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STATE OF WISCONSIN

SUPREME COURT

In the matter of the mental commitment of Helen E.F.:

FOND DU LAC COUNTY,

Petitioner-Respondent-Petitioner

v.

HELEN E.F.,

Respondent-Appellant

District: 2

Appeal No. 2010AP002061

Circuit Court Case No. 2010ME000146

BRIEF OF PETITIONER-RESPONDENT-PETITIONER

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ISSUES PRESENTED

1. Whether the behavioral disturbances associated with Helen E.F.'s Alzheimer's dementia constitutes a mental illness within the meaning of Wis. Stat. § 51.01 (13) (b).

   The circuit court answered yes.

   The court of appeals determined as a matter of law that Alzheimer's dementia is not a mental illness for purposes of involuntary commitment.

2. Whether the administration of psychotropic medication designed to improve and control the behavioral disturbances associated with Helen E.F.'s Alzheimer's dementia constitutes treatment within the meaning of Wis. Stat. § 51.01 (17).

   The circuit court answered yes.

   The court of appeals determined as a matter of law that Alzheimer's dementia is not treatable under an involuntary commitment.

POSITION ON ORAL ARGUMENT AND PUBLICATION

Petitioner-Respondent-Petitioner anticipates that oral argument would be helpful in shedding further clarification on the issues presented in this review. Issues concerning the treatment of an individual with Alzheimer's dementia under the involuntary commitment statute have not been addressed by the Supreme Court and are deserving of discussion outside the written briefs. Publication of the decision of the Supreme Court would serve to clarify the involuntary commitment statutes as they relate to individuals with dementia, particularly where no other avenue of treatment for these individuals is available or feasible.

STATEMENT OF THE CASE

This is a case brought by the filing of a petition for examination under Wisconsin Statutes (Section) 51.20 (1) (a) for the involuntary commitment of Helen E.F., an 85 year old nursing home resident suffering from Alzheimer's dementia with behavioral disturbance, causing her to physically strike out at caregivers and refusing to cooperate with required cares at the nursing home. After reviewing the petition, the circuit court judge issued an order detaining Helen E.F. at the Behavioral Health Unit at St. Agnes Hospital, an inpatient psychiatric facility, pending the preliminary hearing.

A circuit court commissioner determined at the preliminary hearing that there was probable cause to believe that Helen E.F. met the criteria for involuntary commitment and further determined that the Behavioral Health Unit, a locked psychiatric facility, was the least restrictive level of treatment consistent with her needs,

and ordered that she continue to be detained at the facility pending the final hearing.

At the final hearing the circuit court found by clear, satisfactory and convincing evidence that Helen E.F. met the statutory standards for involuntary commitment, ordered her commitment for a period of six months, found that the least restrictive level of treatment consistent with her needs was an inpatient psychiatric unit, and designated the Behavioral Health Unit at St. Agnes Hospital as the facility to receive her into the system. The court based its decision on the uncontroverted testimony of psychiatrist Robert Rawski, M.D., which the court found to be extremely compelling and persuasive. A copy of the court's decision is included in the Appendix to this memorandum.

Helen E.F. appealed the order of the circuit court to the Court of Appeals of Wisconsin, District 2. The Court of Appeals reversed the order of the circuit court, holding as a matter of law that Alzheimers dementia is not a treatable mental illness for purposes of involuntary commitment. The Wisconsin Supreme Court granted

Fond du Lac County's petition for a review of the decision of the Court of Appeals.

STATEMENT OF FACTS

Dr. Robert Rawski is a psychiatrist who was appointed by the circuit court to evaluate the mental condition of Helen E.F. (8) He filed a five page written report with the Court (10). The report was received into evidence at the final hearing before the circuit court. (16:4) Dr. Rawski also testified at the hearing. (16:4)

Helen E.F. resided in a nursing home for six years prior to the bringing of the petition in this matter. (16:6) She has progressive dementia, exhibiting memory impairment, forgetfulness, inability to learn new information, and capable of very limited verbal communication. (16:6) Cognitively, her condition is considered to be a progressive mental defect that is not treatable. (16:7)

Dementia, especially Alzheimer's, can involve behavioral disturbances. (16:6) These disturbances

can include poor judgment, aggression toward others, and periods of agitation. (16:6) The behavioral disturbances are often accelerated by confusion. (16:6) Patients can become anxious and depressed. (16:6) They oftentimes have disturbed sleep which can increase the behavioral disturbance. (16:6) They can also become paranoid and hallucinate. (16:6) Any medical conditions can exacerbate the behavioral disturbances. (16:6) Helen E.F. suffered from at least two episodes of urinary tract infection, one of which preceded her hospitalization and a second one which was discovered while she was inpatient. (16:6-7)

Dr. Rawski testified that the behavioral disturbances are considered to be a substantial disorder of thought, mood or perception that grossly impair Helen E.F's judgment, behavior, capacity to recognize reality, and the ability to meet the ordinary demands of life. (16:7) That meets the statutory definition for mental illness for purposes of involuntary commitment.

Helen E.F. is a substantial danger to herself and others as a result of her behavioral disturbances. (16:9)

Helen E.F. represented a risk of harm to others due to impulsive combativeness toward the treatment staff, primarily individuals who are in harm's way. (16:9,10) These episodes primarily occur when caregivers are assisting her to get to the bathroom or to clean her as she is unable to manage those cares on her own. (11:2) Dr. Rawski testified that her urinary tract infections are likely the result of her inability to properly clean herself and care for her daily needs, and staff are having difficulty in caring for her daily needs, including hygiene, as they run the risk of being assaulted by her, as they have on a few occasions, both at the nursing home and on an inpatient basis. (16:10)

Dr. Rawski's report states that Helen's acute risk of harm to herself and others remains a daily concern given the need for treatment staff to assist her with daily cares in order to reduce the potential for morbidity and mortality associated with medical illnesses and infection. (11:4) When staff are required to assist her with getting up and going to the bathroom or cleaning her up or getting her dressed for the day or simply

bathing or administering medications, Helen E.F. has struck out at them. (16:10) She has scratched one caregiver, struck another nurse in the chest, another one in the head, and also has been grabbing at peers as they walk by. (16:10) She has a tendency to grab out and reach at others which, both in an inpatient setting and in a nursing home, raises the risk of aggression toward her. (16:10)

Helen E.F's agitation and aggressive and assaultive behavior was impacting the ability of caregivers to properly give her the care she needs. (16:10,11) Dr. Rawski testified that her behavioral disturbances certainly raises the risk of aggression towards staff, and her not being able to cooperate with those cares reduces the likelihood that they will be able to accomplish them in a safe and appropriate manner. (16:11)

Dr. Rawski testified that Helen E.F. is a proper subject for treatment for her mental illness. (16:7) His written report stated that her treatable symptoms of dementia include behavioral disturbance characterized

by irritability, mood lability, hostility, impulsive episodes of agitation, and physical combativeness. (11:4) Dr. Rawski testified that her treatment consists of using medications commonly prescribed for symptoms of psychosis, mood disturbances, impulsivity and aggression in a judicious fashion to result in improvement in impulsivity, agitation, and physical combativeness. (16:7) The least restrictive level of treatment consistent with Helen E.F.'s needs, at the time of the final hearing, was inpatient hospitalization on a psychiatric unit. (16:7-8)

The medication prescribed for Helen E.F. on the unit initially included Depakote, which is a mood stabilizer often used in individuals with dementia in reducing agitation and aggression. (16:8) Dr. Rawski testified, however, that Depakote alone has not been satisfactorily sufficient in controlling Helen E.F.'s periods of agitation and aggression. (16:8) He testified that, more recently, the psychotic medication, Seroquel, had been discontinued and replaced with a different antipsychotic medication, Risperdal, which was

prescribed at low doses consistent with Helen E.F.'s age and medical conditions. (16:8)

According to Dr. Rawski, the medications improved Helen E.F.'s condition, as evidenced by the removal of a one-to-one sitter that had been instituted due to increased combativeness. (16:8)

Dr. Rawski opined that Helen E.F. would continue to require medications to maintain control over her symptoms of behavioral disturbances associated with dementia so that she can be acutely stabilized and eventually transferred to outpatient status such as a nursing home. (16:11)

ARGUMENT

I. The Behavioral Disturbances Associated With Helen E.F.'s Alzheimer's Dementia Constitute A Mental Illness Within The Meaning Of Wis. Stat. § 51.01 (13) (b), Based On The Record And the Clear, Compelling And Uncontroverted Medical Judgment Of Robert Rawski, M.D.

Wis. Stat. Section 51.20 (1) (a) permits the involuntary commitment of individuals who are mentally

ill, a proper subject for treatment, and dangerous to themselves or others by criteria set forth in the statute.

The interpretation of the meaning of a statute is a question of law. But the application of a statute to the particular set of circumstances as to whether an individual is mentally ill is a medical judgment, a question of fact. In re the Commitment of Dennis H. 255 Wis. 2d 359, 375-376, 647 N.W.2d 851 (2002); see also Humphrey v. Cady, 405 U.S. 504, 509, 92 S.Ct. 1048, 31 L.Ed. 2d 394 (1972).

Helen is mentally ill within the meaning of the involuntary commitment statutes. Wis. Stat. Section 51.01 (13) (b) defines mental illness, for purposes of involuntary commitment, as a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.

Helen's mental condition, as evidenced by her behavior and the medical judgment of Dr. Rawski,

clearly meets this standard. Dr. Rawski expressly testified that, in Helen E.F.'s case, her dementia qualifies as a substantial disorder of thought, mood, and perception that grossly impairs her judgment, behavior, capacity to recognize reality and the ability to meet the ordinary demands of life.

Helen's disorders are clearly documented in the record. She experienced repeated episodes of agitation, paranoia, and hostility that caused her to experience great mental anguish, and resulted in her impulsively striking out at and physically assaulting her caregivers when they attempted to dress, clean or toilet her. This not only caused physical harm to her caregivers, but caused substantial harm to herself by interfering with their ability to provide necessary care. Due to the cognitive aspects of her dementia, Helen E.F. is unable to perform nearly all of the activities of daily living. She is totally reliant on others to provide proper care to keep her healthy and safe. Dr. Rawski opined that her urinary tract infections were caused by her inability to clean herself, and, very relevant to this

proceeding, her inability to cooperate with hygiene and toileting care. He further opined in his report that her acute risk of harm to herself and others remains a daily concern given the need for treatment staff to assist her with daily cares in order to reduce the potential for morbidity and mortality associated with medical illnesses and infection.

Helen's disorders were not manifested in mere cognitive deficits commonly associated with dementia. There was something more going on than mere cognitive impairment. Dr. Rawski labeled the disorder behavioral disturbances associated with the dementia, but whatever the label, the disorder meets all of the criteria of a mental illness for purposes of involuntary commitment. Moreover, at the time Dr. Rawski examined Helen E.F., her mental condition and behavior was improving with the institution of the anti-psychotic/mood stabilizer medication Risperdal. This improvement is strong evidence of the existence of a treatable mental illness. Not every individual with Alzheimer's dementia experiences the mental

conditions and behaviors that were being exhibited by Helen E.F. The mere existence of Alzheimer's dementia in an individual should not forever disqualify him or her from involuntary commitment, when substantial attributes of the individual's mental state and behavior clearly reveal the existence of a mental illness.

The court of appeals erred in determining that it could decide the question of this case only as a question of law. As previously cited in this memorandum, the Wisconsin Supreme Court has stated that the issue of whether an individual is mentally ill is a medical judgment. In re the Commitment of Dennis H. 255 Wis. 2d 359, 375-376, 647 N.W.2d 851 (2002); see also Humphrey v. Cady, 405 U.S. 504, 509, 92 S.Ct. 1048, 31 L.Ed. 2d 394 (1972). The court of appeals virtually ignored the uncontroverted testimony of Dr. Robert Rawski, who testified in clear and persuasive fashion that Helen E.F. has a mental illness for purposes of involuntary commitment as defined in the statute, and that she is a danger to herself and others as a result of her mental illness.

Not only did the court of appeals ignore Dr. Rawski's medical judgment that Helen E.F. has a mental illness, but it impermissibly substituted instead liberal quotations from sources that were not contained in the trial record. None of those sources were introduced as evidence in the trial court and none of them were subject to the scrutiny of examination, sworn testimony and cross examination. The court of appeals acted as legislators rather than deciding the case based on the trial record.

Holding, as a matter of law, that an individual with Alzheimer's dementia does not have a mental illness for purposes of involuntary commitment is contrary to the legislative policy articulated in Wis. Stat. § 51.001, which states as follows:

> It is the policy of the state to assure the provision of a full range of treatment and rehabilitation services in the state for all mental disorders and developmental disabilities and for mental illness, alcoholism and other drug abuse. There shall be a unified system of prevention of such conditions and provisions of services which will assure all people in need of care access to the least restrictive treatment alternative appropriate to their needs, and movement of through all treatment components to assure continuity of care, within the limits of available state and federal funds required to be appropriated to match state funds.

No legislative intent can be gleaned from the statutes that would support the court of appeal's holding that individuals with Alzheimer's dementia should not be assured the provision of a full range of treatment and rehabilitation services for mental disorders when needed merely because of their diagnosis of Alzheimer's dementia. On this issue, the court of appeals impermissibly substituted its own judgment for the judgment of the legislature.

The court of appeals determination that Alzheimer's dementia is a "degenerative brain disorder" and therefore not a mental illness misperceives the term "degenerative brain disorder" and where it stands in relation to Chapters 51 and 55. The court of appeal's conclusion is totally unnecessary, and is not supported by statutory authority or case law.

Degenerative brain disorder is defined, identically, in Wis. Stat. §§ 51.01 (4r), 54.01 (6), and 55.01 (1v) as "the loss or dysfunction of brain cells to the extent that the individual is substantially impaired in his or her ability to provide adequately for his or her own care or

custody or to manage adequately his or her property or financial affairs." Degenerative brain disorder is one of four conditions, among other criteria, concerning an individual's mental state that may qualify him or her for the appointment of a guardian and for protective placement. It is not a term that is related to the criteria for involuntary commitment, and there is no exclusion in the statute that would remove an individual who has a degenerative brain disorder from consideration for involuntary commitment if the individual otherwise meets the commitment standards.

Far more is transpiring with Helen E. F.'s mental condition than is contained in the definition of organic brain disorder. Nowhere in the definition is there any reference to agitation, hostility, paranoia, depression, or physical aggression toward others. Nor is there any mention of the inability to cooperate with care or custody when it is attempted to be provided. Alzheimer's dementia does not fit so neatly into any one of the categories or remedies the legislature created for the purpose of providing for appropriate care and treatment

commensurate with the individual's needs. Holding that Helen E.F. has an organic brain disorder and therefore does not qualify for the benefits of involuntary commitment ignores the reality of her condition as it exists in its entirety.

Moreover, protective placement would not meet Helen E. F.'s treatment needs. The main purpose of protective placement is to provide an individual with primary residential care and custody. Wis. Stat. § 55.08 (1). Protective placement may be made to nursing homes, public medical institutions, centers for the developmentally disabled, foster care services or other home placements, or to other appropriate facilities, but may not be made to units for the acutely mentally ill. Wis. Stat. § 55.12 (2). Helen E.F. resided in a nursing home for six years prior to the petition for examination that brought this proceeding. Helen E.F. could not provide for her own needs due to her dementia. But she was not in need of protective placement. The record is uncontroverted that she had, in the medical judgment of Dr. Rawski, a mental illness that grossly interfered with

her ability to cooperate with nursing home care that was necessary to keep her healthy and safe.

In order for Helen E.F. to be able to cooperate with, and benefit from, residential care, she required treatment on an inpatient psychiatric unit, where her treating psychiatrist could properly monitor her mental condition and properly administer and adjust, as needed, her psychotropic medication. The record shows several changes in Helen E.F.'s medication were required to succeed in controlling her agitation. This could only be safely accomplished on an inpatient unit through an involuntary commitment.

The Wisconsin Statutes contemplate the same individual being subject to both involuntary commitment and protective placement. Wis. Stat. § 55.12 (2) provides that an individual who is subject to an order for protective placement may be detained on an emergency detention under s. 51.15 or involuntarily committed under s. 51.20. The court of appeals decision that Helen E.F. has a degenerative brain disorder and therefore cannot be a subject for involuntary

commitment not only flies in the face of reality, but is in direct conflict with this statute.

II. The Administration of Psychotropic Medication Designed To Improve And Control The Behavioral Disturbances Associated With Helen E.F.'s Alzheimer's Dementia Constitutes Treatment Within The Meaning of Wis. Stat. § 51.07 (17).

Helen is a proper subject for treatment for her mental illness because the treatment prescribed for her illness improved, controlled, and ameliorated the conditions of her illness. Wis. Stat. 51.01 (17) 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.

In the Matter of the Mental Condition of C.J., 120 Wis. 2d 355, 354 N.W.2d 219 (Ct. App. 1984) held that the control and suppression of C.J.'s aggressive tendencies and compulsion to act on his delusions constitute rehabilitation for purposes of treatment for involuntary commitment. That holding is directly on point with the facts in this matter.

CJ had cited In re Athans, 107 Wis. 2d 331, 320 N.W.2d 30 (Ct. App. 1982), the case relied on by the court of appeals in this matter. CJ argued that the Athans case must be construed to view control as a component of habilitation, not rehabilitation. Id. at 359. The CJ court concluded that CJ defined habilitation too broadly and rehabilitation too narrowly.

The court stated:

> Services which "assist an impaired person's ability to live in the community" suggest that habilitation is more closely related to daily living needs and skills than to treatment of a particular disorder. A practical definition of habilitation would include eating, dressing, hygiene, minimum social skills and such other things that facilitates personal maintenance and functioning.

The court went on to state:

> In comparison, treatment going beyond custodial care to affect the disease and symptoms would be more accurately characterized as rehabilitation. Rehabilitation has a broader meaning than returning an individual to a previous level of function. There are many situations where the prior level of functioning is unattainable because of the nature of the disorder. Rehabilitation cannot be considered the equivalent of Cure. An individual with an incurable physical or mental illness or disability may still be considered capable of rehabilitation and able to benefit from treatment in the sense that symptoms can be controlled and the ability to manage the illness ameliorated. The term "ameliorate," also contained in the HEW definition of rehabilitation, does not mean to terminate a disease – it means to make better or more

> tolerable." In the Matter of the Mental Condition of CJ at 360.

Furthermore, there was testimony in the case of In re Athans by a psychiatrist that Athans suffered from schizophrenia, chronic paranoid type, but that Athans was not a proper subject for treatment because rehabilitation in her case was not possible. In re Athans at 333. A psychologist also testified that Athans was not treatable because she would not change her delusional scheme no matter what the treatment attempted. Id. at 333. There can be little question that the expert testimony in Athans led to the trial court's finding, affirmed by the court of appeals, that Athans was not a proper subject for treatment because the disorder could not be improved or controlled in any way.

By contrast, the psychiatrist testifying at C.J.'s trial concluded that C.J. was a proper subject for treatment. In the Matter of the Mental Condition of C.J. at 361. Dr. Yapa testified that the medication structured environment of the institution might serve to suppress C.J.'s aggressive tendencies and the compulsion to act

on his delusions. Id. at 361, 362. By alleviating some of the symptoms of C.J.'s mental disorder, the treatment program might make his illness more manageable. Id. at 362. In C.J., the trial and appellate court properly concluded, based on the medical judgment of the testifying psychiatrist, that C.J. was a proper subject for treatment for purposes of involuntary commitment.

These were the same objectives and consequences of treatment for Helen E.F. Her treatable symptoms of dementia include irritability, mood lability, hostility, impulsive episodes of agitation, and physical combativeness, all expected to improve with and be controlled by judicious use of psychotropic medications appropriate to her age and medical condition.

The provision of custodial care that Helen E.F. requires, due to the cognitive aspects of her dementia, would constitute habilitation. But the improvement and control of the behavioral disturbances associated with her dementia, including her agitation, hostility, and physical acts of aggression, which in the medical judgment of Dr. Rawski is a mental illness, constitutes

rehabilitation. It would allow her to cooperate with required care, and benefit her by helping keep her healthy and safe, and restoring her to a more comfortable and dignified level of well-being.

Furthermore, jury instruction **Wis. JI-Civil,** 7050 (2007), concerning the special verdict for an involuntary commitment proceeding, is consistent with the holding in C.J. It instructs the jury that, In determining if a mentally ill person is treatable, you should consider whether the administration of any, or a combination of treatment techniques may control, improve or cure the substantial disorder of the person's thought, mood, perception, orientation or memory.

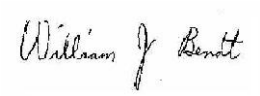
Because of the treatment she received under the involuntary commitment, Helen E.F. was able to return to a nursing home and is better able to cooperate with and receive the care she requires. Left untreated, she would have continued in a near constant state of agitation.

CONCLUSION

For the reasons set forth above, I respectfully request the Wisconsin Supreme Court to reverse the decision of the court of appeals and affirm the order of the Fond du Lac County Circuit Court for the involuntary commitment of Helen E.F. as lawfully issued.

Dated this 29th day of September, 2011

Respectfully submitted,



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CERTIFICATION AS TO FORM/LENGTH

I certify that this brief meets the form and length requirements of Rule 809.19(8)(b) and (c) in that it is: proportional serif font, minimum printing resolution of 200 dots per inch, 13 point body text, 11 point for quotes and footnotes, leading of minimum 2 points and maximum of 60 characters per line of body text. The length of the brief is 4,551 words.

CERTIFICATE OF COMPLIANCE WITH RULE 809.19 (12)

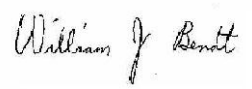
I hereby certify that:

I have submitted an electronic copy of this brief, Including/excluding the appendix, if any, which complies with the requirements of § 809.19(12). I further certify that:

This electronic brief is identical in content and format to the printed form of the brief filed on or after this date.

A copy of this certificate has been served with the paper copies of this brief filed with the court and served on all opposing parties.

September 29, 2011



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APPENDIX

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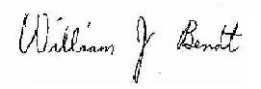
CERTIFICATION AS TO APPENDIX

I hereby certify that filed with this brief, either as a separate document or as part of this brief, is an appendix that complies with s.809.19 (2) (a) and that contains, at a minimum: (1) a table of contents; (2) the findings or opinion of the circuit court and the court of appeals; (3) no unpublished opinion has been cited as part of this brief; and (4) portions of the record essential to an understanding of the issues raised, including oral or written rulings or decisions showing the circuit court's reasoning and the court of appeals reasoning regarding these issues.

I further certify that the record is required by law to be confidential, that portions of the record included in the appendix are reproduced using first names and last initials instead of full names of persons, with a notation that the portions of the record have been so reproduced to preserve confidentiality and with appropriate references to the record.

September 29, 2011



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you don't cure mental illness, but you improve and control it and without that, I don't believe a nursing home would even be able to handle her.

THE COURT: Anything else, Miss Vinz?

MS. VINZ: No, sir.

THE COURT: Well, we have the uncontroverted testimony of Dr. Rawski, and I found Dr. Rawski's testimony to be extremely thorough, extremely persuasive, and, quite frankly, was somewhat refreshing to hear testimony articulated the way he did it. He walked down the mental illness issue, was sensitive to recognize that this young lady has some certain cognitive problems, has a good grasp on how that interplays with behavior, talks about behavior, talks about how disruptive she is, talked about her mental illness, talked about her level of dangerousness, talked about the fact that she is treatable, and the clear and convincing evidence is what this Court has to ultimately find has been established. That's what we had. We had his testimony. We don't have any controverting testimony to present, but I find that -- I find that testimony to be extremely compelling, extremely persuasive.

We have a -- we would like to -- I think we would like to all believe that maybe the manifestations of this subject at this time are a direct result of a UTI

issue and leave it at that and say, fine, we aren't going to medicate that, any of those concerns we are just going to -- we are just going to move on.

I think what we all have to do is to live with that experience with a family member and you will quickly realize the advantages and disadvantages of medications when people have the unfortunate occasion in that maturation process to have Alzheimer's and dementia. My mother-in-law went through this exact same scenario, so this Court is extremely familiar with this type of a situation. She had a UTI issue, and I'm not sitting here passing judgment on Miss F[redacted] but suffice to say we eventually catheterized her because that was the best way of dealing with that issue. Whether or not that in fact is the end result of Miss F[redacted], I don't know. But what it has done is that coupled with her other behavioral issues have been extremely disrupting and has provoked and compromised staff and others that are commissioned, quite frankly, to care for her.

We have aa young lady 85 years old weighing about a hundred pounds that, evidently, is not able to come into court today. But under the same token, they are saying, quite frankly, she ought to be let go because there is no basis to commit her. I find that disappointing. We apparently have a feeling that there

is some lack of connection between mental illness and dangerousness. And with regard to the behavior of Miss F[redacted], I don't think that Dr. Rawski could have said it any clearer as to what that connection is, and certainly to suggest that the subject would not get the very best of care under the best of circumstances, given her unfortunate stage in life, would be, quite frankly, a judicial miscarriage.

There is little doubt in this Court's mind that the County has met its burden of clear and convincing. There is little doubt in this Court's mind that the record clearly supports a finding of mental illness, and a subject -- and a subject that is proper for treatment and that the subject -- and that she is proper subject for treatment. There is no doubt in my mind that the dangerousness standard has, in fact, been satisfied. I don't know what else has to be said. She is combative, she is very disruptive, and we might all want to think this is because of a urinary tract infection. I think that's putting the cart before the horse. She is in a nursing home not because of a UTI. She is in a nursing home because of her Alzheimer's and dementia and that has accelerated itself. Those are cognitive problems that can't be corrected, unfortunately, but they try to medicate that as best they can. It's just a tragic stage

in everybody's life.

I think it's very disappointing that we place our emphasis on the UTI side of this young lady and not on her mental illness issues. So I find, unequivocally, that the record supports the relief that the County has requested and it's so ordered. So I'll order the commitment. I find that she is not competent to refuse medications, and I find the least restrictive is an inpatient, locked psychiatric unit, and she will be committed for six months.

Anything else?

MR. BENDT: Nothing further.

MS. VINZ: Yes, sir. The Court may not fully be aware that in a situation where an individual is uncommunicative, unable to make their wishes known to a case, a default position is one one must advocate for an individual to be free of a commitment order and free of a medication order and so I'm concerned about the Court's use on two occasions of the word "disappointed." I have no choice but to advocate for a client against a commitment order when the individual is uncommunicative and unable to express their wishes. That is the law. If the Court has a concern about that aspect of the law, of course the proper place is to advocate with one's legislature, for instance. But in terms being

disappointed in what I'm advocating, it is necessary to advocate in that fashion because that is what the default position is under the law.

THE COURT: And I appreciate that comment. It's just a matter of how we advocate. So that's fine. So noted. We stand adjourned.

(Proceedings adjourned.)

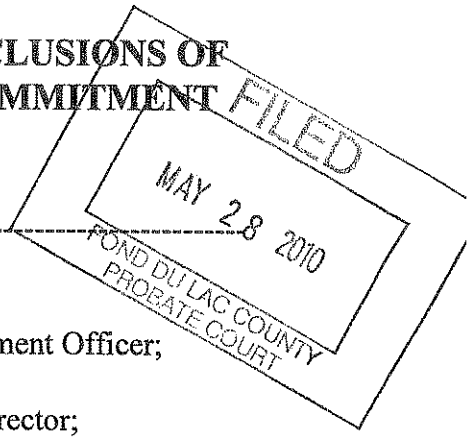
STATE OF WISCONSIN CIRCUIT COURT FOND DU LAC COUNTY

In the matter of the condition of:

HELEN E. F[redacted],
D/O/B - 02/06/25

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR COMMITMENT

Case no.: 10-ME-146



This matter having been brought on by the filing of a:

___ Statement of Emergency Detention by Law Enforcement Officer;

___ Statement of Emergency Detention by Treatment Director;

__x__ **Petition for Examination;**

___ Petition for Recommitment;

to determine the mental condition of **HELEN E. F[redacted]** (Hereinafter, "the subject");

The matter having been scheduled for final hearing on **May 28, 2010**;

The subject having appeared in person and by counsel, **Margaret Vinz ;**

The court having appointed experts to personally examine the subject and having considered the records, file and evidence admitted herein,

NOW, THEREFORE, THE COURT BY CLEAR AND CONVINCING EVIDENCE FINDS THE FOLLOWING:

1. The subject is mentally ill, drug dependent or developmentally disabled; and

2. The subject is dangerous because he/she does any 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.

-or-

__x__ **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 and serious physical harm, as evidenced by a recent overt act, attempt or threat to do such physical harm.

-or-

___ c) Evidences such impaired judgment, manifested by evidence of a pattern of recent acts or omissions, that there is a substantial probability of physical impairment or injury to himself/herself.

-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 subject receives prompt and adequate treatment for this mental illness.

-or-

___ e) Evidences 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.

3. The subject is a proper subject for treatment.

4. The subject is not competent to refuse psychotropic medications.

5. The maximum level of treatment for the subject, which may be used is:

__x__ **locked inpatient facility**.

___ outpatient commitment

CONCLUSIONS OF LAW

1. The criteria under s. 51.20(1)(a), Stats., have been proven.

2. That the subject:

__x__ **is not competent to refuse medication and treatment under s. 51.61(1)(g), Stats.,**

-or-

___ is competent to refuse medication and treatment under s. 51.61(1)(g), Stats.

ORDER

IT IS THEREFORE ORDERED THAT:

1. The subject be committed to the care and custody of the Wisconsin Department of Health and Family Services for treatment for a period not to exceed **six (6) months** from **May 28, 2010 through November 27, 2010**; with the **St. Agnes Hospital, Behavioral Health Unit** designated as the facility or service to receive the subject and which may include, as the maximum level of placement:

__x__ **locked inpatient facility**

____ outpatient commitment

Dated this 28 day of May, 2010.

BY THE COURT:

Honorable Richard J. Nuss
Circuit Court Judge

STATE OF WISCONSIN CIRCUIT COURT FOND DU LAC COUNTY

In the matter of the condition of:

HELEN E. F[redacted],
D/O/B - 02/06/25

ORDER FOR INVOLUNTARY MEDICATION & TREATMENT

Case no.: 10-ME-146

FILED
MAY 28 2010
FOND DU LAC COUNTY
PROBATE COURT

A motion for an order for involuntary medication and treatment of the subject during commitment having been made, pursuant to s. 51.61(1)(g), Stats.;

A hearing having been held on **May 28, 2010**, before the **Honorable Richard J. Nuss, Circuit Judge;**

The subject having appeared in person and by counsel, **Margaret Vinz;**

The interest of the public having been represented by **William J. Bendt**; and the court having considered the records, file and evidence admitted herein;

FINDINGS OF FACT

1. Medication and treatment will have therapeutic value.

2. Medication and treatment will not unreasonably impair the subject's ability to prepare for or participate in subsequent legal proceedings.

3. The advantages, disadvantages and alternatives to accepting the particular medication or treatment offered have been explained to the subject.

4. ☒ Because of mental illness, developmental disability, alcoholism or drug dependence, the subject is incapable of expressing an understanding of the advantages and disadvantages of accepting medication or treatment, and the alternatives to accepting the particular medication or treatment offered after the advantages, disadvantages and alternatives have been explained to the subject.

☐ Because of mental illness, the subject is substantially incapable of applying an understanding of the advantages, disadvantages and alternatives to her mental illness, in order to make an informed choice as to whether to accept or refuse medication or treatment.

CONCLUSION OF LAW

The subject is not competent to refuse medication or treatment under s. 51.61(1)(g), Stats.

ORDER

IT IS ORDERED that medication and treatment may be administered to the subject, regardless of his/her consent, until further order of the court.

IT IS FURTHER ORDERED THAT:

This order will be effective from **May 28, 2010 through November 27, 2010.**

Dated this 28 **day of May, 2010.**

BY THE COURT:

Honorable Richard J. Nuss
Circuit Court Judge

FILED
APR 28 2011
FOND DU LAC COUNTY
PROBATE COURT

COURT OF APPEALS
DECISION
DATED AND FILED

April 27, 2011

A. John Voelker
Acting Clerk of Court of Appeals

NOTICE

This opinion is subject to further editing. If published, the official version will appear in the bound volume of the Official Reports.

A party may file with the Supreme Court a petition to review an adverse decision by the Court of Appeals. *See* WIS. STAT. § 808.10 and RULE 809.62.

Appeal No. 2010AP2061 Cir. Ct. No. 2010ME146

STATE OF WISCONSIN IN COURT OF APPEALS
DISTRICT II

IN THE MATTER OF THE MENTAL COMMITMENT OF HELEN E. F.:

FOND DU LAC COUNTY,

PETITIONER-RESPONDENT,

V.

HELEN E. F.,

RESPONDENT-APPELLANT.

APPEAL from orders of the circuit court for Fond du lac County: RICHARD J. NUSS, Judge. *Reversed and cause remanded with directions.*

Before Brown, C.J., Anderson and Reilly, JJ.

¶1 ANDERSON, J. Helen E. F. appeals from an order for commitment and an order for involuntary medication. The evidence presented at trial was

insufficient to sustain Helen's WIS. STAT. ch. 51 (2009-10)[1] involuntary commitment as a matter of law given that Helen, who is afflicted with Alzheimer's disease,[2] does not suffer from a qualifying mental condition and is not a proper subject for treatment. We therefore reverse and remand the orders and instruct the trial court to proceed not inconsistently with this opinion.

Standard of Review

¶2 Construction of a statute is a question of law. As to questions of law, this court is not required to give special deference to the trial court's determination. ***Hucko v. Joseph Schlitz Brewing Co.***, 100 Wis. 2d 372, 376, 302 N.W.2d 68, 71 (Ct. App. 1981). When interpreting a statute, we begin with the language of the statute. ***State ex rel. Kalal v. Circuit Court for Dane Cnty.***, 2004 WI 58, ¶45, 271 Wis. 2d 633, 681 N.W.2d 110. We give words their common and ordinary meaning unless those words are technical or specifically defined. ***Id.*** We do not read the text of a statute in isolation, but look at the overall context in which it is used. ***Id.***, ¶46. When looking at the context, we read the text "as part of a whole; in relation to the language of surrounding or closely related statutes; and reasonably, to avoid absurd or unreasonable results." ***Id.*** Thus, the scope, context, and purpose of a statute are relevant to a plain-meaning interpretation "as long as the scope, context, and purpose are ascertainable from the text and structure of the statute itself." ***Id.***, ¶48. If the language is clear and unambiguous, we apply the plain words of the statute and ordinarily proceed no further. ***Id.***, ¶46.

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[1] All references to the Wisconsin Statutes are to the 2009-10 version unless otherwise noted.

[2] Alzheimer's disease is a degenerative brain disorder, causing irreversible decline. *See* http://www.medterms.com/script/main/art.asp?articlekey=2213 (last visited Apr. 18, 2011).

¶3 The inquiry does not stop if a statute is ambiguous, meaning that "it is capable of being understood by reasonably well-informed persons in two or more senses." *Id.*, ¶47. If a statute is ambiguous, we may turn to extrinsic sources. *Id.*, ¶51. Extrinsic sources are sources outside the statute itself, including the legislative history of the statute. *Id.* We sometimes use legislative history to confirm the plain meaning of an unambiguous statute, but we will not use legislative history to create ambiguity where none exists. *Id.*

Facts

¶4 The facts are not in dispute. Helen is an eighty-five-year-old woman with Alzheimer's dementia. Her condition has regressed to the point that "she is very limited in any verbal communication." Helen's appearance at the proceedings in this case was waived because "she would not understand or comprehend or be able to participate meaningfully."

¶5 *Motion to Dismiss*: Prior to the probable cause hearing on May 18, 2010, Helen's attorney moved the court to dismiss the WIS. STAT. ch. 51 proceeding. In support of the motion, Helen's attorney outlined the procedural history of Helen's confinement.

¶6 Helen's attorney explained that Helen was taken to St. Agnes Hospital on April 12, 2010. On April 15, 2010, a probable cause hearing was conducted on a prior WIS. STAT. ch. 51 petition. Following this hearing, the court commissioner concluded there was not sufficient probable cause to proceed. At that point, the ch. 51 petition was converted to a WIS. STAT. ch. 55 protective placement action and a thirty-day temporary guardianship was issued.

¶7 The thirty-day-time period to proceed with the WIS. STAT. ch. 55 protective placement expired on May 15 and a second WIS. STAT. ch. 51 petition was filed. Helen's attorney argued that contrary to the teaching of ***State ex rel. Sandra D. v. Getto***, 175 Wis. 2d 490, 498 N.W.2d 892 (Ct. App. 1993), the filing of this new ch. 51 petition constituted an impermissible attempt "to circumvent this time limit." Counsel argued the new ch. 51 petition must be dismissed, because "[y]ou can't keep detaining and detaining and detaining an individual once that time period has expired."

¶8 Insisting that the new WIS. STAT. ch. 51 proceeding was the product of "a separate petition," Fond du Lac County argued that Helen "hasn't been detained continuously under the old order" because after the thirty-day-time period expired for the WIS. STAT. ch. 55 protective placement action and a thirty-day temporary guardianship, "she was wheeled off the unit, and then she was brought back on." The County argued that because she was off the unit, that ended the thirty-day order and therefore, "[t]his [was] a new detention." When pressed as to how long Helen was "wheeled off the unit," the County responded:

> She was off the unit. It doesn't matter how long she was off the unit. She was off the unit. And that ended the 30-day order. This is a new detention. This is a new detention. It doesn't matter if it's two seconds; it split in two, it is not continuous.

¶9 The County further defended the filing of the second WIS. STAT. ch. 51 petition, maintaining it was based on new information since the prior ch. 51 petition was dismissed. According to the County, at the time the prior ch. 51 petition was dismissed, it appeared that Helen's disruptive behavior was the product of a medical problem, i.e., a urinary tract infection. The County argued that inasmuch as Helen's disruptive behavior has continued even after this medical

condition was treated, it now appears that Helen's disruptive behavior is the product of her dementia. The County further argued:

> [Y]ou can have a [WIS. STAT. ch.] 51 on someone with dementia, in that dementia is treatable in some way and this one is treated. She is not going to get cognitively better, but it's going to improve or control the aggressiveness, the physical aggressiveness that she is showing....

Helen's attorney maintained the position that the filing of a new WIS. STAT. ch. 51 petition constituted an end run around the government's failure to comply with the time limits of a prior WIS. STAT. ch. 55 proceeding. The trial court denied Helen's motion to dismiss without explanation: "I'll deny your motion."

¶10 *Probable cause hearing.* During the probable cause hearing that immediately followed the court's denial of Helen's motion to dismiss, the County presented testimony from psychiatrist Dr. Brian Christenson. Christenson treated Helen during her initial WIS. STAT. ch. 51 emergency detention at St. Agnes on April 12 and throughout the subsequent thirty-day WIS. STAT. ch. 55 emergency placement order. In Christenson's opinion, Helen suffers from "[s]enile dementia of Alzheimer's type." Christenson explained that this "progressive loss of brain function, brain deterioration" is exhibited in the following ways:

> [S]he is extremely confused and forgetful and disoriented and agitated, aggressive, uncooperative, anxious, incontinent, and unable to carry on conversations; it grossly impaired her judgment and she is unable to make any decisions regarding her own self care.

Christenson was "not certain" whether Helen's agitation and aggressiveness was related to the dementia or the urinary tract infection, but believed it was "most likely predominantly from the dementia."

¶11 With regard to whether Helen's dementia was subject to treatment, Christenson indicated "the cognitive deterioration is not treatable, but the psychiatric complications of her dementia are treatable," in that "her agitation, aggressiveness, combativeness can be treated with medications that can have some calming effects." Helen is "completely unable to understand" the advantages and disadvantages of the medication. In Christenson's opinion, Helen poses a danger to herself and others through her combativeness with treatment staff and "could harm herself inadvertently."

¶12 Christenson noted that when Helen was taken off the unit at St. Agnes, he "[did not] think she was placed anywhere." Further, Christenson acknowledged that Helen was off the unit "[n]ot very long" and that he believed she was wheeled off the unit because of a problem with the expiration of the WIS. STAT. ch. 55 thirty-day-time period. The court found sufficient probable cause to proceed.

¶13 *Final commitment hearing.* The final commitment hearing was conducted on May 28, 2010. The sole witness at the hearing, psychiatrist Dr. Robert Rawski, testified that Helen "suffers from Alzheimer's Dementia with a behavioral disturbance," that Helen "has progressive dementia" and "has been in a nursing home for the last six years." Rawski explained that Helen's "dementia has progressed to the point where she is very limited in any verbal communication" and she is "so cognitively impaired by her dementia" that she is unable to express an understanding of the advantages or disadvantages of medication.

¶14 Rawski further explained that Alzheimer's dementia can involve behavioral disturbances such as "poor judgment, aggression towards others,

periods of agitation [and] wandering." And that "[c]ognitively, [dementia] is not considered to be a treatable mental disorder. It's a progressive mental defect that is not treatable." Rawski indicated, however, that the behavioral disturbances resulting from dementia are subject to treatment. He said that treatment consists of using medications to address impulsivity, agitation, and physical combativeness.

¶15 Rawski testified that it was his opinion that Helen poses a risk of harm to others due to her impulsive combativeness and grabbing of treatment staff. Rawski said he believed, due to "her advanced age, medical issues, and dementia," Helen also poses a risk of harm to herself because she is unable to manage her daily needs. Based on Rawski's testimony, the trial court found that the grounds for a WIS. STAT. ch. 51 commitment and an involuntary medication order had been proven by clear and convincing evidence. A ch. 51 commitment order and an involuntary medication order were entered following the bench trial. Helen appeals both orders.

The Alzheimer's Challenging Behaviors Task Force Report[3]

¶16 We begin by noting that the issues raised in this case are of great public import. The number of people aged sixty-five or older with Alzheimer's disease is expected to reach 7.7 million in 2030 from the current 5.3 million. Nearly one out of two people who reach age eighty-five will develop Alzheimer's.

[3] *See Handcuffed: A Report of the Alzheimer's Challenging Behaviors Task Force*, http://www.planningcouncil.org/PDF/Alzheimers_Report_Handcuffed.pdf (last visited Apr. 17, 2011). For readability, we do not repeatedly cite to the link to our source. However, the discussion and facts below this task force subheading are all derived from the cited source unless otherwise noted.

In Wisconsin alone, the current number of people with Alzheimer's is estimated at 110,000. All too often, instead of engaging in behavioral management techniques or careful discharge planning, facilities will use WIS. STAT. ch. 51 civil commitment procedure to immediately remove residents with challenging behaviors, many of whom suffer from Alzheimer's disease.

¶17 One way to measure the greatness of our society is to look at how we treat our weakest members, such as our growing population of people afflicted with Alzheimer's.[4] In April 2010, the Alzheimer's Challenging Behaviors Task Force was called together by the Alzheimer's Association of Southeastern Wisconsin to look into the treatment of people with Alzheimer's. The task force was called together following the tragic death of Richard Petersen. Petersen, an eighty-five-year-old gentleman with late stage dementia who exhibited challenging behaviors, was placed under emergency detention after being at two hospitals, and was eventually transferred by police to the Milwaukee County Behavioral Health Division where his family found him tied in a wheel chair with no jacket or shoes. In spite of his family's efforts to intervene, he later developed pneumonia, was transferred to a hospital, and died. The Alzheimer's Association and scores of members of the community were deeply concerned, not only about the treatment of Mr. Petersen and his family, but about others in the Milwaukee county area that are in the same or similar circumstances. The Alzheimer's Association sought and obtained support from several charitable foundations to

[4] A similar sentiment is often attributed to Mohandas Karamchand Gandhi (2 Oct. 1869-30 Jan. 1948), commonly known as Mahatma Gandhi: "A nation's greatness is measured by how it treats its weakest members." http://www.biography.com/articles/Mahatma-Gandhi-9305898 (last visited Apr. 14, 2011); Timothy A. Kelly, *Healing the Broken Mind: Transforming America's Failed Mental Health System* 1 (N.Y. University Press 2009).

partner with the Planning Council for Health and Human Services, Inc., to staff a task force and produce a report to the community.

¶18 The task force found that using WIS. STAT. ch. 51 as a vehicle to deal with challenging behaviors in persons with dementia can lead to transfer trauma, medical complications, exacerbated behaviors, and even death. The use of ch. 51 emergency detentions and the administration of psychotropic drugs, though common, are controversial strategies used to deal with challenging behaviors among people with Alzheimer's and related dementias.[5] These two controversial strategies are precisely what were used to deal with Helen's challenging behaviors.

¶19 While WIS. STAT. ch. 51 provides a means to place persons with mental illness who are considered to be a danger to themselves or others in emergency detention and to administer involuntary treatment, the task force found that a ch. 51 petition is often used for persons with Alzheimer's and related dementias. It found that the usual treatment is the involuntary administration of psychotropic drugs to reduce agitation and aggression and produce a state of sedation. "People come to us in handcuffs, they are out of their milieu, they are put on someone else's schedule, put on meds, and are surrounded by chaos. This will worsen their situation. If they weren't confused before, they will be now."

[5] Other strategies that are used to deal with challenging behaviors among people with Alzheimer's and related dementias reflect promising practices, including activities and interventions that incorporate the interaction of the person with dementia, the caregiver and the environment in which the behaviors occur. These include formal support for caregivers, training in promising methods of assessment and intervention, a culture shift toward "person-centered" care, pain management, use of the Star Method, and instituting appropriate policies and guidelines within facilities regarding the management of challenging behaviors among people with Alzheimer's disease and other dementias.

¶20 Finally, the task force found that across Wisconsin, there is variation in the way different counties apply WIS. STAT. ch. 51 to people who have Alzheimer's and related dementias. At least two counties do not believe ch. 51 should apply to this population and will not prosecute older adults with dementia under ch. 51.

Discussion and Law

¶21 Helen's case provides the opportunity to clarify the proper application of WIS. STAT. ch. 51 and eliminate the variation in ways counties apply the law to people who have Alzheimer's and related dementias.

¶22 Our consideration of the law and the parties' arguments, as well as the well-written amicus briefs[6] and task force report, lead us to conclude that Helen was not a proper subject for detainment or treatment under WIS. STAT. ch. 51 because Alzheimer's disease is not a qualifying mental condition under that chapter.

¶23 Both WIS. STAT. chs. 51 and 55 define "degenerative brain disorder" as the "loss or dysfunction of brain cells to the extent that the individual is substantially impaired in his or her ability to provide adequately for his or her own care or custody or to manage adequately his or her property or financial affairs." WIS. STAT. §§ 55.01(1v) & 51.01(4r). WISCONSIN STAT. ch. 46 specifically defines Alzheimer's disease as "a *degenerative disease* of the central nervous system characterized especially by premature senile mental deterioration, and also

[6] We are grateful to Disability Rights Wisconsin, Coalition of Wisconsin Aging Groups, and Wisconsin Counties Association for the very helpful and well-written briefs, pertinent parts of which we track in this opinion.

includes any other irreversible deterioration of intellectual faculties with concomitant emotional disturbance resulting from organic brain disorder." WIS. STAT. § 46.87(1)(a) (emphasis added). Thus, looking at the text of these closely related statutes, we are able to ascertain that Alzheimer's disease is simply one type of a degenerative brain disorder. *See* ***Kalal***, 271 Wis. 2d 633, ¶46.

