Chapter DOC 314

MENTAL HEALTH TREATMENT FOR INMATES

Note: Chapter DOC 314 was created as an emergency rule effective 9-10-84.

Note: Several sections in this chapter have explanatory notes. This information is located after the last section in the chapter.

Note: Chapter HSS 314 was renumbered Chapter DOC 314 and revised under s. 13.93 (2m) (b) 1, 2, 6 and 7, Stats., Register, April, 1990, No. 412.

DOC 314.01 Authority, applicability and purpose. (1) This chapter is promulgated pursuant to the authority vested in the department by ss. 51.20 (19), and 227.11 (2), Stats., and applies to the department and to all adult inmates in its legal custody in correctional institutions. The chapter interprets ss. 51.20 (1) (ar), (13) (a) 4, (cm), (g) 2g, 2m, and 3, and (19), 51.35 (1) (e), and 51.37 (5) (a) and (8), Stats.

(2) The department considers involuntary treatment for mental illness of adult inmates to be the form of treatment of last resort. Whenever feasible and appropriate, the department intends to use other forms of treatment for mental illness, including voluntary treatment in the correctional institution or mental health institution or transfer to another more appropriate correctional institution. This chapter provides guidance to institution staff concerning the times when it will become necessary to treat an inmate involuntarily and also regulates the administration of psychotropic medications for all inmates taking them.

History: Cr. Register, April, 1985, No. 352, eff. 5-1-85.

DOC 314.02 Definitions. In this chapter:

(1) "Appropriate" or "appropriate treatment" means treatment which in the judgment of a physician or psychologist conforms to accepted medical and psychological practice.

(3) "Clinical case file" means a file in a correctional institution containing confidential information regarding psychological or psychiatric treatment of a particular inmate.

(4) "Correctional institution" or "institution" means a facility named in s. 302.01, Stats.

(5) "Department" means the department of corrections or the secretary of the department of corrections or the secretary's designee.

(7) "Less restrictive treatment" means any appropriate treatment for an inmate's mental illness short of involuntary commitment under the standard set forth in s. 51.20 (1) (ar), Stats.

(8) "Health services treatment staff" means persons employed by the department's bureau of correctional health services who work in the adult correctional institutions.

(9) "Outpatient" means an inmate receiving treatment for a mental disorder in a correctional institution.

(10) "Physician" means a person licensed to practice medicine in Wisconsin.

(11) "Psychologist" means a person licensed to practice psychology in Wisconsin.

(12) "Psychotropic medication" means medication which is used to influence psychological functioning, behavior or experience and includes, but is not limited to, medication in the following pharmacological categories:

(a) Anti-psychotics such as haloperidol;

(b) Anti-depressants such as imipramine;

(c) Agents for control of mania and depression such as Lithium;

(d) Anti-anxiety agents such as oxazepam;

(e) Sedatives or hypnotics such as flurazepam hydrochloride; and

(f) Psychomotor stimulants such as methylphenidate hydrochloride;

(13) "Secretary" means the secretary of the department of corrections.

(14) "State treatment facility" has the meaning precribed in s. 51.01 (15), Stats.

History: Cr. Register, April, 1985, No. 352, eff. 5-1-85.

DOC 314.03 Commitment procedures. (1) PETITION. (a) The department may file a petition for an inmate's involuntary commitment to mental health care after complying with the requirements under par. (b) and ss. DOC 314.04 and 314.05.

(b) Before a petition is submitted to a court, a physician or psychologist from a state treatment facility shall personally visit an inmate whom the correctional institution believes to be mentally ill and in need of treatment and shall evaluate the inmate's mental health needs. The physician or psychologist shall also attempt to convince the inmate to accept voluntary admission to the state treatment facility or voluntary treatment at the correctional institution and shall explain the treatment programs available at the state treatment facility unless there is reason to believe that the inmate is likely to withdraw consent soon or not cooperate with voluntary treatment.

