respondent by mental health personnel on Ward 53B, especially that gained by the staff psychiatrist who conducts the initial mental health evaluation of the respondent. Public defenders visit Ward 53B almost daily and are quite familiar with the staff and the ward's daily routine. One indication of the accommodation of the public defenders into the daily routine of Ward 53B is that public defenders have their own keys to Ward 53B which is normally locked to other non-employees of the Mental Health Complex. Public defenders have ready access to the staff of 53B and to respondents' records available in the nurses' station. In formulating a settlement proposal the respondent's counsel considers past medical records when such histories are available. Corporation counsel may also consider medical histories and make independent inquiries with family members and acquaintances prior to accepting the proposal. Due to the short time that a respondent is in Ward 53B prior to the probable cause hearing, the availability of past

mental health records in Ward 53B is limited. When such information is available, both Ward 53B staff and the public defenders appear eager to use it to further the best interests of the respondent.

According to one Ward 53B psychiatrist, stipulated settlements are, as a rule, formulated in discussions between the respondent's counsel and the staff psychiatrist. This Ward 53B psychiatrist stated quite emphatically that the first concern in these discussions is always the best interest of the patient; legal matters are of secondary concern. Reportedly, disagreements between the psychiatrist and the respondents' attorneys are infrequent.

Typically, corporation counsel waits until a proposal for settlement is presented to him by the respondent's counsel. He makes few investigations of alternative arrangements before the respondent's counsel presents a proposed stipulated settlement. Once a proposed stipulated settlement is before corporation counsel, however, he may review the proposal with the Ward 53B psychiatrist and with members of the respondent's family to get their reaction to it. Corporation counsel might then accept the proposal as presented, negotiate modifications of conditions of the proposal, or reject the proposal outright and proceed to a probable cause hearing.

The negotiation and settlement process has been both criticized and praised. Critics argue that the negotiations and settlements tip the balance in involuntary civil commitment proceedings too much in favor of the respondent's liberty interests, that they compromise much needed treatment and care, that they ignore the community's interest in the treatment and care of mentally disturbed individuals, that they do not adequately take into account the interest of the respondent's family, and, finally, that they are nothing but a ruse perpetrated by attorneys of the two public defender programs in Milwaukee, a ruse to which corporation counsel is a willing accomplice. Another criticism of the negotiated settlement process, discussed at length in Chapter Five, is that the monitoring of a respondent's compliance with the terms and conditions of the negotiated settlement, usually some type of outpatient care, is inadequate.

Supporters of the negotiated settlement process state that it embodies the intents of the least restrictive alternative doctrine and the legislative policy of the SMHA (see Section 51.001). They argue that the negotiated settlement process serves to assure access to the least restrictive treatment alternative appropriate to the respondent's needs, that by avoiding prolonged and unnecessary judicial proceedings the process serves the community's and the court's interests by not imposing undue fiscal and administrative burdens, and that the process saves the considerable costs of unnecessary inpatient hospitalization.

Unfortunately, the debate about the merits of the negotiated settlement process has been largely devoted to arguing extremes. To buttress their positions, critics have cited apparently clear or "easy" cases that make very difficult issues, such as balancing the competing interests in the involuntary civil commitment process, appear easily resolvable. Proponents of the process have countered by finding equally

"easy" cases of clear success.[72] Valid criticism and praise of the negotiated settlement process have been largely obscured.

In general, we cannot find fault and can find much to praise in the negotiated settlement process. It appears to be an innovative and successful application of the least restrictive alternative doctrine insofar as it screens and diverts appropriate cases from involuntary civil commitment to voluntary inpatient and outpatient care and treatment. It has channeled the energies of attorneys, judges, and mental health personnel, previously devoted to litigious confrontation in the courts, to finding, investigating, and arguing the merits of mental health care and treatment alternatives. It is consistent with the national trend toward conciliation rather than litigious confrontation in involuntary civil commitment proceedings by emphasizing needed care and treatment (without rejecting the civil-libertarian concerns reflected in the SMHA), to promote cooperative efforts among the various components involved in the involuntary civil commitment process, and to recognize the flexibility and adaptability of commitment criteria to individual patient's situations.[73] In our opinion, which we have expressed previously,[74] the procedures involved in the negotiation and settlement of cases in Milwaukee County contains all the essential elements needed to balance the interests of the respondent, the respondent's family, the community, the court, and the taxpayer of Milwaukee County. Modifications of the negotiated settlement process in accordance with the improvements recommended below should serve to adequately balance these interests.

> <u>RECOMMENDATION 12</u>: (1) THE MENTAL HEALTH-LEGAL COMMUNITY IN MILWAUKEE COUNTY SHOULD GIVE THEIR SUPPORT TO THE GENERAL PROCESS OF THE NEGOTIATION AND SETTLEMENT OF APPROPRIATE INVOLUNTARY CIVIL COMMITMENT CASES.
>
> (2) THE FOLLOWING IMPROVEMENTS OF THE PROCESS SHOULD BE MADE: (a) INFORMATION OBTAINED FROM PETITIONERS AND FAMILIES OF RESPONDENTS SHOULD BE CONSIDERED IN EVERY NEGOTIATED SETTLEMENT; (b) PROPOSALS FOR NEGOTIATED SETTLEMENTS AND COURT-ORDERED VOLUNTARY (COV) AGREEMENTS SHOULD BE EVALUATED MORE THOROUGHLY, FIRST BY CORPORATION COUNSEL, AND THEN BY THE COURT; CORPORATION COUNSEL SHOULD BE PROVIDED ADEQUATE

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[72]See e.g., the case of Ruth related by N. Bernstein, <u>supra</u>, note 68.

[73]See e.g., Appelbaum, <u>supra</u>, note 4; Paschall, N., and Eichler, A. Rights promotion in the '80's. <u>Mental Disability Law Reporter</u>, 1982, <u>6</u> (2); and Institute, <u>supra</u>, note 23, at II-6.

[74]See Meeting Minutes, Subcommittee on Involuntary Civil Commitment Study, Task Force on Human Services and the Law, November 23, 1982.

RESOURCES FOR THIS PURPOSE; (c) POLICIES AND PROCEDURES SHOULD BE DEVELOPED FOR MONITORING COMPLIANCE, AND RESPONDING TO CASES OF NONCOMPLIANCE, WITH THE TERMS AND CONDITIONS OF NEGOTIATED SETTLEMENTS AND COURT-ORDERED VOLUNTARY (COV) AGREEMENTS; AND (d) A SYSTEM SHOULD BE ESTABLISHED SO THAT CURRENT INFORMATION IS READILY ACCESSIBLE FACILITIES AND PROGRAMS ABOUT COMMUNITY-BASED, LESS RESTRICTIVE TREATMENT AND THEIR WILLINGNESS AND CAPACITY TO ACCEPT INVOLUNTARY CIVIL COMMITMENT CASES DIVERTED FROM INPATIENT HOSPITALIZATION.

(Parts (2)(b) and (2)(c) of Recommendation 12 are discussed in detail in Chapter Five of this report.)

The adequacy of input by the respondent's family and acquaintances in developing a negotiated settlement, the focus of the first recommended improvement, can be questioned. Corporation counsel has neither the time nor the resources to take full advantage of the information about the respondent that can be acquired from family, friends, and acquaintances of the respondent. Access to information may be especially a problem in emergency detention cases. Unlike three-party petition cases, where the respondent's family and acquaintances acting as petitioners supply information, precious little information about a respondent's social and family situation, and past mental health history, may be available in emergency cases. And even when such information is available as a result of contacts which Ward 53B staff have with the respondent's family, corporation counsel may not have sufficient time to use this information into his review of the proposed negotiated settlement.

Understandably, a respondent's counsel is likely to devalue the interests of petitioners and family members relative to the interest of his or her client. A respondent's attorney is, therefore, not likely to agressively seek the input of petitioners and family members, and when the attorney does seek this information, he or she is likely to selectively screen or present information unfavorable to the proposed settlement in the light most favorable to the proposed settlement agreement. In brief, it appears that family members and petitioners do have access to and make input into the negotiated settlement process, but probably not enough. In our opinion, a better balancing of interests could be achieved by bringing petitioners and family members more into the arena in which negotiated settlements are made.

Compliance with the terms and conditions of negotiated settlements and COV agreements is a major concern in Milwaukee County. Many people we interviewed complained that monitoring and review of compliance, and mechanisms for appropriate responses to noncompliance, are inadequate. This complaint appears to be quite valid. Again, the solution to the problem appears to be that which there is precious little of, namely additional resources. Just as corporation counsel has little time to consider information provided by a respondent's family in determining whether to accept a negotiated settlement, he has few

resources to monitor compliance with the conditions of a negotiated settlement once it is approved by the court. Corporation counsel makes no independent review of compliance. Reportedly, community mental health resources are unavailable for the purposes of monitoring compliance and reporting noncompliance to corporation counsel. The "out stations" of the Milwaukee County Mental Health Complex are, reportedly, overbooked with long waiting lists for requested services. The only real check on compliance occurs when petitioners, members of the respondent's family, mental health professionals, or others in the community bring a respondent's failure to comply with the conditions of a negotiated settlement to the attention of the corporation counsel.

While additional resources available to the corporation counsel for monitoring, review, and follow-up of compliance may appear to be the only complete solution to the problem, a coordination and linking of existing services, and a modification of the legal proceedings to better accommodate the negotiated settlement process may provide partial solutions. (<u>These partial solutions are discussed in detail under the topic of compliance and the application of the least restrictive alternative doctrine in Chapter Five</u>.)

It is easy to decry the lack of community-based mental health services in Milwaukee, especially during periods of decreasing federal support. Many of the people we interviewed blame this lack for the deficiencies in the involuntary civil commitment process. Solutions that have been offered call for more of that which there is too little of--money. However, at the same time that we heard complaints of a lack of community resources, we were told that the focus on inpatient care at the Milwaukee County Mental Health Complex may have blinded mental health and legal personnel to community mental health services that actually are available. If the least restrictive alternative doctrine is to have any practical meaning in Milwaukee County, and we believe it should, then it is important for court officials (e.g., judges, probate court commissioners), attorneys, mental health personnel, social services personnel, and others involved in the involuntary civil commitment process to have access to current information about available facilities that are less restrictive than the Milwaukee County Mental Health Complex.

> <u>RECOMMENDATION 13</u>: (1) A COMPREHENSIVE GUIDE TO MENTAL HEALTH RESOURCES IN MILWAUKEE COUNTY SHOULD BE PREPARED FOR USE BY MEMBERS OF THE MENTAL HEALTH-LEGAL COMMUNITY IN MILWAUKEE COUNTY WHO ARE INVOLVED IN THE INVOLUNTARY CIVIL COMMITMENT PROCESS.
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> (2) THIS GUIDE SHOULD BE DESIGNED TO FURTHER THE APPLICATION OF THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE AND SHOULD INCLUDE THE FOLLOWING INFORMATION: (a) A COMPLETE LISTING OF PUBLIC, PRIVATE, NON-PROFIT, AND VOLUNTARY RESOURCES, AND THEIR LOCATIONS, SERVING MENTALLY ILL PERSONS; (b) A SHORT DESCRIPTION OF THE TYPE OF SERVICES OFFERED BY EACH RESOURCE LISTED; (c) A BRIEF HISTORY OF SERVICES, IF ANY, PROVIDED TO PERSONS

INVOLVED IN INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS; AND (d) THE SERVICE CAPACITY OF EACH RESOURCE INCLUDING: (i) STAFF, (ii) BED CAPACITY, AND (iii) FISCAL ARRANGEMENTS FOR CLIENTS.

(3) THE GUIDE SHOULD BE UPDATED REGULARLY BY THE PLANNING COUNCIL FOR MENTAL HEALTH SERVICES, THE MENTAL HEALTH ASSOCIATION IN MILWAUKEE COUNTY, OR SOME OTHER APPROPRIATE AGENCY OR AGENCIES.

The development and preparation of the proposed guide is the first important step in the establishment of a system proposed in part (2)(d) of the previous recommendation that would make information of less restrictive alternatives available to those who need it. A brochure entitled "Guide to Mental Health Resources in Milwaukee County," recently compiled by the Mental Health Association in Milwaukee County, respresents an approximation of the proposed guide. It lists close to 50 agencies in the mental health care system in Milwaukee County, provides a short description of the services provided, and lists fees, if any, for services provided. Another comprehensive guide, titled Human Services Resource Directory for the Greater Milwaukee Area and compiled by the United Way of Greater Milwaukee in 1980, represents another product similar to the guide recommended above. A major shortcoming of the United Way guide is that it is apparently compiled once every two years and is outdated shortly thereafter for any other purposes other than general reference.

If recommendation 13 is implemented, the guide developed by the Mental Health Association and United Way of Greater Milwaukee should definitely be used as a starting point and reference. The guide need not be produced at great cost. Inexpensive and expedient reproduction of the guide should facilitate regular updating, printing, and dissemination. The proposed guide should be advertised as a working reference to all those in the mental health-legal community involved in the involuntary civil commitment process.

Although reviewers of the last two recommendations were generally supportive of their intent of improving the involuntary civil commitment process, they raised two concerns that should be noted. Both concerns pertain, to a greater or less extent, to subsequent recommendations in this report as well. The first concern is about the cost of implementing the recommendations. Although we have tried to be as sensitive as possible to the fiscal ramifications of our recommendations and have attempted to balance economy with equity, effectiveness, and efficiency in the procedures that we have recommended, we openly acknowledge our relative naivete about the complex fiscal considerations of the many agencies involved in the involuntary civil commitment process in Milwaukee County. We must, therefore, defer to the Planning Council for Mental Health and Social Services and the Subcommittee on Involuntary Civil Commitment Study (of the Task Force on Human Services and the Law) to whom we submit this final report to provide whatever guidance may be necessary to address specific concerns about costs associated with the implementation of recommendations in this report.

We must, as a matter of necessity, respond in similar fashion to a second concern expressed by reviewers about Recommendations 12 and 13 and other recommendations that follow. Several reviewers raised concerns about our identifications of specific agencies to implement recommendations. Unfortunately, reviewers expressed differing opinions about the appropriateness of identifying specific agencies to perform specific duties or assume specific responsibilities. One reviewer, perhaps appropriately so, doubted that we have gained sufficient knowledge about the broad array of community agencies and their specific capabilities to be able to designate one or even a few to implement a recommendation. On the other hand, another reviewer urged us to "provide leadership by identifying services of agencies who need to take the task in hand and implement [the recommendations]." We have not attempted to resolve this disagreement in this report. We do not profess to have even a working knowledge of the many public, private, non-profit, and voluntary mental health resources in Milwaukee County. When we have been able, albeit in a very general way, to identify an agency or group that appears to be a likely candidate for involvement in the implementation of a recommendation, we have not hesitated to mention it in connection with a particular recommendation. We feel compelled to convey the best information that we have, fully recognizing that it may be incomplete. Again, we must defer to the Planning Council and the Subcommittee to provide futher guidance in this matter.

CHAPTER FIVE

JUDICIAL PROCEEDINGS

PROBABLE CAUSE HEARINGS

The State Mental Health Act provides respondents with a right to a judicial hearing to determine probable cause for commitment (51.20(7)). If a respondent is detained, a probable cause hearing must be held within 72 hours after the respondent's arrival on Ward 53B, excluding Saturdays, Sundays, and legal holidays (51.20(7)(a)). If the respondent is not detained pending the probable cause hearing, a rare occurrence in Milwaukee County, a hearing is held "within a reasonable time of the filing of the petition" (51.20(7)(b)). As mentioned in the brief overview of involuntary civil commitment in Wisconsin in Chapter One, the probable cause hearing, and all other judicial hearings required under the State Mental Health Act, must conform to the essentials of due process, including the rights to an open hearing, to request a closed hearing, to counsel, to present and cross-examine witnesses, and to remain silent during the proceedings (51.20(5)). A court commissioner from the probate division of the circuit court presides at Milwaukee County probable cause hearings.

Probable cause hearings are held in a conference room on Ward 53B arranged to accommodate these hearings. The probate court commissioner typically sits at the center of a large, rectangular table facing the respondent and his or her counsel, who are sitting at a smaller table opposite the commissioner. Corporation counsel and a court stenographer sit at opposite ends of the court commissioner's table. Folding chairs have been placed at the sides of the conference room to accommodate witnesses, the court laison officer, and observers.

The commissioner must make two primary decisions during each hearing: whether there is probable cause for commitment and whether the respondent should be detained in Ward 53B while the final commitment hearing is pending. If the commissioner determines that no probable cause to believe the allegations exists, he may dismiss the proceedings (51.20(7)(e)). If the commissioner finds no probable cause to justify involuntary civil commitment, but instead finds probable cause to believe that the respondent is a fit subject for guardianship and protective placement or services, he may proceed as if the petition or application for emergency detention had been made for guardianship and protective placement or services as authorized by Chapter 55 (51.20(7)(d)). If the commissioner finds probable cause, however, he schedules a final commitment hearing within 14 days from the time the respondent was detained, unless the respondent or his or her counsel has already requested a postponment of the probable cause hearing (51.20(7)(b)) or requests a jury for the final commitment hearing (51.20(7)(c) and (11)(a)). The commissioner can release the respondent from Ward 53B pending the full commitment hearing and may issue an order stating the conditions under which the respondent is released (51.20(8)). Of course, as discussed at length in the previous chapter, the case may be held open and the probable cause hearing postponed if the parties agree to a voluntary admission or some type of outpatient treatment by way of a

stipulated settlement. (Recommendations and discussion about the commissioner's review and evaluation of proposals for negotiated settlements and court-ordered voluntary (COV) agreements appear in Chapter Four and later in this chapter.)

Patients' Rights and Privileges

The State Mental Health Act gives respondents certain rights and privileges (see 51.61), among them the right to wear their own clothes (51.61(1)(q)) and to see visitors each day (51.61(1)(t)). While we do not suggest that these rights of Ward 53B respondents have been violated, we do believe that Ward 53B personnel, attorneys, and the probate court commissioner presiding at the probable cause hearing should be more sensitive to the realization of these rights in two situations. First, in our observations of several probable cause hearings, we observed four respondents entering the conference room in Ward 53B wearing only hospital gowns. One respondent wore no shoes. Of course, all others in attendance at the probable cause hearings (i.e, attorneys, witnesses, court personnel, and spectators) were attired in keeping with the solemnity of the probable cause hearings. Although, strictly speaking, the right of respondents to wear their own clothes does not impose a duty on 53B staff to provide each respondent with street clothes to wear at hearings, it would be beneficial for 53B staff to do so. Wearing a hospital gown is an implicit affirmation of a respondent's "committability" and is inconsistent with the decorum of a judicial proceeding.

RECOMMENDATION 14: (1) WARD 53B STAFF AND ATTORNEYS BEFORE ALL PROBABLE CAUSE HEARINGS SHOULD ASK RESPONDENTS IF THEY WISH TO WEAR THEIR OWN CLOTHES AT THE PROBABLE CAUSE HEARING.

(2) IF THE RESPONDENT WISHES TO WEAR STREET CLOTHES BUT HAS NO PERSONAL CLOTHES TO WEAR, WARD 53B STAFF SHOULD ENDEAVOR WHENEVER POSSIBLE TO SECURE APPROPRIATE STREET CLOTHING FOR THE RESPONDENT.

The second situation involves respondents' rights to see visitors daily. Visiting hours on Ward 53B are daily from 11 a.m. to 8 p.m. Strict adherence to these visiting hours causes hardships for respondents and family members who may have participated in probable cause hearings ending before official visiting hours commence. A long gap between the end of a hearing and the beginning of visiting hours may force respondents and their family members to be apart during what may be an extremely emotional time. This may be especially frustrating for family members who have traveled long distances to appear at a probable cause hearing only to find that the matter is settled within a few short minutes and they must wait for up to two hours to visit with the respondent.

RECOMMENDATION 15: WARD 53B VISITING HOURS SHOULD BE MODIFIED TO ALLOW RESPONDENTS TO MEET WITH THEIR FAMILY MEMBERS AND FRIENDS AT THE CONCLUSION OF THE PROBABLE CAUSE HEARING.

In their review of Recommendation 14 and 15 in draft form, two spokespersons for the Milwaukee County Mental Health Complex indicated that procedural changes were made in the Fall of 1982 in accordance with these two recommendations. One of the reviewers stated that 99% of the patients wear their own clothes. Presumably, he was speaking of Ward 53B detainees. Another spokesperson for the Mental Health Center stated that family members and friends are definitely allowed to visit with patients at the conclusion of the probable cause hearing. He indicated that a visiting room has been made available if Ward 53B may be inappropriate for visitation at the time. A registered nurse, designated as the Family Contact Coordinator, reportedly briefs families on the hearing process and visitation procedures.

Is There a Need for a Probable Cause Hearing?

The SMHA provides the individual facing involuntary civil commitment with opportunities to test the allegations against him or her in three separate judicial hearings: a probable cause hearing (51.20(7)), a final hearing (51.20(10)), and a review hearing for continued commitment (51.20(13)(g)). Several members of the mental health-legal community in Milwaukee County question the need for probable cause hearings.[75] The probable cause hearing is another example, they argue, of a cumbersome, onerous, and expensive legal procedure that is unnecessary because there are other sufficient checks on the validity of procedures affecting the respondent both before and after the probable cause hearing. At least one mental health professional[76] advocates the elimination of the probable cause hearing, and the shortening of the required time between detention and the final commitment hearing.

Like most states,[77] Wisconsin law mandates a judicial hearing before an individual may be committed involuntarily for an extended period of time. Whether respondents should have a right to a probable cause hearing in involuntary civil commitment proceedings has been addressed by a number of federal and state courts.[78] A majority of these courts implicitly acknowledge the desirability, if not the practicality, of a probable cause hearing before the respondent is taken into custody and involuntarily committed, but grapple primarily with the arguments for and against a probable cause hearing after the respondent has already been taken to a hospital against his or her will. The issue in practice, thus, is how long can a person be involuntarily detained prior to a judicial hearing.

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[75]See also, Gerhardstein, supra, note 13.

[76]Id.

[77]Institute, supra, note 23, at IV-6.

[78]See e.g., Doe v. Gallinot, 657 F. 2d 1017 (1981); see also, generally, Institute, supra, note 23, at Part IV, Chapter One; and Los Angeles, supra, note 16, Chapter IV.

Determining how much time should elapse before a hearing is required involves balancing several considerations. On the one hand is the respondent's interest in being released quickly if custody by law enforcement officials and subsequent detention is unjustified. On the other is a need for a sufficient period of time for the respondent to be properly examined and for the parties in the proceedings to adequately prepare. If prehearing treatment is refused, there is the additional concern of authorizing needed treatment expeditiously in emergency situations or of otherwise providing, care, comfort, and secure shelter to a respondent who has refused treatment. When prehearing treatment is permitted, there is the countervailing factor of giving the respondent an opportunity to recover without incurring a record, or perhaps the stigma of an involuntary commitment.

Eliminating a mandatory probable cause hearing and shortening the time before a "full" commitment hearing may appear to be an attractive proposition very much in the interests of economy and efficiency. Indeed, federal courts have been increasingly more willing to balance the liberty interests of the individual against legitimate state interests in efficiency and economy.[79] As attractive as eliminating the probable cause hearing altogether may appear, we do not recommend such a change at this time.

No ideal balance among the often competing interests of the individual, the family, and the state can be achieved. The postponement of a judicial review of the validity of detention, even from 72 hours to five or seven days, a possible time frame if only a single judicial hearing is used, may be difficult to implement. In the abstract, few of us would place economy, efficiency, and expediency above liberty. Given that a substantial deprivation of liberty that can not be justified without a judicial review, it is difficult to retreat from that stand in the interests of saving time, money, and other resources. In theory, we would favor the elimination of the probable cause hearing requirement in the SMHA and its replacement with a requirement of only one judicial hearing at the end of five days. However, we do not recommend such a change in Milwaukee County at this time for several practical reasons.

Our recommendations for simplified hearing procedures in other jurisidictions[80] were met with great resistance. In Columbus, Ohio, for example, the majority of the individuals we interviewed--judges, referees, attorneys, and mental health personnel alike--were in favor of discontinuing the practice of automatic probable cause hearings in commitment cases. Importantly, the elimination of probable cause

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[79]See e.g., Parham v. J.R., 442 U.S. 599-600 (1979); Vitek v. Jones, 445 U.S. 496 (1980); Doe v. Gallino , supra, note 78, at 1024; Youngberg v. Romeo, 50 U.S.L.W. 476, 4685 (1982).

[80]Keilitz, I. Involuntary Civil Commitment in Columbus, Ohio. Williamsburg, Virginia: National Center for State Courts, 1982, 73-77, 84-86 (hereafter Columbus); also, Los Angeles, supra, note 16, at 43-50.

hearings and the shortening of the time requirement for full commitment hearings required no change in the Ohio law. Such a change in the hearing requirements in Wisconsin would necessitate revision of the SMHA. Yet, the interests of liberty held the day in Columbus. One attorney in Columbus, acknowledging the expense of conducting probable cause hearings, nonetheless argued strongly that the price paid is worth the check against a "massive curtailment of liberty." In short, in the opinion of this attorney, any increase in the time of detention without judicial review constitutes a substantial deprivation of liberty to be avoided if at all possible. Given what we considered to be a favorable climate for change in Columbus, and given that a change in Columbus would have required no legislative reform, we see little chance of success in changing the hearing requirements in Wisconsin. As we will discuss later in this chapter, we believe that the resources of the mental health-legal community in Milwaukee County should be channeled into improvements of practices under the current requirements of the State Mental Health Act rather than into legislative reform.[81]

> <u>RECOMMENDATION 16</u>: WITHIN THE FRAMEWORK OF THE STATE MENTAL HEALTH ACT FOR PROBABLE CAUSE HEARING REQUIREMENTS, MEMBERS OF THE MENTAL HEALTH-LEGAL COMMUNITY IN MILWAUKEE COUNTY SHOULD STRIVE TO ACHIEVE A PROPER, ACCEPTABLE BALANCE AMONG THE COMPLEX AND COMPETING INTERESTS OF THE RESPONDENT, THE FAMILY, AND THE STATE IN INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS. LEGISLATIVE REFORM TO CHANGE THE PROBABLE CAUSE HEARING REQUIREMENTS IN WISCONSIN IS NOT RECOMMENDED AT THIS TIME.