¶24 We further conclude that the intended application of the term "degenerative brain disorder" in WIS. STAT. chs. 51 and 55 is unambiguous. Chapter 51's definition of the term is included only to specifically *exclude* it from the chapter's authority, whereas ch. 55's definition is used to *include* it in the scope of authority granted under ch. 55's protective placement and services laws. In ch. 51, "degenerative brain disorder" is referred to only as an exception to both the definitions of "developmental disability" and "serious and persistent mental illness." WIS. STAT. § 51.01(5)(a) & (14t). Chapter 51's definition of "mental illness" is silent on the term "degenerative brain disorder," and defines "mental illness" for purposes of involuntary commitment as "a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, but does not include alcoholism." Sec. 51.01(13)(b).

¶25 Accordingly, it would be inconsistent to include "degenerative brain disorder" in this statutory definition. Despite the definition not specifically excluding the term "degenerative brain disorder," the term is specifically statutorily defined separately from "mental illness," thereby creating an intentional distinction between the two terms.

¶26 Contrary to WIS. STAT. ch. 51, WIS. STAT. ch. 55 specifically *includes* individuals with degenerative brain disorders when defining the scope of

who may receive protective services and for whom emergency and temporary protective placements may be made. WIS. STAT. §§ 55.01(6r)(k), 55.135(1). Even more telling is each respective statutory section's initial statement of legislative policy. Chapter 51 states that "[i]t is the policy of the state to assure the provision of a full range of treatment and rehabilitation services in the state for all mental disorders and developmental disabilities and for mental illness, alcoholism and other drug abuse." WIS. STAT. § 51.001. Chapter 55 explains that "[t]he legislature recognizes that many citizens of the state, because of serious and persistent mental illness, *degenerative brain disorder*, developmental disabilities, or other like incapacities, are in need of protective services or protective placement." WIS. STAT. § 55.001 (emphasis added). Notably and repeatedly absent from ch. 51 is the term "degenerative brain disorders" and, just as notably, the term is specifically included throughout ch. 55. *See* ***Kansas v. Hendricks***, 521 U.S. 346, 359 (1997) ("[W]e have traditionally left to legislators the task of defining terms of a medical nature that have legal significance.").

¶27 Moreover, the primary purpose of WIS. STAT. ch. 51 is to provide treatment and rehabilitation services for the individuals described in ch. 51's legislative policy. WIS. STAT. § 51.001. Even if we were to assume, which we do not, that Alzheimer's disease could reasonably be classified under ch. 51's definition of "mental illness," commitment of an individual with Alzheimer's disease under ch. 51 is nonetheless not appropriate because Alzheimer's disease falls outside the scope of ch. 51's limited definition of "treatment." "Treatment" is defined by ch. 51 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." WIS. STAT. § 51.01(17).

¶28 Consequently, rehabilitation is a necessary element of treatment under WIS. STAT. ch. 51. Because there are no techniques that can be employed to bring about rehabilitation from Alzheimer's, an individual with Alzheimer's disease *cannot* be rehabilitated. Accordingly, Helen is not a proper subject for ch. 51 treatment. *See Alzheimer's Association, 2010: Alzheimer's Disease Facts and Figures*, http://www.alz.org/documents_custom/report_alzfactsfigures2010.pdf, 8 (last visited Apr. 8, 2011).

¶29 Though we could end here, we consider it relevant to note that this court has in fact distinguished the term "rehabilitation" from "habilitation" in a similar WIS. STAT. ch. 51 context. *See* ***Milwaukee Cnty. Combined Cmty. Servs. Bd. v. Athans***, 107 Wis. 2d 331, 334-35, 320 N.W.2d. 30 (Ct. App. 1982). In ***Athans***, Milwaukee County Combined Community Services Board petitioned the trial court for the involuntary commitment of Theodora Athans and Gerald Haskins pursuant to WIS. STAT. § 51.20. ***Athans***, 107 Wis. 2d at 332. The trial court found Athans mentally ill and evincing a danger to herself, but not a proper subject for treatment. ***Id.*** at 333. The trial court found Haskins developmentally disabled, but not a proper subject for treatment. ***Id.*** The trial court ordered both petitions dismissed. ***Id.***

¶30 The Board appealed, arguing that we should broadly construe the term rehabilitation to include within it habilitation in order to carry out the intent of the legislature as embodied in WIS. STAT. ch. 51. ***Athans***, 107 Wis. 2d at 335. We determined that "[o]nly if rehabilitation includes habilitation may we say that Athans and Haskins are proper subjects for treatment." ***Id.*** The two issues on appeal then were (1) whether treatment as defined in WIS. STAT. § 51.01(17) includes habilitation as well as rehabilitation and (2) whether the findings of the

trial court are against the great weight and clear preponderance of the evidence. ***Athans***, 107 Wis. 2d at 335.

¶31 In order to determine whether WIS. STAT. ch. 51 treatment included "habilitation" as well as "rehabilitation," we looked to the definitions given by and agreed upon by the two testifying doctors. ***Athans***, 107 Wis. 2d at 334, 336. "Habilitation" means "the maximizing of an individual's functioning and the maintenance of the individual at that maximum level." ***Id.*** at 334. "Rehabilitation" means "returning an individual to a previous level of functioning which has decreased because of an acute disorder." ***Id.*** We then concluded that "rehabilitation is not an ambiguous term with two or more meanings of which one meaning might include habilitation." ***Id.*** at 335. We held that because WIS. STAT. § 51.01(17) defines treatment in terms of rehabilitation *only* and because the terms habilitation and rehabilitation are separate and distinct in their meanings, Athans and Haskins—*who were unable to be rehabilitated*—were therefore not suitable for ch. 51 treatment. ***Athans***, 107 Wis. 2d at 335-37.

¶32 ***Athans*** is very much on point. Like Athans and Haskins, Helen has a condition that cannot be rehabilitated; thus, like Athans and Haskins, Helen is not suitable for WIS. STAT. ch. 51 treatment. *See* ***Athans***, 107 Wis. 2d at 335-37.

¶33 Finally, the legislative scheme concerning involuntary civil commitment supports our holding today, just as strongly as it supported our holding in ***Athans***. *See* ***id.*** at 337. WISCONSIN STAT. ch. 51 provides for active treatment for those who are proper subjects for treatment, while WIS. STAT. ch. 55 provides for residential care and custody of those persons with mental disabilities that are likely to be permanent. *See* ***Athans***, 107 Wis. 2d at 337. With the ever-

growing Alzheimer's population, "[t]he distinction between these two statutes must be recognized and maintained." *See id.*

¶34 Helen is not a proper subject for treatment under WIS. STAT. ch. 51. We therefore reverse the orders and remand with instructions to proceed not inconsistently with this opinion.[7]

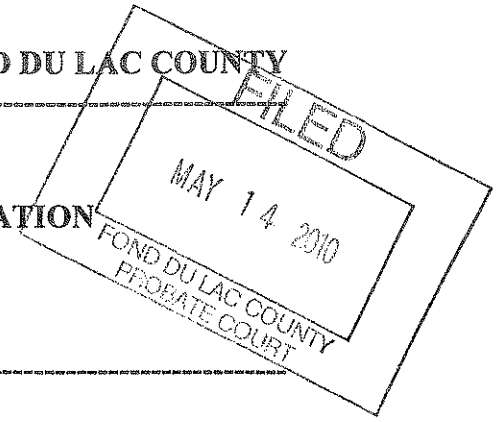
By the Court.—Orders reversed and cause remanded with directions.

Recommended for publication in the official reports.

[7] The appellants also argued that the trial court lacked competency to proceed. We need not reach this argument given our holding. *See* ***Walgreen Co. v. City of Madison***, 2008 WI 80, ¶2, 311 Wis. 2d 158, 752 N.W.2d 687 (noting that when resolution of one issue is dispositive, we need not reach other issues raised by the parties).

We also leave for another day the question of what is proper under the law when a person has a duel diagnosis of Alzheimer's and a WIS. STAT. ch. 51 qualifying illness.

STATE OF WISCONSIN CIRCUIT COURT FOND DU LAC COUNTY



In the matter of:

HELEN E. F[redacted] PETITION FOR EXAMINATION
D.O.B. 10-14-42,

Alleged mentally ill Case No. 10-ME-

The petition of Patricia Burns, Mary Ebert, and Kristi Sook, adult residents of the State of Wisconsin, being duly sworn on oath, states as follows:

Helen E. F[redacted] hereinafter referred to as "Helen" in this petition, is an adult who most recently resided at All About Life Nursing and Rehabilitation Center, 115 E. Arndt Street, Fond du Lac, Fond du Lac County, Wisconsin. She is currently a patient on the Behavioral Health Unit at St. Agnes Hospital in Fond du Lac, Wisconsin, is mentally ill, is a proper subject for treatment, and is dangerous pursuant to s. 51.20(1)(a) 2. b. and c., Stats., because:

1. The petitioners Patricia Burns and Mary Ebert are employed by Agnesian Health Care as registered nurses on the Behavioral Health Unit at St. Agnes Hospital, Fond du Lac. The petitioner Kristi Sook is employed by Agnesian Health Care as a psychiatric social worker on the Behavioral Health Unit. They are in personal contact with Helen, who has been a patient on the unit since April 12, 2010.

2. Helen has resided at All About Life Nursing and Rehabilitation Center in Fond du Lac for the past six years. Helen has chronic dementia, secondary to Alzheimer's Disease, which is growing progressively worse. Her dementia is a substantial disorder of thought, mood and perception which grossly impairs her judgment, behavior and capacity to recognize reality. Her cognitive decline resulting from the dementia is permanent and untreatable. However, attributes of the dementia, comprised of agitation and physically aggressive behavior, can be improved or controlled by treatment. Treatment would improve her ability to cooperate with necessary daily cares, particularly in the area of personal hygiene.

3. Helen is becoming increasingly agitated, and when she becomes agitated she physically strikes out at others. This happens most frequently during caregiving such as toileting, dressing and bathing. On April 12, Helen became physically aggressive toward others at the nursing home and at the emergency room at St. Agnes Hospital, where she had been taken for medical care. As a result, she was placed on an emergency detention by a City of Fond du Lac police officer on the Behavioral Health Unit at St. Agnes Hospital. A probable cause hearing was held on April 15, which resulted in the appointment of Helen's daughter, Barb Venne, as temporary guardian and for her temporary protective placement for thirty days at St. Agnes Hospital. At the time of her admission to the Behavioral Health Unit, Helen was diagnosed as having a urinary tract infection (UTI), which can result in agitation and physically assaultive behavior.

4. Helen has been treated for her UTI since her admission to the unit, but her agitation and physically assaultive behavior has continued. Helen requires assistance for daily cares such as bathing, dressing, and toileting. She is incontinent of bladder. Helen has had numerous incidents since April 15 where she has become agitated and hit or scratched caregivers. Most recently, on Sunday, May 9 the petitioner Mary Ebert and a sitter were assisting Helen getting into the bathroom. Helen became agitated and hit Mary on the left breast and then hit her in the upper chest. On Monday, May 10, Renee Tasso, a certified nursing assistant, observed Helen strike a caregiver, Cindy Rodriguez, in the face, causing the caregiver's glasses to go flying. On Tuesday, May 11 the petitioner Patricia Burns was dressing Helen when Helen hit Patricia in the head. Helen attempted to hit her again, but Patricia was able to catch Helen's hands in time to prevent it. On May 12, Helen struck Patricia while Patricia was assisting her during bathing. In the last few days, Helen has also been grabbing at other people as they walk by. Helen's treating psychiatrist prescribed antipsychotic and antidepressant medication to treat the agitation and combativeness, in order to improve and control it. She remains on the Behavioral Health Unit because she has not progressed to the point where she may be safely returned to a nursing home setting. Helen is not only a danger to others, but her combativeness greatly interferes with the provision of her necessary daily care.

5. Petitioners are requesting court involvement in order to get help for Helen. Petitioners believe that the foregoing conduct of Helen evidences that she is mentally ill and a substantial danger to herself and others and will remain so unless she receives appropriate treatment.

The names and addresses of the petitioners and interested parties are:

Patricia Burns, RN, St. Agnes Hospital Behavioral Health Unit,
430 E Division Street, Fond du Lac, WI 54935
Mary Ebert, RN, St. Agnes Hospital Behavioral Health Unit,
430 E Division Street, Fond du Lac, WI 54935
Kristi Sook, psychiatric social worker, St. Agnes Hospital
Behavioral Health Unit, 430 E Division Street, Fond du Lac, WI 54935
Barb Venne, daughter and temporary guardian,
W6931 Brookview Drive, Fond du Lac, WI 54937
Bill F[redacted], son, 258 Sheboygan Street, Fond du Lac, WI 54935
Mike F[redacted], son, N57W24683 Clover Drive, Sussex, WI 53089

Petitioners request an order of the Court for a hearing to determine whether Helen E. F[redacted] is mentally ill, a subject for treatment, and a danger to herself and others, and commitment to the care and custody of the Fond du Lac County Department of Community Programs for treatment as may be necessary.

Dated this 14th day of May, 2010

Patricia L Burns RN
Patricia Burns, RN

Mary J. Ebert RN
Mary Ebert, RN

Kristi L. Sook CSAC/LCSW
Kristi Sook

Subscribed and sworn to before me
this 14th day of May, 2010

William J Bendt
NOTARY PUBLIC, STATE OF WISCONSIN
My commission is permanent

STATE OF WISCONSIN CIRCUIT COURT FOND DU LAC COUNTY
PROBATE DIVISION

In the Matter of:

HELEN E. F[redacted].

Case No. 10-ME-146

TRANSCRIPT OF PROCEEDINGS

COPY

Proceeding: Final Hearing

Date: May 28, 2010

Before: HONORABLE RICHARD J. NUSS,
Circuit Judge, Branch 3

Appearances: WILLIAM J. BENDT
CORPORATION COUNSEL
160 S. Macy Street
Fond du Lac, Wisconsin 54935
appearing on behalf of the County;

MARGARET VINZ,
ASST. STATE PUBLIC DEFENDER
160 S. Macy Street, Third Floor
Fond du Lac, Wisconsin 54935
appearing on behalf of HELEN E. F[redacted],
who did not appear.

AnnaMaria H. Casper, RMR
Official Court Reporter

INDEX OF EXAMINATION

INDEX OF EXHIBITS

EXHIBIT	DESCRIPTION	MK'D	OFR'D	RCV'D
**None were marked				

P R O C E E D I N G S

THE COURT: The Court will call case 10-ME-146. This is in the interest of Helen F[redacted]. She does not appear in person but by Margaret Vinz. State appears by Corporation Counsel William Bendt.

We're here for a mental commitment hearing. State and County is ready to proceed. Please call the doctor.

MR. BENDT: I'm going to call Dr. Robert Rawski by telephone. And, for the record, I would agree that it would be appropriate for Helen F[redacted]'s appearance to be waived. She does have a form of dementia where she would not understand or comprehend or be able to participate meaningfully or in any way, actually, in these proceedings.

THE CLERK: Dr. Rawski, please hold. This is Judge Nuss's courtroom calling.

THE COURT: Dr. Rawski.

THE WITNESS: Good morning.

THE COURT: This is Judge Nuss. I'm presiding over this matter. Margaret Vinz, the subject's attorney, is here. Helen F[redacted] has been excused. The subject has been excused. William Bendt, Corporation Counsel, is present.

We are here for a mental commitment hearing.

You have a report of May 26, 2010. I have not invited counsel to stipulate to its admission subject to direct and cross. I will now do that.

Mr. Bendt, any objection?

MR. BENDT: No.

THE COURT: Miss Vinz.

MS. VINZ: No.

THE COURT: So your report of May 26, 2010, with regard to Helen F[redacted] is received subject to direct and cross. I'm going to have the clerk administer the oath, and Mr. Bendt can ask you questions.

ROBERT RAWSKI, M.D., called as a witness herein, having been first duly sworn, testified as follows:

THE COURT: Proceed, Mr. Bendt.

DIRECT EXAMINATION

BY MR. BENDT:

Q Please state your full name for the record.

A Robert Rawski, R-A-W-S-K-I.

Q And you are a psychiatrist; is that correct?

A Yes.

MR. BENDT: I would ask the attorney for Helen F[redacted] if she would stipulate to Dr. Rawski's credentials to testify as an expert in psychiatry for the purpose of this hearing.

THE COURT: Any objection?

MS. VINZ: Yes.

THE COURT: You have an objection?

MS. VINZ: No, I'm stipulating

THE COURT: All right. Thank you.

Doctor, you have been certified to testify. Your credentials are not being questioned.

BY MR. BENDT:

Q Dr. Rawski, you received a directive from the Fond du Lac County Circuit Court to examine the condition of Helen E. F[redacted]; is that correct?

A Yes.

Q And did you prepare a report in writing and file that with the Court?

A I did.

Q And did you review the treatment records in preparing your report?

A I did. I reviewed treatment records from St. Agnes Hospital.

Q And when did your interview take place?

A May 24, 2010.

Q Do you have an opinion concerning Helen F[redacted]'s mental condition?

A Yes.

Q What is that opinion?

A Helen F[redacted] suffers from Alzheimer's Dementia with a behavioral disturbance.

Q And can you describe the Alzheimer's Dementia?

A Alzheimer's is a progressive dementia that typically develops after the age of 60 years old. It is characterized by multiple cognitive deficits primarily involving memory impairment and associated decision-making.

Miss F[redacted] has progressive dementia, has been in a nursing home for the last six years because of memory impairment, forgetfulness, inability to learn new information, and her dementia has progressed to the point where she is very limited in any verbal communication.

Now, dementia, especially Alzheimer's, can also involve behavioral disturbances and these can include poor judgment, aggression towards others, periods of agitation, wandering. The behavioral disturbances are often accelerated by confusion. Patients can become anxious, they can become depressed. They oftentimes have disturbed sleep which can increase the behavioral disturbance. They can also become paranoid and hallucinate as well. Any medical conditions can exacerbate the behavioral disturbances as well, and Ms. F[redacted] has suffered from at least two episodes of urinary tract infection, of which preceded the original

hospitalization or at least coming to the hospital in order to get treatment and a second one was discovered a couple of weeks ago while inpatient. It can also add to the confusion in an elderly person with dementia more so than one would expect in a person who did not suffer from dementia. Cognitively, it is not considered to be a treatable mental disorder. It's a progressive mental defect that is not treatable. But the behavioral disturbances are considered to be a substantial disorder of thought, mood, or perception that grossly impairs Miss F[redacted]'s judgment, behavior, capacity to recognize reality, and the ability to meet the ordinary demands of life.

Q And is she a proper subject for treatment for the behavioral disturbances?

A Yes.

Q What would that treatment consist of?

A That treatment would consist of using medications commonly prescribed for symptoms of psychosis, mood disturbances, impulsivity, and aggression in a judicial fashion to result in improvement in impulsivity, agitation, and physical combativeness.

Q And, first of all, what is the least restrictive level of treatment consistent with her needs?

A At the current time the least restrictive level is

inpatient hospitalization on a psychiatric unit.

Q In a locked psychiatric unit?

A Yes.

Q And you mentioned medications as a treatment possibility. Could you describe that further?

A Yes. Miss F[redacted] is currently prescribed a combination of Depakote which is a mood stabilizer often used in individuals with bipolar disorder but frequently helpful in individuals with brain injuries, mental retardation, and dementia in reducing agitation and aggression. That, however, alone has not been satisfactorily sufficient in controlling periods of agitation and aggression on the inpatient unit.

More recently, the psychotic medication Seroquel that had been utilized at the nursing home and in her first weeks at St. Agnes had been discontinued and replaced with a different antipsychotic medication, Risperdal. That medication is being prescribed at low doses consistent with Miss F[redacted]'s age and medical conditions, and the early signs are an improvement in her condition evidenced by the ability to remove a one-to-one sitter that had been reinstituted for approximately 15 days the first and second week of May due to increased combativeness when the Seroquel was discontinued.

Q Did you talk to her about the advantages and

disadvantages of taking the Depakote and Risperdal?
A I tried. Miss F[redacted] did not respond coherently to most of my questions and on a couple that she did, she merely answered yes or no without offering any further details to identify to what degree she even really understood the question.
Q And you formed an opinion as to whether she is able to understand those advantages and disadvantages?
A Yes.
Q And what's that opinion?
A My opinion is that Miss F[redacted] is so cognitively impaired by her dementia that she is unable to express an understanding of the advantages and disadvantages to alternative treatment, the consequences of no treatment, to apply that situation to her particular situation, or to make an informed choice as to whether to accept or refuse medications that trigger mental illness.
Q Do you have an opinion as to whether Helen F[redacted] is a danger to herself or others as a result of the behavioral disturbances?
A Yes.
Q And what's that opinion?
A My opinion is that Miss F[redacted] does represent a risk of harm to others due to impulsive combativeness of the treatment staff, primarily of individuals who are in

harm's way. And because of her advanced age, medical issues, and dementia, she is unable to manage daily cares. Her urinary tract infections are likely the result of her inability to properly clean herself and take care of her daily needs, and staff are having some difficulty in doing that as they run the risk of being assaulted by her, as they have on a few occasions, both at the nursing home and on an inpatient basis. She has a tendency to grab out and reach at others which, both in an inpatient setting and in a nursing home, raises the risk of aggression toward her and so that also puts herself at some risk of harm due to the impaired judgment of grabbing onto other individuals.

Q You mentioned the striking out. Could you describe that in more detail? How is that occurring?

A Yes. When staff are required to assist her with getting up and going to the bathroom or cleaning her up or getting her dressed for the day and such or simply bathing or even administering medications, Miss F[redacted] has struck out at them. She has scratched one caregiver, struck another nurse in the chest, another one in the head, and also has been grabbing at peers as they walk by.

Q And this is actually impacting her ability to properly give her the cares that she needs?

A Yes. It certainly raises the risk of aggression towards staff, and her not being able to cooperate with those cares reduces the likelihood that they are going to be able to accomplish those in a safe and appropriate manner.

Q And is the goal to reduce that aggression so that she could return to a nursing home setting?

A Yes. She is likely -- her needs when she is not aggressive can be managed in a nursing home. And if properly medicated and her symptoms improve, she is likely to be able to return there so that the staff there can resume assisting her with her needs.

MR. BENDT: I don't have any further questions.

THE COURT: Cross-examination, Miss Vinz?

MS. VINZ: Thank you.

CROSS-EXAMINATION

BY MS. VINZ:

Q Doctor, when an individual, an elderly individual who has dementia also has urinary -- a urinary tract infection, that can be a source of aggression by that individual, correct?

A What it does is it raises the risk for confusion and delirium superimposed on the dementia, and that -- and confusion can increase the amount of agitation and anxiety and potential aggression in an individual with

dementia.

Q So the urinary tract infection causes confusion which in turn can cause the person to be aggressive?

A It can.

Q Now, in terms of Mrs. F[redacted], she was admitted to St. Agnes Hospital on April 12th of this year, correct?

A Yes.

Q And she was admitted with a urinary tract infection?

A Yes, in addition to other issues.

Q And you have no information that prior -- with the exception of a couple of weeks prior to April 12th that she was physically aggressive, correct?

A That is the entirety of the information that I know of her history prior to, yes.

Q So the physical aggression, as far as you know, began within about a two-week period prior to her admission on April 12th?

A I did not know that.

Q One way or the other?

A One way or the other.

Q All right.

A She was prescribed medication to treat aggression -- actually, three of them, actually, and that would indicate a history of the need to treat aggression in a demented individual.

Q Well, when you say "medication to treat aggression," you are talking about medication that is also prescribed for a number of purposes?

A Yes, for depression and for psychosis. She did not have a history of psychosis from what I understand.

Q But there could have been a history of depression.

A There could have been a history of depression and one of those medications of the three are prescribed for depression. The other two would likely be described -- or prescribed for the behavioral disturbances associated with dementia.

Q Now, since she has been at St. Agnes Hospital, that urinary tract infection has been a continuing problem.

A I understand it was treated and then they rechecked again in May and discovered that the bacteria was back again and only responded to certain antibiotics.

Q And so they were retreating it?

A Yes.

Q Now, Miss -- Mrs. F[redacted] is 85 years old?

A Right.

Q And if you could give your best estimate of her weight, it would be somewhere in the neighborhood of 100 pounds. Would that be true?

A Yes.

MS. VINZ: I have no other questions.

THE COURT: Redirect.

REDIRECT EXAMINATION

BY MR. BENDT:

Q Is it your opinion that there is -- that the behavior disturbances that you were talking about that resulted from the Alzheimer's is independent from the UTI?

A Yes.

MR. BENDT: I don't have any further questions.

THE COURT: Further recross.

MS. VINZ: No, sir.

THE COURT: Doctor, I want to thank you for your testimony. Have a nice day and have a nice weekend.

THE WITNESS: Thank you. Enjoy the weekend.

THE COURT: Thank you.

THE COURT: Further testimony.

MR. BENDT: No. I had -- Dr. Patel is available, but I think Dr. Rawski's report and his testimony were so pervasive here, I think it would be repetitive, not necessary to take up the Court's time.

THE COURT: Miss Vinz, other than argument, anything to offer?

MS. VINZ: No, sir.

THE COURT: Thank you, Mr. Bendt.

MR. BENDT: I would ask the Court find that Helen F[redacted] is a proper subject for commitment. She has

a form of Alzheimer's that has cognitive impairment that is not treatable, but there are behavioral disturbances that are associated with it that are. Those behavioral disturbances meet the statutory criteria as a substantial disorder of thought, mood, and perception that grossly impairs her judgment and behavior capacity to recognize reality.

Fortunately, she is a subject for treatment. There are medications, Depakote and Risperdal which is replacing a former medication, Seroquel, that actually, according to the doctors, shows early signs of improvement in her condition that would allow her to be less combative and able to cooperate with needed cares.

She is not able to understand the advantage and disadvantages of taking the medication, and I would ask for a medication order. She has been a danger to herself and others, especially during caregiving. She is striking out at staff. She is hitting staff in the head, chest, the arms. She reaches out and grabs at people, all of which is unintended. It has -- it's a response to her agitation and confusion but it is resulting in the inability of the nursing home to provide her care and even, to some extent, at the psychiatric unit. She still has the same need for cares, including hygiene which Dr. Rawski's starting to believe may have been part of

the reason why she has a urinary tract infection. She hasn't been allowing staff to properly bathe her and keep her clean and so she would meet the criterion for dangerousness towards others and herself, and I would ask the Court order a six-month commitment. Initially it's inpatient. I'm hoping that she gets better so she can be returned to the nursing home where she has been for at least six years and with a medication order.

THE COURT: Miss Vinz.

MS. VINZ: Thank you. As the Court is certainly aware, the County has to establish three things here. First of all, they have to establish that the individual has a mental illness or disorder. Secondly, that they have to establish that the person is dangerous connected to that mental illness or disorder. It is not enough that the person has a mental illness and then they are dangerous. There has to be a connection between those two things. And then, finally, they have to prove that that individual is treatment -- is treatable, that they are mentally ill -- or disorder is treatable.

Now, in regard to the mental illness or disorder, we acknowledge that Mrs. F[redacted] has Alzheimer's. The problem comes in the connection between that and the dangerousness. Mrs. F[redacted] has been in this nursing home for six years. The doctor has no evidence that she was

in any form dangerous to residents and staff prior to two weeks before her admission on April 12th to St. Agnes Hospital. She was admitted with a urinary tract infection. The doctor testified that urinary tract infections in individuals who have dementia can cause confusion which in turn can cause aggression. And so based on the fact that this just manifested itself, this aggression manifested itself at the same time that the urinary tract infection manifested itself, I don't believe there is that connection between the dementia and the dangerousness.

Furthermore, this is an individual who is 85 years old, weighs about a hundred pounds. The degree to which she can actually be dangerous is very limited. And then, finally, there is the issue of the treatability. We have heard that the symptoms can be treated but that is not what the law requires. The law requires treatability of the mental illness or disorder and the doctor's testimony on that point was that dementia is not treatable, so I don't believe the legal standard has been met.

THE COURT: Mr. Bendt, anything briefly in response?

MR. BENDT: Yeah. It is dangerous to be striking out at staff. You can hit them in the head, you

can hit them in the chest, you can hit them in the arm. Mostly the danger is to herself because they are not able to provide the cares that she needs. In fact, the same argument can be used against the commitment that was well stated by her attorney used to support it. She had been there six years, and they know her, you'd like to think, after six years. They are not able to care for her and that is why she was transferred to an inpatient setting. Yes, there is a UTI. They treated it. It seemed to recur fast, but Dr. Rawski believes that her lack of cooperation with cares probably helped result in her getting a UTI, and if you are not cooperating with cares for cleaning and bathing and providing whatever medication you need, you are in serious harm to yourself. Nursing homes can't do something for you if you are not cooperative to care. So I believe she is a danger, and the doctor did say that he thought that the behavioral disturbance was independent of the UTI. It's part of the illness itself which meets the statutory definition.

Even if the cognitive impairment is not treatable, the behavior is, the agitation is, the fear that results from the confusion that she needs to strike out. That would be treatable. That would help improve and control her condition which is what the statutory definition -- that's what the jury instructions say, that

you don't cure mental illness, but you improve and control it and without that, I don't believe a nursing home would even be able to handle her.

THE COURT: Anything else, Miss Vinz?

MS. VINZ: No, sir.

THE COURT: Well, we have the uncontroverted testimony of Dr. Rawski, and I found Dr. Rawski's testimony to be extremely thorough, extremely persuasive, and, quite frankly, was somewhat refreshing to hear testimony articulated the way he did it. He walked down the mental illness issue, was sensitive to recognize that this young lady has some certain cognitive problems, has a good grasp on how that interplays with behavior, talks about behavior, talks about how disruptive she is, talked about her mental illness, talked about her level of dangerousness, talked about the fact that she is treatable, and the clear and convincing evidence is what this Court has to ultimately find has been established. That's what we had. We had his testimony. We don't have any controverting testimony to present, but I find that -- I find that testimony to be extremely compelling, extremely persuasive.

We have a -- we would like to -- I think we would like to all believe that maybe the manifestations of this subject at this time are a direct result of a UTI

issue and leave it at that and say, fine, we aren't going to medicate that, any of those concerns we are just going to -- we are just going to move on.

I think what we all have to do is to live with that experience with a family member and you will quickly realize the advantages and disadvantages of medications when people have the unfortunate occasion in that maturation process to have Alzheimer's and dementia. My mother-in-law went through this exact same scenario, so this Court is extremely familiar with this type of a situation. She had a UTI issue, and I'm not sitting here passing judgment on Miss F[redacted] but suffice to say we eventually catheterized her because that was the best way of dealing with that issue. Whether or not that in fact is the end result of Miss F[redacted], I don't know. But what it has done is that coupled with her other behavioral issues have been extremely disrupting and has provoked and compromised staff and others that are commissioned, quite frankly, to care for her.

We have aa young lady 85 years old weighing about a hundred pounds that, evidently, is not able to come into court today. But under the same token, they are saying, quite frankly, she ought to be let go because there is no basis to commit her. I find that disappointing. We apparently have a feeling that there

is some lack of connection between mental illness and dangerousness. And with regard to the behavior of Miss F[redacted], I don't think that Dr. Rawski could have said it any clearer as to what that connection is, and certainly to suggest that the subject would not get the very best of care under the best of circumstances, given her unfortunate stage in life, would be, quite frankly, a judicial miscarriage.

There is little doubt in this Court's mind that the County has met its burden of clear and convincing. There is little doubt in this Court's mind that the record clearly supports a finding of mental illness, and a subject -- and a subject that is proper for treatment and that the subject -- and that she is proper subject for treatment. There is no doubt in my mind that the dangerousness standard has, in fact, been satisfied. I don't know what else has to be said. She is combative, she is very disruptive, and we might all want to think this is because of a urinary tract infection. I think that's putting the cart before the horse. She is in a nursing home not because of a UTI. She is in a nursing home because of her Alzheimer's and dementia and that has accelerated itself. Those are cognitive problems that can't be corrected, unfortunately, but they try to medicate that as best they can. It's just a tragic stage

in everybody's life.

I think it's very disappointing that we place our emphasis on the UTI side of this young lady and not on her mental illness issues. So I find, unequivocally, that the record supports the relief that the County has requested and it's so ordered. So I'll order the commitment. I find that she is not competent to refuse medications, and I find the least restrictive is an inpatient, locked psychiatric unit, and she will be committed for six months.

Anything else?

MR. BENDT: Nothing further.

MS. VINZ: Yes, sir. The Court may not fully be aware that in a situation where an individual is uncommunicative, unable to make their wishes known to a case, a default position is one one must advocate for an individual to be free of a commitment order and free of a medication order and so I'm concerned about the Court's use on two occasions of the word "disappointed." I have no choice but to advocate for a client against a commitment order when the individual is uncommunicative and unable to express their wishes. That is the law. If the Court has a concern about that aspect of the law, of course the proper place is to advocate with one's legislature, for instance. But in terms being

disappointed in what I'm advocating, it is necessary to advocate in that fashion because that is what the default position is under the law.

THE COURT: And I appreciate that comment. It's just a matter of how we advocate. So that's fine. So noted. We stand adjourned.

(Proceedings adjourned.)

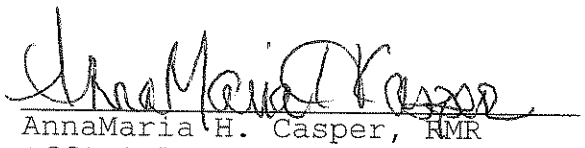
C E R T I F I C A T I O N

STATE OF WISCONSIN)
) ss.
FOND DU LAC COUNTY)

I, AnnaMaria H. Casper, hereby certify that I am a Registered Merit Reporter, and that I have been duly appointed as Official Court Reporter for Circuit Court, Branch 4, Fond du Lac County, Wisconsin.

I further certify that I reported these proceedings by means of machine shorthand, and that the foregoing is a full, complete and correct transcript of my stenographic notes in said proceedings, as prepared by me via computer-aided transcription.

Dated: August 18, 2010.



AnnaMaria H. Casper, RMR
Official Court Reporter
Fond du Lac County, Wisconsin

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Associates in Psychiatry and the Law
Forensic and General Psychiatry

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May 26, 2010

FILED
MAY 26 2010
FOND DU LAC COUNTY
PROBATE COURT

The Honorable Richard J. Nuss
Circuit Court—Branch 3
Fond du Lac County Courthouse
160 South Macy Street
Fond du Lac, Wisconsin 54935

RE: HELEN E. F[redacted]
DOB: 02/06/1925
CASE NO: 10-ME-146

Dear Judge Nuss:

Pursuant to a court order dated May 17, 2010 and Wisconsin Statute 51.20, I evaluated Helen F[redacted]s suitability for civil commitment in Fond du Lac County.

Database: My evaluation consisted of the following:

1. A psychiatric interview conducted on May 24, 2010 at St. Agnes Hospital in Fond du Lac.

2. A review of the original petition for examination authored by St. Agnes staff dated May 14, 2010.

3. A review of Ms. F[redacted]s treatment records at St. Agnes Hospital.

Preliminary Advisement: Prior to beginning this evaluation, I attempted to inform Ms. F[redacted] of the purpose of the evaluation and limits of confidentiality. I attempted to explain that she had the legal right to remain silent and that what she told me would not be confidential, but would rather be used by the Court in determining its opinion regarding her suitability for civil commitment. I also attempted to explain that this information would be conveyed to the Court in a report with copies for the judge, the County attorney and her attorney. While Ms. F[redacted] listened to the advisement, she mumbled irrelevant questions and showed me some folded washcloths in front of her on the table. At no time did she indicate that she understood the purpose of the evaluation or the limits of confidentiality.

Collateral Record Review: Helen F[redacted] is 85-year-old Caucasian female who has resided at All About Life Nursing and Rehabilitation Center in Fond du Lac for the last six years. Ms. F[redacted] has a host of medical problems including hypertension, osteoarthritis, hyperlipidemia, anemia and chronic kidney disease. She also suffers from Alzheimer's disease which has grown progressively worse over the years. In late March and early April 2010, Ms. F[redacted] became increasingly agitated and physically struck out at caregivers at All About Life while refusing meds and meals. On April 12, 2010 she became physically aggressive toward others at the nursing home and at the emergency room at St. Agnes Hospital where she was taken for medical care. She was diagnosed with a urinary tract infection, but required restraint and intramuscular medication secondary to her degree of agitation and aggressiveness. Fond du Lac police were called and an emergency detention was filed secondary to her combative behavior. A probable cause hearing was held on April 15, 2010, at which time an order for temporary protective placement at St. Agnes for a period of up to 30 days was instituted and Ms. F[redacted]'s daughter was named temporary guardian.

Prior to her hospitalization, Ms. F[redacted] was treated with three different medications for depression, anxiety and physical aggressiveness, namely Seroquel, Celexa and Depakote. Early in her hospital course, the Depakote was increased in an attempt to reach a therapeutic blood level. Her Depakote level on admission was barely detectable, consistent with reports that she had been refusing medications prior to her hospitalization. Subsequent blood levels drawn at St. Agnes could not be located within the medical records. Secondary to confusion and periods of agitation, Ms. F[redacted] required a one-to-one sitter for the first ten days of hospital course. The sitter was discontinued during a period in which the Seroquel was being tapered secondary to unsteadiness and a fall, and a small dosage of the anti-anxiety medication Ativan was added in its place. Within one week, the sitter was reinstituted secondary to re-emergence of aggressive behavior. Possible causes for the return of aggressiveness included the discontinuation of Seroquel or the addition of Ativan which may have contributed to a disinhibition of behavior. A third possibility was the re-emergence of another urinary tract infection, ultimately diagnosed in mid-May 2010.

Ms. F[redacted] was prescribed the antipsychotic/mood-stabilizer Risperdal on May 12, 2010, the dosage of which was increased two days later. Within one week, the one-to-one sitter was again discontinued and, over the four days prior to this evaluation, she was only noted on one occasion to have been combative with staff but at least two occasions to have resisted or refused to take medications.

Treatment notes and the petition for examination detail Ms. F[redacted]'s aggressive behavior. These episodes primarily occur when assisting her to get into the bathroom or to clean her as she is unable to manage those cares on her own. She has hit or scratched caregivers, struck one nurse in the chest and another in the head, and had also been grabbing at peers as they walk by. At the time of the petition for examination dated May 14, 2010 shortly before the expiration of the 30-day temporary protective placement, Ms.

F[redacted] continued to engage in such aggressive behaviors as the Risperdal was first being prescribed.

Subjective History/Mental Status Examination: I attempted to interview Ms. F[redacted] at a table in a day room where she sat in a wheelchair in front of some folded washcloths. She responded to my greeting, but mumbled incoherent, fragmented, irrelevant responses during the preliminary advisement. She frequently fell silent. On one occasion she looked down the hall and asked, "Where is my mother?" It was difficult to ascertain whether or not she wished to participate in the evaluation. In response to questions regarding her current location, duration of hospitalization, interactions with staff and medication treatment, Ms. F[redacted] frequently sat silently, looked around the area in a nervous manner, traced her finger on the table and occasionally mumbled an incoherent response. At times she responded appropriately, although questionably accurately, in response to the questions about the nurses treating her well and in denial of memory problems. She responded with ignorance to questions regarding recent problems with her temper or her current prescription medications. After 15 minutes of a non-productive contact, I terminated the evaluation.

Psychiatric Diagnosis: Based upon my examination and a review of available records, I believe to a reasonable degree of medical certainty that Helen F[redacted] suffers from Alzheimer's Dementia with behavioral disturbance.

The essential feature of dementia is the development of multiple cognitive deficits that include memory impairment and other associated disturbances. In Ms. F[redacted]'s case, she has demonstrated a memory impairment, forgetfulness, inability to learn new information, and her cognitive deterioration is quite advanced to the degree that she is very limited in any verbal communication.

Behavioral disturbances of dementia can include poor judgment, aggression toward others and wandering. Behavioral disturbances are often accelerated by confusion from the cognitive impairment, as well as associated anxiety, mood, sleep and thought and perceptual disturbances including the potential for persecutory delusions and visual hallucinations. Delirium, an acute medically related confusion, is often superimposed upon dementia because the underlying brain disease increases susceptibility of confusional states that can be produced by medications and other concurrent general medical conditions such as urinary tract infections. Individuals with dementia may be especially vulnerable to physical stressors such as illness or minor surgery.

Although the cognitive impairment in dementia is not considered treatable, the behavioral disturbances in dementia are considered treatable and in Ms. F[redacted]'s case, her dementia qualifies as a substantial disorder of thought, mood, and perception that grossly impairs her judgment, behavior, capacity to recognize reality and the ability to meet the ordinary demands of life. Her pattern of behavior during her inpatient hospitalization has featured an increase in agitated and aggressive behavior with treatment staff requiring a one-to-

one sitter during periods in which medications used to decrease impulsivity and aggression were withdrawn. It appears that her behavior is once again improving with the treatment of a second episode of urinary tract infection and the institution of the anti-psychotic/mood-stabilizer Risperdal. Unfortunately her cognitive capacities to understand her illness and consistently cooperate with treatment remain quite impaired.

Opinions Regarding Civil Commitment: I hold the following opinions to a reasonable degree of medical certainty.

1. Helen F[redacted] suffers from a mental illness as defined by the Wisconsin State Statute 51.01(13)(b). She does not suffer from a developmental disability or drug dependence.

2. Ms. F[redacted] is a proper subject for treatment at this time. Her treatable symptoms of dementia include the behavioral disturbance characterized by irritability, mood lability, hostility, impulsive episodes of agitation, and physical combativeness, all expected to improve with the judicious use of appropriate psychotropic medications.

3. Ms. F[redacted]'s acute risk of harm to herself and others remains a daily concern given the need for treatment staff to assist her with daily cares in order to reduce the potential for morbidity and mortality associated with medical illnesses and infection. During routine cares, Ms. F[redacted] has been physically aggressive with staff including hitting them about the face and torso. She has also impulsively reached out and grabbed at other peers who walk by, raising the potential risk for an aggressive response by another individual.

4. At the current time, I believe the least restrictive and most appropriate level of treatment is inpatient treatment at St. Agnes Hospital under a civil commitment enforcing appropriate psychotropic treatment to reduce impulsive agitation and aggression while allowing staff to actively administer appropriate medical treatment and daily cares. A civil commitment will be required secondary to Ms. F[redacted]'s inconsistent cooperation with her medications secondary to the absence of insight into her behavioral difficulties.

5. Ms. F[redacted] requires medications to maintain control over her symptoms of behavioral disturbance associated with dementia so that she can be acutely stabilized and staff at St. Agnes can eventually transfer her to an outpatient setting, likely a return to the nursing home. Medications are designed to have a therapeutic value and will not impair the subject's ability to prepare or participate in any further proceedings. Ms. F[redacted] is currently prescribed the anti-psychotic/mood-stabilizer Risperdal, the anti-depressant Celexa, and the mood stabilizer Depakote.

6. Ms. F[redacted] is substantially cognitively impaired to the degree that she was unable to coherently communicate and thus is incapable of expressing an understanding of the advantages, disadvantages and alternatives to treatment, the consequences of no treatment, or apply that information to her particular situation in order to make an informed choice as to whether to accept or refuse medications to treat her mental illness. As a result, I currently believe she is incompetent to accept or refuse psychotropic medications.

Thank you very much for this referral. If I can be of further assistance, please do not hesitate to page me at 414-405-2433. Upon hearing the voicemail greeting, press 5, enter the callback number, and press #.

Sincerely,

RR MD

Robert Rawski, M.D.
Board Certified Psychiatrist
Board Certified Forensic Psychiatrist

CERTIFICATION AS TO APPENDIX

I hereby certify that filed with this brief, either as a separate document or as part of this brief, is an appendix that complies with s.809.19 (2) (a) and that contains, at a minimum: (1) a table of contents; (2) the findings or opinion of the circuit court and the court of appeals; (3) no unpublished opinion has been cited as part of this brief; and (4) portions of the record essential to an understanding of the issues raised, including oral or written rulings or decisions showing the circuit court's reasoning and the court of appeals reasoning regarding these issues.

I further certify that the record is required by law to be confidential, that portions of the record included in the appendix are reproduced using first names and last initials instead of full names of persons, with a notation that the portions of the record have been so reproduced to preserve confidentiality and with appropriate references to the record.

September 29, 2011

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STATE OF WISCONSIN

IN SUPREME COURT

Case No. 2010AP002061

In the matter of the mental commitment of Helen E.F.:

FOND DU LAC COUNTY,

Petitioner-Respondent-Petitioner,

v.

HELEN E.F.,

Respondent-Appellant.

On Petition for Review of the Decision of the Wisconsin Court of Appeals, District II, Reversing an Order for Commitment and Order for Involuntary Medication, Entered in the Circuit Court, Fond du Lac County, the Honorable Richard J. Nuss, Presiding

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BRIEF AND APPENDIX OF RESPONDENT-APPELLANT

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ISSUES PRESENTED

1. Did the Court of Appeals correctly conclude Helen's Chapter 51 commitment must be reversed, because Chapter 51 does not authorize the involuntary commitment of a person afflicted with Alzheimer's and Helen is not a proper subject for treatment?

The trial court concluded there was sufficient evidence to support the commitment.

The Court of Appeals concluded current statutes do not authorize the Chapter 51 commitment of a person afflicted with Alzheimer's and Helen is not a proper subject for treatment because a person afflicted with Alzheimer's cannot be rehabilitated.

2. Should the Chapter 51 petition have been dismissed based on either a loss of competency to proceed or an abuse of process, because the present action was initiated only after a prior Chapter 51 proceeding had been dismissed and the County had failed to timely proceed with a Chapter 55 protective placement?

The preliminary hearing court denied Helen's motion to dismiss the second Chapter 51 petition.

The Court of Appeals summarized Helen's challenge to the second Chapter 51 petition, but concluded it was unnecessary to address this issue because it had already determined the evidence was insufficient to sustain the commitment.

POSITION ON ORAL ARGUMENT AND PUBLICATION

Both are appropriate.

STATEMENT OF THE CASE/ STATEMENT OF FACTS

This case is before the Court on a petition to review the Court of Appeals' decision entered on April 27, 2011. The Court of Appeals reversed the Chapter 51 commitment of Helen E. F., an eighty-five year old woman afflicted with Alzheimer's. The Court of Appeals concluded the evidence was insufficient to sustain Helen's "involuntary commitment as a matter of law given that Helen, who is afflicted with Alzheimer's disease, does not suffer from a qualifying mental condition and is not a proper subject for treatment." ***Fond du Lac County v. Helen E.F.***, 2011 WI App 72, ¶1, 333 Wis. 2d 740, 743, 798 N.W.2d 707 (footnote omitted).