(c) The petition shall include the inmate's sentence and expected date of release as determined under s. 302.11 (7) (a), Stats. It shall allege all of the following:

1. That the individual is mentally ill;

2. That the individual is a proper subject for treatment;

3. That the individual is in need of treatment;

4. That appropriate less restrictive forms of treatment have been attempted with the individual and that these treatments have been unsuc-

cessful. The petition shall describe the less restrictive forms of treatment attempted, as described in s. DOC 314.05;

5. That the individual has been fully informed about his or her treatment needs, the mental health services available to him or her and the individual's rights under this chapter, as described in s. DOC 314.04; and

6. That the individual has had an opportunity to discuss his or her needs, the services available to him or her, and his or her rights with a physician or psychologist, as described in s. DOC 314.04.

(d) Attached to the petition shall be 2 signed statements, one by a physician or psychologist of a correctional institution and one by a physician or psychologist of a state treatment facility.

1. Each statement shall attest that:

a. The inmate needs inpatient treatment at a state treatment facility because appropriate treatment is not available in the prison; or

b. Outpatient treatment in the correctional institution can meet the inmate's treatment needs.

2. In making the choice between subd. 1.a. and b., relevant considerations include, but are not limited to, the following:

a. The inmate's previous experience in taking psychotropic medications, including any medications currently recommended;

b. The nature of the medication and possible side effects;

c. The adequacy of professional supervision available;

d. The nature of the environment for treatment and the inmate's likely response to it;

e. The severity of the illness;

f. Other physical disorders of the inmate;

g. The degree of resistance to treatment;

h. Other treatment needs which can be met by the hospital environment;

i. The means of administering psychotropic medications, including the degree of risk of administering the medication and the degree to which restraint of the inmate is required;

j. The likelihood that the inmate will need inpatient treatment in the near future; and

k. The relationship between an inmate's possible history of drug abuse and the potential for abuse of psychotropic medications.

(2) TRANSFERS. (a) If the committing court authorized inpatient treatment for the inmate, the staff of a state treatment facility may, after evaluating the inmate, recommend that the inmate be transferred back to a correctional institution on a conditional basis. The staff of the state treatment facility shall develop an appropriate treatment plan for the inmate and shall inform the inmate prior to transfer of the possible consequences of refusal to abide by the plan, including involuntary treat-

ment in the correctional institution or transfer back to a state treatment facility.

(b) If the committing court authorized only outpatient treatment, the department may petition the court for authorization to treat the inmate as an inpatient in a state treatment facility.

(3) DISCHARGE. The department shall discharge the inmate from commitment under s. 51.20 (1) (ar), Stats., no later than the termination date set by the court or on expiration of 180 days of commitment in a 365-day period, whichever comes first. Upon the recommendation of treatment staff that commitment is no longer necessary, the department may discharge the inmate before the commitment term has expired. The department shall notify the inmate and the court when the inmate is discharged from commitment.

History: Cr. Register, April, 1985, No. 352, eff. 5-1-85.

DOC 314.04 Informing the inmate. (1) Before filing a petition under s. DOC 314.03, institution staff shall inform the inmate about the following:

(a) His or her treatment needs;

(b) The mental health services that are appropriate and available to him or her. This shall include a description of the appropriate voluntary treatment available in either a correctional institution or state treatment facility; and

(c) His or her rights under s. 51.61, Stats. Inpatients have all rights specified in s. 51.61, Stats. Outpatients have only the rights under s. 51.61, Stats., that are specified in s. 51.61 (1) (a), (d), (f), (g), (h), (j), and (k), Stats.

(2) The institution shall give the inmate an opportunity to discuss rights, treatment needs and services available, identified in sub. (1), with a physician or psychologist.

(3) Institution staff shall tell the inmates that they do not lose their status as inmates upon commitment under s. 51.20 (1) (ar), Stats., and that they are subject to the same rules as other inmates, which include for outpatients the grievance procedure under ch. DOC 310 and for inpatients the grievance procedure required under s. 51.61 (5), Stats.

(4) Any information conveyed under subs. (1) to (3) shall be in a manner that is reasonably calculated to best enable the inmate to understand the information.

History: Cr. Register, April, 1985, No. 352, eff. 5-1-85.

DOC 314.05 Attempting less restrictive treatment. (1) Before filing a petition under s. DOC 314.03, the institution staff shall attempt one or more less restrictive forms of treatment.