The above recommendation is based upon two additional practical considerations. First, the elimination of the probable cause hearing would remove the legal means for review, evaluation, and approval or rejection of negotiated settlements. Whether an alternative procedure for judicial review of proposals for negotiated settlements would be less cumbersome than the present probable cause hearing is questionable. Second, it is likely that the elimination of the probable cause hearing may engender an over-reliance on formal litigious procedures during the final commitment hearing. We would not consider this a favorable development.

At least two reviewers of Recommendation 16 registered disappointment that the recommendation and supporting commentary seemed to preclude further study of the possibility of a statutory change of the "complex two-stage hearing process" in Milwaukee County. One reviewer approved of the major thrust of Recommendation 16--that the mental health-legal community in Milwaukee County concentrate on making the present system work--but he thought it unwise to give up entirely on

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[81]We do not wish to discourage efforts at legal reform altogether. Recommendations for simplified hearing procedures in Columbus, Ohio and Los Angeles could be used as starting points for similar reform in Wisconsin. <u>Id</u>.

efforts to try to simplify the statutory framework. He stated that the present hearing system created difficult time constraints and the need for double appearances by lawyers, witnesses, and examiners. Another reviewer stated that Recommendation 16 should be considered on its merits and not on its probable chances of success. The urgings of these reviewers to study the possibility of legislative reform to change the probable cause hearing requirements in Wisconsin should be given some consideration. While we hold strongly to our belief that legislative reform in this area is less likely to achieve the end of reducing burdensome complexity and costs in the hearing procedures, Recommendation 16 focuses on the present and should not be considered an all-or-nothing proposition. Indeed, the channeling of at least some energies of the mental health-legal community in Milwaukee County into exploration of legislative reform in this area may prove useful.

PREHEARING MENTAL HEALTH EXAMINATION

After a probable cause hearing in which the commissioner has found probable cause to believe the allegations that the respondent is a proper subject for involuntary commitment, two examiners are appointed to personally examine the respondent. The SMHA lists the various licensed professionals who may qualify as examiners (51.20(9)(a)). In Milwaukee County, the examiners are usually a psychologist and a psychiatrist appointed, from a roster published annually, to examine all respondents who will have final commitment hearings in a given week. A respondent may select one of the examiners if he or she informs the court of his or her selection within 24 hours after the probable cause hearing (51.20(9)(a)). The court may deny to appoint the respondent's selected examiner if that examiner is unavailable or does not qualify under statutory requirements. Finally, the respondent may secure an additional examiner and may offer that examiner's testimony as evidence at the final hearing (51.20(9)(a)).

Each examiner conducts an independent examination of each respondent. Because respondents who do not agree to stipulated settlements generally remain in custody following a probable cause hearing, the examinations usually take place at Ward 53B of the Milwaukee County Mental Health Complex. When an examiner arrives at the ward to conduct an examination, he or she picks up an examination form at the nurses' station (see Appendix A, pp. 38-41). He or she then fills out this form either during or after the examination. One examiner we interviewed stated that he may, but usually does not, conduct a more thorough examination than the form requires. Reportedly, examiners often consult the respondent's medical chart and Ward 53B staff in forming an opinion regarding the respondent's condition.

At the start of the examination, the examiner informs the respondent that his or her statements may be used as a basis for commitment and that he or she has the right to remain silent as required by the SMHA (51.20(9)(a)). If the examiner determines that the respondent meets commitment criteria, the examiner is required by the State Mental Health Act to indicate on the form recommendations concerning the least restrictive level of treatment appropriate for the

respondent. The completed examination form is filed with the Commissioner in Probate.[82]

Although statute requires that the examiners file independent reports of their examinations with the court (51.20(9)(a)), it does not require that the examiners actually testify at the final hearing. If the examiners do testify, however, each should testify concerning his or her belief as to whether the respondent meets commitment criteria and as to the appropriateness of various treatment modalities or facilities (51.20(9)). Each examiner's beliefs should be based on "a reasonable degree of medical certainty," if the examiner is a psychiarist, or on "a reasonable degree of professional certainty," if the examiner is a psychologist (51.20(9)). If either examiner is unable to reach a conclusion with the required degree of certainty, he or she should so state (51.20(9)).

The examiners appointed in Milwaukee County generally do testify at final hearings. Their testimony during the hearings we observed will be discussed below.

FINAL COMMITMENT HEARINGS

The Setting and the Participants

Section 51.20(5) of the SMHA authorizes court hearings to be held at the institution at which a respondent is detained, unless the respondent or his or her attorney objects. As mentioned above, probable cause hearings in Milwaukee County are generally held in Ward 53B. Final commitment hearings, on the other hand, are held in Room 1032 of the Milwaukee County Mental Health Complex. Room 1032 provides a relatively formal setting appropriate for the solemnity of the final hearing process. At the front of the room is a table at which the presiding judge sits. Testifying witnesses sit to the judge's left and the court reporter, against the side wall. Near the front on opposite sides of the aisle are tables for corporation counsel and for the respondent and his or her counsel. Near the back door is a table for the Mental Health Complex court liaison officer, who functions as bailiff. On either side of the aisle are rows of chairs for other participants and observers.

Final hearings are scheduled for each Friday at 8:30 a.m., but usually begin about 9:00 a.m.. Hearings are open to the public unless the respondent, or his or her attorney acting with the respondent's consent, requests that the hearing be closed (51.20(12)). Reportedly, closed hearings are rarely requested.

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[82] Although we were able to observe several initial examinations of Ward 53B detainees conducted by a Ward 53B psychiatrist (see Chapter Three), and although we did interview two examiners who frequently conduct prehearing examinations in Milwaukee County, we were, unfortunately, unable to observe examinations conducted by court-appointed examiners.

Whenever a probable cause hearing has resulted in a finding of probable cause to believe the allegations in a three-party petition, or in a police officer's statement of emergency detention (together with any treatment director's supplement filed) (see Appendix A, pp. 5-6), the court must schedule a final hearing within 14 days from the time of detention (51.20(7)(c)). In Milwaukee County, the Commissioner in Probate meets this time requirement by scheduling a final hearing on the Friday of the next week after the probable cause hearing.

Before discussing how the hearing itself is conducted in Milwaukee County, it is worthwhile to mention a few miscellaneous, yet important, statutory rules which are relevant. First, within a reasonable time before the hearing, corporation counsel must notify the respondent and his or her attorney of persons who may testify in favor of commitment, and of the time and place of the final hearing (51.20(10)(a)). The court may designate additional persons to be notified of the time and place of the hearing (51.20(10)(a)). At least 48 hours prior to the final hearing, the respondent's counsel must also be given access to all psychiatric and other reports (51.20(10)(b)). Secondly, the hearings must conform to the essentials of due process and fairness (51.20(5)); as a general matter, the rules of evidence used in other civil proceedings apply to civil commitment hearings (51.20(10)(c)). In addition, the SMHA was recently amended to include a "harmless error rule" requiring that the court may "disregard any error or defect in the pleadings or proceedings that does not affect the substantial rights of either party" (51.20(10)(c)). Thirdly, corporation counsel has the burden or proving all required facts by "clear and convincing evidence" (51.20(13)(e)). Finally, the respondent has a right to a jury to determine if the allegations in the petition or the statement of emergency detention are true (51.20(11)). The respondent, or his or her counsel if the respondent does not object, must demand a jury at least 48 hours prior to the hearing or a jury trial is deemed waived, provided the respondent or his or her counsel has notice of this time requirement (51.20(11)(a)). After a timely demand for a jury trial, the court must direct that a jury of six people be drawn (51.20(11)(a)). If a jury trial demand is made within five days of detention, the final hearing will not be delayed and must be held within 14 days of detention. If the demand is made after five days, however, the final hearing may be delayed but must be held within 14 days from the date of the demand (51.20(11)(a)). At least five of the six jurors must agree to a verdict before the verdict will be valid (51.20(11)(b)).

Each final hearing at Room 1032 begins when the clerk announces the case. The parties then present and cross-examine witnesses. Witnesses typically called by the parties during final hearings include the examiners appointed under Section 51.20(9) (usually a psychiatrist and a psychologist), the police officer(s) who effected an emergency detention or the petitioners who signed a three-party petition, Crisis Intervention Service counselors, and the respondent.

Counsel for the Respondent

In all of the final hearings which we observed, the respondents were represented by attorneys from the private bar -- no attorneys from the two public defender programs in Milwaukee County were involved. Far more cases in which respondents are represented by private counsel reach the final hearing stage than do cases in which respondents are represented by attorneys of the State Public Defender's Office or Legal Aid Society attorneys. Reportedly, attorneys from the private bar prevail at the probable cause hearing in far fewer cases and settle far fewer cases prior to final hearing. Of cases which reach final hearings, the majority result in commitment.[83]

Interviewees offered two primary reasons why private attorneys settle or prevail in fewer cases. First, private attorneys are generally less experienced in substantive, procedural, and tactical matters concerning the involuntary civil commitment process. Private attorneys are appointed to represent a total of approximately 15 percent of all civil commitment respondents in Milwaukee. They are appointed by the State Public Defender's Office from a list of about 200 names. Thus, each attorney is appointed to no more than one or two cases each year. The second reason offered was that private attorneys have not had the assistances of social workers which both the Public Defender's Office and the Legal Aid Society have had. This assistance is invaluable in the development of less restrictive treatment alternatives to hospitalization that are proposed in negotiated settlement of cases prior to the final commitment hearing (see Chapter Four).

The concern that private attorneys are often inexperienced because of the infrequency of their involvement in civil commitment cases is a concern which people in Milwaukee share with people in other cities where we have studied civil commitment processes. One response to this pervasive problem is to establish prerequisites to initial appointment and continued inclusion on the list of private attorneys from which counsel for commitment respondents are appointed. Effective prerequisites are an orientation program and a continuing education program for potential respondents' counsel.[84]

The content and operation of such an educational program should preferably be a joint effort of the judiciary, the local bar, and the public (e.g., under the authority of the Combined Community Services Board in Milwaukee County; see 51.42(5)(d), (e), and (f)) and private mental health system). Precisely who or what organization should be primarily responsible for coordinating the program is an open question. One practical and one conceptual reason suggest that the State Office of the Public Defender assume this responsibility: (1) it has the requisite experience in representing respondents in Milwaukee County and it

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[83]See e.g., Bernstein, N. Commitments: Law is working. The Milwaukee Journal, February 21, 1982 (during 1981, 155 cases reached final hearing; 151 resulted in commitment).

[84]Institute, supra, note 23, at III-8.

currently bears the responsibility of maintaining, and selecting from, a list of members of the private bar who would be willing to represent respondents in involuntary civil commitmnet cases; and (2) it is the one organizational component of the mental health-judicial system in Milwaukee County best equipped to communicate the role of counsel as an adversary and counselor (this role is discussed further below). Regardless of who has the primary responsibility for coordinating the program, the various components of the mental health-judicial system in Milwaukee County should contribute to its content: the State Public Defender's Office, the Legal Aid Society of Milwaukee, Inc., the Milwaukee Bar Association, the Milwaukee County Mental Health Complex, and the Probate Court.

The initial orientation might be as simple as a one-to-one or group meeting between a probate judge or commissioner and potential appointees to discuss the role and functions of respondents' counsel in civil commitment proceedings. Similarly, the State Public Defender's Office in Milwaukee or the Legal Aid Society might conduct a seminar to initiate the orientation program. The seminar might be videotaped or audiotaped for presentation to attorneys subsequently added to the appointment list. Continuing education requirements might also be met by use of tapes of periodic seminars.

The overriding purpose of such an educational program is to ensure that respondents represented by private counsel have a fair opportunity to protect their liberty interests yet still get the mental health treatment they need in accordance with the substantive and procedural provisions of the SMHA.[85] The furtherance of this purpose requires that respondents' counsel understand their functions as advocates and counselors within the civil commitment context. Counsel should understand these functions not only on a conceptual level, but also on a practical level. The conceptual understanding should be addressed during the initial orientation and may require input from the various components of the mental health-judicial system in Milwaukee County mentioned earlier. The practical understanding should be addressed in both the initial and the continuing education programs. This would require input from the legal community, but also from the mental health treatment providers in Milwaukee County. When requested by the coordinator of the program, treatment providers should provide information concerning the types of services and treatment they provide. The legal community should provide information concerning the mechanics of the formal and informal proceedings. Materials throughout this report might also be helpful to the program coordinator in structuring such a program.

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[85] Our suggestions only generally reflect the proper content of such an educational program; a coordinator, in cooperation with the legal and mental health communities in Milwaukee County, should provide details.

RECOMMENDATION 17: (1) AS PREREQUISITES TO INITIAL AND CONTINUED INCLUSION ON THE LIST OF PRIVATE ATTORNEYS WHO ARE POTENTIAL APPOINTEES AS RESPONDENTS' COUNSEL, ATTORNEYS SHOULD BE REQUIRED TO PARTICIPATE IN AN ORIENTATION AND CONTINUING EDUCATION PROGRAM.

(2) THIS PROGRAM SHOULD BE A COOPERATIVE EFFORT AMONG THE COMPONENTS OF THE LEGAL AND MENTAL HEALTH COMMUNITY IN MILWAUKEE COUNTY. THE STATE PUBLIC DEFENDER'S OFFICE, THE MILWAUKEE BAR ASSOCIATION, THE PROBATE COURT, THE LEGAL AID SOCIETY, OR ANOTHER APPROPRIATE ENTITY IN MILWAUKEE SHOULD COORDINATE THE PROGRAM.

(3) THIS PROGRAM SHOULD SEEK TO INFORM ATTORNEYS REGARDING THE CIVIL COMMITMENT PROCESS IN MILWAUKEE COUNTY AND OF THEIR ROLE AND FUNCTION IN IT.

The Supreme Court of Wisconsin has held that counsel appointed in civil commitment proceedings have the same function, duties, and responsibilities as retained counsel in any civil proceeding.[86] Specifically, both statute and case law in Wisconsin require that respondents' counsel be "adversary counsel." Counsel's duties and responsibilities are set forth in the Code of Professional Responsibility.[87] Thus, a respondent's attorney should function as both an advocate and a counselor for his or her client. As one attorney we interviewed in Milwaukee stated, a respondent's attorney should advocate his or her client's wishes regarding the outcome of a civil commitment case, and should never deviate from those wishes. The interviewee also stated that a respondent's attorney has a duty as a counselor to try to influence a client's wishes when it is in the client's best interests. This dichotomous role is one which attorneys generally assume in other types of cases. An educational program tailored to the involuntary civil commitment process in Milwaukee County should help private attorneys to better fulfill that role in commitment cases.

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[86]State ex rel Memmel v. Mundy, 75 Wis. 2d 276, 249 N.W. 2d 573, 577 (1977); see also, 51.20(3).

[87]Id., Memmel, 249 N.W. 2d, at 577.

The Questions: Committability[88] and Treatment

Matters of Law. The commitment court must answer two separable, if not distinct, questions at the final hearing: (1) whether the respondent is committable, that is, whether he or she meets Chapter 51 commitment criteria, and (2) if the respondent is committable, what is the least restrictive treatment alternative sufficient given the respondent's condition. Although statutes in many states do not require judges to consider treatment alternatives less restrictive than involuntary hospitalization, many judges do; as a practical matter, they view less restrictive alternatives as a threshold concern of the question of committability.[89] In some jurisdictions, less restrictive alternatives may be viewed as a threshold question to committability; that is, if a treatment program less restrictive than involuntary hospitalization is appropriate, commitment may not be ordered.[90] This is not the law in Wisconsin. In Wisconsin, the least restrictive alternative is not a threshold question, but is a prime consideration in the placement and treatment decisions to be addressed in the court's final commitment order; that is, a respondent's commitment must be to the least restrictive program that is appropriate. Section 51.20(13)(a)3 of the SMHA expressly provides that if the court determines that a respondent is committable and, "if inpatient care is not required, [the court shall] order commitment to outpatient treatment..." (emphasis added). Indeed, the overriding legislative policy of the SMHA is to protect personal liberty by requiring that "no person who can be treated adequately outside of a hospital, institution or other inpatient facility may be involuntarily treated in such a facility," (51.001(2)). Thus, in Wisconsin, what care and treatment are sufficient given a respondent's condition is the second, but not the first, question to be addressed by the court.

The first question is whether the respondent is, in fact, committable. Before a commitment court finds a respondent to be a fit subject for involuntary commitment, the attorney respresenting the state must prove by clear and convincing evidence (51.20(13)(e)) that the respondent meets commitment criteria as articulated in Section 51.20(1)(a) (see 51.20(13)(a)3.). These commitment criteria differ in several respects from the threshold criteria applied by police officers in determining whether an emergency detention is proper (see 51.15(1)(a)

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[88]We use the neologism "committability" not for want of more established words but to emphasize the important distinction between the two questions posed in final commitment hearings.

[89]See e.g., Fitch, W. L., McGraw, B. D., Hendryx, J., and, Marvell, T.B. Involuntary Civil Commitment in the First Judicial Department, New York City. National Center for State Courts: Williamsburg, Virginia, 1982, at 57 (hereafter New York City).

[90]See, generally, Hoffman, P. B., and Foust, L. F. Least restrictive treatment of the mentally ill: A doctrine in search of its senses. San Diego Law Review, 1977, 14 (5), 1100-1154; also see Institute, supra, note 23, at V-11 to V-14.

and (b)) and, to a lesser extent, they differ from the criteria applied by the Commissioner in Probate in determining probable cause (see 51.20(1)(1m)). To order commitment, the court must find that the respondent is (1) mentally ill, drug dependent, or developmentally disabled, (2) a proper subject for treatment, and (3) dangerous. Before taking a person into emergency detention, however, police officers need not have cause to believe that the person is a proper subject for treatment or that he or she is dangerous. Dangerousness is, essentially, a legal conclusion the commitment court draws from one of four types of fact situations defined in Section 51.20(1)(a)2.[91] In other words, although police officers are not required to form a conclusory opinion that a person is "dangerous" before detaining the person, they must only have cause to believe that one of four similar types of fact situations exists (see 51.15(a)).

The main elements of the fact situations to be addressed by the court (and by the police) may be summarized in general as: (1) a substantial probability of harm, (2) to either the respondent or some other person, (3) which is manifested either by a recent act or omission, or by a "pattern" of recent acts or omissions.[92] Many intricate distinctions exist between each of the fact situations to be addressed by the commitment court. We will not attempt to dissect them here. The point is that "dangerousness" is not a fixed standard. Its meaning may vary depending primarily upon the type of harm which may result from a respondent's condition and upon whether the respondent or some other person might suffer that harm.

<u>Procedures</u>. In our opinion, it is essential that the final hearing court distinguish the questions of committability and treatment. During the final hearings which we observed, it was apparent that these questions were not independently considered. The question of alternative treatment modalities in particular was not sufficiently, if at all, considered. The court, and the parties, seemed to presume that if a particular respondent were to be committed, he or she would be committed to inpatient treatment at the Milwaukee County Mental Health Complex. Such a presumption is not surprising given that the "stipulated settlement" process has resulted in most respondents being diverted at the probable cause hearing to less restrictive care treatment (see Chapter Four).

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[91]In a petition for non-emergency involuntary commitment, dangerousness is alleged by the three individuals signing the petition.

[92]The primary way in which the "commitment" fact situations differ from the "emergency detention" fact situations is that the last two commitment situations require "acts or omissions" (51.20(1)(a)2.c. and d.), whereas the comparable emergency detention situations require only "an act or omission" (51.15(1)(a)3. and 4.). The less stringent emergency detention standard allows police officers to take a person into custody, and thereby mitigate an emergency, in situations which may not permit a commitment under the more strict commitment standard. Similarly, the commitment standard in 51.20(1)(a)2.c. is relaxed at the probable cause hearing and would allow the Commissioner in Probate to find probable cause upon a showing of only one "act or omission" (51.20(1m)).

It is reasonable to speculate that if a respondent has not been diverted by means of voluntary admission or a stipulated settlement, a higher probability exists that the respondent is not a proper subject for treatment less restrictive than hospitalization. From a legal perspective, however, such speculation is not a proper working presumption in a final commitment hearing. The effect of such a presumption is to make commitment synonymous with hospitalization. The definition of commitment in the SMHA, however, is much more broad. Even at the final hearing, after unsuccessful settlement negotiations, a respondent in Wisconsin is entitled to commitment in the least restrictive alternative sufficient to meet his or her treatment needs (see 51.20(13)(a)3 and (c)2; and 51.001(1) and (2)).

Regardless of whether the court and the parties, in fact, held this presumption, the questions of committability and treatment lost their independent significance in the hearings we observed. The discreteness of these two questions can be lost when the evidence presented concerning each is mixed with the presentation of evidence concerning the other. This was most apparent in the corporation counsel's presentation of expert witnesses. The expert testimony presented was that of the psychiatrist and psychologist appointed to examine the respondents 51.20(9). When each examiner was testifying, corporation counsel asked the examiner's opinion concerning whether the respondent was dangerous, whether the respondent was a proper subject for treatment, and whether the examiner recommended the Milwaukee County Mental Health Complex as the proper facility for treatment of the respondent. Obviously, the first two questions address committability and the last addresses treatment. This is but one example of the mixing of the committability and treatment issues which we observed that may create not merely confusion of the issues, but also may create the possibility that a respondent might be found "committable" because he or she needs treatment and not because he or she meets the commitment criteria.[93]

To reduce the confusion of these questions, the court should require that the presentation of evidence regarding the appropriate treatment disposition be minimized until after a finding that the respondent meets commitment criteria. Each final hearing should, thus, consist of two phases. First, the parties should present evidence concerning whether the respondent meets commitment criteria. Immediately upon determining that the respondent is eligible for commitment, the court should initiate the dispositional phase of the hearing and deal with the treatment issue.

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[93]Interestingly, this mixture of the issues of treatment and committability is precisely the aim of the proposed fifth criteria for involuntary civil commitment designed to make the commitment criteria more responsive to treatment needs. A discussion of the proposed fifth standard follows later in this section of the chapter.

This two-phase approach provides an efficient and convenient way to ensure that the committability and treatment questions are properly addressed. While our suggestion of dividing the final commitment hearing into two phases may appear to buck the national trend and the general sentiment in Milwaukee County to uncomplicate the civil commitment proceedings, the two phase hearing procedure should be no more complex than the current procedure. Indeed, it may not only force the parties and the court to deal separately with the issues of committability and treatment, it may actually increase the total time of the commitment hearing devoted to issues of treatment and care. Although many of the witnesses who testify during the committability phase are likely to testify regarding treatment as well, dividing the hearing into two successive phases should require no more time from the witnesses (or the court) than does the procedure now used. The examining psychiatrist and psychologist testify at all of the hearings on a given Friday so that, even under the present procedure, they must be present for the duration of each hearing.[94] During the committability phase, immediately after the testimony of each witness other than the examiners, each party could state whether the witness' testimony will be needed during the second phase. If not, the witness could be dismissed at that point in the proceedings. It is obvious that evidence presented during the committability phase of the hearing would be relevant to the dispositional decision of the second phase. The two-phase process would allow this evidence to be considered in determining treatment without also allowing treatment evidence to be considered in making the commitment decision.

> RECOMMENDATION 18: (1) THE FINAL HEARING COURT SHOULD CAREFULLY DISTINGUISH THE TWO QUESTIONS WHICH IT MUST ADDRESS: COMMITTABILITY AND TREATMENT. TO ENSURE THAT THESE QUESTIONS ARE CONSIDERED IN PROPER ORDER, THE COURT SHOULD IMPLEMENT A TWO-PHASE APPROACH TO FINAL COMMITMENT HEARINGS.
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> (2) DURING THE FIRST PHASE, THE "COMMITTABILITY PHASE," THE COURT SHOULD ALLOW THE PARTIES TO PRESENT EVIDENCE CONCERNING ONLY WHETHER THE REPONDENT MEETS CHAPTER 51 COMMITMENT CRITERIA. EVIDENCE CONCERNING THE APPROPRIATE TREATMENT DISPOSITION SHOULD BE MINIMIZED.

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[94]One examining psychologist disagreed with the suggestion that the divided hearing would require no more time of him than the present system. He stated that it would always have required more time in the 100 or so hearings he has participated in. However, we believe that this psychologist is unique among examiners in that he is not on the rotating list of examiners who are appointed by the court and therefore never examines all respondents who may have hearings on a given day.

(3) THE SECOND PHASE, THE "TREATMENT PHASE," SHOULD COMMENCE IMMEDIATELY AFTER (AND ONLY IF) THE COURT ENTERS A FINDING THAT THE RESPONDENT IS COMMITTABLE. DURING THIS PHASE, THE COURT SHOULD REQUIRE THE PARTIES TO PRESENT EVIDENCE CONCERNING THE LEAST RESTRICTIVE TREATMENT ALTERNATIVE APPROPRIATE GIVEN THE RESPONDENT'S DISABLING CONDITION.