The Chapter 51 commitment and involuntary medication order at issue in this appeal were entered following a bench trial conducted on May 28, 2010, before the Honorable Richard J. Nuss. (12; 13; 16:19-22). Helen's appearance at these proceedings was waived because "she would not understand or comprehend or be able to participate meaningfully." (16:3).

A. Prior proceedings and Helen's motion to dismiss.

As summarized in the Court of Appeals' decision, the current Chapter 51 proceeding was not the first commitment action initiated against Helen. At the preliminary hearing conducted on May 18, 2010, Helen's trial counsel moved to dismiss this Chapter 51 proceeding in accordance with

State ex rel. Sandra D. v. Getto, 175 Wis. 2d 490, 498 N.W.2d 892 (Ct. App. 1993), asserting that this new Chapter 51 petition constituted an end run around the county's failure to comply with the time limits for conducting a Chapter 55 hearing. (9:3-5). In support of her motion, trial counsel summarized the procedural history of the commitment process.

Trial counsel explained that on April 12, 2010, Helen was brought to St. Agnes Hospital on a Chapter 51 emergency detention. On April 15, 2010, the court commissioner concluded there was not sufficient probable cause to proceed. (9:3). The Chapter 51 petition was then converted to a Chapter 55 protective placement action and a 30-day temporary guardianship was issued. (9:3-4).

On May 15, 2010, the thirty-day time period to conduct a Chapter 55 protective placement hearing expired. Trial counsel argued that contrary to the teaching of ***Sandra D.***, the filing of a second Chapter 51 petition constituted an impermissible attempt "to circumvent this time limit." (9:4). Counsel argued this second Chapter 51 petition must be dismissed, because "[y]ou can't keep detaining and detaining and detaining an individual once that time period has expired." (9:4-5).

Insisting that the current Chapter 51 proceeding was the product of "a separate petition," corporation counsel argued that Helen "hasn't been detained continuously under the old order" because after the thirty-day time period expired "they wheeled her off the unit and she was brought back in on a new detention." (9:5, 7, 8). When pressed as to how long Helen was off the unit, corporation counsel responded:

> She was off the unit. It doesn't matter how long she was off the unit. She was off the unit. And that ended the

> 30-day order. This is a new detention. This is a new detention. It doesn't matter if it's two seconds; it split in two, it is not continuous.

(9:8). Corporation counsel defended the filing of a new Chapter 51 petition, claiming it was based on new information since the prior petition was dismissed. According to corporation counsel, at the time the prior Chapter 51 petition was dismissed it appeared that Helen's disruptive behavior was the product of a medical problem, a urinary tract infection. Corporation counsel argued that inasmuch as Helen's disruptive behavior has continued even after this medical condition was treated, Helen's disruptive behavior appears to be the product of her dementia. (9:5-6, 9). Corporation counsel further argued:

> [Y]ou can have a Chapter 51 on someone with dementia, in that dementia is treatable in some way and this one is treated. She is not going to get cognitively better, but it's going to improve or control the aggressiveness, the physical aggressiveness that she is showing.

(9:6). The preliminary hearing court, the Honorable Henry Buslee, summarily denied counsel's motion to dismiss declaring: "I'll deny your motion." (9:9; see appendix).

B. The probable cause hearing.

At the probable cause hearing the County offered testimony from Dr. Brian Christenson, who had treated Helen during her initial Chapter 51 emergency detention at St. Agnes on April 12th, and throughout her subsequent thirty-day Chapter 55 emergency placement. In Dr. Christenson's opinion, Helen suffers from "[s]enile dementia of Alzheimer's type." (9:9-10). He explained that Helen's "progressive loss of brain function, brain deterioration" is exhibited in the following ways:

> [S]he is extremely confused and forgetful and disoriented and agitated, aggressive, uncooperative, anxious, incontinent, and unable to carry on conversations; it grossly impaired her judgment and she is unable to make any decisions regarding her own self care.

(9:11). Dr. Christenson was "not certain" whether Helen's agitation and aggressiveness was related to the dementia or the urinary tract infection, but believed it was "most likely predominantly from the dementia." (9:12-13, 15).

In addressing whether Helen's dementia was subject to treatment, Dr. Christenson indicated "the cognitive deterioration is not treatable, but the psychiatric complications of her dementia are treatable" in that "her agitation, aggressiveness, combativeness can be treated with medications that can have some calming effects." (9:11-12, 13). In Dr. Christenson's opinion, Helen posed a danger to herself and others through her combativeness with treatment staff and "could harm herself inadvertently." (9:14-15).

Dr. Christensen confirmed that when Helen was taken off the unit at St. Agnes she was not placed anywhere else. Helen was not off the unit "very long." She was wheeled off the unit because of a problem with the expiration of the Chapter 55 thirty-day time period. (9:16-17).

C. The final commitment hearing.

The sole witness at the final commitment hearing, Dr. Robert Rawski, indicated Helen "suffers from Alzheimer's Dementia with a behavioral disturbance." He explained:

> Alzheimer's is a progressive dementia that typically develops after the age of 60 years old. It is characterized

> by multiple cognitive deficits primarily involving memory impairment and associated decision-making.

(16:6). Helen "has progressive dementia" and "has been in a nursing home for the last six years." "[H]er dementia has progressed to the point where she is very limited in any verbal communication." (16:6).

According to Dr. Rawski, Alzheimer's dementia can involve behavioral disturbances such as "poor judgment, aggression towards others, periods of agitation, wandering." These disturbances can be "accelerated by confusion" and exacerbated by other factors including disturbed sleep and medical problems such as a urinary tract infection. (16:6-7).

Dr. Rawski explained that "[c]ognitively [dementia] is not considered to be a treatable mental disorder. It's a progressive mental defect that is not treatable." He considered the behavioral disturbances resulting from Helen's dementia "to be a substantial disorder of thought, mood, or perception that grossly impairs [her] judgment, behavior, capacity to recognize reality, and the ability to meet the ordinary demands of life." (16:7). According to Dr. Rawski, Helen is a proper subject for treatment for the behavioral disturbances, which consists of using medications to address impulsivity, agitation, and physical combativeness. (16:7-8).

In Dr. Rawski's opinion, Helen, who weighed only about a hundred pounds, posed a risk of harm to others due to her impulsive combativeness and grabbing of treatment staff. (16:9-11, 13). Due to "her advanced age, medical issues, and dementia" Helen also posed a risk of harm to herself because she is unable to manage her daily needs. (16:10).

ARGUMENT

I. The Court of Appeals Correctly Concluded the Evidence Was Insufficient to Sustain Helen's Commitment Because (1) Chapter 51 Does Not Authorize the Commitment of a Person Afflicted With Alzheimer's, and (2) Helen Is Not a Proper Subject for Treatment.

A. Overview.

A "civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection." ***Addington v. Texas***, 441 U.S. 418, 425 (1979). ***See also***, ***Vitek v. Jones*** 445 U.S. 480, 491-492 (1980)(commitment to a mental hospital entails "a massive curtailment of liberty"). Furthermore, a civil commitment "can engender adverse social consequences" or "stigma" for the individual committed. ***Addington***, at 445-446. Consequently, the Supreme Court concluded the "preponderance" standard of proof provided insufficient protection in a civil commitment proceeding, noting "the possible injury to the individual" from commitment outweighed any possible harm to the state. Therefore, due process required the government prove the requisite grounds for commitment under the more demanding clear and convincing standard. ***Id.***, at 427.

Consistent with the constitutional principles articulated in ***Addington***, Wis. Stats. §§ 51.20(1)(a) and 51.20(13)(a)3, authorize the involuntary commitment of a citizen who is mentally ill, dangerous, and a proper subject for treatment. The party seeking the commitment bears the burden of

proving these elements by clear and convincing evidence. Wis. Stat. § 51.20(13)(e). [1]

At issue in this appeal is whether a person afflicted with a degenerative brain disorder such as Alzheimer's dementia can be involuntarily committed under Chapter 51. Resolution of this issue ultimately boils down to a question of statutory construction. After examining the relevant statutes, the Court of Appeals properly concluded that a patient afflicted with Alzheimer's is not a proper subject for commitment under Chapter 51. Yet, even if the Court of Appeals was mistaken in concluding that Wisconsin's commitment statutes categorically foreclose the involuntary Chapter 51 commitment of a person afflicted with Alzheimer's, the Court properly reversed Helen's commitment because she is not a proper subject for treatment. In accordance with ***Milwaukee County Combined Community Services Board v. Athans***, 107 Wis. 2d 331, 320 N.W.2d 30 (Ct. App. 1982), Helen may not be committed under Chapter 51 because her Alzheimer's disease is not subject to treatment.

Fond du Lac County nevertheless insists that a person afflicted with a degenerative brain disorder such as Alzheimer's may be involuntarily committed under Chapter 51. According to the County, an Alzheimer's patient such as Helen may be committed under Chapter 51 as long as the "behavioral disturbances" he/she exhibits can be characterized "as a substantial disorder of thought, mood, and

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[1] Consistent with this due process requirement, Wis. Stat. § 55.10(4)(d), similarly provides that a protective placement is permitted only upon proof "by clear and convincing evidence." ***Kindcare, Inc. v. Judith G.***, 2002 WI App 36, ¶¶10, 18, 250 Wis. 2d 817, 824, 828-829, 640 N.W.2d 839. At the time ***Judith G.***, was decided, the governing burden of proof was set forth in Wis. Stat. § 55.06.

perception that grossly impairs her judgment, behavior, capacity to recognize reality and the ability to meet the ordinary demands of life." (County's brief, p. 11-12). Helen and the Court of Appeals below disagree.

For the reasons discussed in greater detail in the argument sections below, the County's request to construe Chapter 51 to permit the involuntary commitment of individuals afflicted with Alzheimer's based on their "behavioral disturbances" must be rejected, because such a construction (1) conflicts with the language and structure of Wisconsin's commitment statutes; (2) effectively renders statutory language removing degenerative brain disorders from the reach of Chapter 51 mere surplusage; (3) compromises the constitutional requirement of a mental illness for civil commitment; and (4) obscures the critical distinction between treatment of the patient's mental disorder and management of the patient's behavior in order to facilitate the provision of basic maintaining care. Significantly, the County is unable to point to any statutory language or legislative history demonstrating the legislature's intent to authorize the Chapter 51 commitment of persons afflicted with Alzheimer's.

Furthermore, contrary to the County's suggestion, the Court of Appeals' refusal to extend Chapter 51 to cover persons afflicted with Alzheimer's does not mean that authorities are left powerless to intervene when an Alzheimer's patient poses a danger to themselves or others. On the contrary, when intervention is necessary to address the needs of a person afflicted with Alzheimer's, care and custody may be provided under the protective services system of Chapter 55, including, if warranted, the option of authorizing the involuntary administration of psychotropic medications pursuant to Wis. Stat. § 55.14.

The County's invitation to rewrite the statutes to permit the commitment of persons afflicted with Alzheimer's should also be declined because of the significant ramifications of such a ruling. As the amicus brief submitted on behalf of the Elder Law Section of the State Bar of Wisconsin and the Wisconsin Chapter of the National Academy of Elder Law Attorneys, (hereinafter Elder law), ably explains, classifying Alzheimer's as a mental illness for Chapter 51 purposes would produce unfortunate consequences for the judicial system as well as for the increasing number of Alzheimer's patients and their families. Due to the exclusionary provisions contained in Wis. Stat. § 155.20(2)(c), and Wis. Stat. § 50.06(2)(b), if Alzheimer's is classified as a "mental illness," the placement of an Alzheimer's patient in a residential care facility or skilled nursing facility could no longer be achieved through either a "powers of attorney for health care" (POHAC), or a "family consent" placement. As a result, the probate system would be flooded with an increased number of guardianship and protective placement filings. Perhaps more significantly, foreclosing reliance on these informal placement mechanisms would undermine current efforts to encourage aging and disabled patients and their families to engage in their own placement planning, thereby avoiding the expense, stigma, and loss of dignity that accompanies formal commitment proceedings.

If Chapter 51 is to be expanded to permit the involuntary commitment of persons afflicted with Alzheimer's, such a change should be addressed to the legislature, not adopted by this Court. The legislature is better equipped to conduct fact-finding addressing the multitude of scientific, ethical, economic, administrative and public policy considerations implicated by the challenge of assuring proper care for the increasing number of Alzheimer's patients.

B. The Court of Appeals correctly concluded Chapter 51 does not authorize the commitment of persons afflicted with Alzheimer's.

1. Standard of review.

Whether a person afflicted with Alzheimer's may be committed under Chapter 51 presents a question of statutory construction. The construction of a statute is a question of law subject to independent review. ***Fond du Lac County v. Helen E.F.***, 333 Wis. 2d at 743, ¶2. ***See***, ***State v. Stenklyft***, 2005 WI 71, ¶7, 281 Wis. 2d 484, 494, 697 N.W.2d 769; ***State v. Fischer***, 2010 WI 6, ¶15, 322 Wis. 2d 265, 279, 778 N.W.2d 629.

In construing any statute the objective is to discern and give effect to the intent of the legislature. ***Teschendorf v. State Farm Ins. Cos.***, 2006 WI 89, ¶11, 293 Wis. 2d 123, 133, 717 N.W.2d 258; ***State ex rel. Kalal v. Circuit Court for Dane County***, 2004 WI 58, ¶44, 271 Wis. 2d 633, 662, 681 N.W.2d 110. The primary source of construction of a statute is the plain language of the statute itself. ***Teschendorf***, at 134, ¶12; ***State ex rel. Kalal***, at 663 ¶45. In construing the relevant statutes in this appeal, the Court of Appeals correctly summarized the governing principles of statutory construction.

> When interpreting a statute, we begin with the language of the statute. ***State ex rel. Kalal v. Circuit Court for Dane Cnty.***, 2004 WI 58, ¶ 45, 271 Wis. 2d 633, 681 N.W.2d 110. We give words their common and ordinary meaning unless those words are technical or specifically defined. ***Id.*** We do not read the text of a statute in isolation, but look at the overall context in which it is used. ***Id.***, ¶ 46. When looking at the context, we read the text "as part of a whole; in relation to the language of surrounding or closely related statutes; and reasonably,

> to avoid absurd or unreasonable results." ***Id.*** Thus, the scope, context, and purpose of a statute are relevant to a plain-meaning interpretation "as long as the scope, context, and purpose are ascertainable from the text and structure of the statute itself." ***Id.***, ¶ 48. If the language is clear and unambiguous, we apply the plain words of the statute and ordinarily proceed no further. ***Id.***, ¶ 46.

Helen E.F., 333 Wis. 2d at 743-744, ¶2.

Obscuring the threshold legal question regarding the scope of Chapter 51, the County suggests that appellate review in this matter should be limited to a deferential examination of the trial court's ruling. Granted, as the County correctly points out, the trial judge found the sole witness at Helen's commitment trial, Dr. Rawski, to be persuasive. (County's brief, p. 4). The issue here, however, is not the credibility of Dr. Rawski's testimony, but rather, whether the evidence satisfies the governing legal standard. The Court of Appeals acknowledged the facts in this case are not in dispute. ***Helen E.F.***, 333 Wis. 2d at 744, ¶4.

The County's analysis conflates a reviewing court's obligation to give deference to the trial court's findings of fact with the reviewing court's responsibility to independently ascertain the meaning of the governing legal standard. In this instance, Dr. Rawski's belief that the behavioral disturbances resulting from Helen's dementia constitute a treatable disorder of thought, mood, or perception does not resolve the threshold legal question whether Chapter 51 authorizes the involuntary commitment of a person with Alzheimer's. While a trial court's findings of fact are subject to review under a clearly erroneous standard, whether those facts satisfy the governing legal standard is a question of law subject to independent review. ***Matter of Guardianship of K.N.K.***,

139 Wis. 2d 190, 198, 407 N.W.2d 281 (Ct. App. 1981).[2] Certainly Dr. Rawski is not the final arbiter of the permissible scope of Chapter 51.

2. Under Wisconsin's statutory scheme, a person afflicted with Alzheimer's is to be provided care and custody under Chapter 55, not committed under Chapter 51.

The Court of Appeals correctly concluded that Wisconsin's mental health statutes do not reflect a legislative intent to authorize the Chapter 51 commitment of persons suffering from degenerative brain disorders such as Alzheimer's. Rather, persons afflicted with Alzheimer's and other degenerative brain disorders are, when necessary, to be provided care and custody within the protective services system of Chapter 55.

Underlying the Court of Appeals' statutory analysis is the recognition that the involuntary commitment scheme set forth in Chapter 51 and the protective services system provided under Chapter 55 serve different interests. Addressing a prior version of these two chapters, ***Milwaukee County Combined Community Services Board v. Athans***, 107 Wis. 2d 331, 337, 320 N.W.2d 30 (Ct. App. 1982),

[2] For instance, while an appellate court assessing the sufficiency of the evidence in a criminal case must examine the evidence in the light most favorable to the verdict, the determination whether this evidence satisfies the legal elements of the charge constitutes a question of law subject to independent review. ***See State v. Schutte***, 2006 WI App 135, ¶15, 295 Wis. 2d 256, 269, 720 N.W.2d 469 (whether defendant's driving constituted negligent operation of a vehicle raises a question of law); ***State v. Forster***, 2003 WI App 29, ¶12, 260 Wis. 2d 149, 160-161, 659 N.W.2d 144 (whether contact with a male breast can constitute a sexual assault is a question of law subject to *de novo* review).

succinctly summarized the different functions served by these two provisions.

> Chapter 51 provides for active treatment for those who are proper subjects for treatment, and sec. 55.06, Stats., provides for residential care and custody of those persons with mental disabilities that are likely to be permanent. The distinction between these two statutes must be recognized and maintained.

The different functions served by Chapter 51 commitments and Chapter 55 protective services is reflected in the declaration of legislative policy introducing each of these chapters. The introduction to Chapter 51, Wis. Stat. § 51.001, declares:

> **51.001 Legislative policy.** (1) It is the policy of the state to assure the provision of a full range of treatment and rehabilitation services in the state for all mental disorders and developmental disabilities and for mental illness, alcoholism and other drug abuse. There shall be a unified system of prevention of such conditions and provision of services which will assure all people in need of care access to the least restrictive treatment alternative appropriate to their needs, and movement through all treatment components to assure continuity of care, within the limits of available state and federal funds and of county funds required to be appropriated to match state funds.
>
> (2) To protect personal liberties, no person who can be treated adequately outside of a hospital, institution or other inpatient facility may be involuntarily treated in such a facility.

The declaration of policy introducing the Chapter 55 states:

> **55.001 Declaration of policy.** The legislature recognizes that many citizens of the state, because of

> serious and persistent mental illness, degenerative brain disorder, developmental disabilities, or other like incapacities, are in need of protective services or protective placement. Except as provided in s. 49.45 (30m) (a), the protective services or protective placement should, to the maximum degree of feasibility under programs, services and resources that the county board of supervisors is reasonably able to provide within the limits of available state and federal funds and of county funds required to be appropriated to match state funds, allow the individual the same rights as other citizens, and at the same time protect the individual from financial exploitation, abuse, neglect, and self-neglect. This chapter is designed to establish those protective services and protective placements, to assure their availability to all individuals when in need of them, and to place the least possible restriction on personal liberty and exercise of constitutional rights consistent with due process and protection from abuse, financial exploitation, neglect, and self-neglect.

Chapter 51 is designed to provide "treatment and rehabilitation services" "for all mental disorders and developmental disabilities and for mental illness, alcoholism, and other drug abuse." Unlike Chapter 55, the statement of legislative policy in Chapter 51 does not include "degenerative brain disorder" among the conditions subject to commitment for "treatment and rehabilitation." Chapter 55, on the other hand, expressly includes "degenerative brain disorder" among the conditions and like incapacities for which protective services or a protective placement should be provided.

Given the different purposes served by these two chapters, it is not surprising that Chapter 51 commitments and Chapter 55 placements are not interchangeable. Accordingly, Wis. Stat. § 55.12(2), prohibits the transfer of a Chapter 55

patient to a Chapter 51 treatment facility absent an independent commitment proceeding under Chapter 51.[3]

If the legislature had intended to authorize Chapter 51 commitments for persons afflicted with a "degenerative brain disorder," the legislature could have easily included "degenerative brain disorders" among the list of conditions that may be addressed under Chapter 51. The legislature did not do so. Instead, the legislature determined that persons afflicted with a "degenerative brain disorder" such as Alzheimer's should be provided care and custody under Chapter 55.[4] As the Court of Appeals observed, this legislative distinction is understandable, because Alzheimer's is simply not susceptible to treatment and rehabilitation, the

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[3] Wis. Stat. § 55.12(2) reads:

> (2) Subject to s. 46.279, protective placement may be made to nursing homes, public medical institutions, centers for the developmentally disabled under the requirements of s. 51.06 (3), foster care services or other home placements, or to other appropriate facilities, but may not be made to units for the acutely mentally ill. An individual who is subject to an order for protective placement or protective services may be detained on an emergency basis under s. 51.15 or involuntarily committed under s. 51.20 or may be voluntarily admitted to a treatment facility for inpatient care under s. 51.10 (8). No individual who is subject to an order for protective placement or services may be involuntarily transferred to, detained in, or committed to a treatment facility for care except under s. 51.15 or 51.20. Protective placement in a locked unit shall require a specific finding of the court as to the need for the action.

[4] Pursuant to Wis. Stat. § 55.01(6), the term "[p]rotective placement" "means a placement that is made to provide for the care and custody of an individual."

purpose for a commitment under Chapter 51. ***Helen E.F.***, at 754, ¶¶27-28.

Severing the "behavioral disturbances" resulting from Helen's Alzheimer's disease from her underlying mental condition, the County contends that Helen was properly committed because her behavior exhibits a "substantial disorder of thought, mood, perception, orientation, or memory." The County's expansive reading of the general definition of mental illness in Wis. Stat. § 51.01(13)(b),[5] must be rejected, for it would effectively nullify related portions of the mental health statutes that place degenerative brain disorders such as Alzheimer's outside the reach of Chapter 51. Interpretations of a statute that render any portion of the statute superfluous are to be avoided. ***State ex rel. Kalal***, 271 Wis. 2d at 663, ¶46.

The County invites this Court to construe the general term "mental illness" in isolation, rather than addressing the term "in the context in which it is used" and "in relation to the language of surrounding or closely-related statutes." ***Kalal***, at ¶46. Under the County's expansive reading of this general definition, a person afflicted with a degenerative brain disorder may be committed under Chapter 51, notwithstanding other portions of the statute indicating otherwise. The Court of Appeals recognized this definition of mental illness must be read in the context of a mental health scheme that otherwise categorically removes degenerative brain disorders from the reach of Chapter 51. The Court

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[5] Wis. Stat. § 51.01(13)(b), reads:

(b) "Mental illness", for purposes of involuntary commitment, means a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, but does not include alcoholism.

noted that "Chapter 51's definition of 'mental illness' is silent on the term 'degenerative brain disorder'" which is "defined separately" in the statute. ***Helen E.F.***, at 752-753, ¶24-25.

Chapter 51 does not contain any express authorization for the involuntary commitment of persons afflicted Alzheimer's or any other degenerative brain disorder. Rather, as the Court of Appeals observed, the term degenerative brain disorder is included in Chapter 51 "only to specifically *exclude* it from the chapter's authority, whereas ch. 55's definition is used to *include* it in the scope of authority granted under ch. 55's protective placement and services laws." ***Helen E.F.***, at 752, ¶24. Furthermore, unlike Chapter 51, Chapter 55 "specifically *includes* individuals with degenerative brain disorders when defining the scope of who may receive protective services and for whom emergency and temporary protective placements may be made. Wis. Stat. §§ 55.01(6r)k, 55.135(1)." ***Id.***, at 753, ¶26.

The legislature's intent to remove degenerative brain disorders from the type of conditions that may be addressed under Chapter 51, is further reflected in various other definitional provisions in this chapter. For instance, both the statement of legislative policy set forth in Wis. Stat. § 51.001(1), and the subsequent listing in Wis. Stat. § 51.20(1)(a)1,[6] of the type of qualifying mental health issues that may warrant a Chapter 51 commitment, indicate this chapter may be applied to individuals with developmental disabilities. Significantly, however, the definition of "Developmental disability" set forth in Wis. Stat.

[6] Pursuant to Wis. Stat. § 51.20(1)(a)1, this provision potentially applies when: "The individual is mentally ill or, except as provided under subd. 2. e., drug dependent or developmentally disabled and is a proper subject for treatment."

§ 51.01(5)(a), expressly excludes "dementia that is primarily caused by degenerative brain disorder."

> (5) (a) "Developmental disability" means a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, mental retardation, or another neurological condition closely related to mental retardation or requiring treatment similar to that required for individuals with mental retardation, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. "Developmental disability" does not include dementia that is primarily caused by degenerative brain disorder.

The Court below further observed that the definition of "Serious and persistent mental illness" set forth in Wis. Stat. § 51.01(14t), similarly excludes "degenerative brain disorder." ***Helen E.F.***, at 752, ¶24.

> (14t) "Serious and persistent mental illness" means a mental illness that is severe in degree and persistent in duration, that causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, that may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support, and that may be of lifelong duration. "Serious and persistent mental illness" includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include degenerative brain disorder or a primary diagnosis of a developmental disability or of alcohol or drug dependence.

The definition of "brain injury" in Wis. Stat. § 51.01(2g), similarly excludes "Alzheimer's disease" or "degenerative brain disorder." Wis. Stat. § 51.01(2g)(b), declares:

> (b) "Brain injury" does not include alcoholism, Alzheimer's disease as specified under s. 46.87(1)(a) or degenerative brain disorder, as defined in s. 55.01(1v).

The Court of Appeals further observed that while the primary purpose of Chapter 51 is to provide treatment and rehabilitation services, the classifications of individuals for whom treatment is to be provided does not include persons afflicted with a degenerative brain disorder or Alzheimer's. Rather, "treatment," as more narrowly defined in Wis. Stat. § 51.01(17), "means 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." ***Helen E.F.***, at 754, ¶27. Chapter 51 was simply not intended to apply to persons with a degenerative brain disorder such as Alzheimer's.

Plainly, Alzheimer's disease falls within the definition of a "degenerative brain disorder" identically defined in both Wis. Stats. §§ 51.01(4r) and 55.01(1v), as follows:[7]

> "Degenerative brain disorder" means the loss or dysfunction of brain cells to the extent that the individual is substantially impaired in his or her ability to provide adequately for his or her own care or custody or to manage adequately his or her property or financial affairs.

The history of the definition of "degenerative brain disorder" set forth in Wis. Stats. § 55.01(1v), confirms that this term was intended to include those afflicted with Alzheimer's. The term "degenerative brain disorder" was introduced to Chapter 55 as part of the extensive legislative revision of this chapter resulting from 2005 Wis. Act 264.

[7] The term is also similarly defined in Wis. Stat. § 54.01(6).

The Legislative Council Note accompanying this statutory revision explains that the term "degenerative brain disorder" was designed to replace the prior phrase "infirmities of aging," because this prior term did not sufficiently account for organic brain disorders such as Alzheimer's that were not necessarily caused by the aging process.

> This bill replaces the definition of "infirmities of aging" with a definition of "degenerative brain disorder." This definition is considered to be a more accurate reference to types of organic brain disorders, such as Alzheimer's disease and Parkinson's disease, which are not necessarily caused by the aging process.

2005 Wisconsin Session Laws, Volume 2, p. 1001, 2005 Wis. Act 264, *Legislative Council Note*, 2005 Assembly Bill 785, (Enacted April 5, 2006).

Significantly, as part of this same Act amending the term "infirmities of aging" to "degenerative brain disorders" in Chapter 55, the legislature also amended the Chapter 51 definitions of "Developmental disability" in Wis. Stat. § 51.01(1)(a), "Serious and persistent mental illness" in Wis. Stat. § 51.01(14t), and "Brain injury" in Wis. Stat. § 51.01(2g)(b), in the same fashion. Indeed, the legislature replaced the portion of these definitions that excluded "infirmities of aging" with the phrase "degenerative brain disorder, as defined in s. 55.01(1v)." ***2005 Wisconsin Session Laws***, Volume 2, p. 1016, 2005 Wis. Act 264, §§ 35, 36, and 38. It is evident, therefore, that the definition of "degenerative brain disorder" in Chapter 51, like the identical definition in Chapter 55, was meant to include persons with Alzheimer's.

Just over a month following the enactment of 2005 Wis. Act 264, the legislature enacted 2005 Wis. Act 387.

This Act created Wis. Stat. § 51.01(4r), a definition of "degenerative brain disorder" identical to that set forth in Chapter 55. Curiously, this Act also amended the definitions of "Developmental disability" in Wis. Stat. § 51.01(1)(a), and "Serious and persistent mental illness" in Wis. Stat. § 51.01(14t), substituting the term "degenerative brain disorder" for the prior phrase "infirmities of aging." ***2005 Wisconsin Session Laws***, Volume 2, p. 1338, 2005 Wis. Act 387, §§ 50, 51, 53, 2005 Senate Bill 391 (Enacted May 10, 2006). Obviously, as a stylistic matter, now that Chapter 51 contained its own, albeit identical, definition of "degenerative brain disorder," in amending these Chapter 51 definitions there was no longer any reason to include the additional descriptive phrase "as defined in s. 55.01(1v)" that had been included in the prior Assembly bill.

Unlike Chapter 55, prior to the enactment of 2005 Wis. Act 387, Chapter 51 did not contain its own definition of "infirmities of aging." This omission is understandable, of course, because the "infirmities of aging" would not have been considered a proper reason for an involuntary commitment under Chapter 51.

Furthermore, as the Court of Appeals' slip opinion points out, medical authorities recognize that Alzheimer's disease constitutes a degenerative brain disorder. ***Fond du Lac County v. Helen E.F.***, slip opinion, p. 2, n.2, *citing* ***MedicineNet.com, Definition of Alzheimer's disease***, at http://www.medterms.com/script/main/art.asp?articlekey=2213 ("A progressive neurologic disease of the brain that leads to the irreversible loss of neurons and dementia." . . . "Alzheimer's disease is the most common of all neurodegenerative diseases."). ***See also***, ***Mayo Clinic, Alzheimer's Disease***, at http://www.mayoclinic.com/health/alzheimers-

disease/DS00161 ("Alzheimer's disease causes brain changes that gradually get worse. It's the most common cause of dementia — a group of brain disorders that cause progressive loss of intellectual and social skills, severe enough to interfere with day-to-day life. In Alzheimer's disease, brain cells degenerate and die, causing a steady decline in memory and mental function."); ***2011 Alzheimer's Facts and Figures Report,*** http://www.alz.org/downloads/Facts_Figures_2011.pdf, p. 5 ("Dementia is caused by various diseases and conditions that result in damaged brain cells or connections between brain cells."). Dictionaries similarly recognize that Alzheimer's involves brain or neurological deterioration. ***See***, ***Merriam-Webster Dictionary***, at http://www.merriam-webster.com/dictionary/alzheimer's (Alzheimer's disease: "a degenerative brain disease of unknown cause that is the most common form of dementia, that usually starts in late middle age or in old age, that results in progressive memory loss, impaired thinking, disorientation, and changes in personality and mood, and that is marked histologically by the degeneration of brain neurons especially in the cerebral cortex and by the presence of neurofibrillary tangles and plaques containing beta-amyloid —called also Alzheimer's"); ***The American Heritage Dictionary***, Second College Edition, (1991)("Alzheimer's disease . . . A severe neurological disorder marked by progressive dementia and cerebral cortex atrophy.").

The legislature's recognition that Alzheimer's constitutes a "degenerative" disorder is further reflected in Wis. Stat. § 46.87(1)(a), a statute addressing support programs for Alzheimer's patients and their caregivers. The definition of "Alzheimer's disease" in this statute reads:

46.87 Alzheimer's family and caregiver support program.

(1) In this section:
(a) "Alzheimer's disease" means a degenerative disease of the central nervous system characterized especially by premature senile mental deterioration, and also includes any other irreversible deterioration of intellectual faculties with concomitant emotional disturbance resulting from organic brain disorder.

The County's suggestion that Alzheimer's does not constitute a "degenerative brain disorder" because Wis. Stat. § 46.87(1)(a), employs the phrase "degenerative disease of the central nervous system" is untenable. As the legislative history, the authorities cited above, and the medical witnesses in this case plainly recognize, Alzheimer's is, by its very nature, a form of degenerative brain disorder.[8]

3. The Court of Appeals' ruling does not eliminate the "only" available means to manage difficult Alzheimer's patients.

The Court of Appeals' recognition that Chapter 51 does not authorize the involuntary commitment of persons afflicted with Alzheimer's does not, as the County claims, leave authorities powerless to intervene when Alzheimer's patients pose a danger to themselves or others. On the contrary, as the Court of Appeals observed, when intervention is necessary to address the needs of a person afflicted with Alzheimer's, care and custody is to be provided under the protective services system of Chapter 55.

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[8] Dr. Christenson's indicated Helen suffers from "[s]enile dementia of Alzheimer's type," consisting of a "progressive loss of brain function, brain deterioration." (9:9-10). Dr. Rawski confirmed that Helen suffers from "Alzheimer's Dementia" characterizing her condition as "a progressive mental defect that is not treatable." (16:6-8).

Significantly, the array of protective services available under Chapter 55 includes, if necessary, an independent procedural mechanism for authorizing the "involuntary administration of psychotropic medication." Pursuant to Wis. Stat. § 55.14, a court may authorize the involuntary administration of psychotropic medication to manage a patient's resistive or challenging behavior so that essential care can be provided.

4. Permitting a Chapter 51 commitment based on behavioral disturbances raises potential constitutional concerns.

As the amicus filed by Elder Law points out, the County's emphasis on Helen's "behavioral disturbances" rather than her underlying mental condition calls into question the constitutional integrity of this civil commitment provision. ***Foucha v. Louisiana***, 504 U.S. 71 (1992), teaches that the government's authority to deprive a citizen of liberty through a civil commitment is contingent on the existence of both a mental illness and dangerousness. ***See also***, ***State v. Dennis H.***, 2002 WI 104, ¶36, 255 Wis. 2d 359, 383-384, 647 N.W.2d 851, *citing* ***Addington***, 441 U.S. at 426 ("The state's legitimate interest ceases to exist, however, if those sought to be confined 'are not mentally ill or if they do not pose *some* danger to themselves or others.'"). Yet, under the County's expansive reading of Wis. Stat. § 51.01(13)(b), a subject's behavioral disturbances may supply the requisite "disorder of thought, mood, perception, orientation or memory." As Elder Law points out, the County's focus on Helen's behavioral disturbances results in a troublingly circular definition of mental illness, particularly inasmuch as various medical conditions, including urinary tract infections, may produce behavioral disturbances. Chuang, ***Mental Disorders Seconday to General Medical conditions***,

http://emedicine.medscape.com/article/294131-overview. (Elder law, p.12).

Courts must "interpret statutes to be constitutional if possible." ***Kenosha County Department of Human Services v. Jodie W.***, 2006 WI 93, ¶50, 293 Wis. 2d 530, 560, 716 N.W.2d 845; ***State v. Weidner***, 2000 WI 52, ¶41, 235 Wis. 2d 306, 323-24, 611 N.W.2d 684. In this context, the definition of mental illness in Chapter 51 must be construed to require a link between the alleged "disorder of thought, mood, perception, orientation, or memory" and a qualifying mental condition. For the reasons outlined above, a degenerative brain disorder such as Alzheimer's is not a qualifying mental condition under Chapter 51.

C. Even if the Chapter 51 commitment of a person afflicted with Alzheimer's is not categorically prohibited, the evidence was nevertheless insufficient to establish Helen is a proper subject for treatment.

In order to secure an involuntary commitment under Chapter 51, the county must prove by clear and convincing evidence that the person "is a proper subject for treatment." Wis. Stat. § 51.20(1)(a). In accordance with ***Milwaukee County Combined Community Services Board v. Athans***, 107 Wis. 2d 331, 320 N.W.2d 30 (Ct. App. 1982), the Court of Appeals properly concluded that even if Chapter 51 does not categorically prohibit commitment of a person with Alzheimer's, Helen is not a proper subject for treatment because a person with Alzheimer's disease cannot be rehabilitated. ***Helen E.F.***, at 754-756, ¶¶1, 27-28, 32-34.

As outlined earlier, Dr. Rawski testified that Helen "suffers from Alzheimer's Dementia with a behavioral disturbance." Helen "has progressive dementia" and "has

been in a nursing home for the last six years." (16:6). Dr. Rawski acknowledged that "[c]ognitively [dementia] is not considered to be a treatable mental disorder. It's a progressive mental defect that is not treatable." (16:7).

At a prior hearing, Dr. Christenson's reported that Helen suffers from "[s]enile dementia of Alzheimer's type," which entails "progressive loss of brain function, brain deterioration" (9:9-11). Dr. Christenson acknowledged Helen's "cognitive deterioration is not treatable," though the psychiatric complications of her dementia are treatable" in that "her agitation, aggressiveness, combativeness can be treated with medications that can have some calming effects." (9:11-12, 13).

Granted, to qualify as a proper subject for treatment under Chapter 51, it is not necessary that treatment is actually able to cure the patient. ***In Matter of Mental Condition of C.J.***, 120 Wis. 2d 355, 354 N.W.2d 219 (Ct. App. 1984). In ***C.J.,*** undisputed testimony indicated the committed patient suffered "from a major mental illness described as schizophrenia chronic paranoid type." The expert testified the "primary symptom of C.J.'s illness is recurrent delusions." ***Id***. at 357. The expert indicated "C.J.'s mental disorder was likely to continue and that the prognosis was poor for restoring him to a pre-institutionalization level of functioning." Nevertheless institutionalization and medication were deemed necessary to "enable him to deal with his delusions, even though they were unlikely to cure his disorder." ***Id.***

C.J. challenged the standard jury instruction that permitted jurors to find he was a proper subject for treatment if "the commitment would help to c*ontrol* the mental disorder." ***Id.***, at 356 (emphasis in original). C.J. argued

"that only when involuntary commitment will help cure the disorder, not merely control it, can the person be considered a proper subject for treatment." ***Id.***

The circumstances in Helen's case are distinguishable from the situation in ***C.J.***, where the commitment was deemed necessary to treat the primary symptom of C.J.'s mental disorder, "recurrent delusions." Consistent with this distinction between treatment aimed at controlling the patient's disorder and its symptoms rather than just controlling or managing the particular patient, the Court observed that "[b]y alleviating some of the symptoms of C.J.s' mental disorder, the treatment program might make his illness more manageable." ***Id.***, at 361, 362.

In this case, unlike ***C.J.***, a commitment to treat Helen's Alzheimer's dementia is pointless, for this condition is untreatable. Rather than seeking to treat or control Helen's mental disorder, the county hopes to manage Helen's behavioral disturbances in order to facilitate efforts to provide basic maintaining care. While this objective is certainly laudable, it is not an appropriate application of Chapter 51. This distinction between control of the disorder and control of the person is critical, for it supplies the foundation for the ruling in ***C.J.*** distinguishing ***Athans***.

In ***Athans***, the Court upheld the dismissal of Chapter 51 proceedings against two patients, one who was a chronic paranoid schizophrenic and one who was developmentally disabled. The Court recognized these two patients "were not proper subjects for treatment because these disorders could not be helped in any way." ***C.J.***, 120 Wis. 2d at 361. Concluding the situation in ***Athans*** was distinguishable, ***C.J.*** emphasized this distinction between a commitment designed to treat a patient's mental disorder and

a commitment designed to control a patient's behavior in order to facilitate basic day to day care.

> This is far different from the ***Athans*** testimony which concluded that a treatment program would not cause any change in the disorders of the two subjects. We are satisfied that the ***Athans*** case involved two people who might be helped in terms of maximizing their individual functioning and maintenance, even though they could not be helped in controlling or improving their disorders. In this case, we have evidence that C.J. will benefit from treatment that will go beyond controlling his activity—it will go to controlling his disorder and its symptoms.

C.J., 120 Wis. 2d at 362. Like the two patients in ***Athans***, the Court of Appeals properly reversed Helen's commitment because she is not a proper subject for treatment.

D. Authorizing the Chapter 51 commitment of persons afflicted with Alzheimer's would produce unfortunate consequences.

Over the next few decades there is expected to be a significant increase in the number of individuals afflicted with Alzheimer's. The County's invitation to rewrite the statute to permit the Chapter 51 commitment of individuals afflicted with Alzheimer's should be rejected because of the devastating impact such a ruling will have not only on the judicial system, but on the welfare of Alzheimer's patients and their families.

Elder Law points out that currently, placing an aging patient confronting Alzheimer's in a residential care facility or skilled nursing facility can be achieved through a "powers of attorney for health care" (POHAC) under Wis. Stat. § 155.20, or a "family consent" placement under Wis. Stat.

§ 50.06.[9] These placement mechanisms allow patients and their families an opportunity to engage in their own health care planning. These informal procedures also help patients and their families avoid the stigma, expense and cumbersome legal process that accompanies a formal judicial declaration of mental illness and dangerousness or a finding of incompetency.

Unfortunately, classifying Alzheimer's as a mental illness would effectively foreclose current reliance on "powers of attorney for health care" (POHAC) and "family consent" to place persons afflicted with Alzheimer's dementia in a residential care facility or skilled nursing facility. By the express terms of the authorizing statutes, Wis. Stat. § 155.20(2)(c) and Wis. Stat. § 50.06(2)(b), these informal placement procedures are simply not available if the patient suffers from a mental illness. If these informal placement tools are foreclosed for Alzheimer's patients, concerned family members and guardians will be compelled to pursue guardianships and protective placements. As Elder Law points out, given the projected increase in the number of Alzheimer's patients in the coming years, probate courts will likely be faced with thousands of additional filings. Along with this new burden on the judicial system, this change will place an additional financial and emotional strain on Alzheimer's patients and their families.

The County Association speculates that if private nursing homes cannot invoke Chapter 51 when faced with

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[9] Effective December 1, 2010, Wis. Stat. § 50.08 authorizes the administration of psychotropic medication to a person afflicted with a "degenerative brain disorder" pursuant to an appropriate informed consent. Furthermore, if there is an emergency, Wis. Stat. § 50.08(4), grants a nursing home a limited authority to administer psychotropic medications absent consent.

difficult to manage Alzheimer's patients, these facilities will avoid providing bed space to these individuals. A greater concern is that utilizing Chapter 51 to manage difficult Alzheimer's patients will not only place these individuals in a setting that they do not belong, it will encourage private facilities to unload their more difficult residents on the Chapter 51 mental health system. Moreover, as the amici submitted in the Court below by Disability Rights of Wisconsin and the Coalition of Wisconsin Aging Groups point out, simply the disruption of transferring an Alzheimer's patient to an unfamiliar Chapter 51 setting (transfer trauma) can be detrimental to the patient's welfare. (Disability Rights, p. 7-8, 10)(Coalition, p. 1-2, 18-19, 24-25). ***See also,*** Alzheimer's Association and Planning Council for Health and Human Services, Inc., *Handcuffed: A Report of the Alzheimer's Challenging Behaviors Task Force*, p. 1 (2010)("These transfers to another facility, in and of themselves, create trauma for the individual and can worsen the individual's health and behavioral issues. A person with Alzheimer's often becomes disoriented due to a move, regardless of the distance, and the change in environment is almost a guaranteed way to exacerbate difficult behavior.").

II. The Chapter 51 Petition Should Have Been Dismissed Due to Loss of Competency or an Abuse of Process Because This Action Was Pursued Only After The County Failed to Timely Proceed Under Chapter 55.

As outlined earlier, ***Addington*** teaches that a civil commitment "constitutes a significant deprivation of liberty that requires due process protection." ***See also***, ***State ex rel. Sandra D. v. Getto***, 175 Wis. 2d 490, 499, 498 N.W.2d 892 (Ct. App. 1993) ("Sandra D.'s interest in freedom from involuntary detention is plainly an interest protected by the right to due process of law."); ***Dane County v. Stevenson***

L.J., 2009 WI App 84, ¶11, 320 Wis. 2d 194, 204, 768 N.W.2d 223.

Wisconsin courts have long recognized that time limits governing civil commitment proceedings must be strictly enforced to prevent the continued loss of liberty that necessarily accompanies a delay in the process. Accordingly, in civil commitment proceedings under both Chapter 51 and Chapter 55, the failure to comply with statutory time limits deprives the trial court of competency to exercise jurisdiction over the person who is the subject of the proceeding. ***State ex rel Lockman v. Gerhardstein***, 107 Wis. 2d 325, 328-329, 330, 320 N.W.2d 27 (Ct. App. 1982) (Failure to conduct a final Chapter 51 commitment hearing within fourteen days); ***In Matter of Guardianship of N.N.,*** 140 Wis. 2d 64, 65, 69, 409 N.W.2d 388 (Ct. App. 1987) (Failure to hold a final Chapter 55 protective placement hearing within thirty days); ***In Matter of Mental Condition of G.O.T***., 151 Wis. 2d 629, 631, 635-636, 445 N.W.2d 697 (Ct. App. 1989) (Failure to hear and decide a petition to extend a Chapter 51 commitment before the prior commitment expired); ***State ex rel. Sandra D. v. Getto***, 175 Wis. 2d 490, 493, 494-495, 497, 498 N.W.2d 892 (Ct. App. 1993) (Failure to hold a final Chapter 55 protective placement hearing within thirty days); ***Kindcare, Inc. v. Judith G***., 2002 WI App 36, ¶¶3, 12, 250 Wis. 2d 817, 821, 825, 640 N.W.2d 839 (Failure to hold a Chapter 55 probable cause hearing within seventy-two hours after the person is first taken into custody); ***Dodge County v. Ryan E.M.***, 2002 WI App 71, ¶12, 252 Wis. 2d 490, 498, 642 N.W.2d 592 (Failure to hold a Chapter 51 probable cause hearing within seventy-two hours of detention); ***Dane County v. Stevenson L.J***., 2009 WI App 84, ¶¶12, 15, 320 Wis. 2d 194, 205-206, 208, 768 N.W.2d 223 (Failure to hold a Chapter 51 probable cause hearing within seventy-two hours after the person is first taken into custody).

Compliance with civil commitment time limits is compelled not only by the language of the statutes, but also by due process concerns. Concluding the time limit for conducting a final Chapter 51 hearing is mandatory, ***Lockman*** explained that the injury resulting from a delay in the civil commitment process is more substantial than any harm resulting from a delay in other civil proceedings.

> The supreme court has held that the statutory time limit for holding a hearing on the forfeiture of a car under the uniform Controlled Substances Act was mandatory because the car owner's interest in the use of his vehicle is jeopardized. The supreme court has also determined that the statutory time limit for holding a hearing on the charges against a public employee suspended without pay has to be mandatory because the employee is suffering injury both to his livelihood and his reputation. Certainly an individual such as Lockman, who is incarcerated and deprived of her liberty until the holding of a final commitment hearing, is injured to an even greater degree.