(2) Less restrictive forms of treatment are:

(a) Voluntary treatment in a correctional institution. Types of voluntary treatment include:

1. Individual psychotherapy;

2. Group psychotherapy;

3. Transfer to a special unit within the institution for specialized care of mental illness;

4. Transfer to a more appropriate correctional institution; and

5. Voluntary treatment with psychotropic medications.

(b) Voluntary transfer to a state treatment facility, including transfer under s. 51.10 (4m), Stats.

(3) Clinical staff shall document in the inmate's clinical file:

(a) If the inmate participated in other treatments, the results of those treatments; and

(b) If the inmate did not participate in other available treatments and those treatments are within the range of treatments normally considered in treating the inmate's condition, why the inmate did not participate. Reasons may include, but are not limited to:

1. Alternative treatments were not appropriate for the inmate, with an explanation of why they were not appropriate; or

2. The inmate refused treatment by words or conduct after being informed of the advantages and disadvantages of treatment.

History: Cr. Register, April, 1985, No. 352, eff. 5-1-85.

DOC 314.06 General standards for use of psychotropic medications. (1) ORDER AND PURPOSE. Psychotropic medications may be administered to inmates only upon written order of a physician and only for the purpose of alleviating psychiatric disorders or enhancing the coping capacity of the patient. Medication may not be administered to punish the inmate, to sedate the inmate in order to produce docility, or as a convenient substitute for interpersonal communication.

(2) PRESCRIPTION. In prescribing psychotropic medication, the physician shall:

(a) Utilize medical histories and appropriate physical and laboratory examinations before prescribing medication and document the behaviors and symptoms which the medication is to treat or modify;

(b) Prescribe the lowest effective dose of a clinically indicated medication;

(c) Use caution in prescribing drugs known to produce psychological or physiological dependency, or to have significant potential for abuse;

(d) Indicate in the medical record a specific stop date;

(e) Specify limited amounts and limited refills, if any, for prescriptions; and

(f) Reduce or withdraw medication as soon as clinically indicated.

(3) REVIEW OF USE. (a) A physician shall review and evaluate the appropriateness and need for use of psychotropic medications, the need for continuation of treatment, and possible side effects for each inmate committed under s. 51.20 (1) (ar), Stats. All review shall be according to established professional standards for the administration of psychotropic medications.

(b) 1. Where treatment is voluntary, a review shall take place as often as professional practice requires but at least once every 180 days.

2. Where treatment is involuntary, a review shall take place every 30 days.

History: Cr. Register, April, 1985, No. 352, eff. 5-1-85.

DOC 314.07 Voluntary treatment with psychotropic medication. An inmate may be treated voluntarily with psychotropic medications in a correctional institution without being committed under ch. 51, Stats. The institution shall ensure that treatment is voluntary in the following manner:

(1) The physician shall discuss the following with the inmate:

(a) The nature of the condition;

(b) The purpose, nature and dose of the medication;

(c) Anticipated benefits;

(d) Substantial risks and side effects;

(e) Appropriate alternatives, if available; and

(f) Prognosis without medication.

(2) The physician shall ask the inmate to consent to take the medication, and may proceed with voluntary treatment only if the inmate consents by words, in writing, or by action.

(3) The physician may not prescribe psychotropic medication unless he or she reasonably believes that the patient's decision to take medication is not the result of coercion, threats, or promises.

(4) An inmate may withdraw or reinstate consent at any time by words, in writing or by action.

(5) An inmate who has been adjudicated under ch. 880, Stats., to be incompetent to consent to treatment may not be treated voluntarily unless the inmate's guardian consents to treatment.

History: Cr. Register, April, 1985, No. 352, eff. 5-1-85.