Burdens of Proof. As stated above, corporation counsel bears the burden of proving by clear and convincing evidence that a respondent meets commitment criteria. Corporation counsel met this burden during the hearings we observed by questioning the examining psychiatrist and psychologist, and the police officers who effected emergency detentions of each repondent, but without cross-examining the respondent. Questions asked of the police officers related to the specific circumstances surrounding each police officer's decision to detain the respondent. Questions asked of each examiner pertained to whether the examiner had consulted Ward 53B staff concerning the respondent's behavior on the ward, whether the examiner had consulted the repondent's hospital chart, what had transpired during the examination of the respondent, and what opinions concerning the respondent the examiner had formed "to a reasonable degree of medical [or clinical] certainty." Corporation counsel effectively presented evidence relevant to committability. In several respects, however, the respondent's counsel may have more effectively challenged the testimony offered by corporation counsel. This is particularly true with respect to the cross-examination of the examining psychiatrist and psychologist.

Corporation counsel bears not only the burden of proving committability, but also the burden of proving that the treatment and care which he advocates (usually hospitalization) is the least restrictive treatment alternative appropriate given the respondent's condition. Although this burden of proof technically lies with corporation counsel (see 51.20(13)(e)), as a practical matter, the responsibility for investigating and offering less restrictive alternatives falls on the respondent's counsel. The SMHA does not require corporation counsel as part of its case in chief to explore treatment alternatives less restrictive than that which it advocates. Rather, the ultimate responsibility lies with the court to determine whether corporation counsel's preferred treatment of the respondent, or some less restrictive modality, is appropriate. Corporation counsel has neither the responsibility, nor the incentive, to present the court with less restrictive alternatives. Once corporation counsel has presented his evidence supporting the treatment it advocates, the onus shifts to the respondent's counsel to rebut that evidence, and to present alternatives to the court. The respondent's counsel has the incentive to explore and present evidence of less restrictive alternatives to protect his or her client's liberty interests. Thus, the shifting of the onus places the responsibility for presenting alternatives evidence on the

party with the incentive to present it. Once the respondent's counsel presents his or treatment evidence, the court must determine whether corporation counsel's evidence clearly and convincingly outweighs the respondent's evidence. The court then must order the least restrictive alternative sufficient to meet the respondent's treatment needs.

Although the court ordered involuntary hospitalization in all but one of the cases which we observed,[95] it is our opinion that the court reached this disposition not because corporation counsel presented sufficient treatment evidence, but because respondent's counsel failed to present less restrictive alternatives evidence. In most of the cases we observed, the treatment evidence which corporation counsel presented consisted of counsel asking the examiners, "Would you recommend this facility [i.e., the Milwaukee County Mental Health Complex] for treatment?" The examiners unanimously responded, "Yes." Such a leading question and affirmative response, without more, should be insufficient to carry corporation counsel's burden of proof if a respondent's attorney challenges the adequacy of that evidence and presents less restrictive alternatives to the court. During each of the hearings we observed, however, the respondent's counsel simply failed to do so. As mentioned earlier in this chapter, in all of these hearings, and in most cases reaching the final hearing stage, respondents were represented by private attorneys, not by public defenders or Legal Aid Society attorneys. The failure of these attorneys to present even minimal evidence of less restrictive alternatives should probably be attributed to their relative inexperience in civil commitment cases and their lack of assistance by social workers in preparing for hearing. The relative inexperience of private attorneys, and their lack of social workers' assistance, should be mitigated by implementing the following recommendation.

> <u>RECOMMENDATION 19</u>: (1) THE ORIENTATION AND CONTINUING EDUCATION PROGRAM PREREQUISITE TO INCLUSION ON THE APPOINTMENT LIST OF PRIVATE ATTORNEYS SHOULD INCLUDE INSTRUCTION REGARDING (a) THE STATUTORY MANDATE CONCERNING THE LEAST RESTRICTIVE ALTERNATIVE, (b) THE RESPONSIBILITY OF RESPONDENT'S COUNSEL FOR EXPLORING LESS RESTRICTIVE ALTERNATIVES AND FOR OFFERING THESE ALTERNATIVES TO THE COURT, (c) THE ALTERNATIVE TREATMENT MODALITIES AVAILABLE IN THE COMMUNITY, AND (d) THE PROCEDURE OF ENLISTING THE ASSISTANCE OF SOCIAL WORKERS IN IDENTIFYING, EXPLORING AND COMMUNICATING THESE ALTERNATIVES.

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[95]The case which did not result in commitment resulted in a stipulated settlement being approved by the court.

(2) ATTORNEYS RESPRESENTING RESPONDENTS IN INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS SHOULD EXPLORE TREATMENT ALTERNATIVES LESS RESTRICTIVE THAN HOSPITALIZATION AND SHOULD PRESENT THESE ALTERNATIVES TO THE FINAL HEARING COURT. RESPONDENTS' ATTORNEYS ARE ENCOURAGED TO ENLIST THE ASSISTANCE OF SOCIAL WORKERS IN IDENTIFYING, EXPLORING, AND COMMUNICATING LESS RESTRICTIVE ALTERNATIVES.

As an interim measure, while the orientation and continuing education program is being developed, the Commissioner in Probate should inform each attorney representing a respondent at the probable cause hearing that the attorney is responsible for exploring less restrictive alternatives and for offering them to the final hearing court, and that the attorney may enlist the assistance of a social worker in exploring these alternatives. Before actually presenting the alternatives to the court, however, the respondent's counsel has the opportunity to cross-examine the expert witnesses which corporation counsel has presented to support the level of treatment which he advocates. Most of the attorneys we observed failed to effectively cross-examine the examining psychiatrist and psychologist presented by corporation counsel. As mentioned above, corporation counsel presented only minimal treatment evidence. It consisted of counsel asking the examiners, "Would you recommmend this facility for treatment?," and the examiners responding, "Yes." Although attorneys representing respondents must determine case-by-case and witness-by-witness how (and whether) to cross-examine expert witnesses, these attorneys should carefully consider whether to probe such conclusory and cursory treatment evidence. It may be very appropriate for a respondent's attorney to ask the expert witness to specifically detail how he or she reached the conclusion that hospitalization was the least restrictive alternative sufficient for the respondent. For example, the attorney might ask the witness what alternatives (if any) did the witness consider and why were they insufficient. The attorney may find that no explicit alternatives were actually considered. One glaring example of a respondent's attorney failing to effectively cross-examine an expert witness occured when the witness stated that he had seen the respondent for only 15 seconds -- the respondent had merely told the examiner that he did not want to talk to him. Nevertheless, the witness stated not only that the respondent was committable, but also that he must be committed to the Milwaukee County Mental Health Complex. The respondent's attorney did not cross-examine.

RECOMMENDATION 20: ATTORNEYS REPRESENTING RESPONDENTS AT FINAL COMMITMENT HEARINGS SHOULD CAREFULLY CONSIDER HOW TO CROSS-EXAMINE EXPERT WITNESSES OFFERED BY CORPORATION COUNSEL AS PROPONENTS FOR INVOLUNTARY HOSPITALIZATION. IMPORTANT CROSS-EXAMINATION CONCERNS MIGHT INCLUDE HOW THE WITNESS REACHED THE CONCLUSION THAT HOSPITALIZATION IS THE LEAST RESTRICTIVE ALTERNATIVE SUFFICIENT GIVEN THE RESPONDENT'S DISABLING CONDITION, AND SPECIFICALLY WHICH TREATMENT ALTERNATIVES THE WITNESS INVESTIGATED AND WHY THEY WERE INSUFFICIENT.

In addition to the respondent's attorney having the responsibility to present less restrictive alternatives, the court has a duty to order treatment in the least restrictive alternative. This does not mean that the court must decide the appropriate dosages of the drugs to be administered, or the type of therapy. Rather, it requires the court to consider the types of settings and the broad classes of therapy and services proposed, and to select the one(s) which best addresses the respondent's needs and which intrudes least upon the respondent's freedom of action and bodily integrity.[96]

For the court to make a well-informed treatment decision, it is necessary that it be presented with sufficient alternatives evidence. To carry out its statutory and constitutional duty to order the least restrictive alternative, whenever corporation counsel completes its presentation of treatment evidence, the court should directly ask the respondent's attorney whether he or she will present alternatives evidence. Merely bifurcating the committability and treatment evidence as recommended above should impress upon a respondent's counsel the necessity of presenting alternatives to the court. Whenever a respondent's counsel fails to present alternatives evidence, the court should request a post-hearing conference with the attorney -- either in chambers or by telephone. The purpose of this conference should be for the court to determine whether the attorney was aware of his or her responsibility to investigate and present alternatives, and to briefly instruct the attorney concerning that responsibility if he or she is unaware of it or inexperienced at it. Without unduly demanding the court's time, this brief conference would provide an additional check on the quality of representation provided by attorneys who are inexperienced in civil commitment cases.

> RECOMMENDATION 21: (1) IN APPROPRIATE CASES, THE FINAL HEARING COURT SHOULD COMMIT RESPONDENTS TO TREATMENT PROGRAMS LESS RESTRICTIVE THAN HOSPITALIZATION.
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> (2) TO ENSURE THAT THE COURT IS ABLE TO MAKE WELL-INFORMED DISPOSITIONAL DECISIONS, AND TO ENSURE THAT RESPONDENTS' COUNSEL SYSTEMATICALLY INVESTIGATE AND PRESENT TREATMENT ALTERNATIVES, WHENEVER A RESPONDENT'S ATTORNEY FAILS TO PRESENT ALTERNATIVES EVIDENCE, THE COURT SHOULD PRIVATELY BRIEF THE ATTORNEY REGARDING HIS OR HER RESPONSIBILITY FOR INVESTIGATING AND PRESENTING SUCH ALTERNATIVES.

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[96]See, generally, e.g., Chambers, Alternatives to civil commitment of the mentally ill: Pratical guides and constitutional imperatives, 70 Michigan Law Review, 1007 (1972); Shapiro, Legislating the control of behavior control: Autonomy and coercive use of organic therapies, 47 Southern California Law Review, 237 (1974); Institute, supra, note 23, at V-11 to V-14.

Commitment Criteria. We have argued elsewhere that too much emphasis is placed on substantive rather than procedural and practical changes by those wishing to improve involuntary civil commitmnet.[97] Despite evidence that major substantive changes in civil commitment laws have had relatively little impact on practice,[98] lawyers and mental health personnel continue to focus their energies on effecting changes in the substantive law. We believe that this is true in Milwaukee County as well. In this last subsection concerned with the questions of committability and treatment, we deal briefly with the subject of a proposed fifth standard to be added to the current commitment criteria.

Dr. Darold A. Treffert, Director of the Winnebago Mental Health Institute in Wisconsin, has proposed the addition of a fifth criteria to be added to the commitment criteria of the State Mental Health Act.[99] In essence, persons would be subject to involuntary civil commitment under this proposal, which has undergone a number of revisions and has been approved by various groups in Wisconsin, if they are mentally ill, drug dependent, or developmentally disabled, and are proper subject for treatment, and are either dangerous or unable to make an informed decision regarding treatment.[100] The intent of this proposed revision of the statutory criteria for involuntary civil commitment in Wisconsin is to allow the commitment of persons who are obviously and seriously ill without a showing of dangerousness as prescribed in the current law. This proposal is thoughtfully conceived and clearly articulated.

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[97]Institute, supra, note 23, at I-4.

[98]See e.g., the report of an evaluation of the Massachusetts Mental Health Reform Act of 1970 which concluded that the "most profound statistical changes [associated with the implementation of the law] appear to have been associated largely with procedural, rather than substantive, changes in the law." McGarry, A. L., Schwitzgebel, R. K., Lipsitt, P. D., Lelos, D. Civil commitment and social policy: An evaluation of the Massachusetts mental health reform act of 1970. Rockville, Maryland: National Institute of Mental Health, 1981, at 139-141.

[99]Treffert, D. A. Unpublished memorandum to the State Medical Society of Wisconsin. June 15, 1982.

[100]In this proposal for a new fifth criteria, "unable to make an informed decision regarding treatment" means that the individual:

(a) evidences substantial probability of serious mental or emotional deterioration unless treatment is provided: and

(b) is incapable because of mental illness, drug dependence, or developmental disability, of expressing an understanding of the advantages and disadvantages of accepting treatment, and the alternatives to the particular treatment offered, after the advantages, disadvantages, and alternatives have been explained to the individual.

We are not prepared to argue the merits of the proposed fifth standard as a matter of substantive law. Our point is to question the costs and benefits of attempting to revise the current State Mental Health Act in accordance with this proposal.

> RECOMMENDATION 22: ALTHOUGH THE PROPOSED ADDITION OF A FIFTH STANDARD MAY MERIT CONSIDERATION AS A MATTER OF SUBSTANTIVE LAW, LEGISLATIVE REFORM IS NOT RECOMMENDED. AT THE PRESENT TIME, THE RESOURCES OF THE MENTAL HEALTH-LEGAL COMMUNITY IN MILWAUKEE COUNTY SHOULD BE CHANNELED INTO IMPROVEMENTS OF THE PRACTICES IN INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS UNDER THE CURRENT STATE MENTAL HEALTH ACT RATHER THAN INTO SEEKING IMPROVEMENTS BY LEGISLATIVE REFORM.

We emphasize again that we are not finding fault with the proposed criterion as a matter of substantive law. We do, however, strongly believe a major support aimed at legislative reform provided by Milwaukee's mental health-legal community will result in few practical changes and will also contribute to further unnecessary polarization of several forces within that community. In our opinion, it is the practices and procedures not necessarily expressly provided by statute--negotiated settlements, diversion to voluntary admission, crisis intervention, to name just a few familiar ones--that make the difference. Michael Perlin put it this way:

> In the practice of law, just as in the practice of other professions or trades, it is often the mores and customs which deserve the attention usually paid to the written rules of substance and procedure. Although thousands of words are written about the subtle words of a significant court decision or statutory revision, usually limited analysis is given to what can be termed the "socialization of the law."[101]

With the above recommendation, <u>we are not suggesting that the members of Milwaukee's mental health-legal community shun completely attempts at legal reform. We are, simply, urging the mental health-legal community in Milwaukee County to take a hard look at what happens in practice and to look for creative practical solutions to perceived needs, instead of looking to legislative reform as a means of improving involuntary civil commitment in Milwaukee County</u>.

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[101]Perlin, M. The legal status of the psychologist in the courtroom. <u>Mental Disability Law Reporter</u>, 1980, <u>4</u>, at 194.

Another reason that could be offered for concentrating directly on improvements of practice rather than on written rules is that the current law, we believe, provides sufficient flexibility to permit much of the needed treatment and care the proponents of state control are calling for. For example, as discussed in Chapter Four, Ward 53B and other facilities where respondents are held pending the final determination of their legal status need not become jails where treatment is forbidden, as one psychiatrist has suggested.[102] In our view, it is only the perception that the State Mental Health Act is restrictive in this area, coupled with constraints on available resources, that prevents Ward 53B from becoming at least as adequate a treatment and care setting as the other "treatment wards" in the Milwaukee Mental Health Complex.

In addition, the commitment criteria as currently formulated in the SMHA are sufficiently flexible. Specifically, as mentioned earlier in this chapter, the "dangerousness" standard as articulated in the statute is much more flexible than the standard currently applied in Milwaukee County. Section 51.20(1)(a)2. contains four formulations from which the court may infer dangerousness. The meaning of dangerousness may vary within these formulations depending primarily upon the type of harm which may result from a respondent's condition and upon whether the respondent or some other person might suffer that harm. Rather than seeking to amend the current commitment criteria, participants in the mental health-legal system in Milwaukee should focus on recognizing the flexibility in the current statute. Above all, it should be recognized that these criteria were formulated in contemplation of the least restrictive alternative doctrine. Thus, in accordance with proper rules of statutory construction, the dangerousness standard should be construed to allow a finding that a respondent is dangerous, but that he or she may be committed to treatment less restrictive than hositalization.

COMPLIANCE AND THE LEAST RESTRICTIVE ALTERNATIVE

Before ordering a respondent into any treatment and, under the two-phase hearing approach recommended earlier in this chapter, before considering the treatment question, the court must be satisfied that commitment criteria are met. The legislative policy expressed in the SMHA (see 51.001) that the court order respondents meeting the criteria into the least restrictive treatment and care possible is praiseworthy. We have recommended statutory amendments in other jursidictions which would give the final hearing court precisely the dispositional power which the Wisconsin State Mental Health Act expressly provides.[103] Neither the interests of respondents nor those of Milwaukee County are well satisfied when respondents receive treatment that is more intrusive and more expensive than is appropriate to their conditions.

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[102] See, _supra_, note 13, at 1.

[103] See, New York City, _supra_, note 89, at 56.

An argument asserted against application of the least restrictive alternative principle to involuntary civil commitment proceedings is that a respondent's participation and cooperation in a treatment program less restrictive than hopitalization cannot be ensured. The fear is that, within a short time, a new petition will have to be filed or an emergency detention will have to be effected and the whole process begun anew.[104] The same concern has frequently been voiced in Milwaukee in relation to the "stipulated settlement" process (see Chapter Four). Related to this concern is the fear that some respondents who enter less restrictive programs by way of stipulated settlements may find their way into the criminal justice system because insufficient follow-up and monitoring of their compliance with conditions of the stipulated settlements result in the program simply failing to work.[105]

The responsibility for follow-up after a stipulated settlement has been borne by the social workers associated with the two public defender programs in Milwaukee County. We find no fault with the functioning of these social workers in identifying and implementing treatment alternatives prior to the probable cause and final hearings, and we find no fault with their continued interaction with respondents after settlements are achieved. In fact, as should be clear from our discussion in Chapter Four, we find this process very praiseworthy. Viewed from a purely adversarial prospective, however, an inherent conflict of interest exists if these social workers are the people primarily responsible for ensuring compliance with the stipulated treatment program, in effect, for enforcing the settlement. That is, if these social workers are responsible for enforcement, they must, in effect, switch sides. Rather than answering to the respondent's counsel, they must now report to corporation counsel if the respondent fails to comply with the conditions of stipulated treatment. We have addressed this concern in detail earlier in the previous chapter. If a "neutral" social worker monitors compliance with stipulated settlements, this concern may be largely reduced while others, however, may be raised.

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[104]Unfortunately, we are not able to make an assessment of the empirical basis of this fear in Milwaukee County. A recent study focusing on national data on mental hospitalization, however, found little evidence to support the notion of a "revolving door." See Kiesler, C.S., Public and professional myths about mental hospitalization: An empirical resassessment of policy-related beliefs. American Psychologist, 1982, 37 (13), 1323-1339.

[105]See, for example, Libman, supra, note 36. ("Many patients just wander aimlessly in the community because no one can prove they're dangerous. A great many end up in the criminal justice system."); see also, generally, Zahn and Patrinos, supra note 38.

A potentially very effective means of achieving the ideal of the least restrictive alternative principle while enhancing the probability of compliance is provided in the SMHA although it is only infrequently used in Milwaukee County. If developed and used more frequently, this means may diffuse the recent controversy about the "neutrality" of social workers assigned the responsibility of ensuring compliance. The most effective way to achieve the least restrictive alternative while enhancing compliance may be for the court to use the SMHA in the manner central to its overriding legislative policy, a policy committed to the application of the least restrictive alternative principle.[106] Rather than considering the stipulated settlement process as the only means of implementing the least restrictive alternative doctrine in involuntary civil commitment proceedings, it may be viewed as one option among several along a continuum of options involving differing degrees of restrictiveness, intrusiveness, or penetration into the civil justice system. Such a continuum could be described by the following general categories of case dispositions, beginning with the least restrictive and ending with the most restrictive:

(1) Diversion following initial contact with a component(s) of Milwaukee County mental health-judicial network;
(2) outright release from Ward 53B after initial mental health evaluation; no further planned mental health-judicial intervention;
(3) release after a finding of no probable cause; no further mental health-judicial involvement;
(4) conversion to voluntary status and admission to treatment wards of the Milwaukee County Mental Health Complex (see 51.10(6));
(5) release from Ward 53B after a negotiated settlement, outpatient treatment, suspension of probable cause hearing, monitoring of compliance by social workers affiliated with respondent's counsel;
(6) stipulated ("court-ordered") voluntary admission to inpatient treatment, suspension of probable cause hearing;
(7) conditional release from Ward 53B pending final commitment hearing after a finding of probable cause by the court, outpatient treatment, monitoring of compliance by social workers affiliated with the court;[107]

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[106]See the following sections of the Wisconsin State Mental Health Act: 51.001, 51.01(4), 51.10(4m), 51.15(1), 51.20(1), (2), (7), (9), and (13), 51.22(5), 51.35(1), and 51.61(1).

[107]Although Section 51.20(8)(a) permits release, following a finding of probable cause, pending the full hearing with out-patient treatment on a voluntary basis, without court-imposed sanctions, this option appears unrealistic. If such an option were acceptable to the court, respondent's counsel would likely seek disposition by options (3) or (4) cited above. See also note 109.

(8) after a finding of probable cause, continued detention while the final commitment hearing is pending;
(9) commitment by the final hearing court to a treatment alternative less restrictive than inpatient hospitalization; and, finally,
(10) commitment to inpatient treatment at the Milwaukee County Mental Health Complex.

Each successive category of case dispositions may be viewed as more restrictive than that preceding it. Categories (1) through (5) involve relatively minimal, if any, judicial intervention in treatment. Categories (6) through (10) involve progressively more judicial involvement. In brief, we suggest that the authority of the court, including social work designed to enhance the effectiveness of the ordered treatment, be used, in options (6) through (10) above, when full compliance with a treatment and care plan without direct court intervention is seriously questioned. This proposal, including its advantages and disadvantages, is described in some detail below.

An actual finding of probable cause to believe that the respondent is a fit subject for some type of involuntary treatment and an ordering by the court of alternatives less restrictive than hospitalization have been essentially superseded in practice by the stipulated settlement process. Through stipulated settlements many respondents are diverted from commitment before reaching the final hearing and before reaching the probable cause hearing. As discussed in Chapter Four, the stipulated settlement process has arisen as a matter of practice in Milwaukee. This process is not expressly provided for in the SMHA. Although either the probate court commissioner or the final hearing judge must approve a stipulated settlement, the commissioner or judge's involvement in determining the particular treatment disposition is minimal. The commissioner or judge usually does not become involved in analyzing the merits of the terms of the settlement, but rather only determines whether the respondent's counsel has explained the terms of the settlement to his or her client and whether the respondent, in fact, agreed to the terms of the stipulated treatment. It is our opinion, however, that the stipulated settlement process has worked effectively, in part, in guiding respondents to the types of treatment they need. A drawback to the procedure as currently followed in Milwaukee, however, is the lack of a follow-up mechanism to ensure compliance with the terms of the settlement.

Although the stipulated settlement process furthers the implementation of the least restrictive alternative doctrine, the express statutory power of the court to order less restrictive alternatives adds a key factor: a statutory basis for a compliance mechanism. Rather than leading to a settlement, which may result in the case being held open or dismissed, the exercise of the court's statutory power would lead to a direct judicial sanction and an actual commitment order. Direct judicial involvement, including a commitment order and its ramifications, in the context of the comprehensive continuum described above, would further compliance and the application of the least restrictive alternative doctrine.

We do not intend to suggest that this scheme should replace the stipulated settlement process. We strongly oppose the elimination of a process which has proven itself to be an innovative and effective tool for the provision of mental health treatment to many needy people in Milwaukee County. Rather, the stipulated settlement process should become a part of this scheme. Whether a particular case should result in a stipulated settlement or a court-ordered alternative should depend on the degree to which a court-ordered sanction and a compliance mechanism is needed. The following proposed statutory scheme as applied to ensure compliance is described in some detail.[108]

Soon after the initial mental health evaluation on Ward 53B, or soon after a three-party petition has been issued, each party, from its perspective, should determine whether a stipulated settlement or a court-ordered alternative would be preferable. The onus to offer a stipulated settlement (if desired by his or her client) is on the respondent's counsel. In determining whether to accept such a settlement, corporation counsel should consider whether the respondent is likely to comply with the terms of the settlement without some type of court-ordered sanction. Corporation counsel should seek the opinion of the Ward 53B staff who conducted the initial mental health evaluation, the newly appointed CCSB social worker, the petitioners on a three-party petition, the intake workers of the Protective Services Management Team, or of any other person(s) who may be involved. If corporation counsel determines that no substantial compliance problem exists and that treatment terms under the settlement are sufficient, corporation counsel should accept the settlement. If, however, compliance problems do present themselves, then corporation counsel should proceed to the probable cause hearing without entering a settlement.

At the probable cause hearing, the parties would have another opportunity to address the alternatives issue. The SMHA provides a procedure which would allow the commissioner presiding at the probable cause hearing to permit a less restrictive alternative while maintaining judicial involvement in a given case. If probable cause to believe the allegations made in the three-party petition or the application of emergency detention is established, the commissioner may either release or detain the respondent pending the final commitment hearing (51.20(8)(a)). If the commissioner determines that the respondent need

[108]We do not intend to imply that the components of the proposed compliance scheme are novel or unknown to the participants in Milwaukee's civil commitment process.

not be detained,[109] the commissioner may release the respondent and issue an order stating conditions of the release (51.20(8)(a)). Releasing the respondent would be in accord with the least restrictive alternative doctrine. After corporation counsel has refused a stipulated settlement because of compliance concerns, the respondent's counsel could present the treatment alternative to the commissioner and, likewise, corporation counsel could present objections. Rather than detaining the respondent simply because the parties have been unable to reach a settlement, the commissioner would consider releasing the respondent on the condition that the respondent comply with the treatment terms offered by the respondent's counsel or with such additional conditions as the commissioner deems proper. The respondent would have the option of accepting the treatment conditions or of submitting to continued detention in Ward 53B (see 51.20(8)(a)). The case would not be held open, as is usual under a stipulated settlement, but would proceed to final hearing. The commissioner could specify in the release order what remedial actions, including immediate detention and acceleration of the final hearing, may be taken if the respondent breached any conditions (see 51.20(8)(a)). When a respondent is released pending final hearing, statute provides that the final hearing must be held within 30 days of the release order (51.20(8)(a)), not within 14 days of the initial detention, as is required if the respondent is detained in Ward 53B pending final determination of his or her legal status. Thus, the commissioner could order treatment for up to 30 days.[110] The commissioner should clearly set forth in the release order (1) that probable cause has been found, (2) the types of services and treatment to be provided, including whether the services and treatment are to be provided on an inpatient or outpatient basis, (3) the facility, clinic, or mental health professional which is to provide the services or treatment, (4) that the respondent has been released provided that he or she complies with the stated conditions, (5) that the CCSB social worker (or some other "neutral" social worker) should monitor the respondent's participation and progress in the stated treatment program,

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[109]According to one commissioner whom we interviewed, under present procedures, release pending final hearing is rare. Excluding cases in which no probable cause is found or in which a stipulated settlement is reached, the only situation in which a respondent would be released is if the harm threatened by the respondent's condition is related to situational factors which can be controlled (e.g., if the threat of harm is presented by an adult child living with his or her parents and the threat may be eliminated by requiring the adult child to live elsewhere). He stated that release was rare because probable cause has been found to believe that the respondent is "dangerous" (see discussion of dangerousness earlier in this chapter).