State ex rel Lockman v. Gerhardstein, 107 Wis. 2d at 329-330 (footnotes omitted). ***See also***, ***Guardianship of N.N.,*** 140 Wis. 2d at 69 (Restraining a person's freedom awaiting a final Chapter 55 hearing inflicts a "substantial injury.").

Twenty years after ***Lockman***, the Court of Appeals reaffirmed that civil commitment time limits must be strictly enforced to safeguard the subject's significant liberty interest.

> The legislature imposed tight timetables in connection with the involuntary detention of persons alleged to be incapable of caring for themselves in recognition of the significant liberty interest a person has in living where and under what conditions he or she chooses.

Kindcare, Inc. v. Judith G., 250 Wis. 2d at 825, ¶12. ***See also***, ***Dane County v. Stevenson L.J.***, 320 Wis. 2d at 204, ¶11. Accordingly, in ***Judith G.***, the Court concluded the seventy-two hour time period for conducting a probable cause hearing must commence from the filing of the petition rather than from the patient's physical detention. As the Court observed, to defer the starting of this time period "would either dilute or destroy the protection" the legislature intended. The Court explained that these narrow time limits were designed "to limit significantly the time the subject of a protective placement petition must spend in involuntary detention without court approval." ***Judith G.***, 250 Wis. 2d at 829, ¶19.

Less than a month later, a separate appellate panel similarly concluded that strict enforcement of the seventy-two hour time limit for conducting a probable cause hearing is necessary to protect the subject's right to due process. ***Dodge County v. Ryan E.M.***, 252 Wis. 2d at 497, ¶11. The Court explained that the purpose of this time limit "to prevent individuals from being detained any longer than necessary" outweighs the general objective of the commitment scheme to try to protect the subject and public from harm. Cognizant of these conflicting interests, the Court observed: "Although protecting people from harm is important, so is due process, which the time limit is intended to provide." ***Id.*** ***Accord***, ***Dane County v. Stevenson L.J.***, 320 Wis. 2d at 205, ¶11.

Consistent with the principles outlined above, the government cannot evade restrictions on its authority to detain a citizen for a commitment hearing simply by initiating a new commitment proceeding. This point was made clear in ***State ex rel. Sandra D. v. Getto***, 175 Wis. 2d 490, 501, 498 N.W.2d 892 (Ct. App. 1993), wherein the Court concluded the county had abused the emergency protective

placement process by simply filing a new petition when the thirty day time period for conducting a final Chapter 55 hearing had expired.

In ***Sandra D.,*** an initial Chapter 51 proceeding was dismissed when a final Chapter 51 commitment hearing was not conducted within fourteen days of the time of detention. Nevertheless, Sandra D.'s detention was continued through the filing of a new statement of emergency detention whereupon "the commitment proceedings started all over again." ***Id.,*** 175 Wis. 2d at 495. At a subsequent probable cause hearing the case was converted to a protective placement proceeding and an order was entered temporarily detaining Sandra D. for thirty days. However, when the final hearing could not be conducted before the thirty days expired, the commitment proceeding was again dismissed. ***Id***., at 496. At that point a third statement of emergency detention was filed, a new probable cause hearing conducted, and the proceeding was again converted to a Chapter 55 protective placement with a new thirty day temporary detention order. ***Id.***, at 496-497.

On review, the Court of Appeals concluded the trial court no longer retained competency to conduct the protective placement proceeding against Sandra D. While sympathizing with the county's concern for Sandra D.'s welfare, the Court concluded "we cannot ignore the law." ***Id.***, at 497-498. As the Court observed, permitting the government to evade statutory time limits by simply filing a new petition prejudices the person who continues to be detained. ***Id.***, at 499. The Court concluded Sandra D.'s continued detention violated due process. ***Id.***, at 501. The Court rejected the county's contention that the commitment should nevertheless be sustained because it was neither in Sandra D.'s nor the

public's interest to release her. ***Id.***, at 499. Emphasizing the need to uphold the rule of law, the Court observed:

> It may be, as the court ultimately found, that Sandra D. was and remains a fit subject for protective placement. But the next respondent in a commitment or placement proceeding who is similarly deprived of his or her liberty for twice—or three or four times—the thirty-day limit may not be. Either the law is applied to every one or to no one.

Id., at 499.

Subsequent decisions reaffirm that compliance with statutory time limits cannot be evaded through the filing of successive petitions. In ***Kindcare, Inc. v. Judith G.***, the circuit court lost competency to proceed when the Chapter 55 probable cause hearing was not held within seventy-two hours. The Court made it clear that "the mere filing of a new petition does not start the clock anew." ***Id.***, 250 Wis. 2d at 821, ¶¶3. As the Court recognized, to permit the government to restart the clock by filing a new petition would undermine statutory safeguards and produce an unreasonable or absurd result. ***Id.***, at 829, ¶¶18-19. Therefore, "[t]he filing of the successive petition was a nullity." ***Id.***

In ***Dane County v. Stevenson L.J.***, 320 Wis. 2d at 208, ¶15, the Court similarly held that the filing of a second statement of emergency detention "did not operate to cure the unlawful detention" resulting from the failure to timely hold a Chapter 51 probable cause hearing. The Court rejected the contention that the filing of a second statement of emergency detention could, "in essence, reset the seventy-two hour clock while the patient remained involuntarily detained at the institution." Inasmuch as the statutory time limits were designed "to protect the liberty interests of individuals"

facing potential commitment under Chapter 51, the Court concluded the statute "cannot reasonably be construed to allow practices that would defeat that end." ***Stevenson L.J.***, 320 Wis. 2d at 205, ¶12. Accordingly, the filing of a statement of emergency detention after the time limit for holding a probable cause hearing on the original commitment action had expired "was a nullity." ***Id***., at 205-206, ¶12.

In this case, as in ***Sandra D.***, Helen was involuntarily detained as the subject of three consecutive commitment proceedings. Throughout these proceedings Helen remained involuntarily detained at St. Agnes Hospital, starting on April 12, 2010, the date of the original emergency detention, until May 28, 2010, the date of the final commitment hearing. When the court commissioner determined probable cause had not been established to proceed on the original Chapter 51 petition, the matter was converted to a Chapter 55 protective placement and a thirty-day temporary guardianship order was issued. (9:3-4). However, the county did not follow through with a protective placement proceeding. Instead, when the thirty-day time period to proceed with a protective placement expired, the county commenced a new Chapter 51 action. (9:4). As in ***Sandra D.***, the county's filing of successive commitment proceedings constituted an abuse of process depriving the trial court of competence to conduct yet another round of Chapter 51 proceedings. In accordance with the holdings in ***Judith G.***, and ***Stevenson L.J.***, the successive Chapter 51 proceeding should be deemed "a nullity."

In an attempt to circumvent the holdings in ***Sandra D., Judith G.***, and ***Stevenson L.J.***, the county argued that Helen's detention terminated when she was wheeled off the hospital unit at St. Agnes for a few minutes. Plainly, this maneuver was not executed to implement a new placement somewhere else. Helen was not moved to a new placement. There is no

indication any other placement had been arranged. Rather, as Dr. Christenson acknowledged, Helen was wheeled off the unit at St. Agnes because the thirty-day protective placement time limit was expiring. (9:17). As ***Sandra D., Judith G.***, and ***Stevenson L.J.***, caution, to permit officials to side step time limits in such a fashion would "dilute or destroy" the protection the legislature sought to afford those caught in the commitment process.

Likewise, a county cannot avoid the prohibition against initiating successive commitment proceedings by simply including some new allegations in the new filing. This point was made clear in ***Dane County v. Stevenson L.J.***, wherein a second statement of emergency detention was filed in a different county. Concluding this new statement could not set back the clock and restore the trial court's competency to proceed, the Court observed:

> Here, contrary to the County's argument, the fact that the treatment director's subsequent statement of emergency detention contained additional allegations of dangerousness and was filed in a different county by a different detaining authority does not cure its defect. The statement's shortcoming does not lie in its venue or in its content; instead, it lies in the fact that the detention it sought to execute was contrary to statutory requirements and was thus lawful.

Dane County v. Stevenson L.J., 320 Wis. 2d at 206, ¶13.

Significantly, the various decisions enforcing civil commitment time limits do not attempt to explore the underlying motives of those seeking the commitment. Rather, the decisions recognize that time limits are necessary to safeguard vulnerable patients from the deprivation of liberty that necessarily attends any delay in the commitment process. Indeed, in ***State ex rel. Sandra D. v. Getto***, the Court

assumed the county was acting out of genuine concern for Sandra's welfare.

> It is a difficult situation; and we appreciate the county's concern that releasing Sandra D. under the medical facts of the case might have engendered a threat to her welfare.

Id., 175 Wis. 2d at 497.

In this case, the decision to initiate a second Chapter 51 petition against Helen cannot be attributed to a sudden change in Helen's mental condition and behavior. As the Petition for Examination alleges, and Dr. Rawski's report and testimony confirm, Helen, "has been in a nursing home for the last six years" suffering from "chronic" "progressive" "Alzheimer's Dementia," a condition which has grown progressively worse over the years." (1:1; 11:2; 16:6).

Nor can it be reasonably claimed that the filing of this successive Chapter 51 petition was necessitated by Helen's sudden, recent exhibition of aggressive behavior toward caregivers. Helen's aggressive behavior had been an issue for quite some time. Indeed, it was Helen's aggressive behavior that prompted the initial emergency detention back on April 12, 2010. In his examination report Dr. Rawski pointed out:

> In late March and early April 2010, [Helen] became increasingly agitated and physically struck out at caregivers at All About Life while refusing meds and meals. On April 12, 2010 she became physically aggressive toward others at the nursing home and at the emergency room at St. Agnes Hospital where she was taken for medical care.

(11:2).

In accordance with the teaching of ***Dane County v. Stevenson L.J.***, surely the filing of a new Chapter 51 petition cannot be justified based on allegations that Helen continued to engage in aggressive conduct during the course of her thirty day protective placement. Such a ruling would permit a County to take advantage of its own failure to comply with statutory time limits. In effect, the County could continuously initiate a new commitment proceedings based on any new incident that occurs during a delay in affording the timely hearing the legislature has mandated. In this case, alleged incidents of disruptive behavior that occurred subsequent to the entry of the thirty day protective placement order were merely additional products of the underlying condition that prompted the initial commitment action back on April 12, 2010. Procedural time limits designed to safeguard those facing commitment are of little value if these time limits can be disregarded simply by citing new incidents of erratic behavior that occur while the patient is confined waiting for a court hearing.

As the authorities discussed above either directly or implicitly recognize, whether a trial court retained competency to adjudicate the merits of a particular commitment proceeding is ultimately a question of law subject to independent review. ***State ex rel Lockman v. Gerhardstein***, 107 Wis. 2d at 327; ***State ex rel. Sandra D. v. Getto***, 175 Wis. 2d at 493-494; ***Kindcare, Inc. v. Judith G.***, 250 Wis. 2d at 823, ¶9. Judge Buslee's ruling denying Helen's motion to dismiss did not attempt to distinguish ***Sandra D.***, did not address subsequent decisions applying ***Sandra D.***, and did not provide any other explanation for the court's decision denying the motion. (9:9).

CONCLUSION

For the reasons set forth above, this Court should affirm the Court of Appeals' decision reversing the Chapter 51 commitment order and accompanying involuntary medication order. Alternatively, this Court should either conclude the filing of successive commitment proceedings deprived the circuit court of authority to enter the Chapter 51 commitment order, or remand the case to the Court of Appeals to address this issue.

Dated this 27th day of October, 2011.

Respectfully submitted,

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CERTIFICATION AS TO FORM/LENGTH

I certify that this brief meets the form and length requirements of Rule 809.19(8)(b) and (c) in that it is: proportional serif font, minimum printing resolution of 200 dots per inch, 13 point body text, 11 point for quotes and footnotes, leading of minimum 2 points and maximum of 60 characters per line of body text. The length of the brief is 10,592 words.

CERTIFICATE OF COMPLIANCE WITH RULE 809.19(12)

I hereby certify that:

I have submitted an electronic copy of this brief, excluding the appendix, if any, which complies with the requirements of § 809.19(12). I further certify that:

This electronic brief is identical in content and format to the printed form of the brief filed on or after this date.

A copy of this certificate has been served with the paper copies of this brief filed with the court and served on all opposing parties.

Dated this 27th day of October, 2011.

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CERTIFICATION AS TO APPENDIX

I hereby certify that filed with this brief, either as a separate document or as a part of this brief, is an appendix that complies with § 809.19(2)(a) and that contains, at a minimum: (1) a table of contents; (2) the findings or opinion of the circuit court; and (3) portions of the record essential to an understanding of the issues raised, including oral or written rulings or decisions showing the circuit court's reasoning regarding those issues.

I further certify that if this appeal is taken from a circuit court order or judgment entered in a judicial review of an administrative decision, the appendix contains the findings of fact and conclusions of law, if any, and final decision of the administrative agency.

I further certify that if the record is required by law to be confidential, the portions of the record included in the appendix are reproduced using first names and last initials instead of full names of persons, specifically including juveniles and parents of juveniles, with a notation that the portions of the record have been so reproduced to preserve confidentiality and with appropriate references to the record.

Dated this 27th day of October, 2011.

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APPENDIX

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THE COURT: Okay. All right. You, as I understand it, have a motion for the record?

MS. VINZ: Please.

THE COURT: You can be heard.

MS. VINZ: As you no doubt have noticed from the petition for examination in this case, Ms. F has been detained at St. Agnes since April 12th of this year. What happened is she was brought to St. Agnes on April 12th. A prior Chapter 51 petition was filed, and a probable cause hearing was held on April 15th on that prior Chapter 51 petition.

At that hearing, the Court Commissioner did not find probable cause on the Chapter 51, and it was converted to a Chapter 55. The issue in regard to the Chapter 51 was that Mrs. F apparently is suffering from dementia which is untreatable, and therefore there

12:58 1 were not grounds for the Chapter 51, so it was
2 converted to a Chapter 55 on April 15th, and a 30-day
3 temporary guardianship was issued under Chapter 55. So
4 that was on April 15th.
5 May 15th was the 30th day, and so that
6 temporary guardianship only lasted until May 15th,
7 three days ago, and expired at that point; and
8 Mrs. F still remains at St. Agnes Hospital, as I
9 said, ever since April 12th. Under State ex rel Sandra
10 Dee (sp) vs. Getto, G-E-T-T-O, 175 Wisconsin 2nd, Page
11 490, a 1993 Court of Appeals case, a second petition is
12 not possible.
13 Basically what is happening here is that for
14 whatever reason, because the Petitioner did not seek a
15 permanent guardianship within the 30-day time limit,
16 they are apparently trying to circumvent this time
17 limit by filing another Chapter 51 petition; and under
18 the case I just cited, that simply isn't possible. You
19 can't keep detaining and detaining and detaining an
20 individual once that time period has expired.
21 The 30-day time period is expired, and at this
22 point, a second petition can't go forward, and so I'm
23 asking that it be dismissed.
24 The family certainly has the route that they
25 can take of obtaining medical guardianship. I

01:00 understand the need for it that is alleged in the petition, but in terms of doing it under a Chapter 51 mental health petition, a second filing of that, it is not possible, so I am moving to dismiss.

MR. BENDT: Well, this is a separate petition, and she hasn't been detained continuously under the old order; and this order, she actually -- that order is a 30-day order and did in fact expire, and she left the unit and was brought back onto the unit. The person who detained her had-- they wheeled her off the unit and she was brought back in on a new detention. So, you can do that. This is not -- That's not the problem.

In addition, there's more information; there's more events that occurred since the last time we were in court. I wasn't here at the time. I believe Meggin McNamara handled it. But at that time, she had a urinary tract infection and there was the thought that a urinary tract infection was the cause of the behavior, the disruptive and physically violent behavior. And so at that point in time, the conclusion was that she didn't meet the criteria under Chapter 51; that there was a medical reason for her behavior.

But she's been treated for the urinary tract infection and this violent behavior continues. It's

not the result of the UTI, it's a result of the dementia, and you can have a Chapter 51 on someone with dementia, in that dementia is treatable in some way and this one is treated. She is not going to get cognitively better, but it's going to improve or control the aggressiveness, the physical aggressiveness that she is showing that is making it impossible for her to be transferred back to a nursing home setting until she is treated for that condition.

THE COURT: How do you answer -- How do you answer the case which has been cited by counsel?

MR. BENDT: Because this isn't a continuous detention. She was-- She was, in fact, released from the unit. She left the unit and this is a separate petition. That's the answer to that. If you -- Plus, we are not asking for guardianship and protective placement, we are filing this under Chapter 51.

If, in fact, she met the criterion for protective placement and guardianship, we would have brought an emergency or temporary protective placement and we would have pursued that end of it, and then she would actually have, at that time, she would have to be placed in an approved protective placement facility, a nursing home.

But the doctor is of the opinion that she

01:03 can't yet be transferred to a protective placement facility. She is in need of continual care for her mental condition before she can be transferred to a nursing home, so this is not to circumvent -- there was -- there was no need, in fact, for a guardianship and protective placement because there is a health care power of attorney that's in effect, and it's been activated.

So, she was at All About Life Nursing Rehabilitation Center under that power of attorney. There is no need for a guardianship. There is no need for protective placement, but there is a need for a commitment proceeding to treat her mental condition.

THE COURT: Would you like to respond to it?

MS. VINZ: Yes. I'm not understanding why Mr. Bendt is saying that she has not continuously been in custody. The Petitioner's own petition states, quotes:

> They are in personal contact with Helen who has been a patient on the unit since April 12, 2010.

MR. BENDT: That's true that at that time, that was true; but she was released from a 30-day detention, she left the unit, and was brought back in on a new detention.

MS. VINZ: Yes. But this petition is dated

May 14th. I'm reading from the petition dated May 14th which says she has been continuously on the unit since April 12th.

MR. BENDT: She was off the unit, well, from the date of the probable cause; the 30-day hearing, I believe, was actually on April 15th. She was on the unit on May 14th, and after this order for detention was signed by the Judge, she was released; she was wheeled off the unit, and then she was brought back on.

MS. VINZ: When you say "wheeled off the unit," how long was she off the unit?

MR. BENDT: She was off the unit. It doesn't matter how long she was off the unit. She was off the unit. And that ended the 30-day order. This is a new detention. This is a new detention. It doesn't matter if it's two seconds; it split in two, it is not continuous.

MS. VINZ: What was the reason she was taken off?

MR. BENDT: Because the 30-day order expired, and if there hadn't been grounds to file this petition for examination, she would have had to have left the unit. She would not have been able to stay on this unit because the 30 days had elapsed, or it was going to elapse that day. That was the 30th day, and that's

01:05 legal. You can do that. You can have-- As long as there's subsequent separate grounds for the new detention and there are separate grounds that she's not --

THE COURT: All right. I'll deny your motion.

THE COURT: Well, we have the uncontroverted testimony of Dr. Rawski, and I found Dr. Rawski's testimony to be extremely thorough, extremely persuasive, and, quite frankly, was somewhat refreshing to hear testimony articulated the way he did it. He walked down the mental illness issue, was sensitive to recognize that this young lady has some certain cognitive problems, has a good grasp on how that interplays with behavior, talks about behavior, talks about how disruptive she is, talked about her mental illness, talked about her level of dangerousness, talked about the fact that she is treatable, and the clear and convincing evidence is what this Court has to ultimately find has been established. That's what we had. We had his testimony. We don't have any controverting testimony to present, but I find that -- I find that testimony to be extremely compelling, extremely persuasive.

We have a -- we would like to -- I think we would like to all believe that maybe the manifestations of this subject at this time are a direct result of a UTI

issue and leave it at that and say, fine, we aren't going to medicate that, any of those concerns we are just going to -- we are just going to move on.

I think what we all have to do is to live with that experience with a family member and you will quickly realize the advantages and disadvantages of medications when people have the unfortunate occasion in that maturation process to have Alzheimer's and dementia. My mother-in-law went through this exact same scenario, so this Court is extremely familiar with this type of a situation. She had a UTI issue, and I'm not sitting here passing judgment on Miss F but suffice to say we eventually catheterized her because that was the best way of dealing with that issue. Whether or not that in fact is the end result of Miss I , I don't know. But what it has done is that coupled with her other behavioral issues have been extremely disrupting and has provoked and compromised staff and others that are commissioned, quite frankly, to care for her.

We have aa young lady 85 years old weighing about a hundred pounds that, evidently, is not able to come into court today. But under the same token, they are saying, quite frankly, she ought to be let go because there is no basis to commit her. I find that disappointing. We apparently have a feeling that there

is some lack of connection between mental illness and dangerousness. And with regard to the behavior of Miss F , I don't think that Dr. Rawski could have said it any clearer as to what that connection is, and certainly to suggest that the subject would not get the very best of care under the best of circumstances, given her unfortunate stage in life, would be, quite frankly, a judicial miscarriage.

There is little doubt in this Court's mind that the County has met its burden of clear and convincing. There is little doubt in this Court's mind that the record clearly supports a finding of mental illness, and a subject -- and a subject that is proper for treatment and that the subject -- and that she is proper subject for treatment. There is no doubt in my mind that the dangerousness standard has, in fact, been satisfied. I don't know what else has to be said. She is combative, she is very disruptive, and we might all want to think this is because of a urinary tract infection. I think that's putting the cart before the horse. She is in a nursing home not because of a UTI. She is in a nursing home because of her Alzheimer's and dementia and that has accelerated itself. Those are cognitive problems that can't be corrected, unfortunately, but they try to medicate that as best they can. It's just a tragic stage

in everybody's life.

I think it's very disappointing that we place our emphasis on the UTI side of this young lady and not on her mental illness issues. So I find, unequivocally, that the record supports the relief that the County has requested and it's so ordered. So I'll order the commitment. I find that she is not competent to refuse medications, and I find the least restrictive is an inpatient, locked psychiatric unit, and she will be committed for six months.

Anything else?

COURT OF APPEALS
DECISION
DATED AND FILED

April 27, 2011

A. John Voelker
Acting Clerk of Court of Appeals

NOTICE

This opinion is subject to further editing. If published, the official version will appear in the bound volume of the Official Reports.

A party may file with the Supreme Court a petition to review an adverse decision by the Court of Appeals. *See* WIS. STAT. § 808.10 and RULE 809.62.

Appeal No. 2010AP2061 Cir. Ct. No. 2010ME146

STATE OF WISCONSIN IN COURT OF APPEALS
DISTRICT II

IN THE MATTER OF THE MENTAL COMMITMENT OF HELEN E. F.:

FOND DU LAC COUNTY,

PETITIONER-RESPONDENT,

v.

HELEN E. F.,

RESPONDENT-APPELLANT.

RECEIVED
APR 27 2011
STATE PUBLIC DEFENDER
MADISON APPELLATE

APPEAL from orders of the circuit court for Fond du lac County: RICHARD J. NUSS, Judge. *Reversed and cause remanded with directions.*

Before Brown, C.J., Anderson and Reilly, JJ.

¶1 ANDERSON, J. Helen E. F. appeals from an order for commitment and an order for involuntary medication. The evidence presented at trial was

insufficient to sustain Helen's WIS. STAT. ch. 51 (2009-10)[1] involuntary commitment as a matter of law given that Helen, who is afflicted with Alzheimer's disease,[2] does not suffer from a qualifying mental condition and is not a proper subject for treatment. We therefore reverse and remand the orders and instruct the trial court to proceed not inconsistently with this opinion.

Standard of Review

¶2 Construction of a statute is a question of law. As to questions of law, this court is not required to give special deference to the trial court's determination. ***Hucko v. Joseph Schlitz Brewing Co.***, 100 Wis. 2d 372, 376, 302 N.W.2d 68, 71 (Ct. App. 1981). When interpreting a statute, we begin with the language of the statute. ***State ex rel. Kalal v. Circuit Court for Dane Cnty.***, 2004 WI 58, ¶45, 271 Wis. 2d 633, 681 N.W.2d 110. We give words their common and ordinary meaning unless those words are technical or specifically defined. *Id.* We do not read the text of a statute in isolation, but look at the overall context in which it is used. *Id.*, ¶46. When looking at the context, we read the text "as part of a whole; in relation to the language of surrounding or closely related statutes; and reasonably, to avoid absurd or unreasonable results." *Id.* Thus, the scope, context, and purpose of a statute are relevant to a plain-meaning interpretation "as long as the scope, context, and purpose are ascertainable from the text and structure of the statute itself." *Id.*, ¶48. If the language is clear and unambiguous, we apply the plain words of the statute and ordinarily proceed no further. *Id.*, ¶46.

---

[1] All references to the Wisconsin Statutes are to the 2009-10 version unless otherwise noted.

[2] Alzheimer's disease is a degenerative brain disorder, causing irreversible decline. *See* http://www.medterms.com/script/main/art.asp?articlekey=2213 (last visited Apr. 18, 2011).

¶3 The inquiry does not stop if a statute is ambiguous, meaning that "it is capable of being understood by reasonably well-informed persons in two or more senses." *Id.*, ¶47. If a statute is ambiguous, we may turn to extrinsic sources. *Id.*, ¶51. Extrinsic sources are sources outside the statute itself, including the legislative history of the statute. *Id.* We sometimes use legislative history to confirm the plain meaning of an unambiguous statute, but we will not use legislative history to create ambiguity where none exists. *Id.*

Facts

¶4 The facts are not in dispute. Helen is an eighty-five-year-old woman with Alzheimer's dementia. Her condition has regressed to the point that "she is very limited in any verbal communication." Helen's appearance at the proceedings in this case was waived because "she would not understand or comprehend or be able to participate meaningfully."

¶5 *Motion to Dismiss*: Prior to the probable cause hearing on May 18, 2010, Helen's attorney moved the court to dismiss the WIS. STAT. ch. 51 proceeding. In support of the motion, Helen's attorney outlined the procedural history of Helen's confinement.

¶6 Helen's attorney explained that Helen was taken to St. Agnes Hospital on April 12, 2010. On April 15, 2010, a probable cause hearing was conducted on a prior WIS. STAT. ch. 51 petition. Following this hearing, the court commissioner concluded there was not sufficient probable cause to proceed. At that point, the ch. 51 petition was converted to a WIS. STAT. ch. 55 protective placement action and a thirty-day temporary guardianship was issued.

¶7 The thirty-day-time period to proceed with the WIS. STAT. ch. 55 protective placement expired on May 15 and a second WIS. STAT. ch. 51 petition was filed. Helen's attorney argued that contrary to the teaching of ***State ex rel. Sandra D. v. Getto***, 175 Wis. 2d 490, 498 N.W.2d 892 (Ct. App. 1993), the filing of this new ch. 51 petition constituted an impermissible attempt "to circumvent this time limit." Counsel argued the new ch. 51 petition must be dismissed, because "[y]ou can't keep detaining and detaining and detaining an individual once that time period has expired."

¶8 Insisting that the new WIS. STAT. ch. 51 proceeding was the product of "a separate petition," Fond du Lac County argued that Helen "hasn't been detained continuously under the old order" because after the thirty-day-time period expired for the WIS. STAT. ch. 55 protective placement action and a thirty-day temporary guardianship, "she was wheeled off the unit, and then she was brought back on." The County argued that because she was off the unit, that ended the thirty-day order and therefore, "[t]his [was] a new detention." When pressed as to how long Helen was "wheeled off the unit," the County responded:

> She was off the unit. It doesn't matter how long she was off the unit. She was off the unit. And that ended the 30-day order. This is a new detention. This is a new detention. It doesn't matter if it's two seconds; it split in two, it is not continuous.

¶9 The County further defended the filing of the second WIS. STAT. ch. 51 petition, maintaining it was based on new information since the prior ch. 51 petition was dismissed. According to the County, at the time the prior ch. 51 petition was dismissed, it appeared that Helen's disruptive behavior was the product of a medical problem, i.e., a urinary tract infection. The County argued that inasmuch as Helen's disruptive behavior has continued even after this medical

condition was treated, it now appears that Helen's disruptive behavior is the product of her dementia. The County further argued:

> [Y]ou can have a [WIS. STAT. ch.] 51 on someone with dementia, in that dementia is treatable in some way and this one is treated. She is not going to get cognitively better, but it's going to improve or control the aggressiveness, the physical aggressiveness that she is showing....

Helen's attorney maintained the position that the filing of a new WIS. STAT. ch. 51 petition constituted an end run around the government's failure to comply with the time limits of a prior WIS. STAT. ch. 55 proceeding. The trial court denied Helen's motion to dismiss without explanation: "I'll deny your motion."

¶10 *Probable cause hearing.* During the probable cause hearing that immediately followed the court's denial of Helen's motion to dismiss, the County presented testimony from psychiatrist Dr. Brian Christenson. Christenson treated Helen during her initial WIS. STAT. ch. 51 emergency detention at St. Agnes on April 12 and throughout the subsequent thirty-day WIS. STAT. ch. 55 emergency placement order. In Christenson's opinion, Helen suffers from "[s]enile dementia of Alzheimer's type." Christenson explained that this "progressive loss of brain function, brain deterioration" is exhibited in the following ways:

> [S]he is extremely confused and forgetful and disoriented and agitated, aggressive, uncooperative, anxious, incontinent, and unable to carry on conversations; it grossly impaired her judgment and she is unable to make any decisions regarding her own self care.

Christenson was "not certain" whether Helen's agitation and aggressiveness was related to the dementia or the urinary tract infection, but believed it was "most likely predominantly from the dementia."

¶11 With regard to whether Helen's dementia was subject to treatment, Christenson indicated "the cognitive deterioration is not treatable, but the psychiatric complications of her dementia are treatable," in that "her agitation, aggressiveness, combativeness can be treated with medications that can have some calming effects." Helen is "completely unable to understand" the advantages and disadvantages of the medication. In Christenson's opinion, Helen poses a danger to herself and others through her combativeness with treatment staff and "could harm herself inadvertently."

¶12 Christenson noted that when Helen was taken off the unit at St. Agnes, he "[did not] think she was placed anywhere." Further, Christenson acknowledged that Helen was off the unit "[n]ot very long" and that he believed she was wheeled off the unit because of a problem with the expiration of the WIS. STAT. ch. 55 thirty-day-time period. The court found sufficient probable cause to proceed.

¶13 *Final commitment hearing.* The final commitment hearing was conducted on May 28, 2010. The sole witness at the hearing, psychiatrist Dr. Robert Rawski, testified that Helen "suffers from Alzheimer's Dementia with a behavioral disturbance," that Helen "has progressive dementia" and "has been in a nursing home for the last six years.". Rawski explained that Helen's "dementia has progressed to the point where she is very limited in any verbal communication" and she is "so cognitively impaired by her dementia" that she is unable to express an understanding of the advantages or disadvantages of medication.

¶14 Rawski further explained that Alzheimer's dementia can involve behavioral disturbances such as "poor judgment, aggression towards others,

periods of agitation [and] wandering." And that "[c]ognitively, [dementia] is not considered to be a treatable mental disorder. It's a progressive mental defect that is not treatable." Rawski indicated, however, that the behavioral disturbances resulting from dementia are subject to treatment. He said that treatment consists of using medications to address impulsivity, agitation, and physical combativeness.

¶15 Rawski testified that it was his opinion that Helen poses a risk of harm to others due to her impulsive combativeness and grabbing of treatment staff. Rawski said he believed, due to "her advanced age, medical issues, and dementia," Helen also poses a risk of harm to herself because she is unable to manage her daily needs. Based on Rawski's testimony, the trial court found that the grounds for a WIS. STAT. ch. 51 commitment and an involuntary medication order had been proven by clear and convincing evidence. A ch. 51 commitment order and an involuntary medication order were entered following the bench trial. Helen appeals both orders.

The Alzheimer's Challenging Behaviors Task Force Report[3]

¶16 We begin by noting that the issues raised in this case are of great public import. The number of people aged sixty-five or older with Alzheimer's disease is expected to reach 7.7 million in 2030 from the current 5.3 million. Nearly one out of two people who reach age eighty-five will develop Alzheimer's.

[3] *See Handcuffed: A Report of the Alzheimer's Challenging Behaviors Task Force*, http://www.planningcouncil.org/PDF/Alzheimers_Report_Handcuffed.pdf (last visited Apr. 17, 2011). For readability, we do not repeatedly cite to the link to our source. However, the discussion and facts below this task force subheading are all derived from the cited source unless otherwise noted.

In Wisconsin alone, the current number of people with Alzheimer's is estimated at 110,000. All too often, instead of engaging in behavioral management techniques or careful discharge planning, facilities will use WIS. STAT. ch. 51 civil commitment procedure to immediately remove residents with challenging behaviors, many of whom suffer from Alzheimer's disease.

¶17 One way to measure the greatness of our society is to look at how we treat our weakest members, such as our growing population of people afflicted with Alzheimer's.[4] In April 2010, the Alzheimer's Challenging Behaviors Task Force was called together by the Alzheimer's Association of Southeastern Wisconsin to look into the treatment of people with Alzheimer's. The task force was called together following the tragic death of Richard Petersen. Petersen, an eighty-five-year-old gentleman with late stage dementia who exhibited challenging behaviors, was placed under emergency detention after being at two hospitals, and was eventually transferred by police to the Milwaukee County Behavioral Health Division where his family found him tied in a wheel chair with no jacket or shoes. In spite of his family's efforts to intervene, he later developed pneumonia, was transferred to a hospital, and died. The Alzheimer's Association and scores of members of the community were deeply concerned, not only about the treatment of Mr. Petersen and his family, but about others in the Milwaukee county area that are in the same or similar circumstances. The Alzheimer's Association sought and obtained support from several charitable foundations to

[4] A similar sentiment is often attributed to Mohandas Karamchand Gandhi (2 Oct. 1869-30 Jan. 1948), commonly known as Mahatma Gandhi: "A nation's greatness is measured by how it treats its weakest members." http://www.biography.com/articles/Mahatma-Gandhi-9305898 (last visited Apr. 14, 2011); Timothy A. Kelly, *Healing the Broken Mind: Transforming America's Failed Mental Health System* 1 (N.Y. University Press 2009).

partner with the Planning Council for Health and Human Services, Inc., to staff a task force and produce a report to the community.

¶18 The task force found that using WIS. STAT. ch. 51 as a vehicle to deal with challenging behaviors in persons with dementia can lead to transfer trauma, medical complications, exacerbated behaviors, and even death. The use of ch. 51 emergency detentions and the administration of psychotropic drugs, though common, are controversial strategies used to deal with challenging behaviors among people with Alzheimer's and related dementias.[5] These two controversial strategies are precisely what were used to deal with Helen's challenging behaviors.

¶19 While WIS. STAT. ch. 51 provides a means to place persons with mental illness who are considered to be a danger to themselves or others in emergency detention and to administer involuntary treatment, the task force found that a ch. 51 petition is often used for persons with Alzheimer's and related dementias. It found that the usual treatment is the involuntary administration of psychotropic drugs to reduce agitation and aggression and produce a state of sedation. "People come to us in handcuffs, they are out of their milieu, they are put on someone else's schedule, put on meds, and are surrounded by chaos. This will worsen their situation. If they weren't confused before, they will be now."

[5] Other strategies that are used to deal with challenging behaviors among people with Alzheimer's and related dementias reflect promising practices, including activities and interventions that incorporate the interaction of the person with dementia, the caregiver and the environment in which the behaviors occur. These include formal support for caregivers, training in promising methods of assessment and intervention, a culture shift toward "person-centered" care, pain management, use of the Star Method, and instituting appropriate policies and guidelines within facilities regarding the management of challenging behaviors among people with Alzheimer's disease and other dementias.

¶20 Finally, the task force found that across Wisconsin, there is variation in the way different counties apply WIS. STAT. ch. 51 to people who have Alzheimer's and related dementias. At least two counties do not believe ch. 51 should apply to this population and will not prosecute older adults with dementia under ch. 51.

Discussion and Law

¶21 Helen's case provides the opportunity to clarify the proper application of WIS. STAT. ch. 51 and eliminate the variation in ways counties apply the law to people who have Alzheimer's and related dementias.

¶22 Our consideration of the law and the parties' arguments, as well as the well-written amicus briefs[6] and task force report, lead us to conclude that Helen was not a proper subject for detainment or treatment under WIS. STAT. ch. 51 because Alzheimer's disease is not a qualifying mental condition under that chapter.

¶23 Both WIS. STAT. chs. 51 and 55 define "degenerative brain disorder" as the "loss or dysfunction of brain cells to the extent that the individual is substantially impaired in his or her ability to provide adequately for his or her own care or custody or to manage adequately his or her property or financial affairs." WIS. STAT. §§ 55.01(1v) & 51.01(4r). WISCONSIN STAT. ch. 46 specifically defines Alzheimer's disease as "a *degenerative disease* of the central nervous system characterized especially by premature senile mental deterioration, and also

[6] We are grateful to Disability Rights Wisconsin, Coalition of Wisconsin Aging Groups, and Wisconsin Counties Association for the very helpful and well-written briefs, pertinent parts of which we track in this opinion.

includes any other irreversible deterioration of intellectual faculties with concomitant emotional disturbance resulting from organic brain disorder." WIS. STAT. § 46.87(1)(a) (emphasis added). Thus, looking at the text of these closely related statutes, we are able to ascertain that Alzheimer's disease is simply one type of a degenerative brain disorder. *See* ***Kalal***, 271 Wis. 2d 633, ¶46.

¶24 We further conclude that the intended application of the term "degenerative brain disorder" in WIS. STAT. chs. 51 and 55 is unambiguous. Chapter 51's definition of the term is included only to specifically *exclude* it from the chapter's authority, whereas ch. 55's definition is used to *include* it in the scope of authority granted under ch. 55's protective placement and services laws. In ch. 51, "degenerative brain disorder" is referred to only as an exception to both the definitions of "developmental disability" and "serious and persistent mental illness." WIS. STAT. § 51.01(5)(a) & (14t). Chapter 51's definition of "mental illness" is silent on the term "degenerative brain disorder," and defines "mental illness" for purposes of involuntary commitment as "a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, but does not include alcoholism." Sec. 51.01(13)(b).

¶25 Accordingly, it would be inconsistent to include "degenerative brain disorder" in this statutory definition. Despite the definition not specifically excluding the term "degenerative brain disorder," the term is specifically statutorily defined separately from "mental illness," thereby creating an intentional distinction between the two terms.

¶26 Contrary to WIS. STAT. ch. 51, WIS. STAT. ch. 55 specifically *includes* individuals with degenerative brain disorders when defining the scope of

who may receive protective services and for whom emergency and temporary protective placements may be made. WIS. STAT. §§ 55.01(6r)(k), 55.135(1). Even more telling is each respective statutory section's initial statement of legislative policy. Chapter 51 states that "[i]t is the policy of the state to assure the provision of a full range of treatment and rehabilitation services in the state for all mental disorders and developmental disabilities and for mental illness, alcoholism and other drug abuse." WIS. STAT. § 51.001. Chapter 55 explains that "[t]he legislature recognizes that many citizens of the state, because of serious and persistent mental illness, *degenerative brain disorder*, developmental disabilities, or other like incapacities, are in need of protective services or protective placement." WIS. STAT. § 55.001 (emphasis added). Notably and repeatedly absent from ch. 51 is the term "degenerative brain disorders" and, just as notably, the term is specifically included throughout ch. 55. *See* ***Kansas v. Hendricks***, 521 U.S. 346, 359 (1997) ("[W]e have traditionally left to legislators the task of defining terms of a medical nature that have legal significance.").

¶27 Moreover, the primary purpose of WIS. STAT. ch. 51 is to provide treatment and rehabilitation services for the individuals described in ch. 51's legislative policy. WIS. STAT. § 51.001. Even if we were to assume, which we do not, that Alzheimer's disease could reasonably be classified under ch. 51's definition of "mental illness," commitment of an individual with Alzheimer's disease under ch. 51 is nonetheless not appropriate because Alzheimer's disease falls outside the scope of ch. 51's limited definition of "treatment." "Treatment" is defined by ch. 51 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." WIS. STAT. § 51.01(17).

¶28 Consequently, rehabilitation is a necessary element of treatment under WIS. STAT. ch. 51. Because there are no techniques that can be employed to bring about rehabilitation from Alzheimer's, an individual with Alzheimer's disease *cannot* be rehabilitated. Accordingly, Helen is not a proper subject for ch. 51 treatment. *See Alzheimer's Association, 2010: Alzheimer's Disease Facts and Figures*, http://www.alz.org/documents_custom/report_alzfactsfigures2010.pdf, 8 (last visited Apr. 8, 2011).

¶29 Though we could end here, we consider it relevant to note that this court has in fact distinguished the term "rehabilitation" from "habilitation" in a similar WIS. STAT. ch. 51 context. *See* ***Milwaukee Cnty. Combined Cmty. Servs. Bd. v. Athans***, 107 Wis. 2d 331, 334-35, 320 N.W.2d. 30 (Ct. App. 1982). In ***Athans***, Milwaukee County Combined Community Services Board petitioned the trial court for the involuntary commitment of Theodora Athans and Gerald Haskins pursuant to WIS. STAT. § 51.20. ***Athans***, 107 Wis. 2d at 332. The trial court found Athans mentally ill and evincing a danger to herself, but not a proper subject for treatment. ***Id.*** at 333. The trial court found Haskins developmentally disabled, but not a proper subject for treatment. ***Id.*** The trial court ordered both petitions dismissed. ***Id.***

¶30 The Board appealed, arguing that we should broadly construe the term rehabilitation to include within it habilitation in order to carry out the intent of the legislature as embodied in WIS. STAT. ch. 51. ***Athans***, 107 Wis. 2d at 335. We determined that "[o]nly if rehabilitation includes habilitation may we say that Athans and Haskins are proper subjects for treatment." ***Id.*** The two issues on appeal then were (1) whether treatment as defined in WIS. STAT. § 51.01(17) includes habilitation as well as rehabilitation and (2) whether the findings of the

trial court are against the great weight and clear preponderance of the evidence. ***Athans***, 107 Wis. 2d at 335.

¶31 In order to determine whether WIS. STAT. ch. 51 treatment included "habilitation" as well as "rehabilitation," we looked to the definitions given by and agreed upon by the two testifying doctors. ***Athans***, 107 Wis. 2d at 334, 336. "Habilitation" means "the maximizing of an individual's functioning and the maintenance of the individual at that maximum level." ***Id.*** at 334. "Rehabilitation" means "returning an individual to a previous level of functioning which has decreased because of an acute disorder." ***Id.*** We then concluded that "rehabilitation is not an ambiguous term with two or more meanings of which one meaning might include habilitation." ***Id.*** at 335. We held that because WIS. STAT. § 51.01(17) defines treatment in terms of rehabilitation *only* and because the terms habilitation and rehabilitation are separate and distinct in their meanings, Athans and Haskins—*who were unable to be rehabilitated*—were therefore not suitable for ch. 51 treatment. ***Athans***, 107 Wis. 2d at 335-37.

¶32 ***Athans*** is very much on point. Like Athans and Haskins, Helen has a condition that cannot be rehabilitated; thus, like Athans and Haskins, Helen is not suitable for WIS. STAT. ch. 51 treatment. *See* ***Athans***, 107 Wis. 2d at 335-37.

¶33 Finally, the legislative scheme concerning involuntary civil commitment supports our holding today, just as strongly as it supported our holding in ***Athans***. *See* ***id.*** at 337. WISCONSIN STAT. ch. 51 provides for active treatment for those who are proper subjects for treatment, while WIS. STAT. ch. 55 provides for residential care and custody of those persons with mental disabilities that are likely to be permanent. *See* ***Athans***, 107 Wis. 2d at 337. With the ever-

growing Alzheimer's population, "[t]he distinction between these two statutes must be recognized and maintained." *See id.*

¶34 Helen is not a proper subject for treatment under WIS. STAT. ch. 51. We therefore reverse the orders and remand with instructions to proceed not inconsistently with this opinion.[7]

By the Court.—Orders reversed and cause remanded with directions.

Recommended for publication in the official reports.

[7] The appellants also argued that the trial court lacked competency to proceed. We need not reach this argument given our holding. *See* ***Walgreen Co. v. City of Madison***, 2008 WI 80, ¶2, 311 Wis. 2d 158, 752 N.W.2d 687 (noting that when resolution of one issue is dispositive, we need not reach other issues raised by the parties).

We also leave for another day the question of what is proper under the law when a person has a duel diagnosis of Alzheimer's and a WIS. STAT. ch. 51 qualifying illness.

CERTIFICATION AS TO APPENDIX

I hereby certify that filed with this brief, either as a separate document or as a part of this brief, is an appendix that complies with § 809.19(2)(a) and that contains, at a minimum: (1) a table of contents; (2) the findings or opinion of the circuit court; and (3) portions of the record essential to an understanding of the issues raised, including oral or written rulings or decisions showing the circuit court's reasoning regarding those issues.

I further certify that if this appeal is taken from a circuit court order or judgment entered in a judicial review of an administrative decision, the appendix contains the findings of fact and conclusions of law, if any, and final decision of the administrative agency.

I further certify that if the record is required by law to be confidential, the portions of the record included in the appendix are reproduced using first names and last initials instead of full names of persons, specifically including juveniles and parents of juveniles, with a notation that the portions of the record have been so reproduced to preserve confidentiality and with appropriate references to the record.

Dated this 27th day of October, 2011.

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SUPREME COURT

In the matter of the mental commitment of Helen E.F.:

FOND DU LAC COUNTY,

Petitioner-Respondent-Petitioner

v.

HELEN E.F.,

Respondent-Appellant

District: 2

Appeal No. 2010AP002061

Circuit Court Case No. 2010ME000146

REPLY BRIEF OF PETITIONER-RESPONDENT-PETITIONER

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ARGUMENT

1. The First Issue For Review In This Case Is Not Whether Alzheimer's Is A Mental Illness, But Whether the Alzheimer's Suffered By Helen E.F., With Its Particular Behavioral Disturbances, Constitutes A Mental Illness For Purposes of Involuntary Commitment Under Wisconsin Statute 51.01 (13) (b).

Helen E.F.'s response brief misstates the first issue for review before the Court in this case. The issue is not whether Alzheimer's is a mental illness. Fond du Lac County is not contending that Alzheimer's is a mental illness. The issue, as granted for review by the Court, is whether the Alzheimer's suffered by Helen E.F., with its particular behavioral disturbances, constitutes a mental illness for purposes of involuntary commitment within the meaning of Wisconsin Statutes § 51.01 (13) (b).

It is possible for someone with Alzheimer's, or other form of dementia, to develop a condition or set of conditions that constitutes a mental illness for purposes of involuntary commitment, and a court should not rule, as a matter of law, that the individual may not be involuntarily committed for treatment for merely having

Alzheimer's. The Court of Appeals focused on how Helen E.F. acquired her illness. The cause of a mental illness is immaterial. What is material is whether one has it.