DOC 314.08 Involuntary treatment with psychotropic medication. An inmate may be treated involuntarily with psychotropic medications only under the following circumstances:

(1) In an emergency, after reasonable interpersonal efforts have failed to resolve the emergency and if after the brief use of mechanical restraints the inmate continues to struggle unduly, the attending clinical psychologist, clinical social worker or physician shall determine whether an emergency transfer to a state treatment facility under s. 51.37 (5) (b), Stats., is appropriate. Pending that determination, the attending physician may order involuntary treatment with psychotropic medication. The inmate may be treated involuntarily with psychotropic medications for as long as it takes to determine whether to initiate emergency transfer proceedings or for 72 hours, whichever is shorter. If an emergency transfer is initiated, the attending physician may order continued involuntary treatment with psychotropic medications pending completion of the

transfer proceedings. In this subsection, "emergency" means a situation in which:

(a) The inmate's contact with reality appears to be severely impaired as a result of mental illness; and

(b) The inmate appears to pose an immediate danger to self or others, evidenced by a recent overt act or attempt to inflict serious bodily harm;

(2) While the inmate is in a state treatment facility under an involuntary commitment under ch. 51, Stats., for the treatment of mental illness; or

(3) If the inmate is committed under s. 51.20 (1) (ar), Stats., as an outpatient in a correctional institution, and the inmate refuses to take the medication voluntarily. A health services treatment staff member or a physician shall distribute or administer medications to committed inmates being treated on an outpatient basis in a correctional institution. The following steps shall be followed:

(a) The inmate shall be given an opportunity to take the medication voluntarily by a health services unit staff member or a physician. If it is not possible to comply with s. DOC 314.07 (1) due to the inmate's behavior, the staff member or physician shall record the reasons for this in the inmate's clinical or medical services record;

(b) If the inmate refuses, the health services staff member or physician shall counsel the inmate and attempt to persuade the inmate to take the medication;

(c) If the inmate continues to refuse, the attending physician shall be contacted to assess the situation. The attending physician, at his or her discretion, shall decide the course of action to be taken. Possible actions include:

1. Take no action for a period of time;

2. Send the inmate to a special unit within the institution for treatment of mental illness;

3. When appropriate, put the inmate in observation status pursuant to ch. DOC 311;

4. Recommend transfer to a more appropriate correctional institution;

5. Recommend transfer to a state treatment facility, if appropriate under s. 51.20 (1) (ar), Stats.; or

6. Direct that the inmate be ordered to take the medication and that force be used to administer it, if necessary;

(d) If directed by the attending physician, order the inmate to take the medication; and

(e) If the inmate persists in refusing to take the medication, administer it involuntarily.

History: Cr. Register, April, 1985, No. 352, eff. 5-1-85.

Note: DOC 314.02. Subsection (1) defines appropriate treatment. A treatment is not always appropriate even when available. For example, a particular technique may not be appropriate in a given setting or for a particular inmate. Facilities or supervision may be inadequate. Other techniques may be very effective, but would be unethical. Still others may not be effec-

tive in a given situation. The decision about whether a particular treatment is appropriate depends on numerous factors that are unique to each case. The fact that a treatment is appropriate does not guarantee its success.

Note: DOC 314.03. Subsection (1) governs the filing of petitions under 51.20 (1) (ar), Stats. Paragraph (c) catalogues the information that each petition must contain. Paragraph (b) clarifies that a physician or psychologist from a state treatment facility must examine the inmate in the correctional institution before a petition can be filed. This is necessary since, as specified in par. (d), a statement by such a physician or psychologist must be attached to the petition.

Paragraph (d) reiterates the statutory requirement that attached to the petition must be 2 signed statements, one from a physician or psychologist of a state prison and another from a state treatment facility physician or psychologist. Each statement must attest either that the inmate needs inpatient care at a treatment facility or that outpatient treatment at the prison would be effective and appropriate. The two statements need not agree in their conclusions; that is, one may recommend inpatient treatment and the other outpatient. Of course, both must attest that the inmate is mentally ill and in need of treatment.

Paragraph (d) 2. lists factors relevant to whether inpatient or outpatient treatment is appropriate. The factors are not intended to be a mandatory checklist for the examining physician or psychologist. Rather, the list only articulates a range of relevant considerations. The decision is clearly one of professional judgment, and the clinician is not required to state his or her conclusion with regard to each factor. Further, the inmate is not entitled to a factor-by-factor account of the recommendation.