[110]To ensure that the 30-day limit is not exceeded, the commissioner should schedule the final hearing for not later than the last Friday within the 30-day period.

(6) that if the respondent fails to comply with the stated conditions, the noncompliance should be immediately reported to corporation counsel or the court, (7) that immediate detention and acceleration of the final hearing, or another appropriate remedy, will be imposed following a breach of conditions,[111] and (8) that, in any event, a final commitment hearing shall be held on the date specified in the order unless accelerated. Copies of the order should be given to the parties, the stated treatment provider(s), and the CCSB social worker. It should be the responsibility of the social worker, and corporation counsel, to confer with the petitioners or any other third-parties other than treatment providers that may be affected by the conditional release. The commissioner should direct the respondent's counsel to explain to his or her client the terms and consequences of the order.

This procedure, option (7) on the continuum of general categories of case dispositions mentioned earlier, should require no more preparation time from the parties than does the stipulated settlement process, option (5). The procedure may require a longer probable cause hearing, but only in those cases in which a negotiated settlement is unsuccessful. This additional time, however, should increase compliance with less restrictive alternatives. Compliance would be directly monitored by the CCSB social worker, and indirectly by corporation counsel. In an effort to keep the CCSB social worker's caseload at a manageable level, we propose that he or she be responsible for monitoring these cases, but not cases resulting in stipulated settlements.[112] Thus, social workers affiliated with respondent's counsel would work toward the implementation of negotiated settlements; social workers affiliated with the court would ensure compliance with terms of the conditional release.[113]

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[111]"The court order may state the action to be taken upon information of breach of such conditions" (51.20(8)(a)).

[112]This would be consistent with the least restrictive alternative principle. A stipulated settlement would be less restrictive than a court-ordered alternative because the stipulated settlement would involve less judicial involvement in and supervision of the treatment program. In the future, if a court clinic is developed in Milwaukee (as has been suggested by the Planning Counsel for Mental Health and Social Services, Inc.), the clinic might play a supervisory role in both stipulated and court-ordered cases. The clinic's role would be less judicial in nature than that of the court; that is, the clinic would ensure compliance primarily by mental health and social services intervention and contact rather than by the power of the court.

[113]Whenever a respondent is represented by private counsel, the neutral social worker may assume both of these responsibilities. This should not produce divided loyalties, however, because the social worker is not actually employed by the respondent's counsel.

This proposed division of responsibility for social work intervention would appear to be a viable and expedient solution to the controversy about the affiliation of social workers involved in involuntary civil commitment proceedings. Both groups of social workers would serve a valuable function consistent with the least restrictive alternative doctrine. Secondly, the respondent's compliance would be enhanced not only because of the possibility of immediate detention following noncompliance, but also because a final hearing would be ensuing. Compliance with the treatment conditions might be used at the final hearing as favorable evidence either that involuntary commitment is not warranted or that such less restrictive treatment is sufficient. The eminence and certainty of a final hearing, which are absent under stipulated settlements, provide incentive for the respondent to participate in treatment.

Even if the commissioner does not order a conditional release but, instead, orders detention of the respondent in Ward 53B pending the final commitment hearing, the opportunity remains for continued negotiations prior to the final hearing, and for presentation of alternatives during the treatment phase of the final hearing. Such negotiations are implied, if not mandated, by the legislative policy of the SMHA to assure respondents access to the least restrictive treatment alternative (see Section 51.001). When a conditional release is ordered, the respondent's failure to comply with the treatment program would be strong evidence that hospitalization should be ordered. However, if the respondent has complied and the treatment has been beneficial to the respondent, the treatment phase may be modified accordingly, possibly in favor of even less restrictive treatment and care alternatives. The respondent's counsel might have the commissioner's release order entered into evidence and then present evidence of compliance. Alternatively, the parties may agree to enter into a stipulated settlement incorporating the terms of the release order.

In the absence of a stipulated settlement or a finding that the respondent is not committable, the court should order commitment to the least restrictive treatment alternative. The treatment alternatives ordered by the court may be the same treatment programs that respondents now reach through the stipulated settlement process. When the commissioner presiding at the probable cause hearing or when the final hearing judge enters an order adopting a stipulated settlement, that order is not final but merely holds the case open. A final commitment order, however, invokes statutory and expedient compliance checks similar to those discussed above. For example, treatment staff must periodically reevaluate a committed person and report their findings to the court (51.20(17)). Periodic reevaluations must be conducted within 30 days after the commitment order, within three months after the initial reevaluation, and again thereafter at least once each six months (51.20(17)). These reevaluations provide not merely an opportunity to determine whether the individual has progressed sufficiently to warrant discharge from a treatment facility or transfer to a less restrictive program, but also an opportunity to determine if the individual is properly participating in the ordered program, especially when such a program is in a less restrictive outpatient setting. The CCSB social worker may also directly monitor the patient's progress on a more

frequent basis and report to the court. If the court finds the respondent's dangerousness can be controlled by medication on an outpatient basis, for example, the court may direct in its commitment order that an inpatient facility detain the respondent long enough to evaluate him or her, develop a treatment plan, and then release the respondent (51.20(13)(dm)). The release may be conditioned on the respondent taking the prescribed medication, and on the respondent reporting to a treatment facility on an outpatient basis as often as required (51.20(13)(dm)). The order may direct that if the respondent fails to meet either of these conditions, the treatment director may request that a law enforcement officer take the respondent into custody, and that the medication may be administered involuntarily (51.20(13)(dm)). If the respondent fails to comply with the conditions, the respondent may be transferred back into the facility which detained him or her following the commitment order (see Sections 51.20(13)(dm) and 51.35(1)(a)). For many respondents, the mere fact that they have been judicially ordered into treatment may ensure compliance.[114]

> RECOMMENDATION 23: (1) WHENEVER CORPORATION COUNSEL DETERMINES THAT A RESPONDENT MAY BE A PROPER SUBJECT FOR INVOLUNTARY TREATMENT LESS RESTRICTIVE THAN HOSPITALIZATION, YET THE RESPONDENT MAY (OR IS LIKELY TO) FAIL TO COMPLY WITH THE TERMS OF A STIPULATED SETTLEMENT, CORPORATION COUNSEL SHOULD REFUSE TO SETTLE AND SHOULD PROCEED TO THE PROBABLE CAUSE HEARING.
>
> (2) FOLLOWING A FINDING OF PROBABLE CAUSE, IF THE COMMISSIONER PRESIDING AT THE PROBABLE CAUSE HEARING DETERMINES THAT TREATMENT LESS RESTRICTIVE THAN HOSPITALIZATION IS APPROPRIATE, THE COMMISSIONER SHOULD CONSIDER RELEASING THE RESPONDENT ON THE CONDITION THAT HE OR SHE ACCEPTS AND COMPLIES WITH TREATMENT WHILE THE FINAL COMMITMENT HEARING IS PENDING.
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> (3) THE CONDITIONAL RELEASE ORDER SHOULD CLEARLY SET FORTH: (a) THAT PROBABLE CAUSE TO BELIEVE THAT THE RESPONDENT IS A FIT SUBJECT FOR COMMITMENT HAS BEEN FOUND, (b) THE TYPES OF

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[114]We have observed in other jurisdictions that judicial sanctions, even when those sanctions would be extremely difficult to enforce in practice, appear to increase compliance with outpatient treatment and care programs (see Zimmerman, J. Involuntary Civil Commitment in Chicago. Williamsburg, Virginia: National Center for State Courts, 1982.) In extreme cases in which noncompliance is a serious concern yet outpatient treatment is preferrable in other respects, the court, in its discretion, may inform a respondent that in the event of noncompliance with the commitment order he or she may be subject to contempt proceedings (see Wis. Stat. Ann. §785.02, 785.03(1), and 785.04(d) and (e)).

SERVICES AND TREATMENT TO BE PROVIDED, INCLUDING WHETHER THE SERVICES AND TREATMENT ARE TO BE PROVIDED ON AN INPATIENT OR OUTPATIENT BASIS, (c) THE FACILITY, CLINIC, OR MENTAL HEALTH PROFESSIONAL WHICH IS TO PROVIDE THE SERVICES OR TREATMENT, (d) THAT THE RESPONDENT HAS BEEN RELEASED PROVIDED THAT HE OR SHE COMPLIES WITH THE CONDITIONS OF THE RELEASE, (e) THAT THE CCSB SOCIAL WORKER (OR SOME OTHER "NEUTRAL" SOCIAL WORKER) SHOULD MONITOR THE RESPONDENT'S PARTICIPATION AND PROGRESS IN THE STATED TREATMENT PROGRAM, (f) THAT IF THE RESPONDENT FAILS TO COMPLY WITH THE STATED CONDITIONS, NONCOMPLIANCE SHOULD BE IMMEDIATELY REPORTED TO CORPORATION COUNSEL OR TO THE COURT, (g) THAT IMMEDIATE DETENTION AND ACCELERATION OF THE FINAL HEARING, OR ANOTHER APPROPRIATE REMEDY, WILL BE IMPOSED FOLLOWING A BREACH OF CONDITIONS, AND (h) THAT, IN ANY EVENT, A FINAL COMMITMENT HEARING SHALL BE HELD ON THE DATE SPECIFIED IN THE ORDER UNLESS ACCELERATED. COPIES OF THE ORDER SHOULD BE GIVEN TO THE PARTIES, THE STATED TREATMENT PROVIDERS, AND THE CCSB SOCIAL WORKER. THE COMMISSIONER SHOULD DIRECT THE RESPONDENT'S COUNSEL TO EXPLAIN TO HIS OR HER CLIENT THE TERMS AND CONSEQUENCES OF THE ORDER.

(4) THE CCSB SOCIAL WORKER, UNDER THE DIRECTION OF THE COURT, SHOULD NOTIFY AND CONFER WITH THE PETITIONERS OR ANY OTHER THIRD PARTIES, OTHER THAN THE TREATMENT PROVIDER(S), WHO MAY BE AFFECTED BY THE CONDITIONAL RELEASE OF THE RESPONDENT.

(5) WHILE THE FINAL COMMITMENT HEARING IS PENDING, AND FOLLOWING A FINAL COMMITMENT ORDER TO A TREATMENT ALTERNATIVE LESS RESTRICTIVE THAN HOSPITALIZATION, THE CCSB SOCIAL WORKER SHOULD MONITOR THE RESPONDENT'S COMPLIANCE WITH ORDERED TREATMENT TERMS. IF THE CCSB SOCIAL WORKER DISCOVERS THAT A RESPONDENT HAS VIOLATED ORDERED TREATMENT TERMS, OR IF SUCH A VIOLATION IS RELIABLY REPORTED TO THE SOCIAL WORKER (E.G., BY THE TREATMENT PROVIDER OR BY A RELIABLE THIRD PARTY), THE SOCIAL WORKER SHOULD IMMEDIATELY REPORT THE VIOLATION TO CORPORATION COUNSEL OR TO THE COURT.

(6)(a) IF A RESPONDENT HAS MATERIALLY VIOLATED A CONDITIONAL RELEASE PENDING FINAL HEARING, CORPORATION COUNSEL OR THE COURT SHOULD REQUEST THAT A LAW ENFORCEMENT OFFICER TAKE THE RESPONDENT INTO CUSTODY AND TRANSPORT HIM OR HER TO AN APPROPRIATE INPATIENT TREATMENT FACILITY.

A NEW DETENTION ORDER SHOULD NOT BE REQUIRED.[115] THE FINAL COMMITMENT HEARING SHOULD BE ACCELERATED. (b) IF A RESPONDENT FAILS TO COMPLY WITH THE TERMS OF A FINAL COMMITMENT ORDER TO A TREATMENT ALTERNATIVE LESS RESTRICTIVE THAN HOSPITALIZATION, THE COURT, OR THE TREATMENT PROVIDER IF SO PROVIDED BY STATUTE OR IN THE COMMITMENT ORDER, SHOULD TAKE APPROPRIATE REMEDIAL ACTION AS PROVIDED IN STATUTE OR IN THE COMMITMENT ORDER.

Generally, the procedures recommended above closely track the statutory provisions of Chapter 51. They address two related controversial questions centering on the function of social workers in involuntary civil commitment proceedings: first, do social workers have a role in involuntary civil commitment proceedings and, second, if so, where should they play that role? We propose that social workers do have a very valuable role to play in exploring less restrictive alternatives and ensuring respondent's compliance with treatment and care less restrictive than involuntary hospitalization. Affiliated with respondents' counsel, they would function to explore treatment alternatives and to ensure compliance with stipulated settlement of cases prior to a probable cause determination. Affiliated with the CCSB, or some other "neutral" entity such as a court clinic, they would work to make the proposed conditional release and commitment to less restrictive alternatives a workable and meaningful process.

In our references throughout this section to the role of social work in the involuntary civil commitment process we have attempted to be sensitive to the social work resources that are _at this writing_ applied to the process: essentially, one social worker assigned to the State Public Defender's Office and one CCSB social worker at the Milwaukee County Mental Health Complex. Due to the formative nature of the social workers' role in the commitment process in Milwaukee County, references to divisions of labor in the above recommendation and text may quickly become outdated. Regardless of how the allocation of social work resources may be changed in the future, the social work function, _per se_, should be encouraged and continued. As we view it, three important questions should be raised about the social work function: (1) Do social workers have an important role to play n the involuntary civil commitment process in Milwaukee? (2) What resources should be allocated to the

[115]One reviewer of section (5)(a) questioned whether corporation counsel can request a law enforcement officer to detain a respondent following breach of a conditional release or whether a new detention order is required. Section 51.20(8)(a) provides that "[t]he court may state the action to be taken upon information of breach of such conditions." A conservative reading of this provision indicates that if the court states in the conditional release order that a respondent may be redetained following a breach, such renewed detention, accompanied by acceleration of the final hearing, is appropriate without the issuance of a new detention order.

social work? (Essentially, how many social workers should there be?) (3) What administrative, budgetary, and organizational structures should support the social work function? There appears to be a consensus among people we interviewed that the first question can be answered in the affirmative. However, our fear is that debate over the third question will obscure serious study of the second question--that the inability to reach agreement on such questions as "Can the CCSB social worker maintain "neutrality" in a particular case?" will cause people in Milwaukee County to assume an all-or-nothing stance about the importance of social work in the involuntary civil commitment process in. With this in mind we offer the following recommendation.

RECOMMENDATION 24: (1) A SOCIAL WORKER SHOULD BE ASSIGNED TO EVERY INVOLUNTARY CIVIL COMMITMENT CASE TO ASSIST THE ATTORNEYS AND THE COURT IN IDENTIFYING THE LEAST RESTRICTIVE, APPROPRIATE TREATMENT AND CARE AND TO MONITOR RESPONDENTS' COMPLIANCE WITH CONDITIONS OF NEGOTIATED SETTLEMENTS AND COURT ORDERS.

(2) THE PLANNING COUNCIL FOR MENTAL HEALTH AND SOCIAL SERVICES, INC. AND THE TASK FORCE ON HUMAN SERVICES AND THE LAW SHOULD STUDY THE CURRENT SOCIAL WORK PERFORMED UNDER THE AUSPICES OF CCSB AND THE STATE PUBLIC DEFENDER'S OFFICE IN MILWAUKEE AND RECOMMEND THE MOST EFFECTIVE, EQUITABLE, EFFICIENT, AND ACCEPTABLE ADMINISTRATIVE AND ORGANIZATIONAL STRUCTURE TO SUPPORT THE SOCIAL WORK FUNCTION.

The procedures in Recommendation 23 further the application of the least restrictive alternative while allowing judicial leverage when needed to ensure compliance. These procedures should not merely lead to greater compliance by respondents who otherwise would have been diverted through stipulated settlements, but also should lead to some respondents who would have been involuntarily hospitalized receiving treatment by less restrictive means. Because the above procedures require the commissioner and the court to evaluate the merits of less restrictive alternatives, the treatment and liberty interests of respondents should be furthered.

The least restrictive alternative doctrine, considered by some to be meaningful as a legal principle but a "sham" in practice,[116] is realized in practice by the above recommendation. The recommendation most directly addresses the implementation of options (7) and (9) on the dispositional continuum discussed earlier. There is little room for application of the least restrictive alternative doctrine when only two dispositional options--outright release to the community or forced hospitalization--are used by the court. The negotiated settlement

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[116] See Hoffman and Foust, *supra*, note 90.

procedure currently used in Milwaukee is an innovative beginning toward developing the means of applying the least restrictive alternative doctrine in the commitment process. The recommended procedures continue this development.

One possible disadvantage to the recommendation, if implemented, is worth mentioning. Invoking the authority of the court to increase compliance with less restrictive treatment alternatives has a possible negative consequence that must be borne by respondents: a stigma attached to a finding of probable cause or to a commitment order. If the court and respondent's counsel take steps to minimize such stigma, we believe that this cost to the respondent is worth the benefits of better compliance with terms of less restrictive alternative treatment. In addition, we believe the cost is outweighed by the promise of greater public confidence that the court can be effective; that is, that the authority of the court can be used to encourage needed treatment.

CHAPTER SIX

COORDINATION OF SERVICES, TRAINING AND EDUCATION

It has been said that social rules work best when they are not written into law but are followed because they are accepted as part of the mores and customs of the people.[117] The written and implied social rules governing involuntary civil commitment in Milwaukee County are no exception. In this last chapter we will discuss two means--coordination of services and public education--by which the social rules for involuntary civil commitment may be made to work better and may be incorporated into the mores, customs, and practices of the mental health-legal community and the general public in Milwaukee County.

LINKAGES, COORDINATION, AND COOPERATION

In the past two decades, the fair and humane treatment of mentally ill persons became a civil rights issue of the first order. The involuntary civil commitment of allegedly mentally ill persons to large public institutions came under close public scrutiny and attack.

> Agressive work on behalf of mental patients was the hallmark of mental health advocacy in the 1970s. Patient groups as well as legal advocates adopted the strategy of confrontation with the mental health system--confrontation in the courts, in administrative hearings, in wards, and sometimes in the streets. These confronttional approaches were used in part because the mental health system seemed insensitive to other cooperative strategies.[118]

Spawned by a number of important court decisions,[119] Wisconsin became the bellwether, with Milwaukee County as the major arena, for reform of the laws governing the involuntary civil commitment of persons alleged to be mentally ill. Most commentators throughout the country, as well as those we interviewed in Milwaukee County, considered that the agressive work on behalf of mental patients and the increased involvement of lawyers and courts in mental health policies and practicies has been necessary and desirable. This major reform movement lead to the provision of significant rights and legal safeguards for mentally

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[117]This point was made, for example, in a recent analysis of the controversy over the insanity defense in the aftermath of the acquittal by reason of insanity of John Hinckley. Summary and Analysis. Mental Disability Law Reporter, 1982, 6 (4), 218-219.

[118]Paschall and Eichler, supra, note 73, at 116.

[119]Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), and 379 F. Supp. 1376 (1974); Memmel, supra, note 86; and In the Matter of Seefeld, Case No. 441-417, Milwaukee County Circuit Court, August 18, 1976.

disordered individuals facing commitment. Today, the major problems which made these confrontational tactics necessary in the past--patient abuse and an unresponsive mental health delivery system--now may be largely gone. The litigious approach may have fallen prey to its environment, such that it is now much too blunt of an instrument for improvement of the current involuntary civil commitment process.[120]

The dominant issue in the involuntary civil commitment process in Milwaukee County and throughout the country today seems to be how to create linkages, coordination, and cooperation among the various units of the complex interorganizational network comprising the mental health-legal system. A litigious approach to involuntary civil commitment, successful in the past, now may have to given way to cooperation as the best approach to promote positive change in involuntary civil commitment. Such an approach may entail a deliniation of responsibilities and division of labors among the components of the mental health-legal system in Milwaukee County, in recognition that improvement of the involuntary civil commitment process is an immense job that cannot be done by one or two components.

In Milwaukee County, like in most cities throughout the country,[121] linkages, coordination, and cooperative efforts among the various agencies involved in the involuntary civil commitment process are, at best, in the formative stages. They are not part of settled law or written rules and are still very malleable. The prehearing portion of the commitment process, for example, involves complex interorganizational factors, shifting authorities, and unfocused responsibilities as a case moves through the involuntary civil commitment process toward the first judicial hearing before a court commissioner. The court usually becomes actively involved in a case only after law enforcement officials, the Protective Services Management Team, the State Public Defender's Office in Milwaukee (or attorneys from the Legal Aid Society or the private bar), corporation counsel, and personnel of the Milwaukee County Mental Health Complex have made both formal and informal determinations regarding the validity of the commitment of an individual.

The person may first come to the attention of police officers or Crisis Intervention Service personnel (e.g., after a suicide attempt), or of the Protective Services Management Team and the Sheriff's Department (if the person is the subject of a three-party petition). Agents of these components of the mental health-legal system may effect the person's temporary detention after some type of formal or informal prehearing screening, investigation, or review of allegations supporting

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[120]Cf. Shah, S.A. Legal and mental health system interactions: Major developments and research needs. International Journal of Law and Psychiatry, 1981, 4, 219-270.

[121]Institute, supra, note 23, at I-5 and I-6; II-5 and II-6.

involuntary commitment, As the person is admitted into Ward 53B of the Milwaukee County Mental Health Complex, another separate organizational unit--the mental health hospital and its staff--becomes involved in the case. Law enforcement agencies, having done their job of apprehending, transporting, and detaining the respondent, retreat from the case. And as long as the person remains an inpatient in the Milwaukee County Mental Health Complex, community mental health service agencies are removed from the case. Seldom are agents of these agencies drawn back into a case, except indirectly by means of their written records, until the person is released from inpatient care.[122] As the case moves closer to formal hearing, the hospital and the court are dominant, at least in terms of responsibility and authority. Finally, during the formal judicial hearing, the court exerts its strongest influence over the case.

Within the circle of responsibility of one component of the mental health-legal system, commitment procedures may be quite equitable, efficient, effective, and meaningful, but what assurances are there that the same procedures will not become onerous, complex, and meaningless when they move out of this circle and begin to affect another component with different goals, structural components, and operations? Above all, it should be clear that involuntary civil commitment proceedings involve numerous components of the mental health-legal system that need to be linked and coordinated. Their personnel need to work cooperatively if the involuntary civil commitment process is to make any sense at all.

RECOMMENDATION 25: (1) IN ACCORDANCE WITH THE POWERS AND DUTIES PRESCRIBED IN SECTION 51.42 OF THE STATE MENTAL HEALTH ACT, THE COMBINED COMMUNITY SERVICES BOARD OF MILWAUKEE COUNTY SHOULD PROVIDE FOR THE INTEGRATION OF THE ADMINISTRATION OF ALL AGENCIES, SERVICES, AND FACILITIES INVOLVED IN THE INVOLUNTARY CIVIL COMMITMENT PROCESS, INCLUDING THE PROBATE DIVISION OF THE CIRCUIT COURT, LAW ENFORCEMENT AGENCIES, THE PROTECTIVE SERVICES MANAGEMENT TEAM, CORPORATION COUNSEL, THE PUBLIC DEFENDER'S OFFICE, THE LEGAL AID SOCIETY, WARD 53B, THE CRISIS INTERVENTION SERVICE, WISCONSIN CORRECTIONAL SERVICE, COMMUNITY MENTAL HEALTH CLINICS, AND OTHER VOLUNTARY, NON-PROFIT AND PUBLIC SERVICES AS MAY BE APPROPRIATE.

(2) THE COMBINED COMMUNITY SERVICES BOARD SHOULD ESTABLISH AN ADVISORY BOARD TO ENCOURAGE LINKAGES, COORDINATION, AND COOPERATION AMONG THE FACILITIES, SERVICES, AND AGENCIES LISTED IN PARAGRAPH (1).

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[122]An exception to this occurs in the negotiated settlement process (see Chapter Four) when outpatient services personnel work cooperatively with attorneys to seek less restrictive placements for the person prior to the probable cause hearing.

(3) THE ADVISORY BOARD SHOULD BE COMPRISED OF REPRESENTATIVES OF THE FACILITIES, SERVICES, AND AGENCIES IN PARAGRAPH (1) WHO ARE INVOLVED IN THE INVOLUNTARY CIVIL COMMITMENT PROCESS.

(4) THE TASK FORCE ON HUMAN SERVICES AND THE LAW SHOULD BE SPECIFICALLY CHARGED BY THE COMBINED COMMUNITY SERVICES BOARD WITH REVIEWING AND FACILITATING LINKAGES, COORDINATION, AND COOPERATION AMONG THE VARIOUS COMPONENTS OF THE MENTAL HEALTH-LEGAL SYSTEM INVOLVED IN THE INVOLUNTARY CIVIL COMMITMENT PROCESS IN MILWAUKEE COUNTY.

