# Chapter DOC 314

## APPENDIX

**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 effective 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 s. 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 sub. (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 contemplated.

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 s. 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.