Subsection (2) provides for the transfer of committed inmates between state treatment facilities and correctional institutions. Paragraph (a) permits transfer from a state treatment facility back to a correctional institution when it is determined that outpatient treatment at a correctional institution is feasible and appropriate for the inmate. The inmate must be informed that failure to cooperate in the treatment plan could result in forcible treatment in the correctional institution or transfer back to the state treatment facility.

Note: DOC 314.04. Subsection (1) states the statutory requirement that the inmate be informed about treatment needs and rights prior to attempting an involuntary commitment of the inmate. When possible, an inmate should be informed about his or her treatment needs and alternatives before any treatment is started. Informing a potential patient about needs and rights also represents good medical practice. An inmate need not be informed about all possible treatments, since many will be inappropriate for that person or will be unavailable.

Subsection (4) requires the institution and physician or psychologist to communicate with an inmate in a manner that is most reasonably calculated to enable an inmate to understand the information. For example, if an inmate does not understand English, institution staff are expected to convey the information to the inmate in a language that he or she understands. If the inmate is functionally illiterate or has a reading level that does not enable him or her to understand written material designed to inform the inmate about rights and treatment needs, a knowledgeable person should read the information to the inmate, explain it to him or her, and discuss it with the inmate.

Note: DOC 314.05. Subsection (2) lists some of the possible less restrictive forms of treatment that an institution could attempt with an inmate. Since each inmate's case is unique, some forms of treatment may not be appropriate in a given case. The rule does not require that an institution attempt all less restrictive forms of treatment prior to filing a petition for commitment. Neither does the rule require that the institution attempt different treatments in any particular order. Voluntary transfer to a state treatment facility under s. 51.10 (4m), Stats., permits an individual who refuses to sign a voluntary admission (perhaps due to catatonia, paranoia or some other mental condition) but who does not protest admission to be admitted to a treatment facility as a non-protesting voluntary patient as long as certain procedures are followed.

Subsection (3) requires that the institution document the available treatments it has and has not tried. Not only is documentation good clinical practice, but it will help a person reviewing the file, including a court, understand why the division did or did not try a particular form of treatment with an inmate. This subsection requires listing of some of the reasons why an institution may not have attempted some forms of treatment. One of the main reasons is that the treatment is not appropriate, according to the professional judgment of a physician or psychologist. Another reason is that the inmate, either by words or by conduct, refuses treatment. Further, an institution may wish to try an alternative such as transfer to another institution, but that alternative may be unavailable because the other institution, for example, is refusing voluntary admissions or the other institution lacks bed space. Finally, sub. (3) (b) only requires that the department explain why other available treatments were not utilized when the other treatments are within the range of treatments normally considered for

the illness in question. This obviates the need to list all the department's treatment programs since many of them would not be seriously considered in treating the inmate's illness.

Note: DOC 314.07. This section states that inmates may be treated voluntarily with psychotropic medications.

Subsection (1) recognizes that it is good medical practice to inform the inmate about why he or she needs medication and what possible side effects there are. The rule recognizes that a physician need not inform the inmate about all possible side effects. Some of the side effects may be so rare that the possibility of their occurring would not have a significant impact on an inmate's decision to take medication, judged by the standard of a reasonable person in the inmate's position.

In subsection (4), one way in which an inmate may withdraw consent is by refusing to take medication; he or she may reinstate consent by voluntarily taking medication.

Note: DOC 314.08. This section defines when involuntary treatment with psychotropic medications is appropriate. Subsection (1) states that an inmate may be involuntarily treated in an emergency. The use of psychotropic medication is to be considered only after reasonable interpersonal efforts have failed to resolve the emergency and if after the brief use of physical restraints the inmate continues to struggle unduly. Emergency involuntary treatment with psychotropic medication should be used only if emergency transfer to a state treatment facility under s. 51.37 (5) (b), Stats., is comtemplated.

Subsection (3) sets out a series of steps that should be followed by staff members administering psychotropic medications in correctional institutions to inmates committed under 51.20 (1) (ar), Stats. Voluntary administration is the ideal, and every effort should be made to persuade the inmate to take the medication. If the inmate is steadfast in refusing, involuntary administration is one of the options open to the attending physician. If the physician decides to proceed with involuntary administration, the most appropriate method and place will likely vary from case to case.