Practically speaking, the recommended advisory board, in conjunction with the Task Force on Human Services and the Law, should provide the forum for finding creative solutions that accommodate the duties and responsibilities of the various units of the mental health-legal system represented. For example, law enforcement representatives and Ward 53B representatives may discuss the difficulties of transporting respondents to the Milwaukee County General Hospital's Emergency Admitting Center for medical clearance and then to Ward 53B. Or larger questions such as the overall access to the involuntary civil commitment process by means of various routes may be discussed by the entire board. Assuming, for example, that the population of mentally disordered, helpless, homeless, and endangered persons in Milwaukee County who are potentially subject to involuntary civil commitment proceedings numbers approximately 5,000 (an estimate offered by one interviewee), what proportion of this population actually does or should come into contact with the involuntary civil commitment process? What established routes (e.g., emergency detention) and other routes (e.g., by way of the criminal courts) should bear the most traffic? These types of questions probably cannot be adequately addressed from the perspective of only one component of the mental health-legal system. A broad overview, which recognizes the important effects of a change in the operations of one component upon another component, seems to be necessary to address these questions.

It would be unfair to state that this type of overview does not exist, or has not existed, in Milwaukee County. In 1980 the Combined Community Services Board created the "Task Force on Human Services and the Law" and charged it with reviewing and making recommendations in the broad area of mental health and the law, of which the involuntary civil commitment process is only one part. We strongly recommend that a subgroup of members of the Task Force be appointed by the Combined Community Services Board as part of the recommended advisory board.

TRAINING AND EDUCATION

Involuntary civil commitment proceedings necessitate the knowledge and skills of professionals in several disciplines including law, psychology, psychiatry, mental health administration, law enforcement, and social work. Most of the professionals who are involved in commitment proceedings, however, have had formal training only in one

of these disciplines. Mostly by means of on-the-job training and occasional workshops and seminars, these individuals develop a working, albeit limited, knowledge of the relevant theory and practice of the "other" disciplines.

In Milwaukee County, professionals from both the judicial and mental health disciplines express their impressions that the "other" discipline is in need of further training and education, that they lack information and understanding. Attorneys would like mental health professionals to be more familiar with the philosophy of law, the adversary system, and involuntary civil commitment proceedings as prescribed in the State Mental Health Act. Mental health and social service professionals, on the other hand, feel that judges, commissioners, and attorneys do not understand the nature of mental illness, the day-to-day operations of the mental health services delivery system, and the nature of mental health treatment and care.

Two distinct types of training and education needs should be addressed in Milwaukee County. First, training and education is needed for orientation. Judges, commissioners, attorneys, and law enforcement officers who have never been involved with civil commitment cases may be unfamiliar with the State Mental Health Act, let alone the translation of the law into practice in Milwaukee County. Mental health professionals frequently are not only unfamiliar with, but offended by, the adversary nature of the judicial system. A standard packet of orientation materials that will provide a theoretical and practical introduction to the mental health-law area and a thorough explanation of the Milwaukee County involuntary civil commitment process would be a benefit to and, we believe, greatly appreciated by inexperienced professionals in Milwaukee County. Further, although many useful descriptions of the court, other legal system agencies, Ward 53B, and social agencies have been prepared, such descriptions need to be updated fairly regularly. It should be clear that in the area of involuntary civil commitment, most theory and practice is not fixed and unchanging. The development of the procedure of negotiated settlements described in Chapter Four, illustrates that what was known a few years ago may not be relevant now. In short, the information about relevant knowledge and practice of involuntary civil commitment in Milwaukee County must regularly be refreshed and updated.

RECOMMENDATION 26: THE MENTAL HEALTH ASSOCIATION IN MILWAUKEE COUNTY, THE TASK FORCE ON HUMAN SERVICES AND THE LAW, THE PLANNING COUNCIL FOR MENTAL HEALTH AND SOCIAL SERVICES, THE ADVISORY BOARD PROPOSED IN RECOMMENDATION 25 ABOVE, OR SOME OTHER APPROPRIATE AGENCY, ORGANIZATION, OR GROUP DESIGNATED BY THE MILWAUKEE COUNTY COMBINED COMMUNITY SERVICES BOARD, SHOULD ARRANGE FOR THE PREPARATION OF A SET OF STANDARD ORIENTATION MATERIALS TO BE USED BY PROFESSIONALS IN THE MENTAL HEALTH-LEGAL NETWORK WHO BECOME INVOLVED WITH INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS IN MILWAUKEE COUNTY.

As mentioned in several places throughout this report with reference to private attorneys, law enforcement officials, and mental health professionals, many persons become involved in involuntary civil commitment proceedings without proper education or preparation. Although everyone learns, more or less, by trial and error, many professionals regret their inadequate formal training. A set of standard orientation materials would help to ensure the consistent application of principles and methods to commitment cases and would facilitate the entry of new professionals into the mental health-legal system in Milwaukee County.

A second need is continuing education. As we have noted several times throughout this report, involuntary civil commitment laws and practices in Milwaukee County and throughout the country have undergone enormous changes in the last decade. Laws have evolved constantly, in reaction to a changing environment, shifting societal interests, and generational cycles of mores and customs. Even more recently, economic and social developments have dramatically affected the nature and number of community services available to the population potentially subject to involuntary civil commitment.[123] We believe that professionals who work within the mental health-legal system in Milwaukee County must keep abreast of these developments and interact with others who work in the system in an educational environment in which ideas and points of view can be exchanged freely.

> RECOMMENDATION 27: THE MENTAL HEALTH ASSOCIATION IN MILWAUKEE COUNTY, THE TASK FORCE ON HUMAN SERVICES AND THE LAW, THE PLANNING COUNCIL FOR MENTAL HEALTH AND SOCIAL SERVICES, THE ADVISORY BOARD PROPOSED IN RECOMMENDATION 25 ABOVE, OR SOME OTHER APPROPRIATE AGENCY DESIGNATED BY THE MILWAUKEE COUNTY COMBINED COMMUNITY SERVICES BOARD, SHOULD ARRANGE FOR PERIODIC CONTINUING EDUCATION SEMINARS IN MILWAUKEE COUNTY TO KEEP PROFESSIONALS WHO WORK IN THE MENTAL HEALTH-LEGAL SYSTEM ABREAST OF RELEVANT DEVELOPMENTS IN MENTAL HEALTH AND THE LAW.

The area of mental health and the law is one that continues to experience rapid change. A program of periodic continuing education seminars, held on a regular basis two or three times a year, would help maintain a high level of expertise among professionals in Milwaukee County. It would enable a stimulating interchange of ideas and opinion that would probably have a beneficial impact on service provision to the mentally ill.

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[123] See Kiesler, *supra*, note 103.

In addition to the training and continuing education of practitioners in the mental health-legal community in Milwaukee County, the public must be informed and educated. The paroxysm of legislative reform and change in the mental health and law area following the acquittal of John F. Hinckley illustrates the importance of public perception, even if that perception is out of proportion with reality. In addition to the substance of this report, we suggest that the Milwaukee County public be made aware of the following general points, the theme of which was suggested in the quotes introducing Chapter One of this report:

- There is no <u>ideal</u> solution to the personal, family, and social problems that the involuntary civil commitment process seeks to address.

- The involuntary civil commitment process entails compromise and a balancing of often conflicting individual, family, and state interests.

- Proponents of one set of interests are not necessarily unconcerned with other interests that lie in the balance.

- Unrepresentative cases to support extreme positions of one interest (i.e., individual, family, and state) may make for interesting reading but, unfortunately, produce poor public policy and further polarize proponents of specific interests.

- The involuntary civil commitment process in Milwaukee County has undergone dramatic changes within the last decade. It can be expected to change in the future.

- Single components of the mental health-legal system (e.g., law enforcement) are limited in their power to effect dramatic change in the involuntary civil commitment process. Meaningful change is likely to require several of the components acting in concert. Community expectations of one component (e.g., law enforcement; see Chapter Two) may be out of line with reality.

- Mental illness can encompass a great number of mental disorders along a continuum of severity. The terms "chronic" and "acute" are convenient labels identifying a band along that continuum, they are not synonymous with the terms "permanent" and "temporary."

- A continuum of mental health and social services are needed to address the continuum of mental health disorders.

- Volunteer and other non-public resources are needed to address the personal, family, and social problems encountered by persons facing involuntary civil commitment in Milwaukee County. The components of the mental health-legal system in Milwaukee County currently responsible for involuntary civil commitment cannot do it alone.

    <u>RECOMMENDATION 28</u>: THE MENTAL HEALTH ASSOCIATION IN MILWAUKEE COUNTY OR SOME OTHER APPROPRIATE AGENCY, ORGANIZATION, OR GROUP, SHOULD MOUNT A VIGOROUS CAMPAIGN TO EDUCATE THE MILWAUKEE COUNTY PUBLIC ABOUT THE THEORY AND PRACTICE OF INVOLUNTARY CIVIL COMMITMENT IN MILWAUKEE COUNTY.

APPENDIX A

FORMS USED IN THE INVOLUNTARY CIVIL COMMITMENT PROCESS IN MILWAUKEE COUNTY

Descriptive Title of Form(s)	Page
Milwaukee County General Hospital Emergency Admitting Center Medical Record	A3
Treatment Director's Supplement to Law Enforcement Officer's Statement for Detention	A5
Law Enforcement Officer's Emergency Detention Application (51.15)	A6
Petition for Examination	A7
Sworn Affidavit	A8
Notice of Preliminary Hearing and Commitment Rights	A9
Detention Order	A10
Milwaukee County Crisis Intervention Service Assessment and History Form	A11
Treatment Director's Statement of Emergency Detention	A17
Court-Ordered Voluntary Agreement (COV)	A19
District Attorney Mental Health Screening Form	A20
Patient's Rights on Detention Notification Form	A25
Patient's Rights Brochure	A26
Patient's Rights to be Read	A27
"Your Legal Rights"	A28
Affidavit of Service	A29
Consent to Acknowledge Presence in Milwaukee County Mental Health Complex	A30
Authorization to Inform Persons of Patient's Release	A31
Milwaukee County Mental Health Complex Admission Assessment-Nursing	A32
Nursing Admission Assessment	A33
Non-Voluntary Admisson Case Suspension Agreement	A35
Stipulation and Order	A36
Wisconsin Department of Health and Social Services, Division of Community Services, Initial Contact Sheet	A37
Report of Examiner Pursuant to Sec. 51.20(9), Stats.	A38

A3

ADMISSION CASE NUMBER

ADMITTED TO

MILWAUKEE COUNTY MEDICAL COMPLEX

ADMISSION DATE | ADMISSION TIME | ADM. BY | ADMITTED FROM | TRANSPORTATION MODE | UNIT NUMBER

PATIENT'S LAST NAME, FIRST, MIDDLE INITIAL | MAIDEN NAME | SPOUSE'S NAME

STREET ADDRESS | CITY | STATE | ZIP CODE | PATIENT'S TELEPHONE

BIRTHDATE | AGE | SEX | HERITAGE | MARITAL | RELIGION | PATIENT'S FATHER'S NAME | PATIENT'S MOTHER'S NAME

NURSE ASSESSMENT: LMP: LAST TETANUS: MEDICATIONS:

TRIAGE CODE:

T P R BP

LACERATION LOC. LENGTH TETANUS TOXOID ☐

MEDS/IV'S (NONE ☐)

ALLERGIES:

HISTORY, EXAM, TREATMENT:

PROCEDURES DONE (None ☐)

TESTS

☐ HGB/HCT
☐ WBC
☐ DIFF P B L M
☐ CPK
☐ LDH
☐ SGOT
☐
☐ ETOH
☐ C/S
☐ SMEAR
☐ C/S
☐
☐ U/A
☐ EKG

☐ BUN/CR
☐ B. SUGAR
☐ AMY
☐ LYTES
☐ PT
☐ PLT.
☐ T & C (# Units/Type)
☐
☐ ABG
☐ ABG

CONSULTATION:

FINAL DIAGNOSIS

CONDITION ON DISCHARGE: ☐ GOOD ☐ SERIOUS ☐ CRITICAL

INSTRUCTIONS/PLAN:

PRESCRIPTIONS (NONE ☐)

X-RAYS

☐ CHEST
☐
☐
☐

☐ DISCHARGE ☐ ADMIT TO FMLH
☐ EXPIRED ☐ OTHER
☐ ADMIT TO MCMC

DISPOSITION | TRANS. MODE | DISCHARGE DATE | DISCHARGE TIME | DISCHARGE NURSES SIGNATURE

INSTRUCTIONS GIVEN FOR

FOLLOW-UP

SITE
DATE
TIME

PHYSICIAN SIGNATURE 1. ID N

PHYSICIAN SIGNATURE 2. ID N

INSTRUCTIONS RECEIVED AND UNDERSTOOD.

SIGNATURE:

75158-3

MEDICAL RECORD—MCMC EMERGENCY

MEDICAL RECORD

AUTHORIZATIONS, ACKNOWLEDGEMENT AND RELEASE

I, the undersigned, do hereby authorize and consent to any services of an emergency nature, including but not limited to diagnostic procedures, radiology procedures, laboratory procedures, anesthesia, medical or surgical treatment, or hospital services, which are deemed necessary or advisable by the attending physician(s) and rendered to me under the general or special instructions of said physician(s).

I acknowledge that the medical care which will be furnished to me in the Emergency Room at Milwaukee County Medical Complex will be limited solely to emergency treatment. I understand that I may be released before all of my medical problems are known or treated, and that it will be necessary for me to make arrangements for follow-up care.

I do also hereby release Milwaukee County Medical Complex, all of its agents, employees and attending physician(s) from responsibility for anything but such emergency treatment.

I further authorize the release of medical information to any third party payor as may be necessary for the payment of any portion of the related hospital/physician bill and assign payment of insurance benefits directly to Milwaukee County Medical Complex and Faculty Health Services.

I further authorize the release of any medical information regarding my care and treatment to any hospital or physician responsible for my continued care subsequent to this emergency room visit.

I request that a copy of this record be referred to ______________________________, M.D.
Personal/Private Physician

Location: ______________________________

____

______________________________ (Person authorized to consent for patient)

______________________________ (Signature of Patient)

Relationship: ______________________________

______________________________ (Date)

Reason: ______________________________

______________________________ (Witness)

Address: ______________________________

____

MANDATORY for RELATIONSHIP and REASON to be completed when other than patient signs consent

STATE OF WISCONSIN CIRCUIT COURT MILWAUKEE COUNTY PROBATE JURISDICTION

IN THE MATTER OF

____

____

TREATMENT DIRECTOR'S SUPPLEMENT TO LAW ENFORCEMENT OFFICERS STATEMENT OR DETENTION

File No.__________

The undersigned Treatment Director, or his designee, at the Milwaukee County Mental Health Complex, states as follows:

1. The above patient was admitted to the Mental Health Center on __________, 19____, at ________ A.M./P.M., by a law enforcement officer on the basis of an emergency detention under s. 51.15, Stats. See attached detention statement.

2. To a reasonable degree of medical certainty, the subject suffers from mental illness/developmental disability/drug dependence as defined in Section 51.01, Stats, and is a proper subject for treatment.

3. The subject's specific diagnosis or condition is as follows: (Include descriptions of conduct since admission.)

4. It is recommended that involuntary commitment proceedings be initiated to secure treatment for the subject.

5. Copies of the attached law enforcement officers statement of detention, this supplement and the attached statement of rights have been duly served upon the subject and the statement of rights was read aloud to the subject.

Dated____________________, 19____.

____
Treatment Director or Designee

EMERGENCY DETENTION 51.15

I, THE UNDERSIGNED LAW ENFORCEMENT OFFICER OF THE ____________________

____________ LAW ENFORCEMENT AGENCY, DISTRICT ____________________ DO HEREBY

STATE THAT ON THE ________ DAY OF ________ 19____ AT ____________ A.M./P.M., AT

____________________ IN THE CITY OF ____________________, MILWAUKEE
(location)

COUNTY, I TOOK INTO CUSTODY THE FOLLOWING NAMED PERSON PURSUANT TO SEC. 51.15:

____________________ ____________________ ________
(Name) (Address) (Age)

THE REASON FOR SAID DETENTION WAS AS FOLLOWS:
(Describe in detail the actions, conduct, appearance, specific overt acts, attempts or threats or a pattern of recent acts or omissions observed by you.)

OBSERVED BY ME PERSONALLY: (Describe dangerous behavior - use reverse side if necessary.)

ON ____________________ ____________________ 19____, AT ____________ A.M./P.M.
(Day) (Date)

AT THE ABOVE LOCATION, I OBSERVED ____________________
(Name)

INFORMATION REPORTED TO ME BY THE FOLLOWING NAMED WITNESSES WHO I BELIEVED TO BE RELIABLE. TIME-PLACE-DATE-CONDUCT--STATE WHAT EACH WITNESS REPORTED (Use reverse side if necessary).

____________________ ____________________ ________
(Name) (Address) (Phone)

That the person taken into custody was detained at Milwaukee County Mental Health Complex - 9455 Watertown Plank Road - Ward 53B,

pursuant to Wis. Stats. 51.15.

That the undersigned has cause to believe that the individual taken into custody is: mentally ill/drug dependent/developmentally disabled, and that said individual evidences:

A. A substantial probability of physical harm to self as manifested by evidence of recent threats of/or attempts at suicide or serious bodily harm s. 51.20(1)(a) 2a OR

B. Evidences a substantial probability of physical harm to other individuals as manifested by evidence of recent homicidal or other behavior, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt or threat to do such serious physical harm s. 51.20 (1) (a) 2b OR

C. Evidences such impaired judgment manifested by evidence of a pattern of recent acts or omissions, that there is substantial probability of physical impairment or injury to self s. 51.20 (1) (a) 2c. The probability of physical impairment or injury is not substantial under this subparagraph if reasonable provision for the subject individual's protection is available in the community or if the individual is not appropriate for placement under s. 55.06 or in the case of a minor if the individual is appropriate for services or placement under s. 48.13 (4) or (11). The subject individual's status as a minor does not automatically establish a very substantial probability of physical impairment or injury under this subparagraph. OR

D. Evidences behavior manifested by recent acts or omissions that due to mental illness, he or she is unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt and adequate treatment so that a substantial probability exists that death, serious physical injury, serious physical debilitation or serious physical disease will imminently ensure unless the individual receives prompt and adequate treatment for this mental illness. No substantial probability of harm under this subparagraph exists if reasonable provision for the individual's treatment and protection is available in the community, if the individual can receive protective placement under s. 55.06 or, in the case of a minor, if the individual is appropriate for services or placement under s. 48.13 (4) or (11). The individual's status is a minor does not automatically establish a substantial probability of death, serious physical injury, serious physical debilitation or serious disease under this subparagraph.

My belief is based on the above mentioned specific recent overt acts, attempts, or threats to act or a pattern of recent acts or omissions made by the individual and observed by or reliably reported to me.

Dated this ________ day of ____________________, 19____.

Signatures of Officers:

Officer/Law Enforcement Agency	Officer/Law Enforcement Agency.
District	District
Telephone	Telephone

NOTE: More than one officer may sign. One signing officer must appear to testify. INCLUDE ALL WITNESS' TELEPHONE NUMBERS.

STATE OF WISCONSIN   CIRCUIT COURT   MILWAUKEE COUNTY   PROBATE JURISDICTION

IN THE MATTER OF

PETITION FOR EXAMINATION

File No. ______________

____

____

The petition of ____________________________, ____________

______________, and ____________________________ all adult residents of the State of Wisconsin, being duly sworn on oath, state as follows:

1. ________________________________, residing at ____________________________ in Milwaukee County, Wisconsin, is believed to be mentally ill/drug dependent/developmentally disabled and is a proper subject for treatment.

2. That the subject is dangerous and evidences one or more of the following:

(a) Evidences a substantial probability of physical harm to himself/herself as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm. (51.20(1) (a) 2.a)

AND/OR

(b) A substantial probability of physical harm to other persons as manifested by evidence of recent homicidal or other violent behavior or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to themselves as evidenced by a recent overt act, attempt or threat to such serious physical harm. (51.20(1) (a) 2.b)

AND/OR

(c) Evidences such impaired judgment manifested by evidence of a pattern of recent acts or omissions that there is a very substantial probability of physical impairment or injury to himself/herself. The probability of physical impairment or injury may not be deemed very substantial under this subparagraph if reasonable provision for the subject individual's protection is available in the community or if the individual is not appropriate for placement under s. 55.06. The subject individual's status as a minor does not automatically establish a very substantial probability of physical impairment of injury under this subparagraph. (51.20(1) (a) 2.c)

AND/OR

(d) Evidences behavior manifested by recent acts or omissions that, due to mental illness, he or she is unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt and adequate treatment so that a

substantial probability exists that death, serious physical injury, serious physical debilitation or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for this mental illness. No substantial probability of harm under this subparagraph exists if reasonable provision for the individual's treatment and protection is available in the community, if the individual can receive protective placement under s. 55.06, in the case of a minor, if the individual is appropriate for services or placement under s. 48.13 (4) or (11). The individual's status as a minor does not automatically establish a substantial probability of death, serious physical injury, serious physical debilitation or serious disease under this subparagraph.

AND/OR

(e) If the individual has been the subject of inpatient treatment for mental illness, drug dependency or developmental disability immediately prior to commencement of proceedings, the requirements of specific recent overt acts, attempts or threats to act or pattern of recent acts or omissions may be satisfied by a showing that there is a substantial likelihood based on the subject individual's treatment record that the individual would be a proper subject for commitment if treatment were withdrawn. (51.20(1) (am))

3. The names and addresses of interested parties are:

NAME	ADDRESS	PHONE	RELATIONSHIP
I. <u>Petitioners</u>:			
II. <u>Other Interested Persons</u>:			

4. Petitioners without personal knowledge of the conduct of the subject are ________________________________ who have been personally exposed to the habits and conduct of the subject individual and have reason to believe the allegations contained in the attached affidavit are true.

5. Petitioners request an order of the Court for the detention of the subject, a hearing to determine whether the subject individual is mentally ill and such commitment and treatment as may be necessary.

STATE OF WISCONSIN)
) ss
MILWAUKEE COUNTY)

VERIFICATION

________________________, ________________________

and ________________________ being first duly sworn on oath, allege that they are the petitioners in the above entitled matter, that they have read the attached petition and affidavit (or have had it read to them); that all the matters contained therein are true and are based upon the personal knowledge and observation of each petitioner, as indicated therein, except as to those matters the petitioners believe them to be true.

DATED:________________________,19______

____

____

____

Subscribed and sworn to before me
this____day of______________19____.

____
Notary Public, Wisconsin
My Commission is permanent

STATE OF WISCONSIN MILWAUKEE COUNTY CIRCUIT COURT PROBATE JURISDICTION

IN THE MATTER OF

NOTICE OF PRELIMINARY HEARING AND COMMITMENT RIGHTS

____

____

File No. __________

A petition for your commitment has been filed with the Circuit Court of Milwaukee County, Wisconsin. A hearing to determine if there is probable cause to believe the allegations of the petition will be held at 8:30 A.M. on __________ 19____, at M.C.M.H.C., 9455 Watertown Plank Road, Ward 53B, Wauwatosa, WI , which hearing must be held within 72 hours, exclusive of Saturday, Sunday, and legal holidays, of your detention. If you fail to appear at said time and place, the Court may order your detention. See paragraph 9 below if you were detained by law enforcement officers.

You have been temporarily detained in the custody of the Community Board until the probable cause hearing.

In the event probable cause is found at the preliminary hearing, a final hearing will be ordered to determine whether you may be committed to the custody of the Community Board. You may be committed only if it is established by clear and convincing evidence that you are mentally ill, drug dependent or developmentally disabled; that you are a proper subject for treatment and have been engaged in any of the following:

A. A substantial probability of physical harm to self as manifested by evidence of recent threats of/or attempts at suicide or serious bodily harm s. 51.20 (1) (a) 2a.

OR

B. Evidences a substantial probability of physical harm to other individuals as manifested by evidence of recent homicidal or other behavior, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt or threat to do such serious physical harm s. 51.20 (1) (a) 2b.

OR

C. Evidences such impaired judgment manifested by evidence of a pattern of recent acts or omissions, that there is substantial probability of physical impairment or injury to self s. 51.20 (1) (a) 2c. The probability of physical impairment or injury is not substantial under this subparagraph if reasonable provision for the subject individual's protection is available in the community or if the individual is appropriate for placement under s. 55.06 or in the case of a minor if the individual is appropriate for services or placement under s. 48.13 (4) or (11). The subject individual's status as a minor does not automatically establish a very substantial probability of physical impairment or injury under this subparagraph.

OR

D. Evidences behavior manifested by recent acts or omissions that due to mental illness, he or she is unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt and adequate treatment so that a substantial probability exists that death, serious physical injury, serious physical debilitation or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for this mental illness. No substantial probability of harm under this subparagraph exists if reasonable provision for the individual's treatment and protection is available in the community, if the individual can receive protective placement under s. 55.06 or, in the case of a minor, if the individual is appropriate for services or placement under s. 48.13 (4) or (11). The individual's status as a minor does not automatically establish a substantial probability of death, serious physical injury, serious physical debilitation or serious disease under this subparagraph.

OR

E. If the individual has been the subject of inpatient treatment for mental illness, developmental disability or drug dependency immediately prior to commencement of the proceedings, the requirements of specific recent overt acts, attempts or threats to act or pattern of recent acts or omissions may be satisfied by a showing that there is a substantial likelihood, based on the subject individual's treatment record, that the individual would be a proper subject for commitment if treatment were withdrawn s. 51.20 (1) (am).

OR

BURDEN OF PROOF

All of the allegations of the petition must be proven by evidence which is clear and convincing. The burden of proving the allegations is upon the petitioners.