II. Wisconsin Statutes § 51.20 Authorizes The Involuntary Commitment Of Any Individual Who Meets the Standards Of Being Mentally Ill, A Danger To Self or Others, And A Proper Subject For Treatment, Including Those Who Have Dementia Or Are Subject To An Order For Protective Placement

The Wisconsin Statutes do not support the contention, asserted in Helen E.F.'s response brief, that Chapter 51 does not authorize the commitment of an individual with Alzheimer's. Helen E.F. was not committed because she has Alzheimer's or other form of dementia. She was committed because she meets the standards for involuntary commitment under Chapter 51.

Nothing in the statutes evidences a legislative intent to prevent a person from being involuntarily committed and, being, at the same time, subject to an order for protective placement under Chapter 55. In

fact, a careful reading of the statutes reveals precisely the opposite. Wisconsin Statute § 55.12 (2) expressly provides that no individual who is subject to an order for protective placement or services may be involuntarily transferred to, detained in, or committed to a treatment facility for care except under s. 51.15, the emergency detention statute, or 51.20. The statutes would not contain this provision if it were not possible for the same person to be subject to protective placement and involuntary commitment at the same time.

Even a petition for an order for the involuntary administration of psychotropic medication as a protective service under Wisconsin Statute § 55.14 is intertwined with Chapter 51. It requires, within the 24 months previous to the filing of the petition, either a finding of probable cause for commitment under s. 51.20 (7), a settlement agreement under s. 51.20 (8) (bg), a commitment under s. 51.20 (13), or evidence that the individual meets one of the dangerousness criteria set forth in s. 51.20 (1) (a) 2. a. to e. Chapters 51 and 55 serve different purposes, but they are complementary, and are clearly intertwined. Together,

they may be used to provide the total care an individual requires for mental health and residential care and custody as is appropriate under the circumstances.

III. There Is Clear, Satisfactory and Convincing Evidence In The Record That Helen E.F. Meets The Criteria For Involuntary Commitment Because She Is Mentally Ill, A Danger to Herself And Others, And A Proper Subject For Treatment.

The evidence at trial was uncontroverted that Helen E.F. meets the criteria for involuntary commitment. Her agitation, anxiety, and depression are features of a mental illness. Dr. Robert Rawski, a psychiatrist who performed a court-ordered evaluation of Helen E.F's mental condition, testified to these conditions thoroughly and credibly. It was his uncontroverted medical judgment that Helen E.F. is mentally ill for purposes of involuntary commitment.

The features of Helen E.F.'s mental condition that resulted in the circuit court's finding that she has a mental illness are not the features of a degenerative brain disorder, as defined in Wisconsin Statute § 55.01 (1v). The statute defines degenerative brain disorder as

the loss or dysfunction of brain cells to the extent that the individual is substantially impaired in his or her ability to provide adequately for his or her own care or custody. Nothing in this definition contains any reference to conditions such as agitation, anxiety and depression. No one disputes that Helen E.F. was substantially impaired in her ability to provide for her own care or custody. But that was not the basis for Dr. Rawski's medical judgment, and the circuit court's finding, that Helen E.F. is mentally ill, nor was it an element that formed the basis for her commitment. The entire issue of Alzheimer's as a degenerative brain disorder is not relevant to the disposition of this case.

Nor is there evidence in the record to suggest that the move to a different unit caused Helen E.F.'s confusion, agitation, and anxiety, as asserted in the amicus brief of the Elder Law Section of the State Bar of Wisconsin and the Wisconsin Chapter of the National Academy of Elder Law Attorneys, which, for the sake of brevity, hereinafter will be referred to as Elder Law Section. Helen E.F's agitation and anxiety, and resulting physical aggression and refusal of cares, had

preceded her admission to the psychiatric unit, at the nursing home where she had resided for six years.

There is clear and convincing evidence that Helen E.F. is a danger to herself and others. The record shows that Helen E.F's agitation and anxiety caused her to physically strike out at caregivers, hitting them on various places of their bodies as they attempted to give her required care. As a result she was not able to receive proper care. The record shows that her inability to cooperate with hygiene care was the likely cause of her urinary tract infections, and put her at serious risk of infection and morbidity. This is substantial evidence of danger to self and others.

Contrary to the assertions in Helen E.F.'s response brief, the record contains clear, satisfactory and convincing evidence that Helen E.F. is a proper subject for treatment. Helen E.F. was not treated for Alzheimer's on the inpatient behavioral health unit. She was treated for the agitation, anxiety and paranoia that constitute her mental illness. These symptoms are treatable under the involuntary commitment standards because psychotropic medications improve and control

the agitation and anxiety, relieve her mental anguish, and reduce or eliminate the physical aggression that prevent caregivers from providing the residential care she requires.

Protective placement has little value for someone who is unable to receive or cooperate with care due to mental illness. Treatment enabled Helen E.F. to cooperate with care, and of particular importance, with hygiene care. This was designed not only to reduce her physical aggression toward others and the potential of infection and morbidity, but to achieve for her a measure of dignity and well-being.

The Elder Law Section amicus brief speaks of innovative treatment, but demonizes the commitment process and psychiatric care with references to handcuffs and psychotropic drugs. Helen E.F. was not brought to the Behavioral Health Unit in handcuffs. There are regulations in place to protect those placed on emergency detentions from the inappropriate use of restraints. There have been great advances in psychotropic medication in the past thirty years, to directly treat the disorder of thought, mood or perception

rather than merely sedating someone. This qualifies as "innovative treatment." The petition for examination was brought not only out of legal necessity, but of compassion and genuine concern for Helen E.F.'s situation. She greatly benefited from her treatment, and to deny it to her merely because she has Alzheimer's would be unconscionable.

Finally, Helen E.F.'s response brief has no answer for In the Mental Condition of C.J. 120 Wis. 2d 355, 354 N.W.2d 219 (Ct. App. 1984), cited and discussed at length in Fond du Lac County's Brief, which is directly on point in this case as to the issue of Helen E.F. being a proper subject for treatment.

IV. Helen E.F. Was Found To Be a Proper Subject For Commitment Based On Her Mental Condition, Not On Her Behavior.

Helen E.F. was not involuntarily committed for her behavior, as asserted in Helen E.F.'s response brief and in the amicus brief of the Elder Law Section. There is no constitutional barrier to her commitment. Her commitment was based on her mental condition, which resulted in behaviors that were dangerous to herself and others. It was Helen E.F's agitation, anxiety and

depression that constitute her mental illness. In turn, the illness caused her to physically strike out at caregivers and refuse required care.

Dr. Rawski's psychiatric diagnosis, on page 2 of his written report, differentiated between the essential features of dementia and the essential features of what he called the behavioral disturbances of dementia. He noted that behavioral disturbances are often accelerated by confusion from the cognitive impairment, as well as associated anxiety, mood, sleep and thought and perceptual disturbances including the potential for persecutory delusions and visual hallucinations. Anxiety, mood, sleep, thought, and perceptual disturbances are not behaviors. In terms of semantics, Dr. Rawski uses the term "behavioral disturbances" to describe these features. But they are in actuality mental conditions that cause behavior.

Every mental illness diagnosis necessarily involves an analysis of the patient's behavior, whether in the form of speech, acts or omissions. A psychiatrist may infer from the patient's behavior, during the process of diagnosis, the essential components of a mental

illness, such as an agitated state or state of anxiety, depressed state, mood swings, paranoid ideations, delusions, and visual or auditory hallucinations. The behavior reflects the mental condition, but the behavior alone does not determine the diagnosis of mental illness. A diagnosis is based on the medical judgment of the doctor concerning the patient's mental condition, from which the behavior results. And so it is with Helen E.F., and the evidence presented in the record by her evaluating psychiatrist.

IV. The Involuntary Commitment Of Persons Who Have A Mental Illness Who Also Have Alzheimer's Or Other Form of Dementia Will Have Little Negative Impact On Those People Who Execute A A Power Of Attorney For Health Care, Or On The Operation Of The Courts.

Helen E.F.'s response brief and the amicus brief of the Elder Law Section grossly exaggerate the potential impact of a reversal of the decision of the Court of Appeals in this case.

First, Fond du Lac County is not asking the Court to determine that Alzheimer's is a mental illness. A determination that the involuntary commitment statutes apply to those individuals with Alzheimer's or other form

of dementia, who develop conditions which meet the standard for involuntary commitment, would affect only those individuals, not everyone who has Alzheimer's.

Second, the argument exaggerates the impact on health care power of attorneys. Wisconsin Statutes § 155.20 (2) (c) 2.c. authorizes the admission of individuals to nursing homes and community based residential facilities by their health care agents if the individual is not diagnosed as having a mental illness at the time of admission. In most instances, as it occurred with Helen E.F., the onset of conditions qualifying as a mental illness is more likely to occur after the admission has been made to a nursing home, and in those cases there would be no impact on continued residence.

Third, the response and amicus briefs probably misconstrue the provision cited. There is no Wisconsin case law on point, but the term "diagnosed with a mental illness" for purposes of admission to a skilled nursing facility, could reasonably be construed to mean having a primary diagnosis of a mental illness. The diagnosis should be tied to the need for residential care and custody. If a person needs residential care due to a

decline in cognitive or physical abilities, and is not in need of residential care for any reason associated with a mental illness, a construction of the statute to disallow admission to the residential care facility by the health care agent defeats the primary purpose of the statute and produces an absurd result.

Fourth, instead of asking the Court to prohibit the involuntary commitment of individuals who meet commitment standards, advocacy groups should ask the Wisconsin Legislature to amend a law that makes little sense. Mentally ill people become infirm, too, and should be allowed the same benefits from executing a health care power of attorney as any other person.

Nor is it likely that courts will be flooded with petitions for guardianship and protective placement if the Court reverses the Court of Appeals decision in this case. Powers of attorney are favored under the new statutes governing guardianship and protective placement, as they should be, and they are not easily set aside or defeated. Not everyone who has Alzheimer's have mental conditions that result in dangerous behaviors that meet commitment standards.

But for those that do, they deserve the treatment they require. The decision in this case should not be determined by peripheral considerations raised in amicus briefs, but on the law and the record of the proceedings.

V. Pursuant To The Rules of Appellate Procedure Of The Court In Wisconsin Statutes § 809.62 (6), Helen E.F.'s Argument That The Chapter 51 Petition Should Have Been Dismissed Due To Loss Of Competency Or Abuse Of Process Is Improperly Made Because That Issue Is Not Set Forth In The Petition For Review Granted By The Court, Nor Has It Been Allowed By Order Of The Court

If a petition for review is granted, the parties cannot raise or argue issues not set forth in the petition unless ordered otherwise by the Supreme Court. Wisconsin Statutes § 809.62 (6). The issue Helen E.F.'s response brief raises concerning the loss of competence of the circuit court to hear the matter or abuse of process is not set forth in the petition for review. The Court has not issued an order that allows raising the issue. It is improper for Helen E.F.'s

response brief to raise and argue the issue before the Court.

VI. The Petition For The Involuntary Commitment Of Helen E.F Was Necessary And Legally Appropriate

The treatment Helen E.F. received in the inpatient psychiatric unit was necessary to alleviate and control her agitation and anxiety, reduce the danger to herself and others and restore a measure of dignity, peace and tranquility to her life. The record incontrovertibly shows that. The petition for examination was brought in good faith and with reasonable diligence and attention to Helen E.F.'s needs and the needs of the public, and both benefited greatly by it.

Helen E.F. is not alone in the issues she faces, and offices of corporation counsel regularly face challenges concerning those who have dementia. There is no one solution that may be fashioned to address every situation. Depending on the circumstances, solutions may be fashioned using guardianship and protective placement. But at other times, where involuntary commitment standards are met, the most appropriate solution is treatment on an

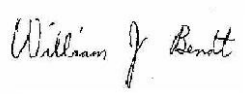
inpatient psychiatric unit, where medication may be most safely administered, adjusted and monitored. The provision for the involuntary administration of psychotropic medication as a protective service may be used as appropriate, but is of limited value in circumstances where the least restrictive level of treatment consistent with a person's needs is a psychiatric unit. Health care agents do not have the authority to admit principles to a psychiatric unit. The statutes provide tools to create solutions for persons with dementia in the most appropriate manner, consistent with the rights of the subject individual, and the Court should recognize and uphold them.

CONCLUSION

I respectfully request the Court to reverse the decision of the court of appeals and affirm the order of the Fond du Lac County Circuit Court for the involuntary commitment of Helen E.F. as lawfully issued.

Dated this 14th day of November, 2011

Respectfully submitted,



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CERTIFICATION AS TO FORM/LENGTH

I certify that this brief meets the form and length requirements of Rule 809.19(8)(b) and (c) in that it is: proportional serif font, minimum printing resolution of 200 dots per inch, 13 point body text, 11 point for quotes and footnotes, leading of minimum 2 points and maximum of 60 characters per line of body text. The length of the brief is 2,687 words.

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I have submitted an electronic copy of this brief, which complies with the requirements of § 809.19(12). I further certify that:

This electronic brief is identical in content and format to the printed form of the brief filed on or after this date.

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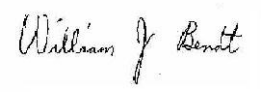
November 14, 2011



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STATE OF WISCONSIN
SUPREME COURT
CASE NO. 2010AP002061

In the matter of the mental commitment of Helen E.F.:

FOND DU LAC COUNTY,
Petitioner-Respondent-Petitioner,

v.

HELEN E.F.,
Respondent-Appellant.

On Certiorari from the Wisconsin Court of Appeals, District 2, reversing an Order for Involuntary Commitment and Medication, entered by the Circuit Court, Fond du Lac County, Hon. Richard J. Nuss, Presiding.

BRIEF AND APPENDIX OF THE ELDER LAW SECTION OF THE STATE BAR OF WISCONSIN AND THE WISCONSIN CHAPTER OF THE NATIONAL ACADEMY OF ELDER LAW ATTORNEYS AS *AMICI CURIAE*

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INTRODUCTION

The attorney members of the Elder Law Section of the State Bar of Wisconsin (ELS) and the Wisconsin Chapter of the National Academy of Elder Law Attorneys (WI NAELA) write this brief to address the following issues: the significant collateral damage of classifying Alzheimer's as a qualifying mental illness; the substantive due process violation in using behavioral symptoms to define mental illness; and the need to develop appropriate care and treatment for individuals in the complicated stages of Alzheimer's.

ARGUMENT

I. IF ALZHEIMER'S IS FOUND TO BE A MENTAL ILLNESS, GUARDIANSHIPS AND PROTECTIVE PLACEMENTS IN WISCONSIN WILL INCREASE DRAMATICALLY, BECAUSE AN AGENT UNDER A POWER OF ATTORNEY CANNOT ADMIT A PRINCIPAL WHO HAS A MENTAL ILLNESS TO A CBRF OR SKILLED NURSING FACILITY.

The specific question before the Court is whether "Alzheimer's dementia....with its particular behavioral

disturbances" (Petition for Review, p.1) is a "mental illness" within the meaning of Wis. Stat. § 51.01(13)(b), allowing an individual to be involuntarily committed under Wis. Stat. § 51.20. Given the wider scope of issues that the Elder Law Bar addresses on behalf of clients with Alzheimer's, we want to advise the Court that the broader impact of this case is not in the laws before it, but in the laws that are closely related. Specifically, an answer of "Yes" to the civil commitment question before the Court will mean that no individual with Alzheimer's who has executed a power of attorney for health care allowing nursing home admission, will be able to rely on that advance directive for admission to a community-based residential facility (CBRF) or skilled nursing facility (SNF). It will mean further, that the provisions of Wis. Stat. § 50.06 allowing a family member to consent to admission to a CBRF or SNF for an incapacitated individual who has not executed a power of attorney for health care, will not apply to individuals with Alzheimer's.

This alarming result is because both the power of attorney for health care statute regarding admissions to certain facilities, Wis. Stat. § 155.20(2)(c), and the "family consent" statute regarding admissions to certain facilities, Wis. Stat. § 50.06(2)(b), specifically prohibit agents and family from admitting individuals with mental illness. Consequently, answering "Yes" to the question before the Court will bring about a dramatic increase in guardianships and protective placements, which will be the only way legally to admit incapacitated Alzheimer's patients to facilities such as the nursing home in which Helen E.F. resided prior to her detention.

As elder law attorneys, we encourage clients to execute advance directives such as powers of attorney for health care (POAHC) to make sure their wishes are carried out by agents of their choice. One decision that our clients are encouraged to make with respect to the POAHC, is whether their agent may admit them to a residential care facility such as a CBRF, or to a skilled nursing facility if the need develops. Almost all elderly

clients will choose to grant this authority to their agents when counseled that the alternative may be a guardianship and protective placement if nursing home care is inevitable and the agent has no authority to consent to admission. Our elderly clients usually choose to grant this authority because they do not want costly court intervention in their private health decisions, nor do they wish to be declared legally incompetent.

In Wisconsin, the delegation of authority to a health care agent is limited. With respect to admission to facilities by a health care agent, Wis. Stat. § 155.20(2)(c) sets forth the parameters of authority:

> 2. A health care agent may consent to the admission of a principal to the following facilities, under the following conditions:
>
> a. To a nursing home, for recuperative care for a period not to exceed 3 months, if the principal is admitted directly from a hospital inpatient unit, unless the hospital admission was for psychiatric care.
>
> b. If the principal lives with his or her health care agent, to a nursing home or a community-based residential facility, as a temporary placement not to exceed 30 days, in order to provide the health care agent with a vacation or to release temporarily the health care agent for a family emergency.
>
> c. To a nursing home or a community based residential facility, for purposes other than those specified in subd. 2. a. and b., <u>if the power of</u>

> attorney for health care instrument specifically so authorizes and if the principal is not diagnosed as developmentally disabled or as having a mental illness at the time of the proposed admission.

(Emphasis supplied.) Under this statute, where an individual has a mental illness, the agent cannot consent to admission to a CBRF or SNF. Thus, the only alternative is protective placement.

Helen E.F. has a valid, activated POAHC (R. 9:7.) If she has mental illness, her daughter, who is the agent, will not lawfully be permitted to consent to her admission to a skilled nursing facility. She will be forced to undergo a permanent guardianship and protective placement despite the existence of an advance directive.

Similarly, individuals afflicted with Alzheimer's who do not have health care powers of attorney, will no longer be able to be admitted to a facility following a hospitalization with the consent of a family member under Wis. Stat. § 50.06, because they are diagnosed as having mental illness.[1]

---

1 Wis. Stat. §50.06 states, in pertinent part:

Statutory language is interpreted "in relation to the language of surrounding or closely-related statutes; and reasonably, to avoid absurd or unreasonable results." *State ex rel. Kalal v. Circuit Court*, 2004 WI 58, ¶46, 271 Wis. 2d 633, 681 N.W.2d 110. In a matter involving the care and treatment of an individual, Chapter 51 (Civil Commitment), Chapter 55 (Protective Placement), and Chapter 155 (Power of Attorney for Health Care) of the Wisconsin Statutes are closely related since they address the various means by which an individual receives that care.

It would be absurd indeed if the legion of individuals for whom the "nursing home and CBRF admission" provision of a POAHC is arguably the most

---

50.06 Certain admissions to facilities.

....

(2) An individual under sub. (3) may consent to admission, directly from a hospital to a facility, of an incapacitated individual who does not have a valid power of attorney for health care and who has not been adjudicated incompetent in this state, if all of the following apply:

....

(b) The individual for whom admission is sought is not diagnosed as developmentally disabled or as having a mental illness at the time of the proposed admission.

(emphasis supplied)

crucial were not able to use it. Reading Chapter 51 in a manner that renders a health care agent powerless to admit an Alzheimer's patient to a CBRF or a nursing home, creates an unreasonable result.

It is also unreasonable and unnecessary to read Chapter 51 in a way that places an immense burden on the protective placement system, Chapter 55[2]. To illustrate this effect, we begin with statistics from the Wisconsin Court System website, which provide the baseline as to cases in the Wisconsin courts. Http://www.wicourts.gov/publications/statistics/circuit/docs/probatestate10.pdf (copy in Appendix). In 2010, there were 2,430 guardianships and 1,750 protective placements instituted statewide.

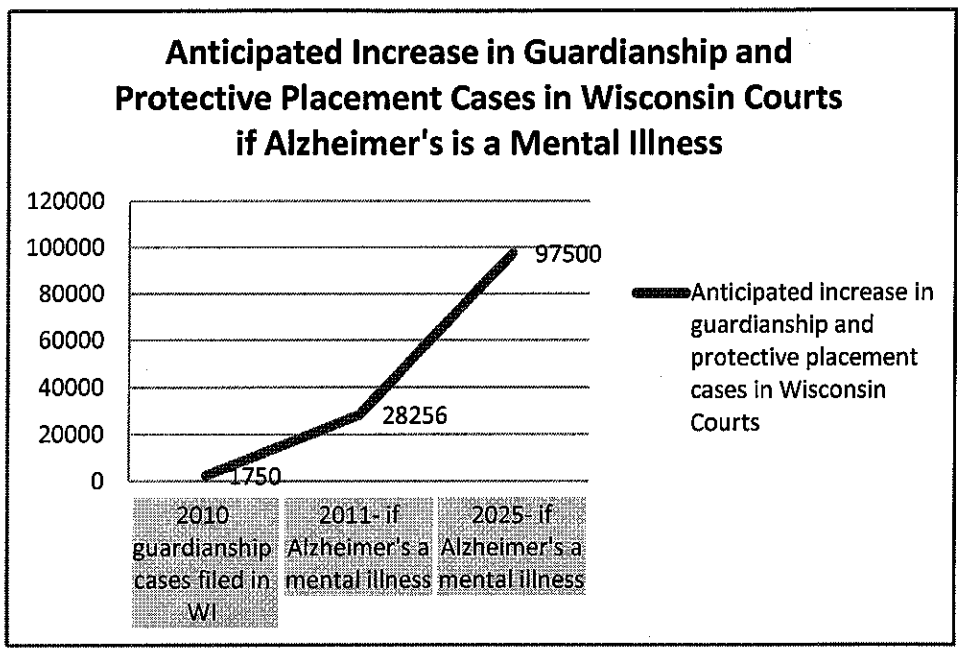
The *2011 Alzheimer's Facts and Figures Report*, http://www.alz.org/downloads/Facts_Figures_2011.pdf (relevant sections included in Appendix), states that in 2008 (the most recent year for which the report

2 The ELS and WI NAELA believe that the protective placement system under Chapter 55 adequately provides for an Alzheimer's patient with disruptive behaviors to be stabilized and treated. We echo the position in pages 22-29 of the *amicus* brief that the Coalition of Wisconsin Aging Groups filed in the Court of Appeals.

gathered this type of data) there were 74,358 people in nursing homes in Wisconsin. *Report*, p.42. Of that total, it is estimated that sixty-six percent (66%) have cognitive impairment, with thirty-eight percent (38%) having moderate to severe levels. *Id.* This means that of the individuals likely to be in nursing homes currently, as many as 38% or 28,256 could be in need of guardianship and protective placement *immediately* due to § 155.20(2)(c), if this Court finds Alzheimer's to be a mental illness. An additional 20,820 may need guardianship and protective placement in the future when their cognitive impairment progresses, for a total of 49,076 guardianships and protective placements based on the 2008 figure alone.

As far as the future, according to the same report, there will be 130,000 individuals over 65 in Wisconsin with Alzheimer's as of 2025. *Report*, p. 19. By the time they reach age 80, seventy-five percent (75%) of the individuals with Alzheimer's are predicted to need nursing home care. *Report*, p. 23. This means that in

2025, 97,500 people would need guardianship and protective placement when it is time to enter a nursing home or CBRF. The chart below summarizes these projections:



The increase from 1750 protective placements, to 28,256 that would be immediately required if Alzheimer's is a mental illness, is enough to bring probate courts to a grinding halt. Processing 97,500 protective placement cases - based on the 2025 figures - would require a vast increase in court personnel and county protective service workers to manage the

caseload. This does not even take into account the annual reviews that will be required for each case under Wis. Stat. § 55.18.

While the anticipated toll on the court system is extreme, of even greater concern is the fact that each one of these individuals will be forced to be declared legally incompetent in a court of law, and subjected to the restriction of liberty associated with a protective placement proceeding. *In the Matter of Protective Placement of Judith G.*, 2002 WI App 36,¶12, 250 Wis. 2d 817, 640 N.W.2d 839. This will be true even for those people who have advance directives.

II. CIVILLY COMMITTING AN INDIVIDUAL BASED ON "BEHAVIOR" VIOLATES SUBSTANTIVE DUE PROCESS.

Commitment to a mental hospital is "a massive curtailment of liberty," *Humphrey v. Cady*, 405 U.S. 504, 509 (1972), and thus "requires due process protection." *Addington v. Texas*, 441 U.S. 418, 425 (1979). The loss of liberty produced by an involuntary commitment is more than a loss of physical freedom.

Commitment to a mental hospital "can engender adverse social consequences to the individual" and "[w]hether we label this phenomena 'stigma' or choose to call it something else . . . we recognize that it can occur and that it can have a very significant impact on the individual." *Addington, supra*, at 425-426.

Fond du Lac County argues that the "behavioral manifestations" of Helen E.F.'s dementia fall within the meaning of "mental illness" as defined in Wis. Stat. § 51.01(13)(b) for purposes of commitment under Wis. Stat. § 51.20. While conceding that her "condition is considered to be a progressive mental defect that is not treatable" (County's Brief at 5) the County goes on to argue that "the behavioral disturbances [associated with her Alzheimer's] are considered to be a substantial disorder of thought, mood or perception that grossly impair Helen E.F's judgment, behavior, capacity to recognize reality, and the ability to meet the ordinary demands of life. (16:7) That meets the statutory definition for mental illness for purposes of involuntary

commitment." County's Brief at 6 (emphasis supplied).

Under the County's theory, any behavioral disturbance associated with a medical condition is a "mental illness" if the behavior falls within the statutory classification. This reading of the statute renders it applicable to all types of medical conditions that involve behavioral aspects during the course of the illness, such as Multiple Sclerosis, urinary tract infections, Parkinson's Disease, brain tumors, HIV related encephalopathy and numerous other physical and neurological illnesses, *see, e.g.* Chuang, *Mental Disorders Secondary to General Medical Conditions*, http://emedicine.medscape.com/article/294131-overview (copy included in Appendix).

Commitment based on behavior alone was found to violate the Due Process Clause of the Fourteenth Amendment to the United States Constitution in *Foucha v. Louisiana*, 504 U.S. 71 (1992). In that case, an insanity acquittee was held in a mental institution despite the fact that he was no longer mentally ill, under

a Louisiana law that required him to prove he was no longer dangerous in order to be released. The Supreme Court found there was no constitutional justification for detaining an individual who was not mentally ill. In similar fashion to this case, the civil detainee in *Foucha* had an antisocial personality disorder, not a mental illness, which "sometimes leads to aggressive conduct." *Id.* at 82. Observing the fatal flaw in that theory of detention, the Court stated:

> This rationale would permit the State to hold indefinitely any other insanity acquittee not mentally ill who could be shown to have a personality disorder that may lead to criminal conduct....It would also be only a step away from substituting confinements for dangerousness for our present system which, with only narrow exceptions and aside from permissible confinements for mental illness, incarcerates only those who are proved beyond reasonable doubt to have violated a criminal law.

Id. at 82-83. Thus it is clear that dangerous behavior[3], by itself, is not constitutionally sufficient to justify a civil commitment. *Accord, O'Connor v.*

---

3 It should be noted in this case, that the "dangerous behavior" of this 85 year old, 100 pound woman consisted of swatting at caregivers during cares, without evidence of any injury whatsoever, and grabbing at people when they walked by. *Petition for Examination,* R.1:¶¶4-5. This can hardly be called "serious physical harm" which is the standard for commitment under Wis. Stat. §51.20(1)(a)2

Donaldson, 422 U.S. 563, 575 (1975), *Addington, supra.* The constitutionality of civil commitment procedures is predicated on their limitation to individuals who are *both* mentally ill and dangerous. Calling the behaviors a "mental illness" is a clever attempt to gloss over the fact that both elements are constitutionally required.

Because of the significant liberty interests involved, a civil commitment statute must be narrowly enough drawn so that its terms have a content that is reasonably precise and those persons it encompasses can be identified with reasonable accuracy. *O'Connor v. Donaldson, supra.* If the definition of "mental illness" in Wis. Stat. § 51.01(13)(b) can be interpreted in such a circular fashion that any person who exhibits behaviors that meet the standards of the statute has a "mental illness" under the statute, then it is overly broad. Most of us have shown poor judgment, exhibited poor memory, and been disruptive on occasion. Without more, none of those things can or should subject us to commitment.

III. SINCE THE GROWTH OF ALZHEIMER'S IS INEVITABLE, INNOVATIVE TREATMENT PROVIDES A BETTER SOLUTION TO CHALLENGING BEHAVIORS THAN MENTAL COMMITMENT.

"How old would you be if you didn't know how old you are?" Satchel Paige

The Wisconsin Counties Association, in support of the Petition for Review, claims that the Court of Appeals decision will result in cherry-picking by private facilities to exclude Alzheimer's patients, and county facilities will become places of last resort for Alzheimer's patients. WCA *Amicus* Brief in Support of Petition for Review, p.2. This assertion is not grounded in reality.

Based on the growth statistics cited *supra* in Section I, any private facility wishing to stay in business is going to have to take Alzheimer's patients. County facilities are also guaranteed to have an increase in Alzheimer's patients, not due to cherry-picking by private facilities, but due to demographics. The real question is not which facilities will take Alzheimer's patients, but how they will treat them.

Alzheimer's is the health care crisis of the Baby

Boomer generation. The effects of Alzheimer's are so debilitating and overwhelming that it is seen quite rightly as a nefarious affliction. There is no doubt that this disease will require significant resources in caregiving, medical treatment, and finances over the next several decades.

At the same time, in some ways Alzheimer's provides blessings that can only be understood when loved ones and caregivers allow themselves to experience life from the patient's perspective. With Alzheimer's, memories of loved ones fade and then disappear completely, causing great sadness to those whose memories remain. However, with the dissipation of cherished memories also comes the end of painful recollections and old hurts, so that the afflicted individual lives purely and simply, in the moment.

Understanding that perspective is what will allow health care facilities to develop and implement treatment methodologies that maximize the "pleasant" moments for each patient, thus reducing the likelihood

of that patient acting out. For examples of this treatment methodology in action, *see* Pam Belluck, *Giving Alzheimer's Patients Their Way, Even Chocolate*, New York Times, Dec. 31, 2010 (part of a series on Alzheimer's entitled "The Vanishing Mind") *available at* http://www.nytimes.com/2011/01/01/health/01care.html. The article describes innovative approaches used at the Beatitudes nursing home in Arizona. Some of the approaches include allowing a patient to eat, sleep and bathe on the patient's schedule, allowing a patient to eat any and all foods that the patient likes, including chocolate, and painting designs on the floor to prevent patients from wandering.

Our response to Fond du Lac County and the Wisconsin Counties Association is this: instead of handcuffs and psychotropic drugs, try chocolate. Instead of locking up our venerated elders in mental hospitals with drug addicts, alcoholics, and violent individuals, try compassion and innovative treatment.

We are not asking this Court to create an

appropriate treatment program for Alzheimer's individuals. At the same time, this Court need not condone the inappropriate detention of these patients in mental institutions simply because the facilities have not yet adopted effective treatments. Wisconsin's elders deserve better.

CONCLUSION

For the reasons set forth above, the Elder Law Section of the State Bar of Wisconsin and Wisconsin Chapter of the National Academy of Elder Law Attorneys urge this Court to affirm the decision of the Court of Appeals. This Brief represents only the position of WI NAELA and the ELS, not the State Bar of Wisconsin.

Dated this 19th day of October, 2011.

Respectfully submitted:

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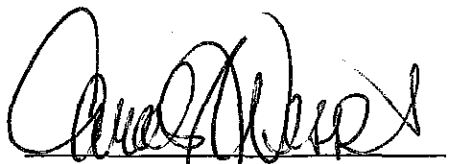
FORM AND LENGTH CERTIFICATION

I hereby certify that this brief conforms to the rules contained in s. 809.19 (8) (b) and (c) for a brief and appendix produced with a proportional serif font. The length of this brief is 2951 words. I am also filing an electronic copy of the brief and appendix which is identical to the text of the paper brief and appendix filed this date.



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CERTIFICATION RELATED TO APPENDIX

I hereby certify that filed with this brief, either as a separate document or as a part of this brief, is an appendix that complies with s. 809.19 (2) (a) and that contains (1) a table of contents; (2) the findings or opinion of the circuit court; **[not applicable to this brief]** (3) a copy of any unpublished opinion cited under s. 809.23 (3) (a) or (b) **[not applicable to this brief]**; and (4) portions of the record essential to an understanding of the issues raised, including oral or written rulings or decisions showing the circuit court's reasoning regarding those issues.

I further certify that if this appeal is taken from a circuit court order or judgment entered in a judicial review of an administrative decision, the appendix contains the findings of fact and conclusions of law, if any, and final decision of the administrative agency **[not applicable to this case]**.

I further certify that if the record is required by law to be confidential, the portions of the record included in the appendix are reproduced using first names and last

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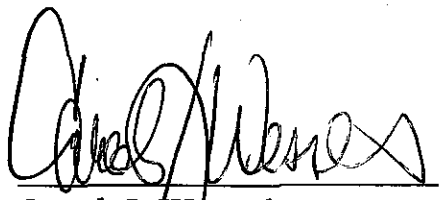
Dated: 10/20/11



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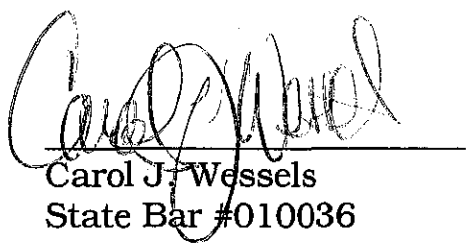
CERTIFICATION OF SERVICE

I, Carol J. Wessels, do hereby certify that on October 20 2011, I am depositing this Brief in the USPS first-class mail. I am also serving the required number of copies on the parties by regular mail this date.

Dated: 10/20/11



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STATE OF WISCONSIN
SUPREME COURT
CASE NO. 2010AP002061

In the matter of the mental commitment of Helen E.F.:

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HELEN E.F.,
Respondent-Appellant.

INDEX TO APPENDIX

Begin Date: 01-01-2010
End Date: 12-31-2010

Probate Disposition Summary
Statewide Report

Statewide

CATEGORIES	Total Opened	Total Disposed	Jury Trial	Court Trial	Dismissed Before Trial	Other	Median Age at Disposition
TOTAL PROBATE-UNCLASSIFIED	1361	1319	0	3	0	1316	1
Formal Estate Proceedings	871	910	0	12	1	897	441
Informal Estate Proceedings	6906	7014	0	13	2	6999	367
Ancillary Proceedings	40	42	0	0	0	42	110
Special Administration	1972	1801	0	3	1	1797	192
Summary Assignment	142	149	0	1	0	148	225
Summary Settlement	110	123	0	0	0	123	68
Termination Of Joint Tenancy	50	49	0	0	0	49	1
Termination Of Life Estate	54	53	0	0	0	53	1
Determination Of Descent	27	20	0	0	0	20	3
Total Other Estate Proceedings	2395	2237	0	4	1	2232	166
TOTAL ESTATES	10172	10161	0	29	4	10128	356
Trusts	369	475	0	4	0	471	1
Guardianships	2430	2937	0	95	0	2842	44
Temporary Guardianships	487	419	0	7	1	411	29
Conservatorships	60	77	0	1	0	76	29
Protective Placements (with new guardianship)	1734	1940	0	43	0	1897	43
Protective Placements (on existing guardianship)	16	53	0	2	0	51	57
Protective Services	13	20	0	0	0	20	65
Mental Commitments	16646	16946	14	843	7227	8862	5
Alcohol Commitments	230	224	0	14	135	75	8
Drug Commitments	29	26	0	1	14	11	9
Minor Commitments	90	80	0	7	44	29	3
Total Commitments	16995	17276	14	865	7420	8977	5
TOTAL PROTECTIVE ACTIONS	22104	23197	14	1017	7421	14745	9
TOTAL ADOPTIONS	1444	1448	0	0	74	1374	31
TOTAL PROBATE	35081	36125	14	1049	7499	27563	28

2011 Alzheimer's Disease Facts and Figures

INCLUDES A SPECIAL REPORT ON EARLY DETECTION AND DIAGNOSIS

AN ESTIMATED **5.4** MILLION PEOPLE HAVE ALZHEIMER'S DISEASE

14.9 MILLION UNPAID CAREGIVERS

183 BILLION DOLLARS IN ANNUAL COSTS

alzheimer's association®

ABOUT THIS REPORT

2011 Alzheimer's Disease Facts and Figures provides a statistical resource for U.S. data related to Alzheimer's disease, the most common type of dementia, as well as other dementias. Background and context for interpretation of the data are contained in the Overview. This information includes definitions of the types of dementia and a summary of current knowledge about Alzheimer's disease. Additional sections address prevalence, mortality, caregiving and use and costs of care and services. The Special Report focuses on the benefits and challenges of early detection and diagnosis of Alzheimer's disease.

Specific information in this year's *Alzheimer's Disease Facts and Figures* includes:

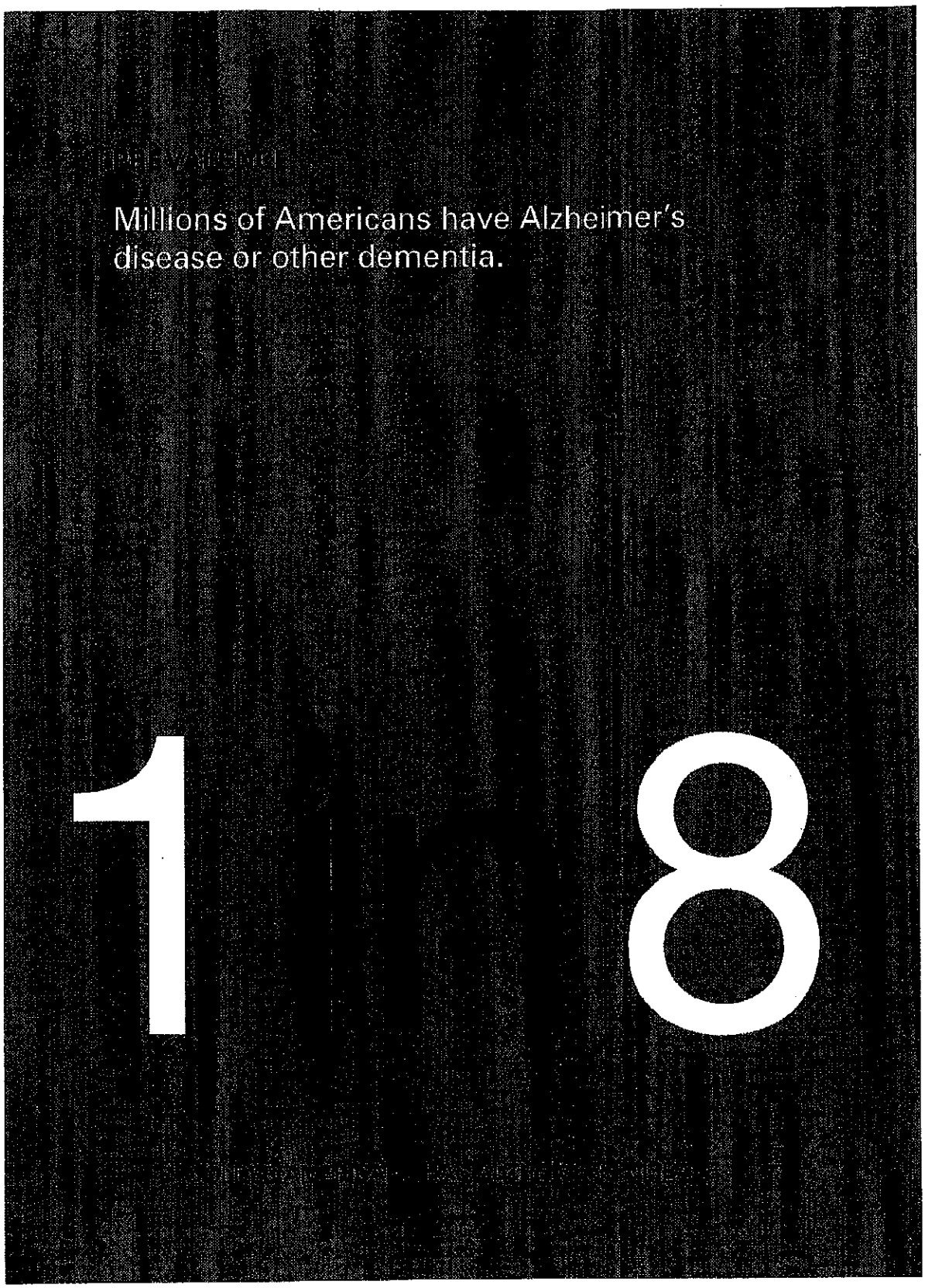
- Overall number of Americans with Alzheimer's disease nationally and for each state
- Proportion of women and men with Alzheimer's and other dementias
- Estimates of lifetime risk for developing Alzheimer's disease
- Number of family caregivers, hours of care provided, economic value of unpaid care nationally and for each state, and the impact of caregiving on caregivers
- Use and costs of health care, long-term care and hospice care for people with Alzheimer's disease and other dementias
- Number of deaths due to Alzheimer's disease nationally and for each state, and death rates by age

The Appendices detail sources and methods used to derive data in this report.

This document frequently cites statistics that apply to individuals with all types of dementia. When possible, specific information about Alzheimer's disease is provided; in other cases, the reference may be a more general one of "Alzheimer's disease and other dementias."

The conclusions in this report reflect currently available data on Alzheimer's disease. They are the interpretations of the Alzheimer's Association.

Contents


Millions of Americans have Alzheimer's disease or other dementia.
1
8

The number of Americans with Alzheimer's disease and other dementias will grow each year as the proportion of the U.S. population that is over age 65 continues to increase. The number will escalate rapidly in coming years as the baby boom generation ages.

Estimates from selected studies on the prevalence and characteristics of people with Alzheimer's and other dementias vary depending on how each study was conducted. Data from several studies are used in this section to describe the prevalence of these conditions and the proportion of people with the conditions by gender, race and ethnicity, and years of education. Data sources and study methods are described in the Appendices.

Prevalence of Alzheimer's Disease and Other Dementias

An estimated 5.4 million Americans of all ages have Alzheimer's disease in 2011. This figure includes 5.2 million people aged 65 and older[41], A1 and 200,000 individuals under age 65 who have younger-onset Alzheimer's.[42]

- One in eight people aged 65 and older (13 percent) has Alzheimer's disease.[A2]
- Nearly half of people aged 85 and older (43 percent) have Alzheimer's disease.[A3]
- Of those with Alzheimer's disease, an estimated 4 percent are under age 65, 6 percent are 65 to 74, 45 percent are 75 to 84, and 45 percent are 85 or older.[41], A4

The estimated numbers for people over 65 come from the Chicago Health and Aging Project (CHAP), a population-based study of chronic health diseases of older people. Recently, the National Institute on Aging and the Alzheimer's Association convened a conference to examine certain discrepancies among estimates from CHAP and other studies, including the Aging, Demographics, and Memory Study (ADAMS), a nationally representative sample of older adults.[43] A panel of experts concluded that the discrepancies in the published estimates arose from differences in how those studies counted who had Alzheimer's disease. When the same diagnostic criteria were applied across studies, the estimates were very similar.[44], A5

National estimates of the prevalence of all forms of dementia are not available from CHAP. Based on estimates from ADAMS, 13.9 percent of people aged 71 and older in the United States have dementia.[43] This number would be higher using the broader diagnostic criteria of CHAP.

Prevalence of Alzheimer's Disease and Other Dementias in Women and Men

More women than men have Alzheimer's disease and other dementias. Almost two-thirds of all Americans living with Alzheimer's are women.[A6] Of the 5.2 million people over age 65 with Alzheimer's in the United States, 3.4 million are women and 1.8 million are men.[A6] Based on estimates from ADAMS, 16 percent of women aged 71 and older have Alzheimer's disease or other dementia compared with 11 percent of men.[43, 45]

Further analyses show that the larger proportion of older women than men who have Alzheimer's disease or other dementia is primarily explained by the fact that women live longer on average than men.[45-48] Moreover, many studies of the age-specific incidence (development of new cases) of Alzheimer's disease[46-52] or any dementia[47-49, 53-54] have found no significant difference by gender. Thus, women are *not* more likely than men to develop dementia at any given age.

Prevalence of Alzheimer's Disease and Other Dementias by Years of Education

People with fewer years of education appear to be at higher risk for Alzheimer's and other dementias than those with more years of education. Prevalence and incidence studies show that having fewer years of education is associated with a greater likelihood of having dementia[43, 55] and a greater risk of developing dementia.[48, 51, 54, 55-57]

Some researchers believe that a higher level of education provides a "cognitive reserve" that enables individuals to better compensate for changes in the brain that could result in Alzheimer's or another dementia.[58-59] However, others believe that these differences in educational attainment and dementia risk reflect such factors as increased risk for disease in general and less access to medical care in lower socioeconomic groups.[60]

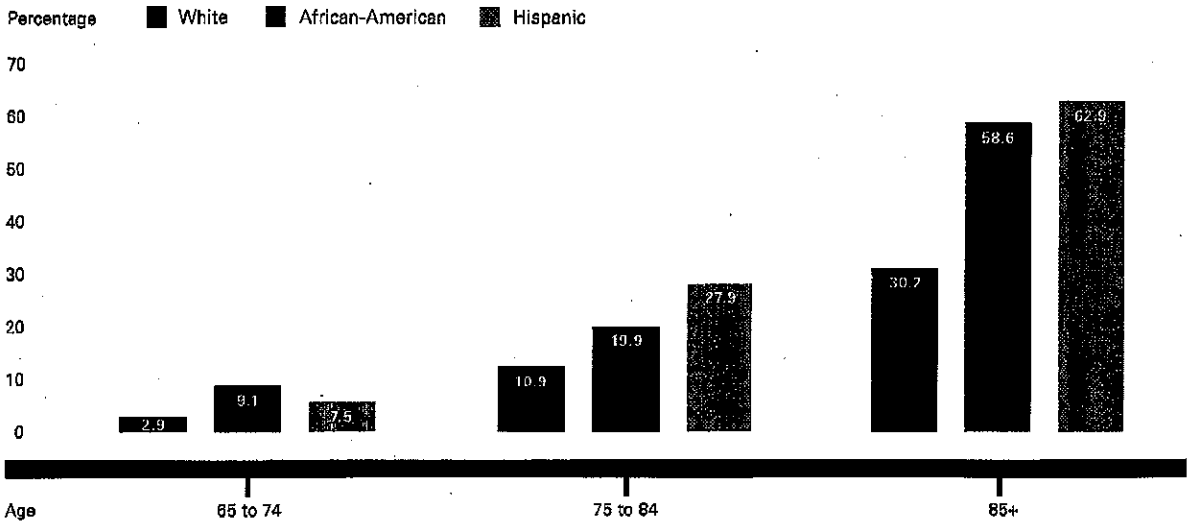
Prevalence of Alzheimer's Disease and Other Dementias in Older Whites, African-Americans and Hispanics

While most people in the United States living with Alzheimer's and other dementias are non-Hispanic whites, older African-Americans and Hispanics are proportionately more likely than older whites to have Alzheimer's disease and other dementias.[61-62] Data indicate that in the United States, older African-Americans are probably about twice as likely to have Alzheimer's and other dementias as older whites,[63] and Hispanics are about one and one-half times as likely to have Alzheimer's and other dementias as older whites.[55] Figure 1 shows the estimated prevalence for each group, by age, from the Washington Heights-Inwood Columbia Aging Project (WHICAP).