YOUR LEGAL RIGHTS

You have the right:

1. To contact and be represented by legal counsel. Free legal counsel will be appointed for you if you are indigent, and the court will assure that you have advisory counsel regardless of your ability to pay.

2. To consult with counsel before a request is made for voluntary treatment.

3. To refuse to converse with anyone as anything you say may be used as evidence against you.

4. To refuse medication and treatment, except as ordered by the Court, unless an emergency is determined to exist by your physician.

5. To be examined by a physician.

6. To have your need for commitment determined by a jury. This demand must be made at least 48 hours in advance of the final hearing, otherwise the jury trial is waived.

7. To have a copy of the commitment petition.

8. To contact a member of your immediate family.

9. If you are detained by a law enforcement officer acting pursuant to Sec. 51.15, State, the facility treatment director or designee must notify you within 24 hours of your detention whether commitment proceedings will be filed, otherwise you must be released at the end of that time. If proceedings are initiated you must have a probable cause hearing within 48 hours of the time the treatment director notifies you, exclusive of weekends and legal holidays.

IN THE MATTER OF

ORDER

____

File No.

It is determined on receipt of a Petition for Examination in due form for the commitment of ______________________________ that:

1. The Petition meets the requirements of Wisconsin Statutes, Chapter 51.

2. A preliminary hearing to determine whether there is probable cause to believe the allegations of the Petition are true will be held at 8:30 a.m. on the _______ day of ______________________________, 19 ___, at Milwaukee County Mental Health Complex, 9455 Watertown Plank Road, Ward 53B, Milwaukee, Wisconsin.

3. An attorney shall be appointed by the Court to represent you.

4. Pending the outcome of the preliminary hearing the above named person shall be temporarily committed to the custody of the Community Board of Milwaukee County. Law enforcement officers of Milwaukee County shall take such person into protective custody and transport said individual to the said Ward 53B.

5. A copy of the Petition, this Order and a Notice of Preliminary Hearing and Commitment Rights shall be personally served on the above named person by the Milwaukee County Sheriff or his deputy.

Dated this _______________ day of ______________________________, 19______

BY THE COURT

____

Circuit Judge

duplicate

Milwaukee County Crisis Intervention Service
Assessment and History

*1. MCIT call # ___ ___ ___ ___ (1 2 3 4)   DECK 1   Unit # ___ ___ ___ ___ ___ ___ ___

*2. Date of Contact ___ ___ / ___ ___ / ___ ___ (5 6 7 8 9 10) mo. day yr.   *3. Census Tract ___ ___ ___ ___ ___ (11 12 13 14 15)

*4. Total Time: ___ (16) (units of service 15 min.=1 unit)

Social Assessment

Client name ______________ Last ______________ First (______________ Maiden)

Address ______________ * Zipcode ______ 17 18 19 20 21

Telephone # ______________ Social Security # ______________

*5. Client's age 00) no answer Date of birth __ __/ __ __/ __ __   22 23

Father's name ______________ Mother's name ______________

Spouse ______________ Time start ________ Time end ________

MCIT members: 1) ______________ 2) ______________

6. Has this client ever been seen by MCIT within this calendar year?
1) yes 2) no   24

Client I.D. # ______________ use first call # ever used

*7. Client's sex: 1) male 2) female   25

*8. Client's marital status: 1) married 2) single 3) widowed
4) divorced 5) separated 0) N/A   26

9. Duration of present status: 1) less than one year 2) 1-3 years
3) 4-6 years 4) 7-9 years 5) 10+ years 6) never married 9) DK   27

*10. Ethnicity: 1) caucasian 2) black 3) oriental 4) hispanic
5) American Indian 6) other ______________ specify   28

11. Living arrangement: 01) in own home 02) apartment 03) room
04) public housing 05) retirement home 06) community based
residential facility 07) intermediate care facility
08) nursing home 10) other ______________ specify 09) DK   29 30

*12. Lives: 1) alone 2) with children 3) spouse 4) relative
5) non-relative 6) other ______________ specify 9) DK   31

13. Number in household: ___   32 33

14. Education: ______________ highest grade completed 9) DK   34 35

15. Religion: 1) Protestant 2) Catholic 3) Jewish 4) Muslim
5) other ______________ specify   36

16. Church affiliation (name) ______________
1) active member 2) inactive member 9) DK 0) N/A   37

*17. Client a veteran? 1) yes 2) no   38

18. If yes, are you eligible for hospitalization benefits?
1) yes 2) no   39

*19. Precipitating event for MCIT call: 1) threatening harm to self
2) threatening harm to others 3) psychotic episode 4) confused, disoriented 5) severe depression with likelihood of suicide attempt 6) suspicious, fearful 7) activities of daily living dysfunction 8) family conflict 9) medical 10) discontinued medication/treatment 11) other   40 41

*20. Client employment outside of home: 1) yes 2) no 9) DK   42

21. Current/previous occupation: 1) professional 2) blue-collar skilled 3) blue-collar unskilled 4) white collar, salesperson/ clerical 5) homemaker 6) student 7) other ______________ specify
9) DK 0) N/A   43

22. Type of employment: 1) full-time 2) part-time 3) unemployed
4) retired 9) DK 0) N/A   44

*23. Monthly income: 1) less than $300 2) $300-699 3) $700-999
4) $1000-1999 5) $2000+ 9) DK   45

24. Source of income: 1) salary, wages 2) SSI 3) AFDC
4) veteran's disability 5) general assistance 6) social security 7) unemployment compensation 8) workmen's compensation 9) retirement/pension 11) spouse's income
12) parent's income 13) other ______________ specify   46 47

*25. Insurance/medical assistance 1) yes 2) no 9) DK
If yes, type of insurance/medical assistance ______________   48

*26. Referral source calling PEH: 1) self 2) Corp. Counsel 3) APS
4) PSHT 5) police 6) ambulance service 7) landlord 8) employer
9) relative 10) neighbor/friend 11) Child Welfare Department
12) other social agency ______________ specify
13) other professional ______________ specify
14) emergency room (MCMC) 15) other ______________   49 50

Referral person:
Name: ______________
Address: ______________
Telephone #: ______________

27. Circle those with whom MCIT had face-to-face contact: (yes=1, no=0)   51 52 53
1) child 2) spouse 3) parent 4) grandchild 5) grandparent
6) sibling 7) self 8) partner/roommate 9) non-relative
______________ specify 0) N/A (#'s 51 through 60 apply to question # 27)   54 55 56

28. Contact person: relationship to client; insert number from above   57 58 59

Name ______________   60

Address ______________ Telephone # ______________   61

29. Significant other (if different from above)
relationship to client; insert number from above

Name ______________

Address ______________ Telephone # ______________   62

30. Willing to help: 1) yes 2) no
referral person ___63
contact person ___64
significant other ___65

31. Is there provision for meeting the following needs?
1) yes 2) no 9) DK 0) N/A

food	__66
rent	__67
utilities	__68
clothing	__69
transportation	__70
health care	__71
housekeeping	__72
personal hygiene	__73

Deck 1 Column __1 80

32. MCIT Call # ___ ___ ___ ___ DECK 2
1 2 3 4

33. Community involvement with client within past year: 1) yes 2) no 9) DK 0) NA

1)	Visiting Nurse Association	__5
2)	Public Health Nurse	__6
3)	Adult Protective Service	__7
4)	Protective Service Management Team	__8
5)	Child Protective Service	__9
6)	Mobile meals	__10
7)	Homemaker Services	__11
8)	Vocational Rehabilitation Agency	__12
9)	Veterans Administration	__13
10)	Health Department	__14
11)	Gero-psychiatry	__15
12)	Police	__16
13)	Transportation	__17
14)	Probation/parole officer ______________ (specify)	__18
15)	Mental Health Services ______________ (specify)	__19
16)	Catchment Area Clinic utilized (circle one) I, II, III, IV, V, VI, VII	__20
17)	Other social service agencies	__21
18)	Emergency shelter	__22
19)	Other ______________ (specify)	__23
20)	N/A	__24

34. Client: 1) is legally self-responsible 2) has a guardian appointed 3) is in process of guardianship proceedings
25

If client has a guardian,
Name: ______________________________

Address: ______________________ Telephone # ______________

35. Social Resources: (Circle those who are in client's network of significant others) NOTE: 0=no, 1=yes
0) No answer/DK 1) children 2) spouse 3) parents
4) grandparents 5) other relatives 6) partner/roommate
7) other friends, neighbors, non-relatives 8) none
(#'s 26 through 34 apply to question #35)
26 27 28
29 30 31

*36. Quality of social support system:
1) excellent 2) good 3) fair 4) poor 5) none exists
32 33 34

35

37. Any previous family mental disorders and treatment?
1) yes 2) no 9) DK 0) N/A
If yes, explain: ______________________________
36

38. Is family conflict contributing to current crisis?
1) yes 2) no 9) DK 0) N/A
37

If yes, explain: ______________________________

*39. Client history involvement with criminal justice system:
1) yes 2) no 9) DK 0) N/A
Explain: ______________________________
38

____

Psychological Assessment

0=Not Present-N/A; 1=Mild; 2=Moderate; 3=Severe 9=DK

40. Appearance:

physically unkempt, unclean	__39
clothing disheveled, dirty	__40
clothing atypical, unusual, bizarre	__41
unusual physical characteristics	__42

41. Communication:

talkative	__43
free-flowing	__44
guarded	__45
relevant	__46
coherent	__47

42. Amplitude & Quality of Speech:

loud	__48
fast	__49
monotone	__50
pressured	__51
rambling	__52
slurred	__53
stuttering	__54
clear	__55
articulate	__56

43. Behavior: Posture:

lying down	__57
slumped	__58
rigid, tense	__59
atypical, inappropriate	__60

44. Motor Activity:

restless	__61
tremulous	__62
posturing	__63
repetitive acts	__64
increased	__65
need for distance	__66
pacing	__67
mannerisms	__68
lethargic	__69
agitated	__70
grimaces	__71
hand-tapping	__72
foot-tapping	__73

Deck 2 __2 80

45. Facial Expression: DECK 3 **46. MCIT #** ___ ___ ___ ___
1 2 3 4

smiling	__5
angry	__6
worried	__7
elated	__8
frightened	__9
expressionless	__10
avoids direct contact	__11
stares into space	__12
bizarreness, inappropriateness	__13
grimaces	__14

0=Not Present-N/A 1=Mild; 2=Moderate; 3=Severe 9=DK

47. Client-Counselor relationship:

domineering	__(15)
submissive, overly compliant	__(16)
provocative	__(17)
suspicious	__(18)
uncooperative	__(19)
manipulative	__(20)

49. MCIT # __ __ __ __ (1 2 3 4) DECK 4

50. Thought Process and Content:

suicidal	__(5)
homocidal	__(6)
blocking	__(7)
tangential	__(8)
perseverations	__(9)
confabulations	__(10)
suspiciousness	__(11)
loose associations	__(12)
flight of ideas	__(13)
paranoia	__(14)
obsessions	__(15)
compulsions	__(16)
feeling of unreality	__(17)
isolation	__(18)
indecision	__(19)
concrete	__(20)
ideas of:	
guilt	__(21)
hopelessness	__(22)
helplessness	__(23)
worthlessness	__(24)
influence	__(25)
reference	__(26)
phobias	__(27)
excessive religiosity	__(28)
somatic preoccupation	__(29)
sexual preoccupation	__(30)
delusions of:	
persecution	__(31)
grandeur	__(32)
systematized	__(33)
thought flow increased	__(34)
thought flow decreased	__(35)
other ________	__(36)

48. Attitude, Mood, Affect:

resistive	__(21)
cooperative	__(22)
complacent	__(23)
interested	__(24)
suspicious	__(25)
trusting	__(26)
passive	__(27)
aggressive	__(28)
depressed	__(29)
euphoric	__(30)
appropriate	__(31)
inappropriate	__(32)
apathetic	__(33)
active	__(34)
self-depreciative	__(35)
changeable	__(36)
irritable	__(37)
anxious	__(38)
hostile	__(39)
silly	__(40)
angry	__(41)
flat	__(42)
evasive	__(43)
blunted	__(44)
relaxed	__(45)
withdrawn	__(46)
negativistic	__(47)
frightened	__(48)
demanding	__(49)
preoccupied	__(50)
dependent	__(51)
manipulative	__(52)
DECK 3	3(80)

*51. Perceptual Disorders:

Hallucinations:	
auditory	__(37)
visual	__(38)
tactile	__(39)
gustatory	__(40)
olfactory	__(41)
illusions	__(42)

*52. Orientation:

disoriented to person	__(43)
disoriented to place	__(44)
disoriented to time	__(45)

*53. Insight:

adequate	__(46)
difficulty in acknowledging the presence of psychological problems	__(47)
mostly blames others or circumstances for problems	__(48)
unrealistic	__(49)
superficial	__(50)

0=Not Present-N/A; 1=Mild; 2=Moderate; 3=Severe 9=DK

*54. Judgement:

adequate	__(51)
impaired ability to manage daily living activities	__(52)
impaired ability to make reasonable life decisions	__(53)

*55. Memory:

impaired immediate recall	__(54)
impaired recent memory	__(55)
impaired remote memory	__(56)
poor concentration	__(57)
poor attention	__(58)
poor fund of knowledge	__(59)

56. Has current mental health therapist?
1) Yes 2) No 9) DK 0) NA __(60)

Name of therapist: ____________________

*57. Has had mental health therapist in the past? (Out-patient)
1) Yes 2) No 9) DK 0) NA __(61)

*58. Has been hospitalized for mental health reasons? (In-patient)
1) Yes 2) No 9) DK 0) NA __(62)

Hospital	Dates
________	________
________	________
________	________

Current psychotropic medication; dosage and schedule: 1=Yes 0=No __(63)

____

____

59. Prescribed, but client refuses: 2) Yes 3) None prescribed
9) DK 0) NA __(64)

60. Past psychotropic medication history: 1) Yes 2) No 9) DK
0) NA __(65)
List prior medications: ____________________

*61. Impression of current psychiatric problem:
(If more than one set of symptoms present indicate primary by 1, secondary by 2 and 3, where applicable.)

1) Psychotic disorder (delusions, hallucinations, loose associations, catatonic, schizophrenia, grossly disorganized behavior, incoherence) __(66)
2) Mood disturbance (depressed, irritable or expansive mood predominant clinical feature) __(67)
3) Anxiety or avoidance behavior (agoraphobia, panic attack, social phobia, separation anxiety) __(68)
4) Antisocial, aggressive, defiant or oppositional behavior __(69)
5) Organic Brain Syndrome (dementia, withdrawal, delirium, delusions, apathy, suspiciousness) __(70)
6) Alcoholism, substance abuse, or substance withdrawal __(71)
7) Mental retardation __(72)
8) Manic-depressive illness __(73)
0) None __(74)

Deck 4 4(80)

DECK 5 MCIT # _ _ _ _

*Suicide Assessment
(method and availability, time of plan)

62. 1) well planned 2) loose plan 3) no plan __(5)

*63. Previous attempts: 1) none 2) once 3) multiple 9) DK __(6)

When:

How:

64. Lethality Index:
Is client alone? 1) Yes 2) No 0) NA __(7)

Currently drinking? 1) Yes 2) No 9) DK 0) NA __(8)

Currently using drugs? 1) Yes 2) No 9) DK 0) NA __(9)

History of violence? 1) Yes 2) No 9) DK 0) NA __(10)

Family/friends with suicide history? 1) Yes 2) No 9) DK 0)NA __(11)

Access to weapons? 1) Yes 2) No 9) DK 0) NA __(12)
Specify:

65. Current Ideation:
1) Has wished to be dead, but rejects suicide 2) Has considered suicide, but suicidal thoughts are fleeting 3) Has seriously considered a suicide method, but has not yet attempted it 4) Has attempted suicide 0) NA __(13)

*66. Suicide Risk Assessment: 1) high 2) medium 3) low 9) DK __(14)

67. Has expressed a desire to seriously harm or kill someone else?
1) Yes 2) No 9) DK 0) NA __(15)

Name of person: Telephone

68. Notified? 1) Yes 2) No 9) DK __(16)

*69. Danger potential to others: 1) high 2) medium 3) low 0) NA __(17)

Alcohol and Drug Assessment

70. Does client appear to be drinking or drunk?
1) Yes 2) No 9) DK 0) NA __(18)

71. Does client drink alcohol?
1) Yes 2) No 9) DK 0) NA __(19)
If yes, how often?

How much, and what does client drink?

72. Did client ever lose a job, gotten into a legal or family problem as a result of alcohol drinking?
1) Yes 2) No 9) DK 0) NA __(20)

73. Has client ever experienced blackouts, severe shaking, heard voices or seen things that were not there, after heavy drinking?
1) Yes 2) No 9) DK 0) NA __(21)

74. Has client ever had D.T.'s?
1) Yes 2) No 9) DK 0) NA __(22)

75. Has client ever had treatment for alcohol abuse?
1) Yes 2) No 9) DK 0) NA __(23)
If yes, list name of treatment facility and dates of treatment:

76. Does client use drugs illicitly?
1) Yes 2) No 9) DK 0) NA __(24)
If yes, how often, how much, and what type(s) is used, and method of use?

77. Does client abuse/misuse prescription drugs?
1) Yes 2) No 9) DK 0) NA __(25)

78. Has client ever had an addiction to drugs?
1) Yes 2) No 9) DK 0) NA __(26)

79. Does the client have needle or scar "track" marks, the result of intravenous drug use?
1) Yes 2) No 9) DK 0) NA __(27)

80. Has client ever had treatment for drug abuse?
1) Yes 2) No 9) DK 0) NA __(28)
List treatment facilities and dates of treatment:

Biological Assessment

Medical Assessment waived due to:

Current private medical physician/clinic?

Previous Medical Hospitalizations (begin with most recent first)

When | Where | Reason

Chief Medical Complaints: (if applicable)

General Appearance (1=Unacceptable; 2=Acceptable)

Body cleanliness ____ Oral hygiene ____

hair ____ posture ____ gait ____

Temp: ____ Pulse: ____ Resp: ____ B/P: ____ Ht. ____ Wt. ____

Code continued on page 10

0=Not Present-N/A; 1=Mild; 2=Moderate; 3=Severe; 9=DK

Past Medical History: Diabetes__ Heart__ Cancer__ Kidney__ T.B.__

Sickle Cell___ COPD__ Asthma__ Epilepsy__ Other________________

Current Treatment: ______________________________

____

Review of Systems

EENT: Impaired: Vision__ Hearing__ Speech__

Further Assessment: ______________________________

____

Neurological: Impaired level of consciousness___

Impaired reflexes: Babinski____ Corneal____ headaches_____

Further Assessment: ______________________________

____

____

Pulmonary: Shortness of breath__ Productive cough__ Orthopnea__

Further Assessment: ______________________________

____

Cardiovascular: Pulses (specify rate) Carotid__ Apical Reg__ Irreg___

Radial__ Neck Vein distention__

Further Assessment: ______________________________

____

Skin: Color__________ Clammy_____ Cool_____ Dry_____ Warm______

Edema (describe) ______________________________

Further Assessment: ______________________________

____

GI: Anorexia___ Diarrhea___ Nausea___ Vomiting___ Constipation___

Further Assessment: ______________________________

____

GU/Reproductive: Dysuria____ Incontinence___ Frequency___ Hematuria__

Penile discharge___ Vaginal discharge___ Last pelvic exam___________

Further Assessment: ______________________________

____

Skin: Rashes___ Discoloration___ Bruises___ Dehydration___ Sores___

Further Assessment: ______________________________

____

Skeletal: Limitation of movement____ Fractures___ Amputations

Further Assessment: ______________________________

____

Patterns: (1=Unacceptable; 2=Acceptable)

Sleep: ______________________________

Eating: ___ ______________________________

Self-assessment (specify) ______________________________

*81. Diagnostic impressions: Medical problem present? 1) Yes 2) No 9) DK 0) N/A __29

*82. Diagnostic impressions: Psychiatric problem present? 1) Yes 2) No 9) DK 0) N/A (include suicide ideation) __30

*83. Diagnostic impressions: Social problem present? 1) Yes 2) No 9) DK 0) N/A __31

*84. Diagnostic impressions: Alcohol or drug abuse problem present? 1) Yes 2) No 9) DK 0) N/A __32

*85. Disposition: (specify agencies)(Primary disposition indicate by 1, Secondary by 2 and 3, where applicable)

1) Counseling intervention by CIS __33
2) Outpatient psychiatric referral ________________ __34
3) Inpatient psychiatric referral ________________ __35
4) Emergency shelter ________________ __36
5) Involuntary hospitalization (Chapter 51) __37
6) Involuntary hospitalization (Chapter 55) __38
7) Other mental health resource ________________ __39
8) Alcohol/drug treatment program ________________ __40
9) Outpatient medical referral________________ __41
10) Inpatient medical referral ________________ __42
11) Family referred to PSMT (3-Party Petition and/or guardianship) __43
12) Client/family referred for case management ____________ __44

Note: List primary disposition and two alternate dispositions if appropriate:

1. ______________________________

2. ______________________________

3. ______________________________

*86. Was client transported to treatment facility? 1) Yes 2) No 9) DK 0) N/A __45

*87. Who transported client? 1) self 2) relative/friend 3) police 4) ambulance 5) taxi 6) MCIT 7) bus 8) other ____________ (specify) __46

88. Evaluation/follow-up needed: 1) client/significant other to contact CIS 2) CIS to contact client/significant other 3) professional to contact CIS 4) CIS to contact professional: __47

Name: ______________________________

Telephone #: ______________________________

Deck 5 5 80

DECK 6 89. MCIT ¯1 ¯2 ¯3 ¯4

*90. If involuntary detention, was probable cause found? __5
1) Yes 2) No

Court date: __/__/__ __

Court time: __ __ __ __-__ __ __ __

Team member(s) that appeared in court: ______________________

____

*91. Client Response:

1) Client accepted MCIT recommendations
2) Client refused
3) Client refused, family referred
4) Client deferred decision
5) Client not there, deceased, not available
9) DK __6

92. How personally dangerous did you find this situation?
0=not at all; 1=felt slight sense of danger; 2=felt definite sense of danger; 3=strong sense of danger
(each counselor assess the situation and respond for self)

Counselor # ¯7 ¯8 __9

Counselor # 10 11 __12

*93. Did you make use of any resources while you were on this call?
0=N/A 1=Yes
Relied on our own personal resources only __13
Called on help from client's family/significant others __14
Called on help from PEH (Emergency Hotline) __15
Called on help from consulting psychiatrist __16
Called on help from police __17
Called on help from others ______________________ __18
specify

*94. Evaluation for Chapter 51 Detention completed: __19
1) Yes 2) No 9) DK 0) N/A

*95. Did situation result in Chapter 51 Detention? __20
1) Yes 2) No 9) DK 0) N/A

*96. Evaluation for Chapter 55 Detention completed: __21
1) Yes 2) No 9) DK 0) N/A

*97. Did situation result in Chapter 55 Detention? __22
1) Yes 2) No 9) DK 0) N/A

*98. Police - cooperative intervention __23
1) police contact MCIT 2) MCIT contacted police 0) N/A

99. Police District # ______________________ __24
Squad #: ______

Officers: 1. ______________________ 2. ______________________

100. Police were used to secure area: __25
1) Yes 2) No 9) DK 0) N/A

101. Police were used as consultants: __26
1) Yes 2) No 9) DK 0) N/A

102. MCIT was used to evaluate situation: __27
1) Yes 2) No 9) DK 0) N/A

103. MCIT was used to function as a witness: __28
1) Yes 2) No 9) DK 0) N/A

104. Counselor(s) who completed this form: (29-30)__ __

(31-32)__ __

Deck 6 6 80

STATE OF WISCONSIN CIRCUIT COURT MILWAUKEE COUNTY PROBATE JURISDICTION

IN THE MATTER OF

TREATMENT DIRECTOR'S STATEMENT OF EMERGENCY DETENTION

File No. ______________

____

______________________________, Treatment Director/Designee

of ______________________________ states to the Court as follows:
(hospital)

1. The above named subject entered this facility on

______________________ as a voluntary patient. On ______________________

he/she filed a written demand for discharge, against medical advice.

2. In the opinion of the undersigned, to a reasonable degree of medical certainty/professional certainty, the subject is mentally ill/drug dependent/developmentally disabled and is a proper subject for treatment. Specifically, his/her diagnosis is ______________________________

____

____

3. The subject has recently engaged in conduct satisfying one or more of the statutory standards for dangerousness which are stated below, as evidenced by the following events or behavior. (List time, date, place and specifics. Use chart material. ID all witnesses.)

4. The names, addresses and telephone numbers of the informants upon whom the undersigned has relied, and whose statements he/she believes to be true, or who witnessed the events, discussed above are:

Name	Address	Telephone

5. The undersigned believes that there is a substantial probability of harm to the subject or to others if he/she does not receive psychiatric treatment immediately.

6. The subject was detained on ______________________________

A.M.
at ____________________ P.M. and served with a copy of this statement and a copy of his/her rights upon detention. The latter document was read to the subject.

Dated ______________________________, 19________

____
Treatment Director/Designee

STATE OF WISCONSIN MILWAUKEE COUNTY CIRCUIT COURT PROBATE JURISDICTION

In the Matter of File No. __________

____

STIPULATION

The parties to the above matter by their respective counsel hereby stipulate to the following resolution of the instant proceeding:

1. The final hearing in the instant case may be adjourned indefinitely until such time as one of the following events occurs:

(a) the subject individual's attorney notifies the Probate Court that the subject individual wishes to have the instant action set on the Court's calendar, in which case the final hearing shall be scheduled for a date not less than fourteen (14) days from the date of the request for final hearing;

(b) the staff of MCMHC determines that the subject individual is no longer a proper subject for inpatient hospitalization, and gives notice to the court of that determination, in which case the involuntary commitment petition pending in the instant action shall be dismissed.