No known genetic factors can account for these prevalence differences across racial groups. Instead, health conditions such as high blood pressure and diabetes, lower levels of education and other differences in socioeconomic characteristics that are risk factors for Alzheimer's disease and other dementias are more common in older African-Americans and Hispanics than in older whites. Some studies suggest that differences based on race and ethnicity do not persist in detailed analyses that account for these factors.[43, 48]

Prevalence studies such as WHICAP are designed so that all individuals with dementia are detected. But in the community, only about half of those with Alzheimer's disease or other dementia receive a diagnosis.[64] There is evidence that missed diagnoses are more common among older African-Americans and Hispanics than among older whites.[65-66] For example, a 2006 study of Medicare beneficiaries found that Alzheimer's disease or another dementia had been diagnosed in 9.6 percent of white beneficiaries, 12.7 percent of African-American beneficiaries and 14 percent of Hispanic beneficiaries.[67] Although rates of diagnosis were higher among African-Americans and Hispanics compared with whites, the difference was not as great as would be expected based on the estimated differences found in prevalence studies. This disparity is of increasing concern because the proportion of older Americans who are African-American and Hispanic is projected to grow in coming years.[68] If the current racial and ethnic disparities in diagnostic rates continue, the proportion of individuals with undiagnosed dementia will increase.

figure 1: Proportion of People Aged 65 and Older with Alzheimer's Disease and Other Dementias, by Race/Ethnicity, Washington Heights-Inwood Columbia Aging Project, 2006



Created from data from Gurland et al.[66]

Incidence and Lifetime Risk of Alzheimer's Disease

Prevalence is the number of *existing* cases of a disease in a population at a given time. Incidence is the number of *new* cases of a disease in a given time period. The estimated annual incidence (rate of developing disease in a one-year period) of Alzheimer's disease appears to increase dramatically with age, from approximately 53 new cases per 1,000 people aged 65 to 74, to 170 new cases per 1,000 people aged 75 to 84, to 231 new cases per 1,000 people over age 85 (the "oldest-old").[69] Some studies have found that incidence levels off after age 90, but these findings are controversial. A recent analysis indicates that dementia incidence may continue to increase and that previous observations of an incidence plateau may be due to sparse data for the oldest-old.[70] Because of the increase in the number of people over 65 in the United States, the annual total number of new cases of Alzheimer's and other dementias is projected to double by 2050.[69]

- Every 69 seconds, someone in America develops Alzheimer's.[A7]
- By mid-century, someone in America will develop the disease every 33 seconds.[A7]

Lifetime risk is the probability that someone of a given age develops a condition during their remaining lifespan. Data from the original Framingham Study population was used to estimate lifetime risks of Alzheimer's disease and of any dementia.[71],[A8] Starting in 1975, nearly 2,800 people from the Framingham Study who were age 65 and free of dementia were followed for up to 29 years. The study found that 65-year-old women without dementia had a 20 percent chance of developing dementia during the remainder of their lives (estimated lifetime risk), compared with a 17 percent chance for men. For Alzheimer's, the estimated lifetime risk was nearly one in five (17.2 percent) for women compared with one in 10 (9.1 percent) for men.[71],[A9] Figure 2 presents lifetime risks of Alzheimer's for men and women of specific

ages. As previously noted, these differences in lifetime risks between women and men are largely due to the longer life expectancy for women.

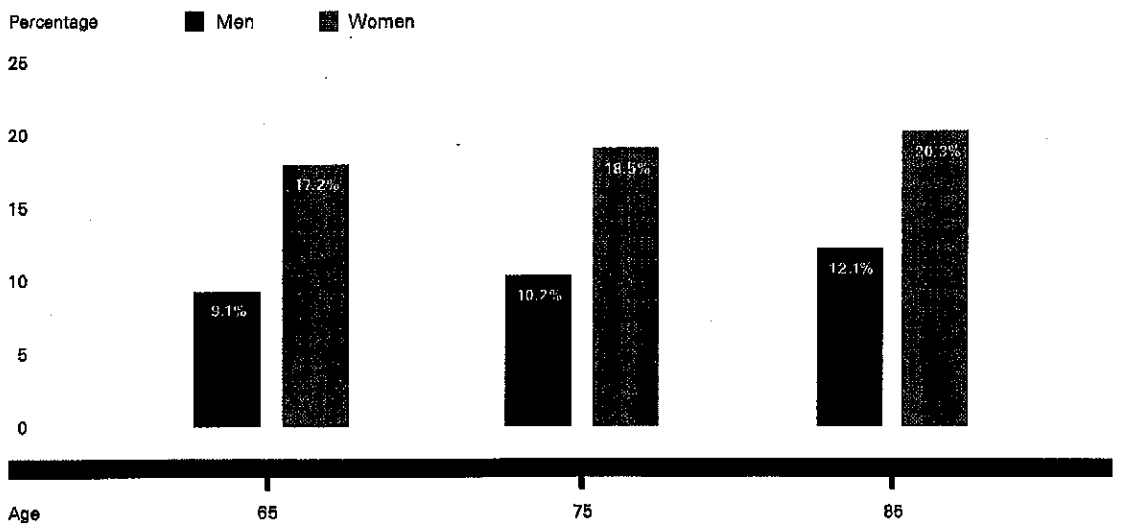
The definition of Alzheimer's disease and other dementias used in the Framingham Study required documentation of moderate to severe disease as well as symptoms lasting a minimum of six months. Using a definition that also includes milder disease and disease of less than six months' duration, lifetime risks of Alzheimer's disease and other dementias may be much higher than those estimated by the Framingham Study.

Estimates of the Number of People with Alzheimer's Disease, by State

Table 2 (pages 18 to 19) summarizes the projected total number of people aged 65 and older with Alzheimer's disease by state for the years 2000, 2010 and 2025.[A10] The percentage changes in the number of people with Alzheimer's between 2000 and 2010 and between 2000 and 2025 are also shown. Note that the total number of people with Alzheimer's will be larger for states with larger populations, such as California and New York. Comparable projections for other types of dementia are not available.

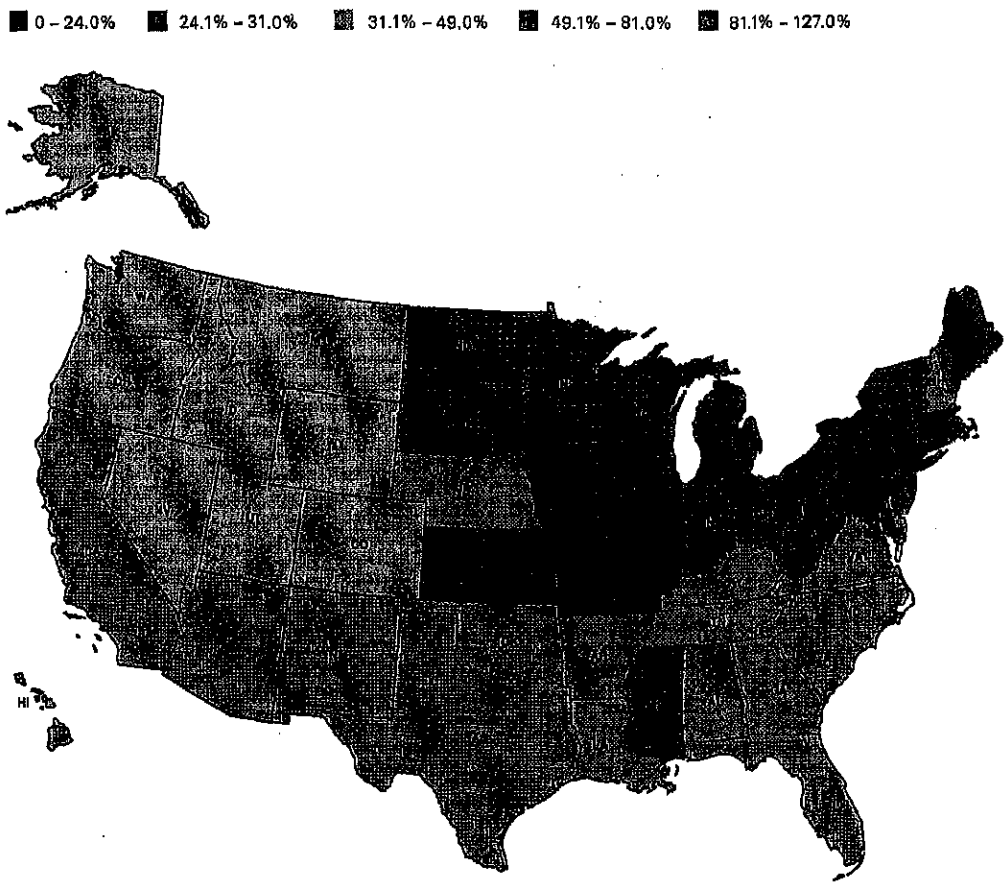
As shown in Figure 3, between 2000 and 2025 some states and regions across the country are expected to experience double-digit percentage increases in the overall numbers of people with Alzheimer's, due to increases in the proportion of the population over age 65. The South and West are expected to experience 50 percent and greater increases in numbers of people with Alzheimer's between 2000 and 2025. Some states (Alaska, Colorado, Idaho, Nevada, Utah and Wyoming) are projected to experience a doubling (or more) in number of people with Alzheimer's.

figure 2: Framingham Estimated Lifetime Risks for Alzheimer's by Age and Sex



Created from data from Seshadri et al.[7]

figure 3: Projected Changes Between 2000 and 2025 in Alzheimer Prevalence by State



Created from data from Hebert et al.[72], A10

Although the projected increases in the Northeast are not nearly as marked as those in other regions of the United States, it should be noted that this section of the country currently has a large proportion of people with Alzheimer's relative to other regions because this region already has a high proportion of people over age 65. The increasing number of people with Alzheimer's will have a marked impact on states' healthcare systems, not to mention families and caregivers.

Looking to the Future

The number of Americans surviving into their 80s and 90s and beyond is expected to grow dramatically due to advances in medicine and medical technology, as well as social and environmental conditions.[73] Additionally, a very large segment of the American population — the baby boom generation — is reaching retirement age. In fact, the first baby boomers are reaching age 65 this year.

By 2030, the segment of the U.S. population aged 65 years and older is expected to double, and the estimated 71 million older Americans will make up approximately 20 percent of the total population.[74]

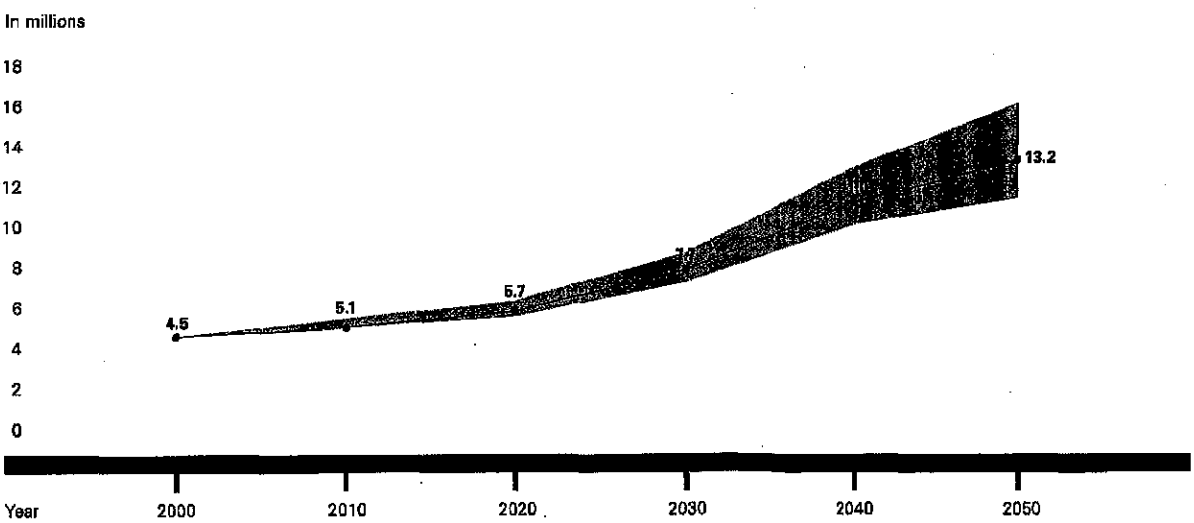
As the number of older Americans grows rapidly, so too will the numbers of new and existing cases of Alzheimer's disease and other dementias, as shown in Figure 4.[A11]

- In 2000, there were an estimated 411,000 new (incident) cases of Alzheimer's disease. For 2010, that number was estimated to be 454,000 (a 10 percent increase); by 2030, it is projected to be 615,000 (50 percent increase from 2000); and by 2050, 959,000 (130 percent increase from 2000).[69]
- By 2030, the number of people aged 65 and older with Alzheimer's disease is estimated to reach 7.7 million — a 50 percent increase from the 5.2 million aged 65 and older currently affected.[41]
- By 2050, the number of people aged 65 and older with Alzheimer's disease may triple, from 5.2 million to a projected 11 to 16 million, barring the development of medical breakthroughs to prevent or more effectively treat the disease.[41], [A11]

Longer life expectancies and aging baby boomers will also increase the numbers and percentages of Americans who will be among the oldest-old. Between 2010 and 2050, the oldest-old are expected to increase from 15 percent of all older people in the United States to one in every four older Americans (24 percent).[73] This will result in an additional 15 million oldest-old people — individuals at high risk for developing Alzheimer's.[73]

- In 2010, an estimated 6 million Americans were 85 years and older; by 2050, that number will nearly quadruple to 21 million.[73]
- In 2010, the 85-years-and-older population included about 2.4 million people with Alzheimer's disease, or 47 percent of the Alzheimer population aged 65 and older.[41]
- When the first wave of baby boomers reaches age 85 years (2031), an estimated 3.5 million people aged 85 and older will have Alzheimer's.[41]

figure 4: Projected Numbers of People Aged 65 and Over in the U.S. Population with Alzheimer's Disease (in Millions) Using the U.S. Census Bureau Estimates of Population Growth*



*Numbers indicate middle estimates per decade. Colored areas indicate low and high estimates per decade.

Created from data from Hebert et al 2003.[41], [A11]

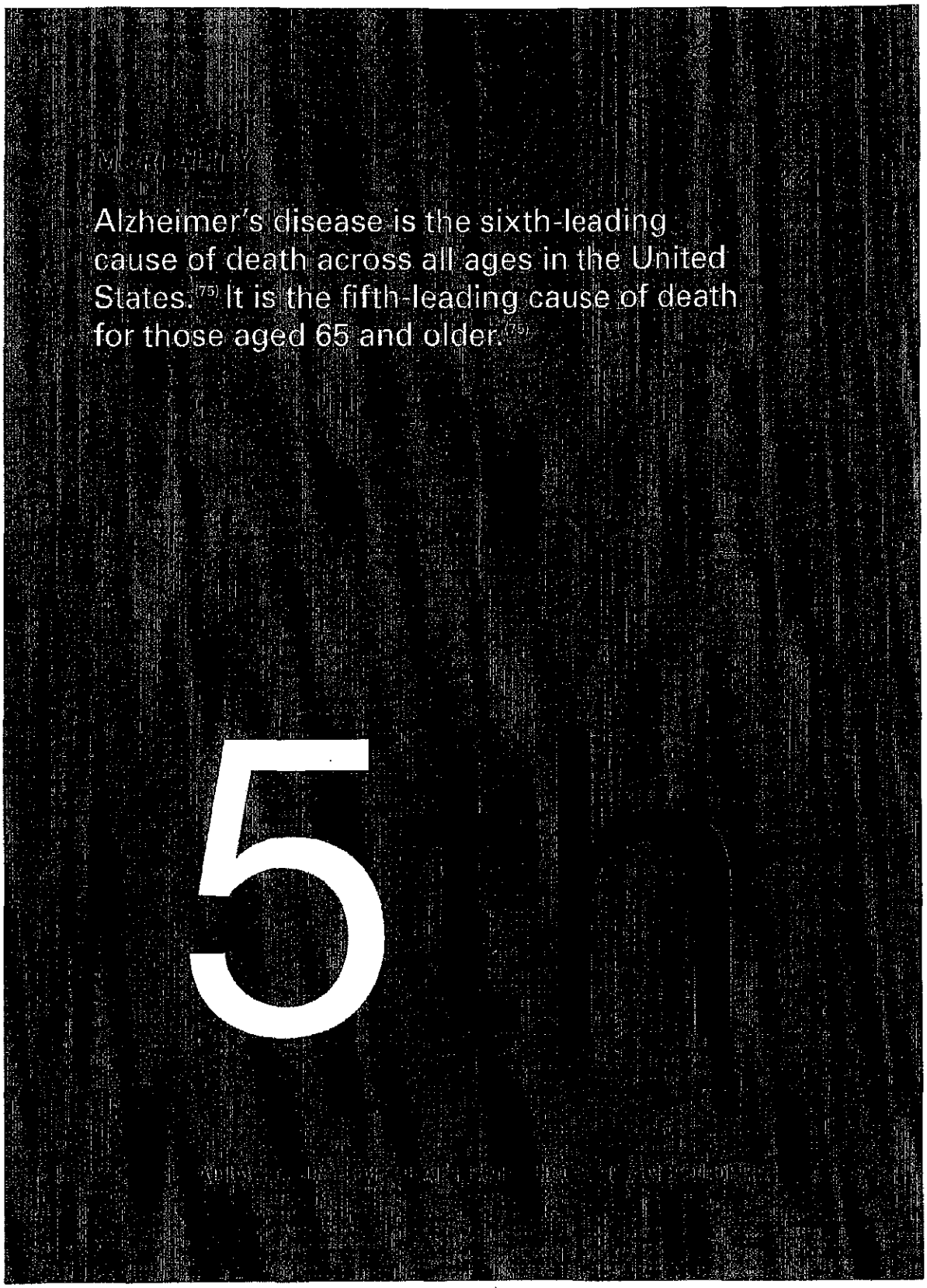
table 2: Projections by State for Total Numbers of Americans Aged 65 and Older with Alzheimer's

State	Projected Total Numbers (in 1,000s) with Alzheimer's			Percentage Change in Alzheimer's (Compared to 2000)	
	2000	2010	2025	2010	2025
Alabama	84.0	91.0	110.0	8	31
Alaska	3.4	5.0	7.7	47	126
Arizone	78.0	97.0	130.0	24	67
Arkansas	56.0	60.0	76.0	7	36
California	480.0	480.0	660.0	0	50
Colorado	49.0	72.0	110.0	47	124
Connecticut	66.0	70.0	76.0	6	15
Delaware	12.0	14.0	16.0	17	33
District of Columbia	10.0	9.0	10.0	-10	0
Florida	360.0	450.0	590.0	25	64
Georgia	110.0	120.0	160.0	9	45
Hawaii	23.0	27.0	34.0	17	48
Idaho	19.0	26.0	38.0	37	100
Illinois	210.0	210.0	240.0	0	14
Indiana	100.0	120.0	130.0	20	30
Iowa	65.0	69.0	77.0	6	18
Kansas	60.0	59.0	62.0	-2	3
Kentucky	74.0	80.0	97.0	8	31
Louisiana	79.0	86.0	100.0	9	27
Maine	25.0	25.0	28.0	0	12
Maryland	78.0	86.0	100.0	10	28
Massachusetts	120.0	120.0	140.0	0	17
Michigan	170.0	180.0	190.0	6	12
Minnesota	88.0	94.0	110.0	7	25
Mississippi	51.0	53.0	65.0	4	27
Missouri	110.0	110.0	130.0	0	18
Montana	16.0	21.0	29.0	31	81
Nebraska	33.0	37.0	44.0	12	33
Nevada	21.0	29.0	42.0	38	100
New Hampshire	19.0	22.0	26.0	16	37
New Jersey	150.0	150.0	170.0	0	13

table 2 (continued)

State	Projected Total Numbers (in 1,000s) with Alzheimer's			Percentage Change in Alzheimer's (Compared to 2000)	
	2000	2010	2025	2010	2025
New Mexico	27.0	31.0	43.0	15	59
New York	330.0	320.0	350.0	-3	6
North Carolina	130.0	170.0	210.0	31	62
North Dakota	16.0	18.0	20.0	13	25
Ohio	200.0	230.0	260.0	15	29
Oklahoma	62.0	74.0	96.0	19	55
Oregon	57.0	76.0	110.0	33	93
Pennsylvania	280.0	280.0	280.0	0	0
Rhode Island	24.0	24.0	24.0	0	0
South Carolina	67.0	80.0	100.0	19	49
South Dakota	17.0	19.0	24.0	12	41
Tennessee	100.0	120.0	140.0	20	40
Texas	270.0	340.0	470.0	26	74
Utah	22.0	32.0	50.0	45	127
Vermont	10.0	11.0	13.0	10	30
Virginia	100.0	130.0	160.0	30	60
Washington	85.0	110.0	150.0	33	76
West Virginia	40.0	44.0	50.0	10	25
Wisconsin	100.0	110.0	130.0	10	30
Wyoming	7.0	10.0	15.0	43	114

Created from data from Hebert et al.[72], A10


MORTALITY
Alzheimer's disease is the sixth-leading cause of death across all ages in the United States.[75] It is the fifth-leading cause of death for those aged 65 and older.[75]
5

In 2008, based on preliminary data from the National Center for Health Statistics, Alzheimer's was reported as the underlying cause of death for 82,476 people.[75] However, as discussed in the Special Report, Alzheimer's disease was often not listed as an underlying cause of death in those who had the condition.[76-78] Thus, Alzheimer's disease may be the cause of death or a contributing cause of death for even more Americans than indicated by official government data.

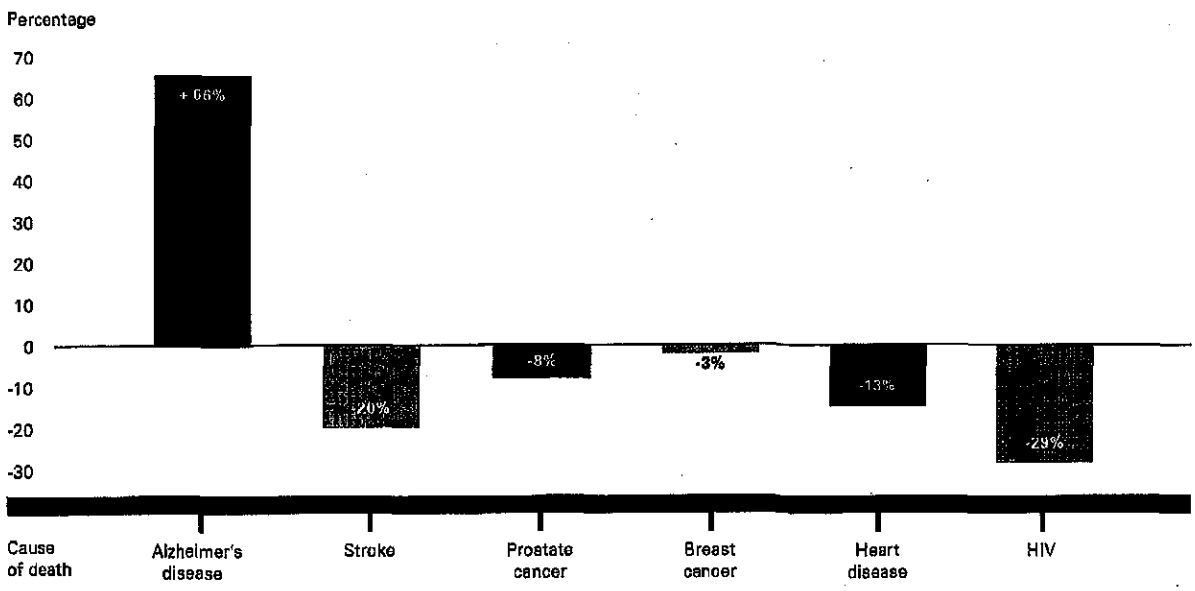
Deaths from Alzheimer's Disease

Alzheimer's is becoming a more common cause of death as the populations of the United States and other countries age. While other major causes of death continue to experience significant declines, those from Alzheimer's disease have continued to rise. Between 2000 and 2008 (preliminary data), deaths attributed to Alzheimer's disease increased 66 percent, while those attributed to the number one cause of death, heart disease, decreased 13 percent (Figure 5).[76,80]

The increase in the number and proportion of death certificates listing Alzheimer's reflects both changes in patterns of reporting deaths on death certificates over time as well as an increase in the actual number of deaths attributable to Alzheimer's.

The different ways in which dementia eventually ends in death can create ambiguity about the underlying cause of death. Severe dementia frequently causes such complications as immobility, swallowing disorders and malnutrition. These complications can significantly increase the risk of developing pneumonia, which has been found in several studies to be the most commonly identified cause of death among elderly people with Alzheimer's disease and other dementias. The situation has been described as a "blurred distinction between death *with* dementia and death *from* dementia."[81] Regardless of the cause of death, 61 percent of people with Alzheimer's at age 70 are expected to die before age 80 compared with 30 percent of people at age 70 without Alzheimer's.[82]

figure 5: Percentage Changes in Selected Causes of Death (All Ages) Between 2000[a] and 2008[b]



a National Center for Health Statistics. *Deaths: Final Data for 2000.*[80]
b National Center for Health Statistics. *Deaths: Preliminary Data for 2008.*[75]

table 3: Number of Deaths and Annual Mortality Rate (per 100,000) Due to Alzheimer's Disease by State, 2007

State	Number of Deaths	Rate	State	Number of Deaths	Rate
Alabama	1,614	32.8	Montana	260	27.1
Alaska	65	9.5	Nebraska	512	28.9
Arizona	2,051	32.4	Nevada	249	9.7
Arkansas	824	29.1	New Hampshire	418	31.8
California	8,497	23.2	New Jersey	1,825	21.0
Colorado	1,109	22.8	New Mexico	322	16.3
Connecticut	764	21.3	New York	992	10.4
Delaware	201	23.2	North Carolina	2,460	27.1
District of Columbia	140	25.8	North Dakota	395	61.7
Florida	4,644	25.4	Ohio	3,671	32.0
Georgia	1,849	19.4	Oklahoma	927	25.6
Hawaii	247	19.2	Oregon	1,200	32.0
Idaho	416	27.7	Pennsylvania	3,805	29.2
Illinois	2,734	21.3	Rhode Island	328	31.0
Indiana	1663	26.2	South Carolina	1,396	31.7
Iowa	1,202	40.2	South Dakota	346	43.5
Kansas	860	31.0	Tennessee	2,276	37.0
Kentucky	1,198	28.2	Texas	4,814	20.1
Louisiana	1,324	30.8	Utah	383	14.9
Maine	470	35.7	Vermont	205	33.0
Maryland	881	15.7	Virginia	1,793	22
Massachusetts	1,695	26.3	Washington	2,689	41.6
Michigan	2,432	24.4	West Virginia	532	29.5
Minnesota	1,179	22.7	Wisconsin	1,658	29.6
Mississippi	797	27.3	Wyoming	110	21.1
Missouri	1,681	28.6	**U.S. Total**	**74,632**	**24.7**

Created from data from Xu et al.[83]

State-by-State Deaths from Alzheimer's Disease

Table 3 provides information on the number of deaths due to Alzheimer's by state in 2007. (State-by-state death data by specific cause of death were not included in the preliminary data for 2008.) The information was obtained from death certificates and reflects the underlying cause of death, as defined by the World Health Organization: "the disease or injury which initiated the train of events leading directly to death."[83] The table also provides annual mortality rates by state in order to compare the risk of death due to Alzheimer's disease across states with varying population sizes. For the United States as a whole, in 2007, the mortality rate for Alzheimer's disease was 24.7 deaths per 100,000 people. Based on the preliminary data for 2008, the U.S. rate increased to 27.1 per 100,000.

Death Rates by Age

Although people younger than 65 can develop and die from Alzheimer's disease, the highest risk of death from Alzheimer's is in people aged 65 or older. As seen in Table 4, death rates for Alzheimer's increase dramatically with age. To put these age-related differences into perspective, in the United States in 2007 (the most recent data available), compared with people aged 65 to 74, the total mortality rates from all causes of death was 2.5 times as high for those aged 75 to 84 and 6.4 times as high for those aged 85 and older. For diseases of the heart, mortality rates were 2.8 times and 9.2 times as high, respectively. For all cancers, mortality rates were 1.8 times as high and 2.2 times as high, respectively. In contrast, Alzheimer's disease death rates were 8.6 times as high for people aged 75 to 84 and 41.2 times as high for people 85 and older compared with people aged 65 to 74.[83] This large age-related increase in death rates due to Alzheimer's underscores the lack of a cure or effective treatments for the disease.

table 4: U.S. Alzheimer Death Rates (per 100,000) by Age, 2000, 2004 and 2007

Age	2000	2004	2007
45–54	0.2	0.2	0.2
55–64	2.0	1.9	2.2
65–74	12.7	19.7	20.6
75–84	139.6	168.7	176.7
85+	1,166.7	918.8	849.1
Total*	17.6	22.5	24.7

*Reflects average death rate for ages 45 and older.
Created from data from Xu et al.[83]

Duration of Illness from Diagnosis to Death

Studies indicate that people 65 and older survive an average of four to eight years after a diagnosis of Alzheimer's disease, yet some live as long as 20 years with Alzheimer's.[84-88] This indicates the slow, insidious nature of the progression of Alzheimer's, with loss of memory and thinking abilities, as well as loss of independence over the duration of the illness. On average, a person with Alzheimer's will spend more years (40 percent of the total number of years with Alzheimer's) in the most severe stage of the disease than in any other stage.[82] And much of this time will be spent in a nursing home, as nursing home admission by the age of 80 is expected for 75 percent of people with Alzheimer's compared with only 4 percent of the general population.[82] In all, an estimated two-thirds of those dying of dementia do so in nursing homes, compared with 20 percent of cancer patients and 28 percent of people dying from all other conditions.[89] Thus, in addition to Alzheimer's being the sixth-leading cause of death, the long duration of illness may be an equally telling statistic of the public health impact of Alzheimer's disease.

As the number of people with Alzheimer's disease and other dementias grows in the future, aggregate payments for their care will increase dramatically.

1.1 TRILLION

For people with Alzheimer's disease and other dementias, aggregate payments for health care, long-term care and hospice are projected to increase from $183 billion in 2011 to $1.1 trillion in 2050 (in 2011 dollars). Medicare and Medicaid cover about 70 percent of the costs of care. This section describes the use and costs of health care, long-term care and hospice by people with Alzheimer's disease and other dementias. All costs are reported in 2010 dollars,[A18] unless otherwise indicated.

Total Payments for Health Care, Long-Term Care and Hospice

Table 7 reports the average per person payments for healthcare and long-term care services for Medicare beneficiaries with Alzheimer's disease or other dementia. In 2004, total per person payments from all sources for health care and long-term care for Medicare beneficiaries with Alzheimer's disease or other dementia were three times as great as payments for other Medicare beneficiaries in the same age group ($42,072 per person for those with Alzheimer's disease or other dementia compared with $13,515 per person for those without these conditions, in 2010 dollars).[126], [A19]

Most older people with Alzheimer's disease and other dementias have Medicare,[A20] and their high use of hospital and other healthcare services translates into high costs for Medicare. In 2004, Medicare payments per person for beneficiaries aged 65 and older with Alzheimer's and other dementias were almost three times as high as average Medicare payments for other Medicare beneficiaries in the same age group.[125]

Twenty-two percent of older people with Alzheimer's disease and other dementias who have Medicare also have Medicaid coverage.[125] Medicaid pays for nursing home and other long-term care services for some people with very low income and low assets,[A21] and the high use of these services by people with Alzheimer's and other dementias translates into high

table 7: Average per Person Payments for Healthcare and Long-Term Care Services, Medicare Beneficiaries Aged 65 and Older, with and without Alzheimer's Disease or Other Dementia and by Place of Residence, 2004 Medicare Current Beneficiary Survey, 2010 Dollars

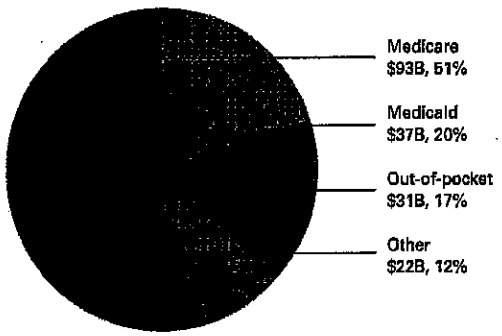
	Beneficiaries with Alzheimer's or Other Dementia by Place of Residence			Beneficiaries without Alzheimer's Disease or Other Dementia
	All	Community-Dwelling Beneficiaries	Facility-Dwelling Beneficiaries	
Medicare	$ 9,804	$ 6,189	$ 24,005	$ 5,720
Medicaid	8,419	895	19,772	915
Uncompensated	333	426	91	256
HMO	523	679	286	897
Private insurance	2,964	2,562	2,041	869
Other payer	662	237	1,301	269
Out-of-pocket	9,141	9,929	2,272	2,442
Total*	42,072	24,260	68,964	13,515

*Payments from sources do not equal total payments exactly due to the effect of population weighting. Payments for all beneficiaries with Alzheimer's disease or other dementia include payments for community-dwelling and facility-dwelling beneficiaries.

Created from data from Alzheimer's Association, *Characteristics, Costs and Health Service Use for Medicare Beneficiaries with a Dementia Diagnosis: Report 1: Medicare Current Beneficiary Survey, 2009.*[125]

figure 11: Aggregate Costs of Care by Payer for Americans Aged 65 and Older with Alzheimer's Disease and Other Dementias, 2011*

Total cost: $183 Billion



*Data are in 2011 dollars.

Source: Model developed by The Lewin Group for the Alzheimer's Association;[A22] B = billions. "Other" payment sources include private insurance, health maintenance organizations, other managed care organizations and uncompensated care.

costs for Medicaid. In 2004, Medicaid payments per person for Medicare beneficiaries aged 65 and older with Alzheimer's and other dementias were more than nine times as great as average Medicaid payments for other Medicare beneficiaries in the same age group ($8,419 per person for people with Alzheimer's disease and other dementias compared with $915 for people without these conditions, in 2010 dollars; Table 7).[126]

Based on a model developed for the Alzheimer's Association by The Lewin Group using the average per person payments from all sources for health care for people aged 65 and older with Alzheimer's disease and other dementias and The Lewin Group's Long-Term Care Financing Model, total payments for 2011 are estimated at $183 billion, including $130 billion for Medicare and Medicaid combined (in 2011 dollars, Figure 11).[A22]

Use and Costs of Healthcare Services

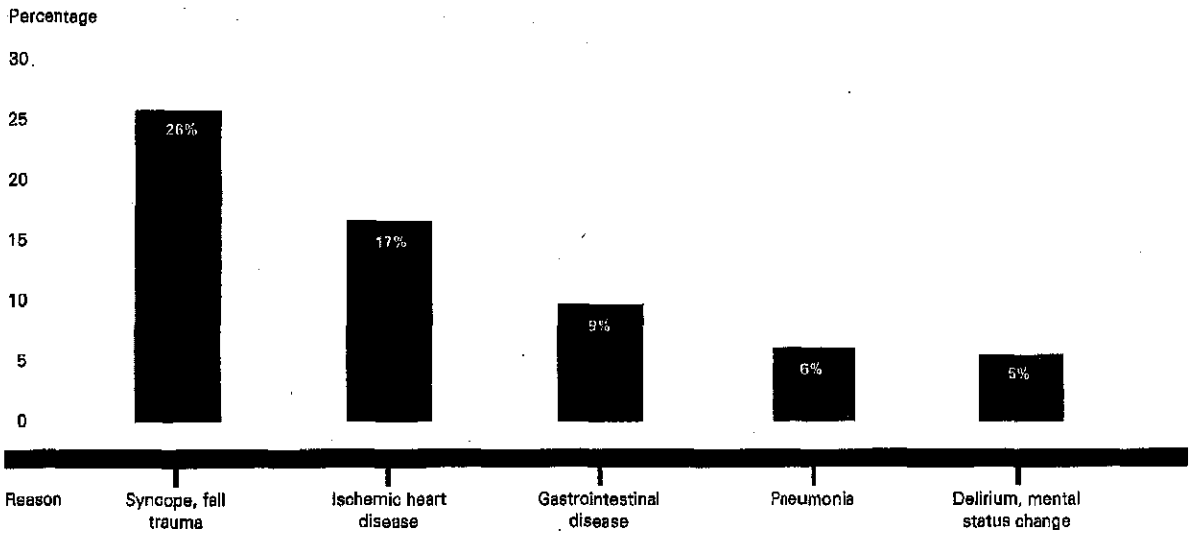
People with Alzheimer's disease and other dementias have three times as many hospital stays as other older people.[126] Moreover, use of healthcare services for people with other serious medical conditions is strongly affected by the presence or absence of Alzheimer's and other dementias. In particular, people with coronary heart disease, diabetes, congestive heart failure and cancer who *also* have Alzheimer's and other dementias have higher use and costs of healthcare services than do people with these medical conditions but no coexisting Alzheimer's or other dementia.

Use of Healthcare Services by Setting

Older people with Alzheimer's disease and other dementias have more hospital stays, skilled nursing home stays and home healthcare visits than other older people.

- *Hospital.* In 2004, there were 828 hospital stays per 1,000 Medicare beneficiaries aged 65 and older with Alzheimer's disease or other dementia compared with 266 hospital stays per 1,000 Medicare beneficiaries without these conditions.[125] At any point in time, about one-quarter of all hospital patients aged 65 and older are people with Alzheimer's and other dementias.[126] The most common reasons for hospitalization of people with Alzheimer's disease include syncope, fall and trauma (26 percent), ischemic heart disease (17 percent) and gastrointestinal disease (9 percent) (Figure 12).[127]
- *Skilled nursing facility.* In 2004, there were 319 skilled nursing facility stays per 1,000 beneficiaries with Alzheimer's and other dementias compared with 39 stays per 1,000 beneficiaries for people without these conditions.[125]
- *Home health care.* In 2004, one-quarter of Medicare beneficiaries aged 65 and older who received Medicare-covered home healthcare services were people with Alzheimer's and other dementias.[128]

figure 12: Reasons for Hospitalization by People with Alzheimer's Disease: Percentage of Hospitalized People by Admitting Diagnosis



Created from data from Rudolph et al.[127]

Costs of Healthcare Services by Setting

In 2004, average per person payments from all sources for healthcare services, including hospital, physician and other medical provider, skilled nursing facility, home health care and prescription medications, were higher for Medicare beneficiaries aged 65 and older with Alzheimer's and other dementias than for other Medicare beneficiaries in the same age group (Table 8).

Impact of Coexisting Medical Conditions on Use and Costs of Healthcare Services

Ninety-five percent of all Medicare beneficiaries have at least one coexisting medical condition.[128] Table 9 reports the proportion of people with Alzheimer's disease or other dementia with certain coexisting medical conditions. In 2004, 26 percent of Medicare beneficiaries aged 65 and older with Alzheimer's disease and other dementias also had coronary heart disease; 23 percent also had diabetes; 16 percent also had congestive heart failure; 13 percent also had cancer; and 8 percent also had Parkinson's disease.[125]

People with serious medical conditions and Alzheimer's or other dementia are more likely to be hospitalized than people with the same serious medical conditions but no Alzheimer's or other dementia (Figure 13). They also have longer hospital stays.

Similarly, average per person payments for many healthcare services are also higher for people who have other serious medical conditions and Alzheimer's or other dementia than for people who have the other serious medical conditions but no dementia. Table 10 shows the average per person total Medicare payments and average per person Medicare payments for hospital, physician, skilled nursing facility and home health care for beneficiaries with other serious medical conditions who either do or do not have Alzheimer's or other dementia.[130] Medicare beneficiaries with a serious medical condition and Alzheimer's or other dementia had higher average per person payments

table 8: Average per Person Payments, from All Sources, for Healthcare Services Provided to Medicare Beneficiaries Aged 65 and Older with or without Alzheimer's Disease or Other Dementia, 2004 Medicare Beneficiary Survey, in 2010 Dollars

	Beneficiaries with Alzheimer's Disease or Other Dementia	Beneficiaries without Alzheimer's Disease or Other Dementia
Hospital	5,976	5,184
Medical provider*	5,551	3,948
Skilled nursing facility	3,862	1,247
Home health care	1,601	359
Prescription medications**	3,198	2,209

*"Medical provider" includes physician, other medical provider and laboratory services, and medical equipment and supplies.
**Information on payments for prescription drugs is only available for people who were living in the community, that is, not in a nursing home or assisted living facility.

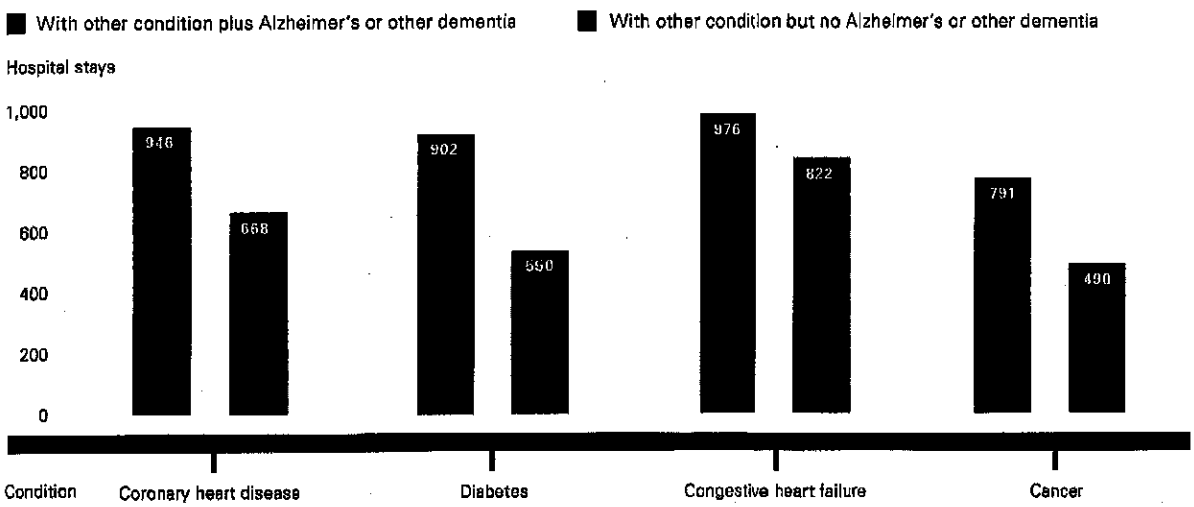
Created from data from Alzheimer's Association, *Characteristics, Costs and Health Service Use for Medicare Beneficiaries with a Dementia Diagnosis: Report 1: Medicare Current Beneficiary Survey, 2009.*[123]

table 9: Percentages of Medicare Beneficiaries Aged 65 and Older with Alzheimer's Disease and Other Dementias by Specified Coexisting Medical Conditions, 2004 Medicare Current Beneficiary Survey

Coexisting Condition	Percentage with Alzheimer's or Other Dementia and the Coexisting Condition
Hypertension	60%
Coronary heart disease	26%
Stroke or its effects	25%
Diabetes	23%
Osteoporosis	18%
Congestive heart failure	16%
Chronic obstructive pulmonary disease	15%
Cancer	13%
Parkinson's disease	5%

Created from data from Alzheimer's Association, *Characteristics, Costs and Health Service Use for Medicare Beneficiaries with a Dementia Diagnosis: Report 1: Medicare Current Beneficiary Survey, 2009.*[125]

figure 13: Hospital Stays per 1,000 Medicare Beneficiaries Aged 65 and Older with Selected Medical Conditions by Presence or Absence of Alzheimer's Disease and Other Dementias, 2006



Created from data from Alzheimer's Association, *Characteristics, Costs and Health Service Use for Medicare Beneficiaries with a Dementia Diagnosis: Report 2: National 20% Sample Medicare Fee-for-Service Beneficiaries, 2008.*[120]

table 10: Average per Person Payments by Type of Service and Medical Condition for Medicare Beneficiaries with or without Alzheimer's Disease and Other Dementias, 2006 Medicare Claims, in 2010 Dollars*

Selected Medical Condition by Alzheimer's Disease/ Dementia (AD/D) Status	Average per Person Medicare Payment				
	Total Payment	Payment for Hospital Care	Payment for Physician Care	Payment for Skilled Nursing Facility Care	Payment for Home Health Care
Coronary Heart Disease					
With AD/D	$24,275	$9,752	$1,690	$3,587	$1,748
Without AD/D	17,102	7,601	1,462	1,124	868
Diabetes					
With AD/D	24,129	9,417	1,598	3,586	1,928
Without AD/D	15,162	6,279	1,277	1,078	884
Congestive Heart Failure					
With AD/D	24,900	9,999	1,663	3,740	1,756
Without AD/D	20,722	9,384	1,696	1,663	1,198
Cancer					
With AD/D	21,933	8,110	1,503	2,905	1,498
Without AD/D	15,887	5,637	1,293	822	583

*This table does not include payments for all kinds of Medicare services, and as a result the average per person payments for specific Medicare services do not sum to the total per person Medicare payments.

Created from data from Alzheimer's Association, *Characteristics, Costs and Health Service Use for Medicare Beneficiaries with a Dementia Diagnosis: Report 2: National 20% Sample Medicare Fee-for-Service Beneficiaries, 2009.*[130, A23]

than Medicare beneficiaries with the same medical condition but no Alzheimer's or other dementia, with one exception (payments for physician care for people with congestive heart failure).

Use and Costs of Long-Term Care Services

Seventy percent of people with Alzheimer's disease and other dementias live at home, usually with help from family and friends.[131] As their dementia progresses, they generally receive more and more care from family and other unpaid caregivers.[78] Many people with Alzheimer's and other dementias also receive paid services at home; in adult day centers, assisted living facilities or nursing homes; or in more than one of these settings at different times in the often long course of their illness. Given the high average costs of these services (e.g., adult day center services; $69 per day;[132] assisted living, $38,596 per year;[132] and nursing home care, $74,239–$82,113 per year,[132] in 2010 dollars), most people with Alzheimer's and other dementias and their families cannot afford them for long. Medicaid is the only federal program that will cover the long nursing home stays that most people with dementia require in the late stages of their illness, but Medicaid requires beneficiaries to be poor to receive coverage. The Affordable Care Act (the national healthcare reform law enacted in 2010) includes a new voluntary insurance program, known as the CLASS Act, to help pay for long-term care and support services, including some nursing home costs. Benefits will not be payable until 2018, however, and

like private long-term care insurance, the program requires individuals to sign up for the insurance with their employer before they develop dementia.