2. IT IS FURTHER STIPULATED that Milwaukee County Mental Health Center is authorized to hold and treat the subject individual pending further order of the Court, provided, however, that the staff of MCMHC may discharge the subject individual outright or conditionally at any time that such discharge is clinically advisable. The staff shall in writing notify the Court and Corporation Counsel of the terms and conditions of the subject's release.

____

____

____

____

____

3. IT IS FURTHER STIPULATED that if, during the pendency of this order, the subject individual does not generally cooperate with the treatment program prescribed at MCMHC, the staff of that facility may notify the Corporation Counsel's Office, which may then have the final hearing scheduled by the Court within fourteen (14) days.

4. IT IS FURTHER STIPULATED that, while the subject individual is being detained pursuant to this order, the subject individual shall have all of the rights and privileges within the MCMHC of a voluntary patient, except the right to be discharged against medical advice.

Dated this __________ day of ______________________, 19______

______________________ Subject

______________________ Attorney for subject

______________________ Attorney for 51.42 Board

ORDER

The parties to the above entitled action, having by their attorneys agreed to the foregoing stipulation,

NOW, THEREFORE, said stipulation is herewith adopted as the Order of this Court.

Dated this __________ day of ______________________, 19______

BY THE COURT

____

CIRCUIT JUDGE

OFFENDER ID#________________

D.A. MENTAL HEALTH SCREENING FORM

Name: ______________________ Date: __________

Referral Source: 1. Screener, 2. D.A., 3. Police, 4. Witness, 5. Victim, 6. Other ______
A. Information Requested, B. Volunteered

DOB: __________ SS# __________ Phone # __________

Address At Arrest: ______________________

Charge/Reason for Arrest: ______________________

Source Of Income: __________ Medical Insurance: __________

Training/Special Education: Past __________ Current __________

Are you currently under the care of an M.D. or Psychiatrist Y/N

Who: __________ Where: __________ Medication: __________

If not, have you ever been Y/N

When: __________ Where: __________ Last Contact: __________

Contact Person(s): Name ______________________

Address ______________________

Phone ______________________

Mental Health Status (Observations and Diagnostic Impressions: General appearance, behavior speech, mood and affect, oriented to person, place, time, level of intellectual functioning, thought process, suicidal ideation.)

D. A. MENTAL HEALTH SCREENING

Detainee Name ______________________

Any indication of mental disorder with this detainee? Yes/No

Proposed Plan:

Any history of mental disorder with this detainee? Yes/No

Any other medical/suicidal concerns regarding this detainee? Yes/No

This form should accompany complaint worksheets.

D.A. Disposition:

D.A. on Case ______________________ WCS Worker ______________________

WISCONSIN CORRECTIONAL SERVICE
Client Intake Sheet

Worker ____________
Program ____________
Intake Date ____________

REFERRAL SOURCE: 1-Screener 2-Self 3-Attorney 4-PO 5-Judge 6-DA 7-Inmate 8-Deputy 9-Relative 10-Other ____________

INTERVIEW LOCATION: 1-Office 2-MCJ 3-HOC 4-Court 5-WSP 6-WSR 7-WCI 8-KMCI 9-CSH 10-Winnebago 11-Other ____________

CLIENT'S NAME ____________
Last First Middle

MAILING ADDRESS ____________
Street City Zip

LIVING WITH: 1-Parents 2-Mother 3-Father 4-Wife 5-Husband 6-Alone 7-Other ____________

TELEPHONE NO. ______ Second No. ______ SOC. SEC. NO. ______

AGE ______ DATE OF BIRTH ______ PLACE OF BIRTH ______

SEX (M) (F) HERITAGE: 1-Caucasian 2-Afro-Amer 3-Mex-Amer 4-P.R. 5-Native-Amer 6-Oriental

PRESENT SITUATION:

1-Incarcerated since ______ 2-On bail since ______ 3-Post-Adju ______
1-On probation since ______ 2-On parole since ______ 3-Est.Rel.Date ______
Agent/Officer ______ Telephone No. ______

P&P HOLD: (Yes ( ) No ( ) REVOCATION PENDING: Yes ( ) No ( )
Date of next revocation hearing: ______ Attorney: ______

PRESENT CHARGE	Court Date	Judge	Nature of Appearance	Plea

ATTORNEY: ______ ______ (1-Public Defender 2-Private 3-Court appointed)
Name Phone

______ ______ (1-Public Defender 2-Private 3-Court appointed)
Name Phone

BAIL SITUATION: Amount ______ Possible ( ) ______ Impossible ( ) ______

CONTACTS FOR BAIL ______

WARRANTS PENDING: No ( ) Yes ( ) Explain ______

LOCATION OF ALLEGED CRIME: ______

PAST RECORD *JUVENILE ARREST RECORD* *PAGE 2*

Offense	*Detentions/Incarcerations Where?*	*Dates?*	*Probation/Parents' Custody-When? How Long?*	*Dismissal Year*

ADULT ARREST RECORD

Offense	*Incarcerations Where?*	*Dates?*	*Probation How Long? Revoked*	*Dates? Why?*	*Dismissal Date*	*Fine/Amt. Date*

WORK HISTORY

Dates	*Employer*	*Job*	*Reason for Leaving*

Comments regarding work history: ______

Job available upon release: *No ( )* *Yes ( )* *Where* ______

Contacts: ______

VALID WISCONSIN DRIVER'S LICENSE: Yes ( ) No ( )

Mode of transportation ____________________

VOCATIONAL/EDUCATIONAL HISTORY

Highest Grade completed ________ When ________ Where ________ GED: Yes ( ) No ( )

Work Training Program, e.g.: JVS Curative Sertoma Goodwill CETA OJT

Dates	Program	Type of Training	Skill Level	Reason for Leaving

MILITARY

1-None 2-Honorable 3-General 4-Undesirable 5-Dishonorable 6-Other ________

Branch ____________________ Dates of service ________

Service No ____________________ Benefits: Yes ( ) No ( )

Comment if other than honorable discharge ____________________

____

FAMILY SITUATION

Marital status: 1-Never 2-Married--how long? ________
3-Separated--how long? ________ Divorced--how long? ________

Family Situation: 1-On welfare 2-Living with relatives 3-Self-supporting
4-N/A 5-Other

Wife/Fiancee ____________________
Name Address Phone

Relationship at present: ____________________

Children: Number ________ Age range ________

Alimony/Child Support: No ( ) Yes ( ) Amount ________

Total number of dependents ____________________

PARENTS: 1-Both alive 2-Father deceased 3-Mother deceased 4-Both deceased
4-Father unknown 5-Mother unknown

Father: ____________________
Name Address Phone

Mother: ____________________
Name Address Phone

Family size: 1-Older child 2-Middle child 3-Younger child
Number of brothers and sisters ________

Brothers/Sisters to be contacted:

Name	Address	Phone

Family members have been treated for alcohol, drug, mental health problems: No ( )
Yes ( )

Comments: ____________________

____

____

____

____

Relationship with family ____________________

____

____

Religious preference ____________________

Church clergymen ____________________
Name Address Phone

ALCOHOL HISTORY

What, how much, how often, length of usage, physical symptoms, e.g; blackouts, tremors, D.T.'s, etc.

ALCOHOL TREATMENT HISTORY

	1	2	3	4	5
Dates					
Place					
Inpatient					
Resident					
Outpatient					
Referral Source					
Therapist					
Discharge Status					

Additional Comments:

DRUG HISTORY

What, how much, how often, length of usage, physical symptoms, e.g.; tracks, withdrawal indications, etc.

DRUG TREATMENT HISTORY

	1	2	3	4	5
Dates					
Place					
Inpatient					
Outpatient					
Urine Surveillance					
Source of Referral					
Therapist					
Discharge Status					

Additional Comments:

MENTAL HEALTH HISTORY

Observations and diagnostic impressions: General appearance, behavior, speech; mood and affect; oriented to person, place, time; level of intellectual functioning, thought process: suicidal ideation.

____

____

____

____

____

MENTAL HEALTH TREATMENT HISTORY

	1	2	3	4	5
Dates					
Place					
Inpatient					
Outpatient					
Type of Medication & dosage					
Doctor/ Therapist					

Group Therapy ____

Individual Therapy ____

Additional Comments ____

____

____

____

____

____

Major disability area ____

Secondary disability area ____

PROPOSED TREATMENT PLAN

Primary Objective: ____

____

Secondary Objectives:

1. ____

2. ____

3. ____

4. ____

Client signature ______________________________ Date ____________

FINANCIAL INFORMATION

Current monthly gross income ____________ Current monthly net income ____________

Do you have:

Private medical insurance	No ( )	Yes ( )	____________ Company
Veterans benefits	No ( )	Yes ( )	____________ Amount
DVR Assistance	No ( )	Yes ( )	____________ Amount
SSI	No ( )	Yes ( )	____________ Amount
SSD	No ( )	Yes ( )	____________ Amount
Welfare Assistance	No ( )	Yes ( )	____________ Amount
Medicare/Medicaid	No ( )	Yes ( )	____________ Number
Title 19	No ( )	Yes ( )	____________ Number

IF NO: Eligible for Title 19 ( )
Not eligible for Title 19 ( )
Unable to determine eligibility ( ) Explain: ____________________

____

____

____

____

____

RIGHTS ON DETENTION

You are being held on 53B for evaluation. Within 24 hours you will be notified of the doctor's decision to either release you or initiate commitment proceedings.

On emergency detention at ______________________________
(facility)

you have the following rights:

1. To contact an attorney.
2. To have an attorney appointed for you at County expense if you are indigent.
3. To contact a member of your immediate family.
4. To remain silent as anything you say may be used as a basis for commitment. A report is required to be made to the Court of your condition even if you remain silent.
5. To a copy of any Petition filed for your commitment.
6. To be treated or medicated in a life threatening situation or if necessary to prevent serious physical harm to yourself or others. Other treatment may be administered only with your consent.
   a. If you are a member of a recognized religious organization whose tenets prohibit medication or treatment you may refuse such medication or treatment even in a life threatening situation.
   b. A report of all treatment administered to you will be filed with the County Court for
   ______________________ County.

Dated: ______________________.

The above rights have been presented and read to me.

____
Patient

I have informed the patient that these rights are in effect during his/her entire involuntary hospitalization preceeding commitment.

____
Staff

Form # 91

PATIENT'S RIGHTS BROCHURE

The Milwaukee County Mental Health Complex supports and protects fundamental human, civil, constitutional and statutory rights of each patient regardless of race, religion, sex, ethnicity, age, or handicap. You have the right:

1) To be treated in a fashion which recognizes your personal dignity in all aspects of care, and to an environment which affords comfort and safety;
2) To get prompt, adequate and impartial treatment, rehabilitation and educational services;
3) To an individualized Treatment Plan with your active participation. The Treatment Plan will be reviewed periodically;
4) To competent, qualified and experienced professional staff to implement and supervise the treatment plan;
5) To be paid if you work for the hospital and/or the right to refuse to perform labor which is of financial benefit to the hospital;
6) To have freedom limited only to the extent it is necessary for treatment;
7) To send sealed mail and to have no one open your mail, unless there is reason to believe there is contraband or objects which threaten security. In this instance, mail will be opened in your presence.
8) To religious worship here if you wish, and if a clergyman of your denomination is available;
9) To know the cost of your care, the source and limitations of your funding; contact your Social Worker who can refer you to the Fiscal Department.
10) To know the identity and professional status of all staff members with whom you deal and to know the reason for any proposed change in the professional staff responsible for your care, or for transfer either within or outside of the facility;
11) To request the opinion of a consultant at your expense, or to request staff to review your treatment plan;
12) Not to be subjected to experimental or unusual medications/procedures, filming or taping without your expressed informed consent.
13) To refuse participation in any research project without jeopardizing the quality of care you receive;
14) To know if other treatment procedures are available beside those you are currently receiving;
15) To be free of physical restraint except in emergency situations to prevent physical harm;
16) To petition the court for review of the commitment order except in the case of a patient committed for alcoholism;
17) To initiate a complaint or grievance procedure and to obtain a hearing or review of the complaint. Grievance forms are available on each unit;
18) To be free from unnecessary or excessive medication at any time; to know the risks, side effects and benefits of all medication and treatment procedures. If these are not explained to your satisfaction, please ask the physician or nurse on your unit for additional information;
19) To refuse specific medication and treatment procedures, to the extent permitted by law;
20) To know that if you refuse medication or treatment, the Mental Health Complex may a) seek appropriate legal alternatives or orders of involuntary treatment, or b) terminate its relationship with you upon reasonable notice.
21) To be informed of your discharge plan including any plans for meeting continuing mental and physical health needs.
22) To confidentiality of communications between you and hospital staff and confidentiality of information contained in your medical record.

The following rights may be suspended by your doctor as a necessary part of treatment. If they are suspended, you have the right to know why and an opportunity to present your side.

1. To conduct private telephone conversations within reasonable limits, unless clinically contraindicated;
2. To meet with clinical staff and your family if practical reasons, (such as money, etc.) prohibit your making phone calls or receiving visitors. Every attempt will be made to facilitate communication and to explain obstacles.
3. To have restrictions on visitors, telephone calls or other communication evaluated by the appropriate staff at least every seven days;
4. To be allowed to visit in private with your family or significant others regardless of age, unless clinically contraindicated.
5. To wear your own clothes if you wish, or be provided with clothes; and to have a place to store your personal effects.
6. To reasonable privacy in bathing and toileting.

IF YOU ARE BEING HELD AGAINST YOUR WILL (INVOLUNTARILY) YOU HAVE THE FOLLOWING RIGHTS:

A. Before Being Committed by a Court:
   1. The right to a lawyer. A lawyer must be provided to you without cost, if you cannot afford one on your own.
   2. The right to a probable cause hearing within 72 hours (not including weekends and holidays), and a final hearing within 14 days of your being held against your will.
   3. The right to refuse drugs unless you pose a physical danger to yourself or others, or unless a judge finds that you are incompetent to refuse drugs.
   4. The right to a jury at your final hearing if you request a jury at least 48 hours before the hearing.
   5. You cannot be committed unless you are found to be "mentally disabled", "a proper subject for treatment" and "physically dangerous to yourself or others".

B. If you are Committed, You Have These Rights:
   1. To appeal your case to the Court of Appeals within 30 days of your being committed.
   2. To petition the Circuit Court for a writ of habeas corpus.
   3. To a reexamination and retrial in court every 120 days.

If you are a patient in this hospital, and if you would like a FREE booklet that explains these rights in more detail, ask the hospital staff, or call or write: WISCONSIN CIVIL LIBERTIES UNION; 135 W. Wells Street; Milwaukee, WI 53203; or phone (414) 272-4032.

BN/pb
9/16/82

To be read to the patient.

PATIENT'S RIGHTS

You have the right to know what your rights are.

Right to be paid if you work for the hospital.

To send sealed mail and no one else may open your mail.

To have your freedom limited only to the extent it is necessary for treatment.

To get prompt and adequate treatment and other necessary services.

To receive only those medications which the doctor orders and which he believes will help you, and the right to other forms of treatment.

To be free of physical restraint except in emergency situations to prevent physical harm.

To not be subjected to experimental procedures.

To not be subjected to procedures such as shock therapy without your written consent after you've spoken with your lawyer.

To religious worship here if you wish, and if a clergyman of your denomination is available.

To humane treatment by staff and decent surroundings.

None of the previously mentioned rights may be denied or suspended without an administrative hearing, and you have the right to have the court review the decision.

If any of the following rights are suspended by your doctor as a necessary part of treatment, you have the right to know why, and an opportunity to present your side.

To make and receive telephone calls within reasonable limits.

To wear your own clothes if you wish or to be provided with clothes.

To have a place to store your personal effects.

To reasonable privacy in bathing and toileting.

To see visitors daily.

YOUR LEGAL RIGHTS

You have the right:

1. To contact and be represented by legal counsel. Free legal counsel will be appointed for you if you are indigent, and the court will assure that you have advisory counsel regardless of your ability to pay.

2. To consult with counsel before a request is made for voluntary treatment.

3. To refuse to converse with anyone as anything you say may be used as evidence against you.

4. To refuse medication and treatment, except as ordered by the Court, unless an emergency is determined to exist by your physician.

5. To be examined by a physician.

6. To have your need for commitment determined by a jury. This demand must be made at least 48 hours in advance of the final hearing, otherwise the jury trial is waived.

7. To have a copy of the commitment petition.

8. To contact a member of your immediate family.

9. If you are detained by a law enforcement officer acting pursuant to Sec. 51.15, Stats., the facility treatment director or designee must notify you within 24 hours of your detention whether commitment proceedings will be filed, otherwise you must be released at the end of that time. If proceedings are initiated you must have a probable cause hearing within 48 hours of the time the treatment director notifies you, exclusive of weekends and legal holidays.

Dated ______________________, 19____.

The above rights have been given to me orally and in writing:

____

Patient

RE: ______________________________

AFFIDAVIT OF SERVICE

I, ____, being first duly sworn,

do certify that on ________________________, 19 _____ at ____________ am/pm
I duly served the attached statement of rights, emergency detention, statement and treatment director's supplement upon the above named subject personally by then and there leaving with the subject a true copy thereof. In addition the statment of rights was read aloud to the subject.

Dated ________________________, 19 ___________ .

____
(Person giving notice)

Time of service ___________________ am/pm

Subscribed and sworn to before me this
_______ day of _________________, 19 _____.

____
Notary Public, Wisconsin
My commission expires ____________________________

I authorize the Milwaukee County Mental Health Complex to acknowledge my presence in this facility to:

( ) All callers and visitors

( ) To those callers and visitors listed below:

____

____

____

( ) No one

The purpose of the disclosure authorized herein is to provide information to parties personally interested in my whereabouts.

This consent may be revoked at any time except to the extent that action has been taken in reliance thereon. This consent (unless expressly revoked earlier) expires upon my formal discharge from the Milwaukee County Mental Health Complex.

Signature of Client/Patient ______________________ Date __________

Signature of Witness ______________________ Date __________

Signature of Parent, Guardian or Legal Representative ______________________ Date __________

Specify Relationship ______________________

CONSENT TO ACKNOWLEDGE PRESENCE

9/29/77
Rev. 10/81

AUTHORIZATION TO INFORM PERSONS OF PATIENT'S RELEASE

You have the right upon admission to the Milwaukee County Mental Health Complex to sign a consent form directing that persons named by you in such form be given notice of your imminent discharge from this facility. Such notice may be given only to adults. If you consent to such notification in writing, the consent will remain valid until you revoke it in writing or until the date you have specified as the automatic cancellation date. The persons you name will be given as much notice as possible prior to your release.

____
Patient's Name

Name and telephone numbers of persons to whom notice shall be given prior to my release:

Name	Address	Age	Telephone No.

The only purpose for which this release is valid is to inform the above persons of the date and time of my discharge.

This consent form shall expire on the date of my discharge or/on ______________, 19__.

Dated this _____ day of __________________, 19____.

Witnessed by:

____

____
Patient's Signature

Effective immediately, I herewith revoke the foregoing consent.
Dated ____________________, 19 _____.

____
Patient's Signature

Adm. Date: ______ Time: ______ Type of Legal Hold: ______

Accompanied by: ______ Physician notified: ______ (Name) Time: ______

Admission bath and body check reviewed by R.N. ______

Vital Signs on Admission:

1. ______ (Date) ______ (Time) T. ______ P. ______ R. ______ B/P ______ L or R ______ (Signature)

2. ______ (Date) ______ (Time) T. ______ P. ______ R. ______ B/P ______ L or R ______ (Signature)

Date ______ and Time ______ of Nursing Admission Assessment.

Informant: ______

Allergies: ______

Allergic response: ______

Present medication: ______

Illicit drug use: ______

Alcohol/Tobacco use: ______

Seizures: ______

Diabetes: ______

Hypertension: ______

Sickle cell: ______

Head trauma: ______

Special Diet: ______

Weight Change: ______

Sleep habits: ______

Physical limitations: ______

Prosthesis or assistive device: ______

Other: ______

Recent or Acute Medical/Surgical traumatic history: ______

Psychiatric History:

Outpatient: ______

Inpatient: ______

Suicidal: ______

Homicidal: ______

Orientation: ______ (Person, Place, Time)

Milwaukee County Mental Health Complex

ADMISSION ASSESSMENT - NURSING

Mental/Emotional status on admission:
(appearance, affect, communication ability)

Patient's stated reason for admission: ______

Nursing treatment plan initiated: Date: ______ Time: ______ R.N. Signature ______

	YES	NO
Rights on Detention read and copy given to patient, if applicable:	[ ]	[ ]
Consent to Acknowledge Presence form explained to patient:	[ ]	[ ]
Patient Information Hand Book given to patient:	[ ]	[ ]
Patient rights explained and copy given to patient:	[ ]	[ ]

Date: ______ R.N. Signature: ______

LEGAL STATUS
( ) Voluntary
Involuntary
( ) 1. Return from Conditional Transfer
( ) 2. Court ordered detention (Chap. 51)
( ) 3. Emergency detention (Chap. 51)
( ) 4. Emergency detention (Chap. 55)
( ) 5. Criminal (Chap. 971)
( ) 6. Other ____

LIVING ARRANGEMENTS:
Does the patient have a place to return to: ( ) Yes ( ) No

LAST SCHOOL ATTENDED:
(for CATC Admission)

THE FOLLOWING ITEMS ARE TO BE INCLUDED AND NUMBERED IN YOUR DOCUMENTATION BELOW:

1. Presenting Problem
2. History of Presenting Problem
3. Past Psychiatric Contact and Treatment
4. Current Mental Status
5. Current Physical Problems & Treatment

DATE ____ INFORMANT ____

ADDRESSOGRAPH OR NAME & NUMBER

MILWAUKEE COUNTY MENTAL HEALTH COMPLEX

INITIAL ASSESSMENT AND PLAN Page 1

PROVISIONAL DIAGNOSIS. (Responsibility of ADMITTING physician) ____

( ) ADMISSION TO INPATIENT SERVICE:

1. JUSTIFICATION FOR THIS ADMISSION: (two reasons for admission should be listed)
2. SEE PHYSICIAN'S ORDER SHEET
3. CRITICAL MISSING INFORMATION TO BE OBTAINED: ____

(SIGNATURE) NON-PHYSICIAN

(SIGNATURE) M.D.

( ) NON-ADMISSION:

( ) REFERRAL -- To Whom: ____

For What Purpose: ____

Appointment Date: ____

( ) OTHER DISPOSITION ____

( ) MEDICATION: (Specify type, dosage and amount) ____

(SIGNATURE) NON-PHYSICIAN

(SIGNATURE) M.D.

ADDRESSOGRAPH OR NAME & NUMBER

MILWAUKEE COUNTY MENTAL HEALTH COMPLEX

INITIAL ASSESSMENT AND PLAN Page 2

NON-VOLUNTARY ADMISSION CASE SUSPENSION AGREEMENT

Having been involuntarily admitted under Chapter 51 of the statutes, I hereby make application for status as a voluntary patient in this treatment facility. I have been fully advised and understand that the tentative acceptance of this application by my physician means that I can be held at this facility for fourteen days from the date of my detention and that my application may be rejected at any time during that period, resulting in a resumption of the commitment proceedings against me.

By making this application, I am asking for treatment and admission to this facility and I agree to cooperate with my treating physician. I understand that if I so request, or if my physician denies this application, prosecution of the commitment case will resume. In the meantime, until resumption of my hearing, I have no right to immediate discharge upon request. I have been further advised of my rights as a patient in this facility. If within 14 days of the date of my detention this application is accepted by both the treatment director of this facility or his or her designee and the 51.42 Board, the case against me will be dismissed and thereafter I will be free to leave the facility upon making written request, subject however to the right of the Treatment Director to initiate an Emergency Detention against me. If he or she does so, I will be detained at this hospital for further proceedings and I may refuse treatment. Following notification of detention, a probable cause hearing will be held within 72 hours, exclusive of weekends and holidays.

Dated this __________ day of ____________________, 19 _____.

* ______________________________ Treatment Director/Designee

______________________________ Patient

______________________________ Acting Clinical Program Director, 51.42 Board

______________________________ Witnessed to Patient's Signature

*To be signed at the time the doctor is satisfied as to the patient's treatability on the voluntary status.........Unit Staff to notify court liaison's office that same day.

4/22/82
RPG

Photocopied Form #90

STATE OF WISCONSIN : CIRCUIT COURT : MILWAUKEE COUNTY
PROBATE JURISDICTION

IN THE MATTER OF:

STIPULATION AND ORDER

____________________ FILE NO. __________

STIPULATION

The parties to the above-entitled matter, by their respective attorneys, hereby stipulate to the following:

1. The subject agrees to full cooperation with the conditions specified in paragraph (3) below, and may be released from the Mental Health Center ____________________

2. This matter shall be held open for a period of __________ __________. At the conclusion of that period the matter shall be dismissed unless the Corporation Counsel, during said period, has requested the scheduling of a hearing by filing a sworn statement that there is cause to believe the subject has violated the conditions of suspension and release.

3. Within 15 days of release, counsel for the subject or his or her designee shall report to the Corporation Counsel regarding the subject's compliance with the following conditions:

____

____

____

____

Dated this ______ day of ____________________, 19____.

____
Attorney for Subject Individual

____
Assistant Corporation Counsel

ORDER

On the basis of the foregoing stipulation, the Court being fully advised in the premises, said stipulation is herewith adopted as the order of this Court.

Dated this _____ day of ______________, 19____.