Use of Long-Term Care Services by Setting

Most people with Alzheimer's disease and other dementias who live at home receive unpaid help from family members and friends, but some also receive paid home and community-based services, such as personal care and adult day center care. A study of older people who needed help to perform daily activities, such as dressing, bathing, shopping and managing money, found that those who also had cognitive impairment were more than twice as likely as those who did not have cognitive impairment to receive paid home care.[133] In addition, those who had cognitive impairment and received paid services used almost twice as many hours of care monthly as those who did not have cognitive impairment.[133]

People with Alzheimer's and other dementias make up a large proportion of all elderly people who receive nonmedical home care, adult day center services and assisted living and nursing home care.

- *Home care.* More than one-third (about 37 percent) of older people who receive primarily nonmedical home care services, such as personal care and homemaker services, through state home care programs in Connecticut, Florida and Michigan have cognitive impairment consistent with dementia.[134-136]
- *Adult day center services.* At least half of elderly adult day center participants have Alzheimer's disease or other dementia.[137-138]
- *Assisted living care.* Estimates from various studies indicate that 45 to 67 percent of residents of assisted living facilities have Alzheimer's disease or other dementia.[125, 139]
- *Nursing home care.* In 2008, 68 percent of all nursing home residents had some degree of cognitive impairment, including 27 percent who had mild cognitive impairment and 41 percent who had moderate to severe cognitive impairment (Table 11).[140] In June 2010, 47 percent of all nursing home residents had a diagnosis of Alzheimer's or other dementia in their nursing home record.[141]
- *Alzheimer special care unit.* Nursing homes had a total of 82,586 beds in Alzheimer special care units in June 2010.[142-143] These Alzheimer special care unit beds accounted for 73 percent of all special care unit beds and 5 percent of all nursing home beds at that time. The number of nursing home beds in Alzheimer special care units increased in the 1980s but has decreased since 2004, when there were 93,763 beds in such units.[144] Since almost half of nursing home residents have Alzheimer's or other dementia, and only 5 percent of nursing home beds are in Alzheimer special care units, it is clear that the great majority of nursing home residents with Alzheimer's and other dementias are not in Alzheimer special care units.

Costs of Long-Term Care Services by Setting

Costs are high for care at home or in an adult day center, assisted living facility or nursing home. The following estimates are for all service users and apply to people with Alzheimer's and other dementias as well as other users of these services. The only exception is the cost of Alzheimer special care units in nursing homes, which only applies to the people with Alzheimer's and other dementias who are in these units.

- *Home care.* In 2009, the average cost for nonmedical home care, including personal care and homemaker services, was $20 per hour or $160 for an eight-hour day.[132]

table 11: Cognitive Impairment in Nursing Home Residents by State, 2008*

State	Total Nursing Home Residents*	Percentage of Residents at Each Level of Cognitive Impairment**		
		None	Very Mild/ Mild	Moderate/ Severe
Alabama	51,482	28	27	45
Alaska	1,291	31	28	41
Arizona	41,443	46	25	29
Arkansas	34,114	24	29	47
California	256,863	35	26	39
Colorado	40,195	31	30	39
Connecticut	60,269	38	26	36
Delaware	9,716	35	27	38
District of Columbia	5,176	37	23	40
Florida	208,486	40	23	37
Georgia	66,743	16	23	61
Hawaii	8,631	27	23	51
Idaho	12,296	31	28	41
Illinois	170,454	29	32	39
Indiana	85,600	36	27	37
Iowa	49,620	22	30	47
Kansas	36,106	23	31	46
Kentucky	51,147	31	24	45
Louisiana	43,506	24	27	49
Maine	18,434	35	25	40
Maryland	65,573	40	23	37
Massachusetts	103,502	35	24	42
Michigan	102,649	32	26	42
Minnesota	71,003	30	30	40
Mississippi	28,567	23	28	49
Missouri	79,422	30	31	39
Montana	11,283	25	30	45
Nebraska	27,381	27	30	43
Nevada	13,072	41	26	33
New Hampshire	15,867	33	24	43
New Jersey	119,505	42	24	34
New Mexico	13,116	30	28	43

table 11 (continued): Cognitive Impairment in Nursing Home Residents by State, 2008*

State	Total Nursing Home Residents*	Percentage of Residents at Each Level of Cognitive Impairment**		
		None	Very Mild/ Mild	Moderate/ Severe
New York	229,569	35	26	40
North Carolina	89,223	34	24	42
North Dakota	10,594	21	31	48
Ohio	191,179	30	27	43
Oklahoma	37,668	30	30	40
Oregon	27,336	35	29	36
Pennsylvania	185,933	32	27	41
Rhode Island	17,242	32	28	40
South Carolina	38,530	29	23	49
South Dakota	11,372	20	30	49
Tennessee	70,494	26	27	48
Texas	189,553	24	32	45
Utah	17,743	38	28	34
Vermont	6,912	29	25	46
Virginia	72,214	33	26	41
Washington	56,775	32	29	39
West Virginia	22,104	36	22	42
Wisconsin	74,358	35	28	38
Wyoming	4,828	20	29	52
U.S. Total	**3,261,183**	**32**	**27**	**41**

*These figures include all individuals who spent any time in a nursing home in 2008.
**Percentages for each state may not sum to 100 percent because of rounding.

Created from data from U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. *Nursing Home Data Compendium*, 2009 Edition.[140]

- *Adult day center services.* In 2009, the average cost of adult day services was $69 per day.[132] Ninety-five percent of adult day centers provided care for people with Alzheimer's and other dementias, and 2 percent of these centers charged an additional fee for these clients.
- *Assisted living facility.* In 2009, the average cost for basic services in an assisted living facility was $3,216 per month, or $38,596 per year.[132] Fifty-nine percent of assisted living facilities provided specialized Alzheimer and dementia care and charged an average of $4,556 per month, or $54,670 per year, for this care. (Differences between the per year totals and the multiplying of per month figures by 12 are the result of rounding.)
- *Nursing home.* In 2009, the average cost for a private room in a nursing home was $225 per day, or $82,113 per year. The average cost of a semi-private room in a nursing home was $203 per day, or $74,239 per year.[132] Twenty-nine percent of nursing homes had separate Alzheimer special care units. The average cost for a private room in an Alzheimer special care unit was $239 per day, or $87,362 per year, and the average cost for a semi-private room was $214 per day, or $77,998 per year.[132] (Differences between the per year totals and the multiplying of per day figures by 365 are the result of rounding.)

Affordability of Long-Term Care Services

Few individuals with Alzheimer's disease or other dementia and their families either have sufficient long-term care insurance or can afford to pay out-of-pocket for long-term care services for as long as the services are needed.

- Income and asset data are not available for people with Alzheimer's or other dementia specifically, but 47 percent of people aged 65 and older had incomes less than 200 percent of the federal poverty level in 2009 (200 percent of the federal poverty level was $21,660 for a household of one in 2010).[148] Even for older people with higher incomes, the costs of home care, adult day center services, assisted living care or nursing home care can quickly exceed their income.
- In 2005, 65 percent of older people living in the community, and 84 percent of those at high risk of needing nursing home care, had assets that would pay for less than a year in a nursing home.[146] Fifty-seven percent of older people in the community and 75 percent of those at high risk of needing nursing home care did not have enough assets to cover even a month in a nursing home.[146]

Long-Term Care Insurance

In 2007, about 8 million people had long-term care insurance policies, which paid out $3.9 billion (in 2010 dollars) for services for those who filed claims in that year.[147] Private health and long-term care insurance policies funded only about 9 percent of total long-term care spending in 2006, representing $18.7 billion of the $207.6 billion (in 2010 dollars) in long-term care spending.[148] However, long-term care insurance plays a significant role in paying for the care of people with dementia who purchase policies before developing the disease.

Medicaid Costs

Medicaid covers nursing home care and other long-term care services in the community for individuals who meet program requirements for level of care, income and assets. To receive coverage, beneficiaries must have low incomes or be poor due to their expenditures on these services. Most nursing home residents who qualify for Medicaid must spend all of their Social Security checks and any other monthly income, except for a very small personal needs allowance, to pay for nursing home care. Medicaid only makes up the difference if the nursing home resident cannot pay the full cost of care or has a financially dependent spouse.

The federal government and the states share in managing and funding the program, and states differ greatly in the services covered by their Medicaid programs. Medicaid plays a critical role for people with dementia who can no longer afford to pay for their long-term care expenses on their own. In 2008, Medicaid spending on institutional care accounted for 58 percent of its long-term care expenditures, and spending on home and community-based services accounted for the remaining 42 percent of expenditures.[148]

Total Medicaid spending for people with Alzheimer's disease and other dementias is projected to be $37 billion in 2011.[A22] About half of all Medicaid beneficiaries with Alzheimer's disease and other dementias are nursing home residents, and the rest live in the community.[131] Among nursing home residents with Alzheimer's disease and other dementias, 51 percent relied on Medicaid to help pay for their nursing home care.[131]

In 2004, total per person Medicaid payments for Medicare beneficiaries aged 65 and older with Alzheimer's and other dementias were nine times as high as Medicaid payments for other Medicare beneficiaries aged 65 and older without the disease. Much of the difference in Medicaid payments for beneficiaries with Alzheimer's and other dementias is due to the costs associated with long-term care (i.e., nursing homes and other residential care facilities, such as assisted living facilities). Medicaid paid $19,772 (in 2010 dollars) per person for Medicare beneficiaries with a diagnosis of Alzheimer's disease and other dementias living in a long-term care facility compared with $895 for those with the diagnosis living in the community (Table 7, page 35).[125]

Out-of-Pocket Costs for Healthcare and Long-Term Care Services

Although Medicare, Medicaid and other sources such as the Veterans Health Administration and private insurance pay for most hospital and other healthcare services and some long-term care services for older people with Alzheimer's and other dementias, individuals and their families still incur high out-of-pocket costs. These costs are for Medicare and other health insurance premiums, deductibles and copayments and for healthcare and long-term care services that are not covered by Medicare, Medicaid or other sources.

In 2004, Medicare beneficiaries aged 65 and older with Alzheimer's disease and other dementias had average annual per person out-of-pocket costs totaling $3,141 for healthcare and long-term care services that were not covered by other sources (Table 7, page 35).[125] Average per person out-of-pocket costs were highest for people with Alzheimer's and other dementias who were living in nursing homes and assisted living facilities ($21,272 per person). Out-of-pocket costs for people aged 65 and older with Alzheimer's and other dementias who were living in the community were 20 percent higher ($2,929 per person) than the average costs for all other Medicare beneficiaries in that age group ($2,442 per person).[126]

Before the implementation of the Medicare Part D Prescription Drug Benefit in 2006, out-of pocket expenses were increasing annually for Medicare beneficiaries.[149] In 2003, out-of-pocket costs for prescription medications accounted for about one-quarter of total out-of-pocket costs for all Medicare beneficiaries aged 65 and older.[150] Other important components of out-of-pocket costs were premiums for Medicare and private insurance (45 percent) and payments for hospital, physician and other healthcare services that were not covered by other sources (31 percent). The Medicare Part D Prescription Drug Benefit has helped to reduce out-of-pocket costs for prescription drugs for many Medicare beneficiaries, including beneficiaries with Alzheimer's and other dementias.[151] Sixty percent of all Medicare beneficiaries were enrolled in a Medicare Part D plan in 2010, and the average monthly premium for Medicare Part D is $40.72 in 2011 (range: $14.80 to $133.40).[152] Clearly, however, the biggest component of out-of-pocket costs for people with Alzheimer's and other dementias is nursing home and other residential care, and out-of-pocket costs for these services are likely to continue to grow over time.

Use and Costs of Hospice Care

Hospices provide medical care, pain management and emotional and spiritual support for people who are dying, including people with Alzheimer's disease and other dementias. Hospices also provide emotional and spiritual support and bereavement services for families of people who are dying. The main purpose of hospice care is to allow individuals to die with dignity and without pain and other distressing symptoms that often accompany terminal illness. Individuals can receive hospice care in their homes, assisted living residences or nursing homes. Medicare is the primary source of payment for hospice care, but private insurance, Medicaid and other sources also pay for hospice care.

Use of Hospice Services

In 2008, 6 percent of all people admitted to hospices in the United States had a primary hospice diagnosis of Alzheimer's disease (60,488 people).[153] An additional 11 percent of all people admitted to hospices in the United States had a primary hospice diagnosis of non-Alzheimer's dementia (113,204 people). Hospice length of stay has increased over the past decade. The average length of stay for hospice beneficiaries with a primary hospice diagnosis of Alzheimer's disease increased from 67 days in 1998 to 105 days in 2008.[153] The average length of stay for hospice beneficiaries with a primary diagnosis of non-Alzheimer dementia increased from 57 days in 1998 to 89 days in 2008.

Costs of Hospice Services

In 2004, hospice care payments from all sources for Medicare beneficiaries aged 65 and older with Alzheimer's and other dementias totaled $3.6 billion (in 2010 dollars).[125] Average per person hospice care payments for these beneficiaries were eight times as much as payments for other Medicare beneficiaries in the same age group ($1,244 per person compared with $153 per person).[125]

Projections for the Future

Total payments for healthcare, long-term care and hospice for people with Alzheimer's disease and other dementias are projected to increase from $183 billion in 2011 to $1.1 trillion in 2050 (in 2011 dollars). This dramatic rise includes a 7-fold increase in Medicare payments and a 5-fold increase in payments from Medicaid and out-of-pocket and other sources (i.e., private insurance, health maintenance organizations, other managed care organizations and uncompensated care).[154]

Medscape REFERENCE Drugs, Diseases & Procedures

Mental Disorders Secondary to General Medical Conditions

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Overview

Evaluation of patients who present to hospitals or physicians with altered behavior and/or mentation can be time-consuming and difficult and may lead to symptoms being quickly and prematurely dismissed as psychiatric in nature. According to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*), the psychiatric presentation of a medical illness is classified as "the presence of mental symptoms that are judged to be the direct physiological consequences of a general medical condition." Therefore, understanding common psychiatric symptoms and the medical diseases that may cause or mimic them is of utmost importance. Failure to identify these underlying causal medical conditions can be potentially dangerous because serious and frequently reversible conditions can be overlooked. Proper diagnosis of a psychiatric illness necessitates investigation of all appropriate medical causes of the symptoms.

The following features suggest a medical origin to psychiatric symptoms:

- Late onset of initial presentation
- Known underlying medical condition
- Atypical presentation of a specific psychiatric diagnosis
- Absence of personal and family history of psychiatric illnesses
- Illicit substance use
- Medication use
- Treatment resistance or unusual response to treatment
- Sudden onset of mental symptoms
- Abnormal vital signs
- Waxing and waning mental status

Because multiple secondary causes of mental disorders exist, as shown in the Table, this article discusses only the most common causes.

Table. Medical Disorders that can Induce Psychiatric Symptoms* (Open Table in a new window)

Medical and Toxic Effects	CNS	Infectious	Metabolic/Endocrine	Cardiopulmonary	Other
• Alcohol • Cocaine • Marijuana • Phencyclidine (PCP) • Lysergic acid diethylamide (LSD) • Heroin • Amphetamines • Jimson weed • Gamma-hydroxybutyrate (GHB) • Benzodiazepines • Prescription drugs	• Subdural hematoma • Tumor • Aneurysm • Severe hypertension • Meningitis • Encephalitis • Normal pressure hydrocephalus • Seizure disorder • Multiple sclerosis	• Pneumonia • Urinary tract infection • Sepsis • Malaria • Legionnaire disease • Syphilis • Typhoid • Diphtheria • HIV • Rheumatic fever • Herpes	• Thyroid disorder • Adrenal disorder • Renal disorder • Hepatic disorder • Wilson disease • Hyperglycemia • Hypoglycemia • Vitamin deficiency • Electrolyte imbalances • Porphyria	• Myocardial infarction • Congestive heart failure • Hypoxia • Hypercarbia	• Systemic lupus erythematosus • Anemia • Vasculitis

*(Adapted from Williams E, Shepherd S. Medical clearance of psychiatric patients. *Emerg Med Clin North Am*. May 2000; 18:2; 193.)[1]

Case study

Mr. A was a 52-year-old gentleman with hypertension and alcohol dependence in complete remission who comes for an evaluation for first-time depressive symptoms and worsening memory. He reports that his symptoms began about 1 month ago prior to a fall in his home with a minor head injury that did not involve medical intervention. Symptoms experienced include decreased appetite, concentration, and insomnia. He also reports depressed mood and noticeable problems remembering simple things like phone numbers or location of keys. Physically he has no complaints except a subtle headache that doesn't seem to go away. How does one evaluate such a patient and what are the considerations?

Neurologic Disorders

Seizure disorder

Epilepsy is one of the most common chronic neurologic diseases, affecting approximately 1% of the US population. Approximately 30-50% of patients with a seizure disorder have psychiatric symptoms sometime during the course of their illness. Psychiatric symptoms can be viewed in the context of their time relationship with the seizures as preictal, ictal, postictal, and interictal. Two major categories of seizures are partial and generalized. Increased psychopathology has been associated with different features (eg, seizure phenomenology, brain pathology, antiepileptic drug use, psychosocial factors). Characteristics of the seizures and their presenting psychiatric symptoms deserve further attention.

Generalized seizures simultaneously involve both cerebral hemispheres, with classic symptoms of loss of consciousness, tonic-clonic movements or limbs, tongue biting, and incontinence. While the diagnosis is relatively straightforward, the postictal state is characterized by a gradual clearing of delirium lasting a few minutes to many hours.

Partial seizures have focal signs and symptoms resulting from electrical discharge in a limited site in one brain hemisphere. Simple partial seizures occur without any impairment of consciousness and usually stem from primary motor, sensory, or visual cortical regions. Complex partial seizures are associated with impairment of consciousness and usually originate from a focus in the temporal lobe. In such seizures, psychiatric signs abound, with memory dysfunction, affective auras, perceptual changes (eg, hallucinations), and depersonalization.

In temporal lobe epilepsy, the most common psychiatric abnormality is personality change. Hyperreligiosity, hypergraphia, and hyposexuality are reportedly more commonly associated with temporal lobe epilepsy. Development of psychosis is also described in temporal lobe epilepsy.

An estimated 4-27% (average, ~10%) of patients with complex partial epilepsy have psychotic symptoms such as paranoid ideation, thought disorder, and hallucinations. Mood disorder symptoms occur most often with foci in the temporal lobe. Statistically, 30% of patients with epilepsy have a history of suicide attempts, which attests to the importance of diagnosing depression in these patients. Fear and anxiety are the most common ictal affective states.

Parkinson disease

Parkinson disease (PD) is a disorder characterized by movement abnormalities caused by degeneration of the neurons in the substantia nigra.[2] Currently, PD affects approximately 1% of the population older than 50 years and up to 2.5% of the population older than 70 years.[3] PD affects all races about equally; men are more often affected than women.

The hallmark clinical signs of the motor triad include (1) tremor, usually a rest tremor involving the hands, described as pill rolling; (2) rigidity; and (3) bradykinesia/akinesia. The classic motor signs may not be obvious early in the disease, and patients may initially present with only clinical signs of depression.[4] Thus, PD may be misdiagnosed as a primary depressive illness, and concomitant depression may remain undiagnosed in a patient with PD. Similarities in the symptoms common to major depression and PD include impaired memory/concentration, slowed psychomotor activity, restricted affect, and fatigue or decreased energy.

The prevalence of major depression in patients with PD is estimated to be 40%, with prevalence rates of 4-70%.[5] Considerable evidence indicates that depression can precede development of motor symptoms, suggesting that the depression itself may be a neurologic sign of PD. In addition to mood disturbances, patients with PD commonly present with symptoms of anxiety, including general anxiety disorder, social phobia, and panic disorder, with a prevalence rate of 25%.[6]

The anxiety syndromes in PD are apparently related to an underlying brain disease, with evidence implicating noradrenergic dysfunction. In several studies, anxiety syndromes developed before or after the onset of motor symptoms.[7]

Hallucinations and delusions can also occur in as many as 40% of patients with PD.[8] The psychosis can develop spontaneously or in association with mood disturbance but usually develops either late in the disease process (when significant cognitive impairment is also evident) or with use of dopaminergically active medication.[9]

Most treatments are aimed at patients' specific symptoms. PD must be considered in the differential diagnosis of an elderly person presenting with first-time depression/anxiety symptoms, especially when the patient appears depressed but denies experiencing a depressed mood. In addition, treatment of symptoms can be complicated in patients with PD because antiparkinsonian drugs may exacerbate psychiatric symptoms and vice versa. Consultation with both neurologists and psychiatrists can be helpful when treating these patients. This population is at high risk for harboring suicidal ideations that can go unnoticed. More recently, a study showed that up to 30% of patients with Parkinson disease harbor suicidal ideations.[10] Thus, comprehensive care and adequate screening for suicide is essential in these patients.

Brain tumors

Brain tumors and cerebrovascular disease are important causes of psychiatric symptoms and patients with these diseases can present with virtually any symptom. A complete clinical history and neurologic examination are essential in diagnosing either condition. Given the nature of the onset and presentation of a cerebrovascular event, it is rarely misdiagnosed as a mental disorder. However, up to 50% of patients with brain tumors reportedly have manifestations of a psychiatric nature.[11]

In general, meningiomas are likely to cause focal symptoms because they compress a limited region in the cortex, whereas gliomas can cause more diffuse symptoms. Delirium is most often secondary to a large, fast-growing, or metastatic tumor. The specific psychiatric symptoms largely depend on the location of the tumor within the brain and the structures affected by direct invasion or pressure.

Frontal lobe tumors, which are responsible for approximately 88% of the patients with psychiatric symptoms, can elicit presenting signs such as cognitive impairment, personality change, or motor and language dysfunction.[12] Patients also frequently have bowel or bladder incontinence.

Patients with dominant temporal lesions can present with memory and speech abnormalities. Nondominant tumors can cause auditory agnosia. Bilateral lesions can lead to Korsakoff amnesia. Occipital lesions can cause visual hallucinations, agnosia, and Anton syndrome (denial of blindness). The visual pathways all cross in the temporal, parietal, and occipital lobes; therefore, visual hallucinations can occur with lesions in any of these locations. Auditory hallucinations can also occur with temporal lesions but are apparently less common.

Limbic and hypothalamic tumors can cause affective symptoms such as rage, mania, emotional lability, and altered sexual behavior.[13] They can also produce delusions involving complicated plots.

Hallucinations, which are often considered the hallmarks of psychiatric illness, can be caused by focal neurologic pathology.

The diagnostic procedure of choice is brain imaging with contrast head CT scan or an MRI. In many clinical cases, when a CNS tumor is considered likely, initial CT scan findings may be normal, and MRI may be required to confirm the diagnosis.

Multiple sclerosis

Multiple sclerosis (MS) is a demyelinating disorder characterized by multiple episodes of symptoms of a neuropsychiatric nature related to multifocal lesions in the white matter of the CNS. Prevalence is estimated to be approximately 50 cases per 100,000 people. MS is more frequent in colder and temperate climates than in tropical locales, which may suggest a viral etiology. MS is more common in women than in men and usually manifests in persons aged 20-40 years. This disorder is a highly variable illness, with differences among patients and changes within a patient over time.

Symptoms can be categorized as cognitive and psychiatric. Recent reviews of neuropsychological performance in patients with MS indicate that 30-50% have cognitive deficits.[14] Of the cognitive deficits, memory loss is the most common and affects approximately 40-60% of patients.[15] Abstract reasoning, planning, and organizational skills are some of the functions also affected by MS. Dementia may eventually ensue.

Behavioral symptoms in MS include personality changes and feelings of euphoria and/or depression. Approximately 25% of patients experience euphoria that is different from hypomania and is characterized by an unusually cheerful mood. One study showed a 2-fold increase in the lifetime risk of bipolar disease in MS patients.[16] Major depression is

very common in individuals with MS; indeed, 25-50% of patients experience major depression after the onset of MS. Suicide attempts are common in patients with MS who are depressed. Personality changes and emotional dyscontrol can also occur. Patients sometimes laugh without cause or weep suddenly. Such emotional lability can be disturbing for patients and their families and can make assessment of psychiatric symptoms more difficult in patients with MS.

Infectious Diseases

Neurosyphilis

Neurosyphilis, once a common cause of admission to mental institutions, has become rare as a result of the invention of penicillin. However, AIDS has reintroduced the infection in certain urban settings. The infection is caused by the organism *Treponema pallidum,* which invades the parenchyma of the brain.

Neurosyphilis is usually clinically apparent as a part of tertiary syphilis, which includes two other types: late benign (gummatous) syphilis and cardiovascular syphilis. Neurosyphilis is now the predominant form of tertiary syphilis and occurs only after a latent period of 10-20 years after the primary infection, although infection with HIV negates this general rule.[17] Neurosyphilis primarily affects the frontal lobes, which can result in personality changes, irritability, decreased self-care, mania, and progressive dementia. Delusions of grandeur occur in 10-20% of patients. Early evidence of neurosyphilis includes tremors, dysarthria, and Argyll Robertson pupils.

The diagnosis is confirmed using serologic tests. Cerebrospinal fluid (CSF) analysis always shows abnormal results and reveals primary lymphocytosis and increased protein level. Always consider neurosyphilis in patients who may have an underlying immunodeficiency disease and present with mental status changes and a progressive dementia incongruent with advanced age.

Meningitis

Acute bacterial, fungal, and viral meningitis can be associated with a psychiatric presentation with or without abnormal vital signs. Patients who are immunocompromised (eg, those with AIDS, individuals in oncology units) are particularly susceptible. Those with indwelling ventriculoperitoneal shunts are also at high risk for developing the infection. Patients usually present with acute confusion, headaches, memory impairments, and fever with possible neck stiffness. Because bacterial meningitis is a life-threatening emergency, persons at high risk who have a sudden onset of mental status changes should always undergo a workup that includes a diagnostic lumbar puncture.

More recently, the *Haemophilus influenzae* type b and the pneumococcal conjugate vaccines have greatly reduced cases of meningitis caused by these agents.[18] Penicillin resistance has emerged in *Streptococcus pneumoniae* infections.

Herpes simplex encephalitis

Herpes simplex virus (HSV) is one of the most common and devastating causes of sporadic and severe focal encephalitis. Infection with HSV can occur in any person—age, sex, and demographic region are irrelevant. HSV reaches the brain from the bloodstream or peripheral nerves by cell-to-cell spread along the branches in the trigeminal nerve, which then innervates the meninges or the anterior and middle fossae. Thus, infection is characteristically localized to the temporal and frontal lobes.

Patients with HSV encephalitis commonly present with bizarre, inconsistent behavior and a waxing and waning mental status. Symptoms often include seizures, anosmia, olfactory and gustatory hallucinations, personality changes, and psychosis. Consider this diagnosis when the patient has a prodrome of 1-7 days of upper respiratory tract infection with headache, fever, and subsequent bizarre psychiatric symptoms.

Lumbar puncture, serology studies, neuroimaging, and EEG are helpful in confirming the diagnosis.

Treatment consists of intravenous acyclovir, but if the condition is not diagnosed and treated quickly, long-term psychiatric and neurologic sequelae are likely.

HIV encephalopathy

An estimated 33.2 million people were estimated to be living with HIV worldwide.[19] The number of infected people continues to increase, especially among poor and socially disadvantaged persons in the United States, although the rate of increase has declined over the years. Thus, recognition and proper treatment of AIDS-related complications involving the CNS and its behavioral and neurologic manifestations is one of the most common challenges faced by physicians.

While patients with AIDS have psychiatric and neurologic symptoms from lesions (eg, primary CNS lymphoma) or opportunistic infections, HIV itself can cause a subacute encephalitis and dementing complex. Clinically, HIV encephalopathy manifests as a progressive subcortical dementia with nonspecific CSF abnormalities and cerebral

atrophy with ventricular dilation. In the early stages, signs of encephalopathy include difficulty concentrating, subtle mood changes, disorientation, withdrawal, or lethargy. Motor signs, such as psychomotor slowing, hyperreflexia, and spastic or ataxic gait, may also be present. Later, psychiatric episodes may become clinically apparent as delirium, mania, or psychosis.[20] Although HIV encephalopathy has become one of the leading causes of dementia in persons younger than 60 years[21], it has become less frequent since the introduction of highly active antiretroviral therapy (HAART).

Consider the possibility of HIV encephalopathy in the evaluation of any patient with a psychiatric disorder who has HIV. Carefully investigate with lumbar puncture and brain imaging to exclude other causes (eg, meningitis, malignancy). Conversely, any patient presenting with first-time psychiatric symptoms and without a positive psychiatric history should undergo HIV testing. In addition, being aware of the neuropsychiatric effects of medications used frequently in HIV infection is helpful.

Early therapy with antiretrovirals, particularly azidothymidine (AZT), is recommended because retrovirals may have a protective effect in delaying or reversing some of the psychiatric and neurologic manifestations of HIV infection.[20] Otherwise, symptomatic treatment with psychopharmacologic medications is an important aspect in the treatment of these patients. Because patients with HIV can be more susceptible to the adverse effects of psychotropic drugs, and because many of these medications may lower seizure thresholds, use care when prescribing them. In addition, lower doses of the drugs are recommended (at least for initial treatment), and the maxim "start low and go slow" should be followed.

Endocrine Disorders

Parathyroid disorder

Dysfunction of the parathyroid glands results in abnormalities in the regulation of electrolytes, especially calcium. Excessive excretion of parathyroid hormone results in a state of hypercalcemia. Such hyperparathyroidism usually occurs in the third to fifth decade of life and is more common in women than in men. Annual incidence is in the 0.1% range and affects up to 0.2% of the population older than 60 years.[22]

Hyperparathyroidism is frequently associated with significant psychiatric symptoms, which are caused by the resultant hypercalcemia and can precede other somatic manifestations of the illness. Patients can experience delirium, sudden dementia, depression, anxiety, psychosis, apathy, stupor, and coma.

Hypomagnesemia also occurs in association with hyperparathyroidism, usually after surgical removal of a parathyroid adenoma. Delirium with psychosis is a common presentation of patients with severe hypomagnesemia. Visual hallucinations and paranoid delusional psychosis are also observed in those with a magnesium deficiency.

In hypoparathyroidism, expect to find low serum levels of calcium and magnesium. Patients most commonly experience delirium but may also experience psychosis, depression, or anxiety. Because imbalances of calcium and magnesium can cause psychiatric symptoms, serum levels of both electrolytes must be ascertained for diagnostic evaluation of any psychiatric presentation. While patients with hypercalcemia should have parathyroid hormone levels checked, they should also be evaluated for other causes of hypercalcemia.

Thyroid disorders

Hyperthyroidism is a common clinical condition caused by excess thyroid hormone. Because this disorder is so common, a high index of clinical awareness for thyroid disease and its complications is needed in any patient who presents with psychiatric symptoms. Always include evaluations of thyroid-stimulating hormone (TSH [thyrotropin]) and free thyroxine (T4) levels in the medical workup of patients presenting with psychiatric symptoms for the first time. Graves disease is the most common cause in the population. Some evidence indicates that stress can precipitate Graves disease and aggravate treated disease.[23] Toxic nodular goiter is most prevalent in the elderly population.

Patients can present in various ways but commonly present with symptoms of anxiety, confusion, and agitated depression. Patients can also present with hypomania and frank psychosis. When hyperthyroidism is suggested, standard clinical symptoms may be present, including heat intolerance, diaphoresis, weight loss despite increased appetite, palpitations, tachycardia, exophthalmos, and hyperactive tendon reflexes.[24]

In most patients who present with depression or anxiety associated with hyperthyroidism without other psychiatric history, psychiatric symptoms usually resolve with treatment of the hyperthyroidism.

Unless hypothyroidism stems from a primary pituitary disorder, it is usually caused by a lack of T4, which results in an elevated TSH level.

Similar to patients with hyperthyroidism, those with hypothyroidism often present with depression and anxiety. The usual clinical features include apathy, psychomotor retardation, depression, and poor memory. However, when hypothyroidism develops rapidly, the psychiatric features are usually delirium and psychosis, which has also been

termed myxedema madness. Physical signs and symptoms, including cold intolerance, weight gain, thin and dry hair, facial puffiness, constipation, menorrhagia, muscle cramps, and slowed and decreased deep tendon reflexes, suggest this diagnosis.

Subclinical hypothyroidism can have either mild or no symptoms of thyroid hormone deficiency. It is fairly common and affects 5-10% of the population, mainly women, and occurs in 15-20% of women older than 45 years.

T4 replacement in these patients usually reverses the psychiatric symptoms, although it may not necessarily reverse the cognitive deficits that occur because of changes in metabolic activity in the CNS.

Adrenal disorders

Adrenal disorders cause changes in the normal secretion of hormones from the adrenal cortex and may produce significant psychiatric symptoms. Few studies have been performed on psychiatric symptoms of patients with Addison disease or adrenocortical insufficiency. This condition may result from fungal or, more commonly, tuberculous infection of the adrenals. Patients with this condition can exhibit symptoms such as apathy, fatigue, depression, and irritability. Psychosis and confusion can also develop. Steroid hormone replacement is used to treat patients with this condition; however, cortisol is psychogenic in nature and may produce mania and psychosis.

The existence of moderate-to-severe depression in up to 50% of patients with Cushing syndrome is well documented, with symptoms sometimes severe enough to lead to suicide. Decreased concentration and memory deficits may also be present. Some patients present with psychotic or schizophreniclike symptoms. Maintain a high index of clinical awareness for this disorder in patients who have additional clinical signs such as central obesity, hypertension, striae, easy bruising, buffalo hump, diabetes, and osteoporosis. In patients with depression believed to be etiologically related to hypercortisolemia, initiate antidepressant treatment while awaiting surgical or medical therapy for Cushing syndrome. Psychiatric symptoms usually resolve when the cortisol excess is controlled.

Pancreatic disorders

The most common pancreatic disorders that can have psychiatric presentations include diabetes mellitus with resulting glycemic dysregulation and pancreatic tumors. Either excessive exogenous insulin administration or endogenous production of insulin can cause hypoglycemia. However, hypoglycemic-induced mental status changes usually occur in persons with diabetes who are insulin dependent. Persons who engage in factitious use of hypoglycemic agents are an exception. Initial symptoms of the hypoglycemic state usually include nausea, sweating, tachycardia, hunger, and apprehension. With progression, patients may become disoriented and confused and may hallucinate. Eventually, stupor and coma ensue. Persistent cognitive impairment can be a serious sequela to frequently occurring hypoglycemic states.

Severe hyperglycemia begins with weakness, fatigability, polyuria, and polydipsia. Symptoms of clinical worsening include hyperventilation, headache, nausea, and vomiting. With ketoacidosis, disorientation and confusion can occur, and this state can be fatal if not properly identified and urgently treated.

Pancreatic tumors, although uncommon, can manifest solely in depression. Despite a broad differential diagnosis, seriously consider this diagnosis in elderly patients with new-onset depression in the setting of back pain.

Rheumatologic Disorder

Systemic lupus erythematosus

Systemic lupus erythematosus (SLE) is an autoimmune disease of sterile inflammation involving multiple organs and multiple autoantibodies. Approximately 90% of cases are in women, usually of childbearing age. The incidence is 2.4 cases per 100,000 across genders and race, 92 cases per 100,000 for black women, and 3.5 cases per 100,000 for white women. Asians are also more often more affected than whites.

The diagnosis of SLE requires that patients have at least 4 of 11 criteria set by the American Rheumatism Association. Remember that the diagnosis usually cannot be confirmed in a single encounter. The myriad of symptoms and serologic abnormalities often occur over time; therefore, diagnosis involves compiling a thorough history. Organ involvement of the synovium and skin usually prompts rheumatologists and dermatologists to consider the diagnosis. However, the neuropsychiatric manifestations of lupus can occur any time during the disease, and most appear in the first few years or before diagnosis of the illness. Thus, patients with undiagnosed lupus may initially present in psychiatric clinics, neurologic clinics, or inpatient wards.

Neuropsychiatric manifestations of patients with lupus have a prevalence of up to 75-90%.[25] Major psychiatric symptoms include depression, emotional lability, delirium, and psychosis. The presence of severe depression or psychosis is associated with anti-P antibodies in the serum, which suggests an autoimmune mechanism for inducing mental symptoms.

Treatment is with high-dose steroids, which can precipitate or exacerbate psychiatric symptoms. However, most

instances of psychosis in patients with lupus who are on steroid therapy are secondary to lupus cerebritis, and many improve with an increase in dosage. When patients are on steroid therapy, remembering to exclude infectious causes of possible brain dysfunction is always important because steroids may mask fever, resulting in an atypical presentation of infection.

Because of the multiple organ systems involved and the complexities of this illness, it behooves the clinician to consult rheumatologists, neurologists, and psychiatrists as appropriate.

Metabolic Disorders

Sodium imbalance

Hyponatremia occurs in various conditions. This condition is usually observed in postoperative patients and in patients with severe vomiting and diarrhea, syndrome of inappropriate secretion of antidiuretic hormone (SIADH), extensive burns, cirrhosis, or endocrine abnormalities (eg, myxedema, Addison disease). Consider hyponatremic disorders in patients experiencing acute mental status changes such as the following[28]:

- Nausea and anorexia
- Muscle weakness
- Irritability
- Confusion
- Anxiety
- Delusions and hallucinations

Without proper treatment, seizures, stupor, and coma ultimately ensue. Treatment consists of correcting the serum sodium level at a slow but adequate rate. Overly rapid correction of hyponatremia can lead to central pontine myelinolysis.

Hypernatremia usually results from inadequate ingestion of water or from the inability of the kidneys to conserve water. The elderly population is particularly sensitive to dehydration, and elderly persons can have acute mental status changes. As with hyponatremia, the rate of correction of hypernatremia is important. Overly rapid correction can lead to cerebral edema. Always consider cerebral edema if the patient has worsened mental status when hypernatremia has been corrected.

Hepatic failure and encephalopathy

Hepatic encephalopathy is a complex neuropsychiatric syndrome that complicates advanced liver disease. In acute hepatic encephalopathy, fulminant hepatic failure is usually present. Cerebral edema plays an important etiologic role in this setting. Chronic hepatic encephalopathy usually occurs in patients with chronic liver disease, and it manifests as subtle neuropsychiatric disturbances. The clinical picture of this form of encephalopathy varies and is characterized by acute exacerbations and remissions accompanied by neurologic abnormalities. The clinical manifestations of stages of hepatic encephalopathy are listed below.[27]

- Stage I
  - Apathy
  - Restlessness
  - Impaired cognition
  - Impaired handwriting
  - Reversal of sleep rhythm
- Stage II
  - Lethargy
  - Drowsiness
  - Disorientation
  - Asterixis
  - Beginning of mood swings
  - Beginning of behavioral disinhibition
- Stage III
  - Arousable stupor
  - Hyperactive reflexes
  - Short episodes of psychiatric symptoms
- Stage IV - Coma (responsive only to pain)

In acute exacerbations, impairment of consciousness is prominent. Rapid changes in consciousness can be accompanied by hallucinations, mainly visual. Hypersomnia also occurs early in the course of illness. Prior to the development of coma, patients can also experience abrupt mood swings and behavioral disinhibition. Patients may also experience short episodes of depression, hypomania, anxiety, and obsessive-compulsive symptoms. At this stage, patients usually have neurologic signs, which may include asterixis, myoclonus, constructional apraxia, and/or

hyperreflexia.

The etiology of such changes is unclear; however, the pathogenesis of hepatic encephalopathy is believed to involve inadequate hepatic removal of mostly nitrogenous compounds or other toxins formed in the GI tract. Inadequate removal of these toxins results from both impaired hepatocyte function and shunting of portal blood into the systemic circulation. Treatment involves identification of precipitating factors, dietary protein restrictions, and removal of ammonia from the bowel.

Uremic encephalopathy

Uremia results from impairment in kidney functioning. Initially, patients feel nonspecifically and generally unwell and often describe a sense of fatigue. They may have difficulty with concentration and may experience some memory impairment. As uremia progresses, memory worsens. Depression, apathy, and social withdrawal become clinically apparent. In advanced uremia, patients may experience impaired mentation, lethargy, myoclonus, asterixis, and other neuropsychiatric symptoms similar to those in hepatic encephalopathy. Psychosis can also occur.

The differential diagnosis of psychiatric symptoms in persons with chronic renal failure is quite broad and should include hypercalcemia, hypophosphatemia, hypernatremia/hyponatremia, hyperglycemia/hypoglycemia, hypertensive encephalopathy, and cerebrovascular disease, among many others. Adequate dialysis can reverse some of the psychiatric and mental abnormalities, but some subtle deficits in mentation may remain.

Dialysis dementia is a specific syndrome characterized by encephalopathy, dysarthria, dysphasia, poor memory, depression, paranoia, myoclonic jerking, and seizures.[26] Worsening of dialysis dementia can lead to death within a year of diagnosis. High aluminum levels were found during autopsy in the brain tissue of patients who died with this clinical syndrome. The etiology was believed to be the aluminum content of the water used in making the dialysate. In the United States, the incidence of dialysis dementia has diminished because of proper water treatments.

Psychopharmacologic treatment of uremic encephalopathy should target the individual symptoms but with a lower starting dosage of medication and with small, cautious dosage adjustments.

Acute intermittent porphyria

Porphyria is a disorder of heme biosynthesis that leads to buildup of excessive porphyrins. In the classic form, patients have a triad of symptoms, including colicky abdominal pain, motor polyneuropathy, and psychosis. Acute intermittent porphyria is an autosomal dominant disorder, and onset usually occurs in persons aged 20-50 years. Some studies have shown that 0.2-0.5% of psychiatric patients have undiagnosed porphyrias. Barbiturates precipitate attacks of acute porphyria and are therefore absolutely contraindicated.

Vitamin Deficiency States

Vitamin B-1

When discussing the appropriate differential diagnosis of new-onset psychiatric symptoms, consideration of vitamin deficiencies is necessary, especially deficiencies of the B vitamins. Chronic and severe deficiency of vitamin B-1 (thiamine) leads to pellagra, with neuropsychiatric symptoms of asthenia, fatigue, weakness, and depressed mood. Much more commonly today, thiamine deficiency manifests as Wernicke encephalopathy, often, but not exclusively, in individuals with heavy and prolonged alcohol use. The classic triad of gait ataxia, global confusion, and ophthalmoplegia, most often involving the sixth cranial nerve, leads to the inability to abduct the eyes.

Immediate treatment with parenteral thiamine reveals that this syndrome is at least partly reversible because the ocular palsy often resolves within hours. As the confusion improves, impaired cognitive functioning (amnesia) consistent with Korsakoff syndrome often becomes evident. Long-term treatment with thiamine may result in ongoing improvement over a period of months.

Although this is a clinical diagnosis, brain pathology is evident on imaging studies and at autopsy. Symmetric lesions of the mamillary bodies, the third and fourth ventricles, and the periaqueductal areas are present.

Vitamin B-12

Deficiency of vitamin B-12 (cobalamin) is the cause of pernicious anemia. When a patient presents with megaloblastic anemia and neurologic symptoms from subacute combined spinal cord degeneration, and a low serum vitamin B-12 level is found on evaluation, the diagnosis is relatively straightforward.

Although the direct cause and effect of concomitant psychiatric symptoms is not always clear, depression, fatigue, psychosis, and progressive cognitive impairment can accompany neurologic symptoms.[28]

These psychiatric symptoms can predate the neurologic symptoms by months to years and may be present in the

absence of anemia or macrocytosis. When suggested, even if screening vitamin B-12 levels are not revealing, measurements of serum methylmalonic acid and total homocysteine may be more helpful diagnostically.[29]

Folate

As with vitamin B-12 deficiency, interest has been shown in the relationship between folate deficiency and psychiatric symptoms. Evidence suggests that folate deficiency states are observed in patients with depressive syndromes and with dementing syndromes; it appears that folate deficiency is not rare and can cause or exacerbate psychiatric symptoms. Patients with depression have consistently been found to have lower levels of serum and red blood cell folate than normal or nondepressed psychiatric patients. Decreased folate levels have been associated with lowered response rates to standard antidepressant pharmacotherapy; thus, patients may benefit from supplementation even with normal levels.[30]

Since replacing folate in patients with B-12 deficiency can aggravate the progression of neurologic symptoms, it is important to search for and correct vitamin B-12 deficiency either prior to or concurrent with folate replacement.

Exogenous Toxins

The role of exogenous toxins is a very broad subject; however, because of the limited space and scope of this article, only a brief overview is presented. Toxins can include medications, drugs of abuse, solvents, pesticides, and heavy metals. Some of the most common medications associated with induction of a psychoactive state are listed below.[31]

- Antihypertensives
  - Reserpine
  - Methyldopa
  - Beta-blockers
- Oral contraceptives
- Steroids
- Histamine 2 blockers
- Cancer chemotherapy agents
  - Vinca alkaloids
  - Procarbazine
  - *L* -asparaginase
  - Amphotericin
  - Interferon
- Psychoactive substances
  - Alcohol
  - Opioids
  - Amphetamines (withdrawal)
  - Cocaine (withdrawal)
- Benzodiazepines
- Barbiturates

Idiopathic major depression is very common, as is the use of medication, alcohol, and/or illicit drugs. Separating causal factors is not always easy. A high index of clinical awareness is helpful in considering underlying causes of conditions that can appear as primary idiopathic psychiatric illness. Knowledge of the time course can also be helpful, ie, comparing the onset of symptoms to the initiation of or change in dosage of the putative offending agent.

Alcohol

Although volumes have been written concerning the pathologic changes in patients who use alcohol for short and long periods, a brief review is appropriate because patients in alcohol withdrawal can present with numerous psychiatric symptoms that can be fatal if not identified and treated quickly.

Withdrawal symptoms can emerge, particularly in the absence of a measurable blood alcohol level. Florid delirium tremens (DT) is the most serious and potentially fatal alcohol withdrawal syndrome. The clinical picture includes hallucinations (most commonly auditory and/or visual), gross confusion and disorientation, and autonomic hyperactivity (eg, tachycardia, fever, sweating, hypertension). These patients are often agitated and paranoid and may not readily allow physical examination. The temptation to view an agitated, paranoid, overtly hallucinating patient as in need of nothing further than admission to a psychiatric unit may be a grave mistake because untreated DT is potentially fatal.

Patients may also present with hallucinations in a clear sensorium (differentiating it from DT), usually in the setting of recent cessation of or significant decrease in the amount of alcohol used. Known as alcoholic hallucinosis, the hallucinations (most frequently auditory) may be relatively brief, usually resolving within approximately 30 days, but they may persist. Recurrences are likely with continued alcohol use.