BY THE COURT

____
Circuit Judge

INITIAL CONTACT SHEET
Inquiry IM SS
Request IM SS

WISCONSIN DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF COMMUNITY SERVICES

No. D 934131

1 NAME Last/First/Middle (26 Spaces Max.) | 2 FORMER MARRIED OR MAIDEN NAME | 3 BIRTHDATE Mo. Day Yr. | 4 SEX M F | 44 ETHNIC GROUP B Black O Oriental I Amer. Ind. W White H Hispanic X Other | 20 AGENCY NO. | 21 REQUEST DATE Mo. Day Yr.

5 SOC. SEC. NO. | 6 ADDRESS WHERE PERSON CAN BE REACHED | 7 CITY | 8 STATE | 9 ZIPCODE | 10 TELEPHONE NO

22 REFERRAL SOURCE
B Clergy; F Medical; I Intra Agency; S Self Referral; J Client Int. Group; M 51 Agency; O Probation Officer; A Social Agency; C Court; N Non Related Individual; R Relative; G Gr Agency; L Law Enf. Agency; U Other Org.; E School; X Unknown; W WIN; Z WIN Reassessment

11 RESPONSIBLE PARTY NAME: Last, First, Middle | 12 FORMER MARRIED OR MAIDEN NAME | 13 BIRTHDATE Mo. Day Yr. | 14 SEX M Male F Female

15 DIRECTIONS TO THE HOME | 16 PRIOR CONTACT WITH THIS AGENCY Y Yes N No

23 INFORMATION SOURCE IF SELF REFERRED
R Radio; F Relative; N Newspaper; C Prior Agcy Contact; T TV; B Ngnbr/Friend; P Other Pub. Agcy; O Other

17 OTHERS IN HOUSEHOLD (Name, Birthdate, Relationship)

AID REQUESTED
AFDC AF
MA AI
FS GR
RNIP AFDC-U

24 SERVICE REQUESTED
AD DC EM DM AJ PP SE RO
HT DS FP HM LS PS SC XX
CS ED MS HO PC RS TS

25 CRISIS
E Emergency
P Protection
B Both
N Neither

18 PRECIPITATING SITUATION

26 DATE OF FP REQUEST Mo. Day Yr. | 27 NO. FP REQUEST | 28 DISPOSITION FP 1 2 3 4

29 REIMBURSEMENT STATUS
A AFDC; B SSI Blind; U AFDC-U; I Income Elig.; O SSI Aged; M Inc Elig + MA; D SSI Dis; W Without Reg.; N Non FFP

31 FAMILY INC | 32 NO. ON INC | 30 DATE ELIG Mo. Day Yr.

33 SOURCE OF INCOME
WS FE DI PA WC CS UU
SE SS AW UC AL VP

19 ASSESSMENT

34 INTAKE DECISION
CO Information Only
SO Opened for Service
RO Resource Study
CA Service not Available
CN Service not Offered
CW Request Withdrawn
CC Client Dis. Contact
SF Req. Withdrawn-fee
SC Court Dismissed
SW Moved
SD Death
CR Referred Out
SR Service Offered, not Accepted
SN Services not Needed

35 DATE DEC. Mo. Day Yr.

45 DATE CLOSED Mo. Day Yr. | 46 Goal | 47 Goal Status | 48 Obj. | 49 OPTIONAL COUNTY ID

SERV. STRIP	50 Serv. Area	51 Role	52 No. Served	53 Method	54 PROVIDER NUMBER	55 SPECIAL USE
A						
B						
C						
D						

36 REFERRED TO
I IM Agency; L Legal Serv.; C Court; S Other Pub. SS Agency; P Vol/Prop; H Health Fac; M 51 Agcy; O Other; N Not Referred

37 CLEARED
Date Initials
File Clerk
Date Initials

38 CROSS REF. NO.

The information given to support my application for services is true to the best of my knowledge.
41 SIGNATURE | 42 APPLICATION DATE Mo. Day Yr.

39 INTAKE WORKER
43. WORKER ID
40 ASSIGNED WORKER
Name
Date Initials

24 and 50 SERVICE AREA - ITEMS:

AD - Adoption
HT - Chore Services
CS - Court Services
DC - Day Care Services
DS - Day Services
ED - Education Related
EM - Employment Related
FP - Family Planning
MS - Health Related
DM - Home Delivered Meals or Congregate Meals
HM - Home and Financial Management Services
HO - Housing Services
AJ - Individual and Family Adjustment
LS - Legal Services
PC - Supportive Home Care
PP - Protective Payment Services
PS - Psychological - Psychiatric
RS - Recreation
SE - Sheltered Employment
SC - Substitute Care
TS - Transportation Services
RD - Resource Development

THE FOLLOWING ARE FOR ELEMENT 24 ONLY

RO - Resource Development
XX - Undetermined

28 DISPOSITION OF FAMILY PLANNING REQUEST - ITEMS

(A - D) Service provided or arranged for (including, where necessary, the provision of any supportive services such as child care, transportation, etc.) within 30 days of request.

A. Opened for service provided directly by county or state agency within 30 days of request.
B. Arrangements to have services provided by family planning clinic were made within 30 days of request.
C. Arrangements to have services provided by private physician were made within 30 days of request.
D. Arrangements to have services provided by other outside source were made within 30 days of request.

(E - K) Service not provided or arranged for within 30 days of request.

E. Client withdrew request or refused service.
F. Client moved from jurisdiction of agency.
G. Client failed to keep scheduled appointments.
H. Client secured service on his/her own from outside source.
I. Client died.
J. County or State Agency has not yet acted on request - specify in assessment (# 19)
K. Other - specify in assessment (# 19)

33 SOURCE OF INCOME - ITEMS

WS - Money wages or salary
SE - Net income from nonfarm self-employment
FE - Net income from farm self-employment
SS - Social Security
DI - Dividends, interest (on savings or bonds), income from estates or trusts, net rental income or royalties
AW - Public assistance or welfare payments (AFDC, GR, SSI)
PA - Pensions and annuities
UC - Unemployment compensation
WC - Worker's compensation
AL - Alimony
CS - Child Support
VP - Veterans' pensions
UU - Unknown

46 GOAL - ITEMS

S - Self Support
F - Self Sufficiency
P - Protection
R - Strengthen Family
C - Community-Based Care
I - Institutional Care

47 GOAL STATUS AT CLOSING

A - Achieved-Closed
F - Progress-Closed
K - No Progress-Closed

48. OBJECTIVE - ITEMS:

MM - Mentally Healthy Individual and/or Family
MP - Satisfactory Functioning of Individual and/or Family Within Limitations of Physical Handicap, Incapacity or Illness
MR - Satisfactory Adjustment to Mental Retardation
MC - Healthy Individual or Family
MB - Resolution of Problems Related to Alcohol
MD - Resolution of Problems Related to Drugs
OR - Satisfactory Interpersonal Relationships
OC - Satisfactory Social Contact and Recreation Opportunities
OL - Resolution of Problems Regarding Conflict with Law
OE - Adequate Education
OD - Resolution of Problems Regarding Discrimination
JR - Job Readiness
JE - Employment
JW - Resolution of Refusal to Participate in WIN
AA - Resolution of Abuse, Neglect and Exploitation
AF - Safe Physical Environment
LT - Resolution of Temporary Dependence
LA - Adequate Living Arrangement
LM - Maintenance of Living Arrangement
LE - Satisfactory Home and Family Management
LP - Permanent Family
FP - Resolution of Problem of Family Planning
FC - Resolution of Problems Regarding Present or Recent Pregnancy

51. ROLE - ITEMS:

A - Advocacy
L - Coordination
C - Counseling
E - Evaluation
F - Funding
P - Task Performance
T - Teaching

53. METHOD OF PROVISION - ITEMS

ID - Direct
GD - Direct Group
IP - Purchase
GP - Purchase/Group
IN - No Charge
GN - No Charge Group

STATE OF WISCONSIN | CIRCUIT COURT PROBATE DIVISION | MILWAUKEE COUNTY

In the Matter of

_______________________________,

Alleged to be in need of Civil Commitment.

File No. ______________

REPORT OF EXAMINER PURSUANT TO SEC. 51.20(9), STATS.

To the Court:

Date of Examination: ________ / ________ / ________

Place of Examination: *North Division, Ward* ________

Time spent with subject: ________________

Date of Birth / /

Date of Admission / /

PRELIMINARY QUESTIONS

(1) Did you inform the subject as to the nature and reason for the examination, that it was ordered by the Court, and that your findings would be made available to the Court? *YES* *NO:*

(2) Did you inform the subject that any information volunteered could form part of the basis for his/her involuntary commitment and that, therefore, he/she had a right to remain silent? *YES* *NO:*

(3) Did the subject appear to understand your instructions? *YES* *NO*

(4) Is the subject presently under medication, and, if so, what is the medication and dosage? ________________________________

(5) In your opinion, does the medication affect the subject's ability to understand these instructions, and, if yes, how? *NO* *YES:* ________________

MENTAL STATUS EXAMINATION

(6) Description of the subject's interview behavior:

(a) The subject's reaction to the interview: ________________

____

(b) General appearance: *GOOD* *FAIR* *POOR* ________________

(c) Motor behavior: *APPROPRIATE or* ________________

(d) Facial expressions, voice and speech: *APPROPRIATE and/or* ________________

____

(e) Affect and mood: *APPROPRIATE or* ________________

____

(7) Description of the subject's thought content and thought processes:

(a) Compulsions: EVIDENT NOT EVIDENT ______________________

(b) Depressive or manic trends: EVIDENT NOT EVIDENT ______________________

____

(c) Hallucinations: EVIDENT NOT EVIDENT ______________________

(d) Delusions: EVIDENT NOT EVIDENT ______________________

(e) Grandiosity: EVIDENT NOT EVIDENT ______________________

(f) Persecutory trends: EVIDENT NOT EVIDENT ______________________

(g) Conceptual disorganization: EVIDENT NOT EVIDENT ______________________

____

(h) Organic signs: EVIDENT NOT EVIDENT

(1) Orientation: ORIENTED or NOT ORIENTED TO ______________________

(2) Memory: (a) Reflex: 6-1-9-4-7-3 bed-ship-penny-winter

(b) Recent: ⟶ (arrow pointing to "bed-ship-penny-winter")

(c) Remote: Date of birth - Age - When hospitalized & why

(3) Judgment: GOOD FAIR POOR ______________________

(4) Cognition: Last five Presidents
Where does rubber come from?
What is the thing to do if you find an envelope in the street that is sealed, and addressed, and has a new stamp?
What should you do if while in the movies you were the first person to see smoke and fire?
In what way are an orange and a banana alike?
In what way are a coat and a dress alike?

(i) Insight: GOOD FAIR POOR ______________________

SUBJECT'S STATEMENTS

(8) Summary of incidents leading to detention and pertaining to past history and present events: ____

____

____

____

____

____

____

____

____

____

____

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____

____

(9) Based solely on your examination, can you render an opinion to a reasonable degree of professional certainty as to the mental condition of the subject: YES NO

(10) IF YES:

(a) The subject IS IS NOT acutely psychotic;

(b) The subject IS IS NOT capable of benefiting from treatment (as defined in 51.01(17)), if he/she were to participate in such treatment;

(c) The subject CAN CANNOT function adequately outside of a hospital setting, even with community support (e.g., counseling/psychotherapy, homemaker services, living in a group home or halfway house, participation in the Day Hospital program);

(d) The subject's disorder IS IS NOT so extensive that he/she requires care and treatment for his or her own welfare, or the welfare of others, or of the community;

(e) The subject DOES DOES NOT have a SUBSTANTIAL disorder of thought, mood, perception, orientation or memory;

(f) If he/she DOES have a substantial disorder, this disorder DOES DOES NOT GROSSLY impair judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.

(11) Did you consult the patient chart or other records: YES NO

If yes, did that collateral information SUPPORT / CONFLICT WITH your opinion, and how:

____

____

____

(12) What is your opinion regarding the dangerousness of the subject:

(a) No risk __________________________________

(b) Mild risk __________________________________

(c) Moderate risk ________________________________

(d) Substantial risk ______________________________

(13) The above opinion is supported by the PRESENCE ABSENCE of significant

evidence of dangerous behavior on the ward: ______________________

____

____

(14) Did the subject express any interest in any form of mental health treatment or social

services: YES NO

IF YES: Inpatient hospitalization / Outpatient counseling/psychotherapy

Medication / Group Home / DVR/Job training

Other or specifics:

____

____

____

(15) In your opinion, the subject IS IS NOT capable of expressing an understanding of the advantages and disadvantages of accepting treatment, and the alternatives to accepting the particular treatment offered, after the advantages, disadvantages, and alternatives have been explained to him/her.

(16) What would you recommend as an OPTIMAL treatment program for the subject at this time:

Inpatient hospitalization / Outpatient counseling/psychotherapy

Medication / Group home / DVR/Job counseling

Other, or specifics: ______________________________

____

____

____

(17) Additional comments:

(A) From hospital chart or discussion with hospital staff: ______________

____

____

____

____

____

____

(B) From interview: ______________________________

____

____

____

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____

____

____

I, the undersigned examiner, certify that I have, by personal examination and inquiry, satisfied myself as to the mental condition of ______________ ______________, the subject of this proceeding, and that the results of said examination and inquiry is contained in my answers to the foregoing questions, which answers are true to the best of my professional knowledge and belief, and, if called to testify, I will so swear under oath.

____

APPENDIX B

STUDY METHODS

The evaluation upon which this report is based is the sixth evaluation of a local involuntary civil commitment system that the Institute on Mental Disability and the Law has undertaken. The other evaluations were conducted between January 1981 and July 1982 in Chicago, Columbus (Ohio), New York City, Winston-Salem (North Carolina), and Los Angeles. They resulted in five-site specific reports, similar to this one, containing recommendations for improvement of involuntary civil commitment proceedings in the five metropolitan areas, and one volume of provisional guidelines for involuntary civil commitment with a national perspective.*

This appendix describes the general methods which were used to acquire the information that is contained in all of the previous reports mentioned above as well as this report of our evaluation of the involuntary civil commitment in Milwaukee County.** Significant departures from these general methods during our evaluation in Milwaukee County are described in footnotes.

LITERATURE REVIEW

Beginning in January, 1981, the project staff reviewed professional literature on the topic of mental health law, especially that particularly germane to the involuntary civil commitment of allegedly mentally ill adults. The initial period of review lasted for several months, although literature was reviewed continually throughout the project period. Source materials were collected from books and journals in the disciplines of law, psychiatry, psychology, social work, sociology, and public policy administration. Professors and mental health practitioners were informed about the project and asked to provide copies of unpublished papers or other hard-to-find articles that would be of value to our work. Members of the project's national advisory board were particularly helpful in locating valuable literature.+

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*See Institute on Mental Disability and the Law, _supra_, note 23, in the main text of this report.

**Together these seven reports comprise in excess of 1,200 pages of text and contain over 260 guidelines and recommendations for improvement of involuntary civil commitment throughout the United States.

+See Institute, _supra_, note 23 at iii.

Just prior to the meeting of the national advisory board in April 1981, staff prepared an "issues paper" summarizing the relevant literature and defining important contemporary issues of civil commitment with which the project was to be concerned. The substantive portion of this paper has been published as "Involuntary Civil Commitment: The Discerning Eye of the Law" (State Court Journal, 1981, 5(4), 5 ff.; available from the National Center for State Courts Publication Department). At their meeting, members of the board helped staff decide what research questions should be explored during site visits and gave advice on field research methods.

STATUTORY REVIEW

A scheme was devised for analyzing statutes governing civil commitment. The scheme was constructed by identifying all the important questions that might be addressed in a commitment statute and then ordering them roughly as they might become relevant in a typical case.

A complete statutory analysis was performed for approximately 20 states, as well as for the model statute prepared by the Mental Health Law Project (published in the July-August 1977 issue of the Mental Disability Law Reporter). The 20 states were those in which the Institute's project had received funding, or states that had been brought to the staff's attention as having statutes that were particularly interesting, innovative, or modern.

After an individual review of all the statutes, a comparative analysis was made. Using the analytical scheme that had been developed, staff compiled all the variations of statutory provisions relating to each of the analytical categories. This compilation of statutory variations is available from the National Center and formed a basis for the volume titled Provisional Substantive and Procedural Guidelines for Involuntary Civil Commitment, published in July 1982. Based upon this analysis, staff determined where and how state statutes and procedures differed with regard to civil commitment. These points of difference became the focus for field data collection.

In addition to reviewing statutes, staff reviewed important case law. The Mental Disability Law Reporter, law review articles, and statute annotations available for the various states were the major sources for identifying important cases. Where the case law significantly added to or changed the range of variation that had been identified through the statutory analysis, this information was incorporated in the comparative analysis. Particularly thorough analyses of case law were conducted for the six project states: Illinois, Ohio, North Carolina, New York, California, and Wisconsin.

Project staff also contacted court administrators across the country to obtain any types of administrative regulations that might be of help. Several copies of regulations were received. For all states whose statutes were analyzed, published court rules also were examined. Information gleaned from administrative regulations and court rules was sparse, but it also was included in the statutory analysis when appropriate.

PRELIMINARY SITE VISIT

A preliminary visit was made to five of the project sites.* Staff members met with judges, court personnel, attorneys, and mental health professionals. The preliminary visit served several purposes. First, the participants in the civil commitment systems told staff their perceptions of how the systems worked. Cooperation was pledged for the research project. Staff of the courts and the mental health agencies invited the research team to include them in the data collection effort and generously offered their help.

The individuals with whom we met during the preliminary site visit identified the agencies and institutions that were involved with the mentally ill and civil commitment in the project site. Key people within these organizations were named. Others who were unrelated to relevant agencies but who were deemed important or knowledgeable in a particular area were also identified.

FIELD RESEARCH

Intensive data-collection trips to each of the six sites followed the completion of the comparative statutory analysis. During the two weeks prior to the site visit, intensive preparations were made. Important people at the site, who had been identified during the preliminary site visit, were contacted by telephone and appointments were made for visits the next week. Staff thoroughly reviewed state statutes and case law and identified questions of particular theoretical or practical concern for the project/site.

Three major activities were undertaken during site visits: interviews, observations, and staff discussions. Most participants were interviewed individually, although some were interviewed in groups. With few exceptions, all interviews were conducted by two project staff

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*The authors met with the Subcommittee on Involuntary Civil Commitment Study (see PREFACE) on September 2, 1982 to identify the issues to be considered in the evaluation in Milwaukee County. The result of that meeting was the preliminary problem identifiation, delineation of issues, and the preliminary framing of research questions pursuant to our preparation for field work in Milwaukee County. (See memorandum to Subcomittee dated September 22, 1982.)

members. Before each interview, one staff person was assigned the role of "scribe." While the other person attended carefully to substance and led the interview, the scribe's duty was to record all answers. In this manner, one person could attend carefully to what was being said and be sure to investigate thoroughly all important questions; and the other person could be sure that everything that was said was carefully recorded. The site visit began with interviews with judges and observations of hearings. The next interviews tended to be with attorneys, public defenders, deputy district attorneys, and private attorneys. Middle and later interviews tended to focus more on the mental health community: hospital administrators, mental health professionals, and patient advocates.*

Court hearings conducted during the time of the visit were observed. For each site, an observation guide was prepared and studied in advance of the hearings. The project team took notes during the hearings. Notes taken during interviews and court hearings were in rough form. Each staff person rewrote the notes following the site visit.

The third major activity--discussion and analysis--took place at the end of each day, staff met to compare notes and impressions about the system. Key concerns were (1) what answers from various sources agreed with each other; (2) what answers from various sources disagreed; and (3) what answers still were missing. On the basis of these discussions, interview assignments for the next day were planned. When staff members were confident of the answers they had received, no further questions were asked on certain topics. When they were uncertain, additional attention was given to these questions in the next interviews.

The individuals with whom interviews were conducted were not a statistically representative sample in any sense. They were purposively chosen because they were identified as some of the most well-informed and influential people in the site. This was consistent with the project goal; that is, not to establish what is average or typical, or what the typical person thinks about the process, but to gain insight into how the system works and how it might be made better by the actions of the court and its allied agencies, from the perspectives of people with extraordinary and authoritative abilities to understand and comment on it.

Although we did interview ex-patients and patient advocates, we did not speak with patients involuntarily hospitalized at the time of our study. We acknowledge that the perspective of the involuntarily hospitalized persons may be one quite different than that of the ex-patients and advocates to whom we spoke in the various sites, and one potentially valuable for improvement of the system. The close tracking and observation of several cases through the various stages of the commitment process, enriched by the accounts of the patients themselves

---

*The individuals who were interviewed in Milwaukee are named in the PREFACE to this report.

is a particularly attractive inquiry which we were, unfortunately, unable to reach. Such omissions do not make the present work less valid, but only incomplete--an unfortunate flaw of most social research.

THE FORM OF THE DATA

The ultimate goal for this project was to generate information by which the civil commitment process could be made to function as well as possible. The purpose of the data collection was to obtain practitioners' opinions, advice, and suggestions about the civil commitment process, particularly as it operates in their own localities. Accordingly, it was appropriate that the research be qualitative, not quantitative. Our main purpose was not to ask how many. The purpose was rather to ask why, how well, and how else. We sought information about what works best and why.

The questions in the data collection guide were open-ended. Multiple-choice types of question were avoided so that interviewees would be free to formulate their own opinions rather than have their thoughts slotted into predetermined categories by the researchers.

The data collection guide used consists of a complete set of all the questions that were investigated. The interview guide covers many topics. The complete data collection flows in a more-or-less chronological order, as events occur during a typical commitment process. The questions unavoidably overlap to some degree, but repetition was minimized as much as possible.

Because of the length of the data collection guide, every question was not asked of every interviewee. A subset of questions was presented in each interview to optimize the match of peoples' areas of knowledge with the questions asked. All interviewees were invited, however, to discuss any aspect of the commitment process with which they were familiar or about which they had particular opinions or suggestions. Interviewers were able to (and frequently did) stray from the planned path of questions if it seemed useful and appropriate.

The questionnaire was considered only a data collection guide, not a dictum. Precise language in the questions was not important, and neither was the order in which questions were covered. The guide was simply a reminder of important issues and ideas that needed to be discussed. More concern was given to understanding the answers than to writing them down thoroughly or verbatim.

Copies of data collection and observation guides as well as a complete set of field notes, with all names and personal identifiers removed, is available from the Institute on Mental Disability and the Law. It will be provided upon request for the cost of duplication and mailing.

ANALYSES AND REVIEWS

A qualitative content analysis was performed on the data. Interview and observation notes first were reviewed and cross-referenced. Note was made of topics of significance, points of consistent agreement, and points of disagreement.

The statutory analysis scheme was used as a general guide for the analysis of the particular site's civil commitment system. For each topic of concern, the analysis covered the statutory provisions, the actual practice at the site, and commentary about statute and practice.

Three major criteria, consistent with the project's perspective were used to evaluate the civil commitment system described in this report: legal protections, provision for treatment, and social benefits. The judgments of how to apply these criteria to elements of law and practice fell to the project team, based upon their knowledge of the literature, observations, discussions with practitioners, and (as our sociologist colleagues are quick to point out) their sociohistorical biographies. The reader is free, of course, to disagree with this analysis and may choose to view the system's strengths and weaknesses differently. A system characteristic may be simultaneously a strength and a weakness when viewed from different perspectives.

First among the criteria, concern was given to the extent to which legal protections are provided to everyone in the system. The primary consideration was, of course, with the respondent. But statutes and procedures also can provide important legal protections to other people who become involved, such as doctors, attorneys, and members of respondent's family. Generally, this is an important criterion for those who are most concerned about respondent's liberty; but legal protections encompass more than simply protecting respondent from unnecessary hospitalization (*e.g.*, protecting the right to treatment).

The analysis also considered how well a system makes provisions for treatment. Admittedly, we are assuming that a valid need for treatment does exist for some people some of the time, an assumption consistent with the public values reflected in current commitment laws throughout the country. Provisions for treatment should be understood to encompass more than involuntary hospitalization, however; a system might get high marks in this regard by its creative consideration of less restrictive treatment alternatives and the opportunities for voluntary treatment that it provides.

Finally, social benefits, including fiscal factors, were considered. Society in general has a legitimate concern with keeping each of its members safe from harm and contributing productively to the community. Society also is served by minimizing the costs inherent in a civil commitment system, eliminating any unnecessary delays in legal and medical decisionmaking, and avoiding undue burdens on already strained state resources.

These factors are considered equally important in this report, and it is recognized that some system characteristics that score high in one area necessarily will score low in another. It should be noted, too, that we make no claim that this evaluative scheme is either unique or original. Professional literature reveals that these criteria are used commonly in considering commitment systems, as well as by judges in deciding individual commitment cases. The courts are accustomed to the approach of balancing (sometimes conflicting) interests as an approach to analyzing legal problems.

To complete the analysis, possible ways to change and improve the system were considered. These were written into recommendations. The recommendations should not be taken as research conclusions or empirically proven statements of fact. Rather, they are our suggestions, based upon our studies and points of view. The recommendations derive from a variety of sources: suggestions made by people in the site; suggestions made by people in other cities; conclusions from the professional literature; and ideas generated by the researchers during the project work. It is impossible to sort out the influence of these various sources in any recommendation, or to report accurately how extensive any person's or group's agreement would be with any single recommendation.

Site reports were reviewed first by project staff and then sent out as "review drafts" to all individuals who had participated in the data collection effort. Everyone receiving a review draft was invited to make suggestions for change and was urged to correct any statements that were factually incorrect.

These reviews were taken into account in preparing the final report.* It should not be inferred, however, that this report or its recommendations have been or will be adopted officially by any individual, group, or organization in the locality, or that the reviewers and participants had a unanimous concurrence of opinion on all the issues raised in this volume. Thus, although the review comments were incorporated into the reports, the text in its revised form should not be taken as a consensual statement or endorsement.

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*See PREFACE in this report for further details of this review process in Milwaukee County.