Differentiating this syndrome from schizophrenia can be difficult. The hallucinations are frequently threatening and

persecutory in nature, and patients may act in response to these, leading to a potentially dangerous situation that may require involuntary psychiatric hospitalization.[32]

Alcohol is a CNS depressant, and chronic abuse can be associated with significant depression that may, by symptoms alone, be indistinguishable from idiopathic major depression. However, of patients with depressive disorder from alcohol dependence who are monitored for 2-4 weeks without alcohol, more than 50% have full remission of symptoms without additional intervention for the depressive symptoms. A minority of patients, usually those with more severe symptoms, have a continued depressive syndrome despite sobriety and require additional treatment.

Cocaine and amphetamines

Cocaine is a powerful stimulant initially causing euphoria and increased alertness and energy. As the high wears off, the user may develop symptoms of anxiety and depression, often with drug craving. With continued regular use, symptoms of psychosis develop with hallucinations and frank paranoid delusions. The psychiatric presentation can appear similar to that observed in patients with chronic amphetamine abuse.

Amphetamines are also CNS stimulants and initially cause feelings of increased well-being, energy, and concentration. However, amphetamine abuse can cause development of psychotic symptoms.

Laboratory testing with toxicologic screening of blood and urine can assist with or confirm the diagnosis. Knowing exactly what drugs are screened for at any individual facility is important because different routine screens include different drugs. Depending on the clinical presentation, testing for additional individual drugs may need to be specified. For example, patients with phencyclidine (PCP) intoxication may present with psychosis and with particularly agitated and violent behavior; however, most routine drug screens do not test for PCP, which can nevertheless be measured when specified.

Hallucinogens

A brief mention must be made of lysergic acid diethylamide (LSD), a potent hallucinogen that causes intense and vivid hallucinations in a clear sensorium. LSD-elicited hallucinations are usually of relatively short duration, but flashbacks of varying intensity may occur in a small number of users. Hallucinogenic mushrooms containing psilocybin and psilocin can have similar effects.

Ecstasy

Ecstasy (3,4-methylenedioxymethamphetamine [MDMA]), a designer drug synthetically derived from amphetamine, is often used in the context of large and energetic parties (raves) and at nightclubs. Initially, it causes mild euphoria, increased energy, and increased libido. Tolerance develops rapidly. Depression, anxiety, and psychosis have also been described with regular use, and some of the symptoms persist for months after cessation of use.[33]

Solvents

Solvent abuse or huffing involves the inhalation of organic solvents for their euphoriant effects. Inhaled solvents include glues, paints, cleaning fluids, nail-polish removers, lighter fluids, aerosol propellants, and gasolines. Long-term and heavy use can lead to hallucinations, cognitive impairment, personality change, and neurologic impairment, particularly cerebellar findings.

Heavy metals

Lead, mercury, manganese, arsenic, organophosphorus compounds, and others can cause psychiatric symptoms. Exposure is usually industrial or environmental and should be considered in the appropriate settings. Often, CNS or peripheral nervous system signs and symptoms are present.

Patient and Family Education

- Prior to attributing symptoms to psychiatric reasons, medical disorders need to be investigated. It is prudent to not only obtain a psychiatric consultation but to also get a general physical examination with blood tests from the primary care physician.
- The Academy of Psychosomatic Medicine provides information about specialists that work at the interface of psychiatry and internal medicine. Specialists in this field are primarily psychiatrists who have a subspecialty training and certification in psychosomatic medicine.
- Other Web sites of interest include the following:
    - WebMD, Multiple Sclerosis: Depression and MS
    - National Multiple Sclerosis Society, Depression
    - Multiple Sclerosis Society, Bi-polar disorder

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STATE OF WISCONSIN
SUPREME COURT

Case No. 2010AP002061

In the matter of the mental commitment of Helen E.F.:

FOND DU LAC COUNTY,

Petitioner-Respondent-Petitioner

v.

HELEN E.F.,

Respondent-Appellant

BRIEF OF AMICUS CURIAE WISCONSIN ASSOCIATION OF COUNTY CORPORATION COUNSELS

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STATEMENT OF INTEREST

The Wisconsin Association of County Corporation Counsels ("Association") is an unincorporated association of county corporation counsels. Membership consists of 74 attorneys from 38 counties. It is governed by officers selected by its members.

Pursuant to Wis. Stat. § 51.20(4), corporation counsels are charged with representing the interests of the public in Chapter 51 proceedings.

The Association believes that the Court of Appeals incorrectly overturned the lower court's order. The appellate court ignored testimony establishing that Helen E.F. suffered from behavioral disturbances that qualified as a mental illness.[1] The Court compounded this error by establishing an unnecessary bright-line rule that subjects with a degenerative brain disorder don't fall within the definition of mental illness for purposes of commitment.[2] Finally, the appellate court failed to consider established case law when ruling that Helen E.F. was not treatable.[3]

ARGUMENT

I. The Appellate Court Incorrectly Interpreted Wis. Stat. § 51.01(13)(b) When it Held That a Person with a Degenerative Brain Disorder Cannot Meet the Statutory Definition of Mental Illness for Purposes of Involuntary Commitment Under Wis. Stat. § 51.01(13)(b).

Dr. Rawski, the only witness, testified that Helen E.F. suffered from dementia. He stated that dementia patients can

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[1] R.16:6-7.

[2] *Fond du Lac County v. Helen E.F.*, 2011 WI APP 72 (Ct. App. 2011).

[3] *Id.* at ¶ 34.

display behavioral disturbances[4] and that Helen E.F. displayed behavioral disturbances that were "a substantial disorder of thought, mood, or perception." Moreover, he specifically testified that her behavioral disturbances – not dementia – made Helen E.F. a proper subject for treatment.[5] The lower court found Dr. Rawski's testimony convincing.[6]

The appellate court ignored Dr. Rawski's uncontested medical opinion, overturned the lower court, and created an unnecessary bright-line rule limiting the definition of mental illness for purposes of involuntary commitment.[7] That limitation is not supported by the statutes.[8]

Fond du Lac County submits that the issue in this case is a question of fact, not law. It correctly asserts that application of a statute to a particular set of circumstances, here whether an individual is mentally ill, is a medical judgment and a question of fact.[9] Fond du Lac argues that Helen E.F.'s behavioral disturbances constitute a mental illness for purposes of commitment and that her Alzheimer's diagnosis is essentially irrelevant.[10] It argues that the Court of Appeal's overreaches and goes well beyond what is necessary to resolve the issue. Rather than repeat those arguments, we simply endorse Fond du Lac's position.

The Association is concerned by the broader implications of a bright-line rule eliminating any individual with a degenerative

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[4]R. 16:6.

[5]R. 16:7.

[6]R. 16:21.

[7]*Helen E.F.* at ¶ 22-26.

[8]Wis. Stat. § 51.01(13)(b).

[9]Fond du Lac Cty. Brief at 11.

[10]Fond du Lac Cty. Brief at 11-14.

brain disorder from being considered mentally ill for purposes of involuntary commitment. This raises a question of statutory construction and, as such, a question of law. In answering that question, this Court should apply the plain words of the statute because its language is clear and unambiguous.[11]

Wis. Stat. § 51.01(13)(b) states:

> Mental illness, *for purposes of involuntary commitment*, means a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, but does not include alcoholism. (Emphasis added.)

The Court of Appeals observed that "degenerative brain disorder" is defined separately from "mental illness," acknowledged that sec. 51.01(13)(b) is silent with respect to degenerative brain disorders, and reasoned that it would be "inconsistent" to consider a person with a degenerative brain disorder as having a mental illness for purposes of involuntary commitment.[12] In doing so, the appellate court essentially ruled that a diagnosis cannot fall under more than one statutory definition.

Applying this logic to other definitions produces absurd results. For example, schizophrenia, specifically mentioned in the definition of serious and persistent mental illness,[13] would be excluded from the definition of mental illness for involuntary commitment. Similar examples found throughout the statutes produce equally absurd results.

Wis. Stat. § 51.01(13)(b) is clear. The legislature enacted a broadly worded statute covering all disorders of thought, mood,

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[11]*State ex rel. Kalal v. Circuit Court for Dane Cty.*, 271 Wis. 2d 633, 663, 681 N.W.2d 110 (2004).

[12]*Id.* at ¶ 25.

[13]Wis. Stat. § 51.01(14t).

perception, orientation, or memory that grossly impairs a person's judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.

When one looks at other Chapter 51 definitions, the correct reading of sec. 51.01(13)(b) becomes clear. The legislature excluded individuals with degenerative brain disorders from the definition of developmental disability,[14] persistent mental illness,[15] and serious brain injury.[16] Unlike these definitions, the definition of mental illness for purposes of involuntary commitment *does not* exclude individuals with degenerative brain disorders.[17] Yet, the legislature specifically excluded alcoholism from the definition.[18]

The appellate court's statutory interpretation requires one to believe that the legislature meant to exclude degenerative brain disorders from the definition of mental illness for purposes of involuntary commitment, but simply forgot to do so. That interpretation is unreasonable given that the legislature explicitly excluded alcoholism as a mental illness for purposes of involuntary commitment and deliberately excluded degenerative brain disorders from a number of definitions in Chapter 51. Simply put, the appellate court's interpretation runs contrary to a court's duty to read the text of statutes as part of a whole in relation to surrounding and closely related statutes.[19]

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[14]Wis. Stat. § 51.01(5)(a).

[15]Wis. Stat. § 51.01(14t).

[16]Wis. Stat. § 51.01(2g)(b).

[17]Wis. Stat. § 51.01(13)(b).

[18]*Id.*

[19]*Kalal*, 271 Wis. 2d at 663.

II. A Bright Line Rule Excluding Patients with Degenerative Brain Disorders, Especially Those Who Also Exhibit Dangerous Behavioral Disturbances, from the Definition of Mental Illness under Wis. Stat. § 51.01(13)(b) Creates a Significant Treatment Void.

The Court of Appeals staked its decision to the moral high ground by stating: "One way to measure the greatness of our society is to look at how we treat our weakest members, such as our growing population of people afflicted with Alzheimer's."[20] The reality is that the Court of Appeal's decision opens a treatment void for the very population it was trying to protect. It also means that these vulnerable members of society may be continuously exposed to dangerous behaviors.

The vast majority of individuals with degenerative brain disorders will never be the subject of a Chapter 51 proceeding. Many will never develop the behavioral disturbances that necessitated Helen E.F.'s commitment. And because Chapter 51 requires a finding of dangerousness, the number of individuals with degenerative brain disorders that might be subject to a Chapter 51 proceeding is further reduced.[21]

Unquestionably, Chapter 51 should be the last resort when an individual has a degenerative brain disorder exhibits behavioral disturbances. But when an individual's actions create a danger to herself or others, Chapter 51 provides the necessary tools to treat the subject and safeguard the community.

The following scenario is one encountered by most corporation counsels, police officers, and human services personnel at some point:

- An individual is diagnosed with dementia.

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[20] *Helen E.F.* at ¶ 17.

[21] Wis. Stat. § 51.20(1)(a)2.

- The individual resides at an assisted living facility or skilled nursing home that provides some level of supervision and care.

- The individual displays additional behavioral disturbances or psychosis, strike outs, and injures staff or other residents, sometimes seriously.

- The facility cannot safely handle the individual's behavior and the police are called.

Nursing homes find themselves in a difficult quandary. They can transfer or discharge an individual if the health, safety, or welfare of the resident or other residents is endangered.[22] They can even forego the normal thirty day notice requirement.[23] But the facility must find an alternative placement that will accept the resident.[24] This is often impossible because another facility can't accept a resident who exhibits dangerous behavior unless it can appropriately manage that behavior.[25]

The only viable option that will protect the individual, other residents, and staff and provide necessary treatment is a Chapter 51 commitment. But that option doesn't exist under *Helen E.F.* Involuntary commitment is not possible, and engaging the criminal system is not appropriate. The police are left with no options. There is nothing left to do but hope that the nursing home might be able to control the dangerous behaviors.

Some may advocate that a solution lies with seeking an order for the involuntary administration of psychotropic medication under Wis. Stat. § 55.14. But this is not a practical solution when the individual creates an immediate danger that the facility cannot manage. Psychotropic medications are not "magic

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[22]Wis. Adm. Code § DHS 132.53(2)(a)7.

[23]Wis. Adm. Code § DHS 132.53(3).

[24]Wis. Adm. Code § DHS 132.53(2)(b).

[25]Wis. Adm. Code § DHS 132.51(2)(c).

bullets"' that immediately control dangerous behavior. They frequently take time, and dosages may need to be adjusted to properly affect an individual's behavior.

Here, Dr. Rawski testified that Helen E.F. needed treatment in a locked inpatient psychiatric unit.[26] Nothing in the record supports the argument that Helen E.F.'s dangerous behaviors could be controlled *immediately and effectively* solely through the administration of psychotropic medications.

Advocacy groups voice their concern that Chapter 51 proceedings might be invoked too frequently when dealing with patients like Helen E.F., who have degenerative brain disorders accompanied with substantial behavioral disturbances. That does not mean that Chapter 51 proceedings are not a necessary, proper, and valuable tool of last resort to treat and protect this vulnerable population.

It is crucial to remember sec. 51.20(7)(d) gives courts the power to convert commitments to guardianship and protective placement proceedings. Thus, a mechanism exists as a check on a county's decision to pursue a Chapter 51 proceeding that might be handled more appropriately through protective placement.

Finally, the resources for placement and treatment under Chapter 51 and Chapter 55 vary widely across Wisconsin's 72 counties. Creating a bright-line rule that eliminates an entire class of people in all 72 counties from treatment opportunities under Chapter 51 without even considering the severity of the underlying circumstances only hurts those people who are most in need of help. Wise policy would allow executive branch actors the discretion to choose between available legal options, especially when those choices are subject to judicial oversight by the circuit court.

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[26]R. 16:7-8.

III. The Appellate Court Failed to Acknowledge and Apply Long-standing Case Law about Whether an Individual Is a Proper Subject for Treatment.

The Appellate Court held that Helen E.F. was not a proper subject for treatment as defined in Wis. Stat. § 51.01(17).[27] The Court's analysis relied entirely on the *Athans* decision.[28] In doing so, the Court ignored the *C.J.* decision,[29] despite the fact that *C.J.* followed and clarified *Athans*. At the very least, the appellate court should have taken the time to clarify how *C.J.* and *Helen E.F.* fit harmoniously within the current framework of case law. The Appellate Court's silence on this is deafening.

The Association agrees with Fond du Lac County that *C.J.* is directly on point when one takes the time to apply Dr. Rawski's testimony.[30] Because of Fond du Lac County's excellent brief on this point, the Association doesn't need to repeat the argument.

But the bigger picture necessitates the following point: Allowing the appellate court's decision on treatability to stand will create confusing and conflicting case law where none previously existed. The ramifications, if left uncorrected by this Court, will affect all Chapter 51 proceedings by reopening debate on what was a long-settled point of law.

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[27] *Helen E.F.* at ¶ 34.

[28] *Milwaukee Cty. Combined Cmty. Servs. Bd. v. Athans,* 107 Wis. 2d 331, 320 N.W.2d 30 (Ct. App. 1982).

[29] *In the Matter of the Mental Condition of C.J.*, 120 Wis. 2d 355, 354 N.W.2d 219 (Ct. App. 1984).

[30] Fond du Lac Cty. Brief at 20-24.

IV. Other Amicus Participants Present Concerns That Incorrectly Cloud the Issue.

The State Bar's Elder Law Section ("ELS") suggests that considering a person with a degenerative brain disorder as having a mental illness for purposes of involuntary commitment will disrupt other statutory sections. ELS specifically points to Wis. Stat. § 155.20(2)(c) and claims that doing so would destroy power of attorney planning for individuals who have Alzheimers-type dementia and create a need for protective placement proceedings in every case involving degenerative brain disorder. ELS raises similar concerns about admissions to care facilities under Wis. Stat. § 50.06.[31] These are Chicken Little arguments, and the sky is not falling.

Fond du Lac County doesn't claim that everyone with Alzheimer's dementia has a mental illness for purposes of involuntary commitment. It simply argues that a person with dementia who develops behavioral disturbances *may* have a mental illness for purposes of involuntary commitment. This position doesn't impact every individual with a degenerative brain disorder. It applies to a much smaller population — just those individuals whose behavioral disturbances are so substantial that they meet the definition of mental illness for purposes of involuntary commitment.

Even within this much smaller population, individuals with a degenerative brain disorder who exhibit behavioral disturbances will not be permanently affected. That is because behavioral disturbances, unlike dementia, may not be permanent. Moreover, the prohibition against admitting an individual with mental illness under a power of attorney or following a hospital stay only applies to a person diagnosed with a mental illness *at the time of admission*.[32]

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[31]Elder Law Section Amicus Brief at 1-10.

[32]Wis. Stat. §§ 50.06(2)(b) & 155.20(2)(c)2.c.

Even if one ignores Fond du Lac's argument, it doesn't follow that considering degenerative brain disorders accompanied by behavioral disturbances as a mental illness for the purpose of involuntary commitment will create problems with other statutory sections pertaining to mental illness. In fact, the two statutes that ELS cites don't even define mental illness.[33]

The term "mental illness" is used throughout the Wisconsin Statutes. The general term is defined at Wis. Stat. § 51.01(13)(a). This definition is specifically adopted in other statutes, including secs. 48.415(3), 50.36(3g)(a), and 55.01(4m). "Mental illness" is used without definition in numerous statutes.[34] "Mental illness," "serious mental illness," and "serious and persistent mental illness" are specifically defined for other purposes in secs. 46.2785(1)(b), 49.45(6c)(a)7, 51.01(14t), and 51.62(1)(bm).

Mental illness *for purposes of involuntary commitment* is defined at Wis. Stat. § 51.01(13)(b). This is a legal, not medical, definition that is limited in scope, for the express purpose of involuntary commitment, and exclusive to Chapter 51.[35]

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[33]Wis. Stat. chs. 50 & 155.

[34]Examples include Wis. Stat. §§ 46.03, 48.981(2m)(d)2, 50.06(2)(am)2.b., 103.10(g), 155.20(2)(c), 302.365(1)(a)1, 448.01(2), 908.04(1)(a), and 940.225(2)(c).

[35]The Association is aware of only one other statute that specifically references sec. 51.01(13)(b)'s definition of mental illness. Wis. Stat. § 48.415(3), termination of parental rights on the basis of parental disability, references a parent who is "an inpatient . . . on account of mental illness as defined in s. 51.01(13)(a) or (b)." The use of the disjunctive "or"clearly shows that the legislature viewed these as two separate and distinct definitions of mental illness.

In contrast, sec. 50.36(3g)(a)1., hospital rules and standards, refers only to sec. 51.01(13)(a)'s definition of mental illness.

Two statutes — sec. 46.04 (adolescent anchorage program) and sec. 50.04(2r) (county approval required for admission of mentally ill person under 65 to certain facilities) — simply refer to sec. 51.01(13).

A basic principle of construction is that statutes should be interpreted so that no statutory language is reduced to surplusage.[36] Applying Wis. Stat. § 51.01(13)(b)'s definition of mental illness wherever the term "mental illness" is used in the statutes ignores this principal, as it would render the phrase "for purposes of involuntary commitment" meaningless.

Consider, for example, the term "mental illness" in the jury instruction for offenses under Wis. Stat. § 940.225(2)(c).[37] The committee specifically declined to define mental illness in the instruction because existing statutory definitions, specifically those found in Chapter 51, did not seem suitable. The committee concluded that absent a definition in the statute, the term has a meaning within the common understanding of the jury.[38]

Similarly, this Court declined to apply a definition of "mental illness" from any other statute when considering the use of the term in Wis. Stat. § 893.16(1). Instead, the court adopted a definition of mental illness that specifically fits the statutory section.[39]

It is clear that the legislature deliberately crafted a limited definition of mental illness in Wis. Stat. § 51.01(13)(b) to be used *for the purposes of involuntary commitment.* The definition doesn't apply to numerous other statutes, including secs. 50.06(2)(b) and § 155.20(2)(c), because the legislature made no reference to it.

The Elder Law Section fears that finding an individual has a mental illness for purposes of involuntary commitment will affect other areas of Wisconsin law that use the term "mental illness." The statutory structure gives no support for this belief. Whether

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[36]*State v. Martin*, 162 Wis. 2d 883, 894, 470 N.W.2d 900, 904 (1991).

[37]Wis. JI-Criminal 1211 (2002).

[38]Wis. JI-Criminal 1211 - Comment (2002).

[39]*Storm v. Legion Insurance Company, 265 Wis. 2d 169, 196-206, 665 N.W.2d 353, 366-371 (2003).*

an individual has a mental illness under Chapter 155 is simply a different discussion than whether an individual has a mental illness for purposes of involuntary commitment under Chapter 51. In short, sec. 51.01(13)(b)'s definition of mental illness does not apply beyond involuntary commitments.

CONCLUSION

For the reasons set forth above and in Fond du Lac County's brief, the Association respectfully requests that this Court reverse the Court of Appeals and affirm the order of the Fond du lac County Circuit Court.

Dated this 4th day of November 2011.

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CERTIFICATION AS TO FORM/LENGTH

I certify that this brief conforms to the rules contained in s. 809.19(8)(b) and (c) for a brief produced with a proportional font. The length of the brief is 2,998 words.

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I hereby certify that I have submitted an electronic copy of this brief which complies with the requirements of s. 809.19(12).

I further certify that this electronic brief is identical in content and format to the printed form of the brief filed on or after this date.

A copy of this certificate has been served with the paper copies of this brief filed with the court and served on all opposing parties.

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SUPREME COURT

Case No. 2010AP002061

In the matter of the mental commitment of Helen E.F.:

FOND DU LAC COUNTY,
Petitioner-Respondent-Petitioner,

v.

HELEN E.F.,
Respondent-Appellant.

On Certiorari from the Wisconsin Court of Appeals, District 2, reversing an Order for Involuntary Commitment and Medication, Entered by the Circuit Court, Fond du Lac County, the Honorable Richard J. Nuss, Presiding

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BRIEF AND APPENDIX OF THE COALITION OF WISCONSIN AGING GROUPS AND ALZHEIMER'S ASSOCIATION OF SOUTHEASTERN WISCONSIN AS *AMICI CURIAE*

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INTRODUCTION

The Coalition of Wisconsin Aging Groups ("CWAG") and the Alzheimer's Association of Southeastern Wisconsin ("SEWI Alzheimer's Association") write this brief to address the following issues: the protective service system under Wisconsin Statutes Chapter 55 ("Chapter 55") is the proper process for individuals like Helen as opposed to the unlawful use of Chapter 51; Chapter 51 prohibits a transfer to Chapter 55 for someone with a degenerative brain disorder; and the consequences of this decision are enormous but dire if individuals with Alzheimer's disease are mentally committed for challenging behaviors.

ARGUMENT

I. The Chapter 55 Protective Service System is the Appropriate Method of Managing Alzheimer's Patients with Challenging Behaviors.

The County would have this Court believe that there was no other option to help Helen, stating that "no other avenue of treatment of these individuals is available or feasible" and that but for the treatment Helen received under the involuntary commitment, Helen "would have continued in a near constant state of agitation." (County's Br. at 2, 24.)

The County succinctly dismisses the use of the Chapter 55 protective services system, stating that "protective placement would not meet Helen E.F.'s treatment needs." (County Br. at 18.)

Clearly, allowing Helen to languish in agitation by doing nothing is an impermissible and absurd result. However, prohibiting the use of Chapter 51 in this situation does not leave Helen lacking the help she needs, facilities with patients running amuck, or facilities with no option but to deny admission to anyone with Alzheimer's disease.

Chapter 55 allows the county, law enforcement, fire fighters, or guardians to remove an at-risk individual on an emergency basis to the designated protective placement facility every county in Wisconsin is legally required to have. **Wis. Stat.** §§ 55.135, 55.02(2)(b)4; *see* ***State ex rel. Sandra D. v. Getto***, 175 Wis. 2d 490, 494, 498 N.W.2d 892, 894 (Ct. App. 1993). Protective placement to a mental health facility is prohibited, but protective placement may be made to several appropriate places, including a medical facility or even a locked unit. **Wis. Stat.** § 55.12(2).

However, Chapter 55, the "Protective Service System," provides more than just "care and custody." ***Id.*** at §

55.01(6). Many protective services are available, pertinently the involuntary administration of psychotropic medications and subsequent treatment plan. ***Id.*** at §§ 55.01(6r), 55.14, 55.13 (psychotropic medications are also available as an *emergency* protective service). Moreover, Chapter 55 includes the generous provision of "*any* service" that would "prevent the individual from *experiencing deterioration or from inflicting harm* on himself or herself or another person." ***Id.*** at §55.01(6r)(k) (emphasis added).

The County argues that Helen's behavioral challenges were "all expected to improve with and be controlled by judicious use of psychotropic medications appropriate to her age and medical condition." (County's Br. at 23.) Psychotropic medications are defined under Chapter 55 as prescription drugs used to "treat or manage a psychiatric symptom or challenging behavior." **Wis. Stat.** § 55.01(6s). The administration of psychotropic medications that the County argues is Helen's singular need could have been provided to manage psychiatric symptoms and challenging behaviors, as intended, through Chapter 55.[1]

[1] Wis. Stat. §§50.08(3m) and (4)(a) permit a nursing home to administer a psychotropic medication to a resident with degenerative

The Wisconsin Association of County Corporation Counsels ("WACCC") claims a void will appear if Chapter 51 commitment is not available for those with degenerative brain disorders because involuntary administration of psychotropic medications under Chapter 55 is an insufficient solution. (WACCC Br. at 5-7). CWAG and the SEWI Alzheimer's Association emphatically agree with WACCC that psychotropic medications are not "magic bullets" that immediately control challenging behaviors. (***Id.*** at 6-7.) In fact, **there are no FDA-approved psychotropic medications for the psychiatric or behavioral symptoms of Alzheimer's disease; all such use is considered "off-label" and the medications include "black box" warnings that they can be dangerous, lethal, and inappropriate for use with persons with dementia.** Alzheimer's Ass'n, *Statement Regarding Treatment of Behavioral and Psychiatric Symptoms of Alzheimer's Disease,* (copy in Appendix).

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brain disorder without informed consent in certain circumstances. Compliance with 42 C.F.R. § 483.25(1) is required *before* utilizing this authority, meaning that nursing homes are required to prove that the challenging behaviors are persistent, harmful, and not caused by some underlying issue such as pain, illness, or environmental issues. *See* www.dhs.wisconsin.gov/rl_dsl/NHs/psychtroMed.htm

However, it is ironic that WACCC chooses this argument when the primary, and arguably exclusive, use of the Chapter 51 system for individuals with Alzheimer's disease and challenging behaviors – like Helen – is to remove the individual, provide medical treatment for issues like UTIs, and adjust or administer psychotropic medications. Chapter 55 can also remove the individual,[2] provide medical treatment, and adjust or administer psychotropic medications, whether voluntarily or through Wis. Stat. § 55.14.[3]

Moreover, Chapter 55 can provide a variety of follow-up and long-term care services for the individual in addition to necessary medication treatment, effectively helping prevent future behavioral challenges from escalating. *See* **Wis. Stat.** § 55.01(6r). Notably, Chapter 51 provides for long-term community supports under Wis. Stat. § 51.421, but only for persons with "serious and persistent mental illness" which excludes individuals with degenerative brain disorders by definition. **Wis. Stat.** § 51.01(14t).

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[2] CWAG and the SEWI Alzheimer's Association emphasize the importance of trying to treat challenging behaviors in the individual's current environment because mere removal can exacerbate the challenging behaviors. Alzheimer's Ass'n and Planning Council for Health and Human Servs., Inc., *Handcuffed: A Report of the Alzheimer's Challenging Behaviors Task Force* 1 (2010).

[3] Wis. Stat. § 55.08, *supra,* may also be an available option for the administration of psychotropic medications.

II. The County Created the Issue at Hand By Unnecessarily Beginning Under Chapter 51 and Then Converting the Case to Chapter 55 Because a Court Cannot Order the Involuntary Administration of Psychotropic Medications for an Individual with Degenerative Brain Disorder When Transferring a Case from Chapter 51 to Chapter 55.

The County makes perfectly clear that its solution to a case like Helen's is the use of psychotropic medications. (County's Br. at 23.) Helen had been prescribed psychotropic medications prior to her emergency detention, sometimes taking them voluntarily, sometimes protesting. (R: 16:2, 11:2.) After her case was transferred, she protested psychotropic medications at least twice during her 30-day protective placement, and this culminated in the second Chapter 51 petition to obtain an order allowing the involuntary administration of psychotropic medication to Helen. (R: 11:2.)

The situation at hand was in fact a problem of the County's own making. The second Chapter 51 proceeding was necessary because in a case converted from Chapter 51 to Chapter 55, as happened here, the Court cannot order psychotropic medications during the 30-day conversion phase. However, had the proceeding begun initially under

Chapter 55, the Court could have ordered involuntary psychotropic medications throughout Helen's treatment in an appropriate protective placement facility.

To elaborate, Wis. Stats. §§ 51.20(7)(d) and 51.67 limit a court's ability to order involuntarily administered psychotropic medications when a case is transferred from Chapter 51 to Chapter 55, rendering this law inadequate when applied to individuals with degenerative brain disorders.

Authority to order psychotropic medication requires a finding that the individual is "not competent to refuse psychotropic medication." **Wis. Stat.** §§ 51.20(7)(d)(1), 51.67. Both statutory sections expressly define this:

> "An individual is not competent to refuse psychotropic medication if, *because of serious and persistent mental illness*..."

Id. (emphasis added).

> "Serious and persistent mental illness" includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories, *but does not include degenerative brain disorder*..."

Id. at § 51.01(14t) (emphasis added).

This language is specifically defined for the scope of Chapter 51 and should be interpreted accordingly. ***State ex rel. Kalal v. Circuit Court for Dane County***, 2004 WI 58, ¶ 45, 271 Wis. 2d 633, 663, 681 N.W. 2d 110. A degenerative brain disorder is not a serious and persistent mental illness, thereby failing to meet the definition of "not competent to refuse psychotropic medication." **Wis. Stat.** §§ 51.20(7)(d)(1), 51.67. Thus, by initiating this case as a Chapter 51 involuntary commitment proceeding, the County lost the ability to request an order for psychotropic medication when the case was converted. Importantly, there is no such restriction in the Chapter 55 process, where "not competent to refuse psychotropic medication" specifically *includes* degenerative brain disorder in its definition. **Wis. Stat.** § 55.14(1)(b).

Chapter 51 leaves a gaping inadequacy when this provision is applied to an individual with a degenerative brain disorder. The County places significant weight on the use of psychotropic medications under Chapter 51, but they may not even be an option in some cases because of these provisions. In fact, it can be argued that if the County had proceeded

appropriately under Chapter 55 and obtained a medication order, this case would not be before the court.

This discrepancy strongly supports the Court of Appeal's appropriate interpretation of the legislative intent behind the *exclusion* of the term "degenerative brain disorder" from Chapter 51 and its *inclusion* in Chapter 55. ***Fond du Lac County v. Helen E.F.***, 2011 WI App 72, ¶¶ 24-26, 333 Wis. 2d 740, 798 N.W.2d 707. Had the Legislature intended Chapter 51 to apply to individuals with degenerative brain disorders, the common use of and need for psychotropic medications (as evident by Helen's case) during these emergency and subsequent transfers would have been provided for under Chapter 51's alternative to commitment.

III. Current Practice Using Chapter 51's Conversion Process to Chapter 55 Raises Significant Due Process and Equal Protection Concerns.

"[C]ivil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection." ***Addington v. Texas***, 441 U.S. 418, 425 (1979). We support Helen E.F.'s argument that constitutional concerns are raised by this case, and raise our own with respect to emergency detentions converted to Chapter 55

protective placements made to mental health facilities. (Helen E.F.'s Br. at 25-26.)

WACCC states that under Wis. Stat. § 51.20(7)(d), courts can convert Chapter 51 commitments to Chapter 55 protective services/placement proceedings and guardianship and that this is a sufficient "check" to prevent inappropriate use of Chapter 51. (WACCC Br. at 7.) Unfortunately, this "check" is used inappropriately as a method to obtain 30-day mental commitments without respect to an individual's due process and equal protection rights. Helen's initial Chapter 51 emergency detention was transferred to a Chapter 55 protective placement after a finding of no probable cause to mentally commit her, but she was protectively placed in the behavioral health unit at St. Agnes Hospital where she remained. (R: 9:3, 4.)

Prior to 2005 Wis. Act 264, the Act that drastically changed Chapter 55's protective service system, Chapter 55 actually permitted limited protective placement by the court to units for the acutely mentally ill. The Joint Legislative Council Prefatory Note explains the reason why this authority was removed by 2005 Wis. Act 264:

> Under State ex rel. Watts v. Combined Community Services, 122 Wis. 2d 65 (1985), the court found that no rational basis existed for the difference between procedural protections that are afforded to persons who are involuntarily committed for mental health treatment under the mental health laws and the lack of any procedural protections (other than those that are self-requested) for involuntary transfers for psychiatric diagnostic procedures or acute psychiatric inpatient treatment under the protective placement laws. The court held that the constitutional guarantee of equal protection requires that the procedural requirements for emergency detention and involuntary commitment under the mental health laws must be provided to a protectively placed individual for involuntary transfer of that individual to a mental health facility for treatment. This bill amends ch. 55 to comply with the court's ruling.

2005 Wisconsin Session Laws, Volume 2, 2005 Wis. Act 264, *Joint Legislative Council Prefatory Note*, 2005 Assembly Bill 785 (enacted April 5, 2006); *see* ***State ex rel. Watts v. Combined Cmty. Servs.***, 122 Wis. 2d 65, 84, 362 N.W. 2d 104, 113 (1985).

There is now only one exception, relevant *only* to Chapter 51 transfers to protective placement because it is impermissible under Chapter 55:

> "[i]f the individual is in a treatment facility, the individual may remain in the facility during the period of temporary protective placement *if no other appropriate facility is available*."

Wis. Stat. §§ 51.20(7)(d), 51.67 (emphasis added).

Unfortunately, what was intended as an exception has become the norm for individuals with degenerative brain disorders. This deeply concerning practice takes a class of individuals for whom Chapter 51 is not intended to apply and violates their equal protection rights both through the original commitment and through this subsequent option that WACCC argues acts as a protection against inappropriate use of Chapter 51.

IV. The Consequences of This Decision Are of Serious Public Policy Concern if Individuals with Alzheimer's Disease are Allowed to be Mentally Committed for Their Challenging Behaviors.

This decision will have serious and widespread consequences, regardless of how decided. The sobering reality is that Wisconsin is not adequately prepared to meet the needs of the rising Alzheimer's population. Obviously, this case will not solve that problem, no matter the outcome.

Systemic change, possibly legislative change, will be necessary. Education about working with challenging behaviors and utilizing proven efforts – legal, medical, environmental, social, among others – during the escalating time prior to an emergency situation like Helen's to ultimately prevent that emergency is vital and currently lacking. Alzheimer's Ass'n, *Statement Regarding Treatment of Behavioral and Psychiatric Symptoms of Alzheimer's Disease;* Kovach et al, *Behaviors of Nursing Home Residents with Dementia Examining Nurse Responses* (2006) (copies in Appendix).

We must emphasize the distinction between mentally committing someone for a qualifying mental illness as opposed to a challenging behavior of degenerative brain disorder. The County seeks to muddle the waters by arguing that Helen's behavioral disturbances, not the degenerative brain disorder itself, constitute a mental illness. (County's Br. at 10.) CWAG and the SEWI Alzheimer's Association agree with the Elder Law Section of the State Bar of Wisconsin ("Elder Law") that broadening the definition of "mental illness" to include any behavioral manifestation of a degenerative brain disorder would result in an appallingly

broad definition in violation of substantive due process. We agree with the Court of Appeals that its decision does not foreclose the use of Chapter 51 for an individual who has a legitimate dual diagnosis of a Chapter 51 qualifying mental illness requiring treatment and a degenerative brain disorder. ***Helen E.F.***, 2011 WI App, n.6. It is not unfathomable for an individual with a qualifying Chapter 51 mental illness to also suffer from Alzheimer's. Our grave concern is that endorsing the County's profligately broad interpretation will encourage an already prevalent, unlawful and inappropriate practice of mentally committing individuals for behavioral challenges arising from other etiologies like boredom, pain, fear, medication side effect, overstimulation, or unmet daily care needs[4] – none of which are a qualifying mental illness and all of which can be more appropriately managed far outside a Chapter 51 mental commitment.

CWAG and the SEWI Alzheimer's Association understand the enormity of the consequence of what we ask. Transitioning the care of individuals with Alzheimer's disease and challenging behaviors back to the neglected Chapter 55

[4] For more information about the etiologies of behavioral challenges, *see* Michelle Niedens, *The Neuropsychiatric Symptoms of Dementia: A Visual Guide to Response Considerations* (copy in Appendix).

system from the deeply rooted but inappropriate Chapter 51 system will require systematic adjustment statewide. But bending a law at the expense of someone's liberty to avoid change is not an option. The rights of this vulnerable population must be upheld, proper care provided, and a legal and solid foundation established to help Wisconsin rise to meet what is appropriately labeled at the national level as the "Alzheimer's disease crisis."[5]

If degenerative brain disorders are classified as a mental illness, the thousands of individuals in Wisconsin with Alzheimer's disease and powers of attorney for health care ("POAHC") will be ushered through guardianship and protective placements, flooding the probate court system. Wisconsin Statutes Chapter 155 relies on the fact that a person has a mental illness, regardless of whether or not they will be involuntarily committed. Yes, using Chapter 55 for individuals in Helen's situation means guardianship and protective placement,[6] but in far fewer numbers than if

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[5] The National Alzheimer's Project Act, Pub. L. No. 111-375, 124 Stat. 4100 (2011) requires creation of a national strategic plan to address the rapidly escalating Alzheimer's disease crisis and will coordinate Alzheimer's disease efforts across the federal government.

[6] Wis. Stat. § 54.46(2)(b) limits any necessary guardianship proceeding to only what authority is needed that was not authorized in the POAHC;

required for every individual with Alzheimer's disease admitted to a facility under a POAHC. **Wis. Stat.** § 54.46(2)(b).

Overturning the Court of Appeals decision will mean that individuals with Alzheimer's disease will continue to be placed in a setting where Wisconsin law has never permitted them to be placed or where their equal protection and due process rights are violated. Some will continue to languish in a mental health facility after medications are adjusted because no facility will take them back with the stigma of mental illness, while others will be returned to their home or facility to simply wait for the next UTI, the next set of handcuffs, and the next mental commitment.

CONCLUSION

For the reasons set forth above, the Coalition of Wisconsin Aging Groups and the Alzheimer's Association of Southeast Wisconsin respectfully request this Court to affirm the decision of the Court of Appeals. This Brief represents only the position of CWAG and the SEWI Alzheimer's

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the POAHC remains in place for all other authority given to the agent, unless the court finds good cause to revoke or limit the agent's authority.

Association and is not specifically ratified by other chapters or the National Alzheimer's Association.

Dated this 14th day of November, 2011.

Respectfully submitted:

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Madison, WI 53718

CERTIFICATION AS TO FORM/LENGTH

I certify that this brief conforms to the rules contained in s. 809.19 (8) (b) and (c) for a brief and appendix produced with a proportional serif font. The length of this brief is 2,981 words.

Dated this 14th day of November, 2011.

Signed: _____
Maren Beermann
State Bar No. 1065893

CERTIFICATION OF COMPLIANCE WITH RULE 809.19(12)

I certify that I have filed an electronic copy of this brief in compliance with the requirements of s. 809.19(12). I certify that this electronic brief is identical to the text of the paper copy of the brief.

Dated this 14th day of November, 2011.

Signed: _____
Maren Beermann
State Bar No. 1065893

APPENDIX

Record has been so reproduced to preserve confidentiality.

INDEX TO APPENDIX

2011 WI APP 72

COURT OF APPEALS OF WISCONSIN
PUBLISHED OPINION

Case No.: 2010AP2061

†Petition for Review Filed

Complete Title of Case:

IN THE MATTER OF THE MENTAL COMMITMENT OF HELEN E. F.:

FOND DU LAC COUNTY,

PETITIONER-RESPONDENT,†

V.

HELEN E. F.,

RESPONDENT-APPELLANT.

Opinion Filed:	April 27, 2011
Submitted on Briefs:	December 8, 2010
JUDGES:	Brown, C.J., Anderson and Reilly, JJ.
Concurred:	
Dissented:	
Appellant ATTORNEYS:	On behalf of the respondent-appellant, the cause was submitted on the briefs of *Donald T. Lang*, assistant state public defender, Madison.
Respondent ATTORNEYS:	On behalf of the petitioner-respondent, the cause was submitted on the brief of *William J. Bendt* of *Fond du Lac County Corporation Counsel*, Fond du Lac.
NonParty Briefs	Nonparty briefs were filed by *Maren Beermann* of *Coalition of Wisconsin Aging Groups*, Madison; *Andrew T. Phillips* and *Daniel J. Borowski* of *Phillips Borowski, S.C.*, Mequon, for Wisconsin Counties Association; and *Kristin M. Kerschensteiner* of *Disability Rights Wisconsin*, Madison.

2011 WI App 72

COURT OF APPEALS
DECISION
DATED AND FILED

April 27, 2011

A. John Voelker
Acting Clerk of Court of Appeals

NOTICE

This opinion is subject to further editing. If published, the official version will appear in the bound volume of the Official Reports.

A party may file with the Supreme Court a petition to review an adverse decision by the Court of Appeals. *See* WIS. STAT. § 808.10 and RULE 809.62.

Appeal No. 2010AP2061 Cir. Ct. No. 2010ME146

STATE OF WISCONSIN IN COURT OF APPEALS

IN THE MATTER OF THE MENTAL COMMITMENT OF HELEN E. F.:

FOND DU LAC COUNTY,

PETITIONER-RESPONDENT,

V.

HELEN E. F.,

RESPONDENT-APPELLANT.

APPEAL from orders of the circuit court for Fond du lac County: RICHARD J. NUSS, Judge. *Reversed and cause remanded with directions.*

Before Brown, C.J., Anderson and Reilly, JJ.

¶1 ANDERSON, J. Helen E. F. appeals from an order for commitment and an order for involuntary medication. The evidence presented at trial was

insufficient to sustain Helen's WIS. STAT. ch. 51 (2009-10)[1] involuntary commitment as a matter of law given that Helen, who is afflicted with Alzheimer's disease, does not suffer from a qualifying mental condition and is not a proper subject for treatment. We therefore reverse and remand the orders and instruct the trial court to proceed not inconsistently with this opinion.

Standard of Review

¶2 Construction of a statute is a question of law. As to questions of law, this court is not required to give special deference to the trial court's determination. ***Hucko v. Joseph Schlitz Brewing Co.***, 100 Wis. 2d 372, 376, 302 N.W.2d 68, 71 (Ct. App. 1981). When interpreting a statute, we begin with the language of the statute. ***State ex rel. Kalal v. Circuit Court for Dane Cnty.***, 2004 WI 58, ¶45, 271 Wis. 2d 633, 681 N.W.2d 110. We give words their common and ordinary meaning unless those words are technical or specifically defined. ***Id.*** We do not read the text of a statute in isolation, but look at the overall context in which it is used. ***Id.***, ¶46. When looking at the context, we read the text "as part of a whole; in relation to the language of surrounding or closely related statutes; and reasonably, to avoid absurd or unreasonable results." ***Id.*** Thus, the scope, context, and purpose of a statute are relevant to a plain-meaning interpretation "as long as the scope, context, and purpose are ascertainable from the text and structure of the statute itself." ***Id.***, ¶48. If the language is clear and unambiguous, we apply the plain words of the statute and ordinarily proceed no further. ***Id.***, ¶46.

[1] All references to the Wisconsin Statutes are to the 2009-10 version unless otherwise noted.

¶3 The inquiry does not stop if a statute is ambiguous, meaning that "it is capable of being understood by reasonably well-informed persons in two or more senses." ***Id.***, ¶47. If a statute is ambiguous, we may turn to extrinsic sources. ***Id.***, ¶51. Extrinsic sources are sources outside the statute itself, including the legislative history of the statute. ***Id.*** We sometimes use legislative history to confirm the plain meaning of an unambiguous statute, but we will not use legislative history to create ambiguity where none exists. ***Id.***

Facts

¶4 The facts are not in dispute. Helen is an eighty-five-year-old woman with Alzheimer's dementia. Her condition has regressed to the point that "she is very limited in any verbal communication." Helen's appearance at the proceedings in this case was waived because "she would not understand or comprehend or be able to participate meaningfully."

¶5 *Motion to Dismiss*: Prior to the probable cause hearing on May 18, 2010, Helen's attorney moved the court to dismiss the WIS. STAT. ch. 51 proceeding. In support of the motion, Helen's attorney outlined the procedural history of Helen's confinement.

¶6 Helen's attorney explained that Helen was taken to St. Agnes Hospital on April 12, 2010. On April 15, 2010, a probable cause hearing was conducted on a prior WIS. STAT. ch. 51 petition. Following this hearing, the court commissioner concluded there was not sufficient probable cause to proceed. At that point, the ch. 51 petition was converted to a WIS. STAT. ch. 55 protective placement action and a thirty-day temporary guardianship was issued.

¶7 The thirty-day-time period to proceed with the WIS. STAT. ch. 55 protective placement expired on May 15 and a second WIS. STAT. ch. 51 petition was filed. Helen's attorney argued that contrary to the teaching of ***State ex rel. Sandra D. v. Getto***, 175 Wis. 2d 490, 498 N.W.2d 892 (Ct. App. 1993), the filing of this new ch. 51 petition constituted an impermissible attempt "to circumvent this time limit." Counsel argued the new ch. 51 petition must be dismissed, because "[y]ou can't keep detaining and detaining and detaining an individual once that time period has expired."

¶8 Insisting that the new WIS. STAT. ch. 51 proceeding was the product of "a separate petition," Fond du Lac County argued that Helen "hasn't been detained continuously under the old order" because after the thirty-day-time period expired for the WIS. STAT. ch. 55 protective placement action and a thirty-day temporary guardianship, "she was wheeled off the unit, and then she was brought back on." The County argued that because she was off the unit, that ended the thirty-day order and therefore, "[t]his [was] a new detention." When pressed as to how long Helen was "wheeled off the unit," the County responded:

> She was off the unit. It doesn't matter how long she was off the unit. She was off the unit. And that ended the 30-day order. This is a new detention. This is a new detention. It doesn't matter if it's two seconds; it split in two, it is not continuous.

¶9 The County further defended the filing of the second WIS. STAT. ch. 51 petition, maintaining it was based on new information since the prior ch. 51 petition was dismissed. According to the County, at the time the prior ch. 51 petition was dismissed, it appeared that Helen's disruptive behavior was the product of a medical problem, i.e., a urinary tract infection. The County argued that inasmuch as Helen's disruptive behavior has continued even after this medical

condition was treated, it now appears that Helen's disruptive behavior is the product of her dementia. The County further argued:

> [Y]ou can have a [WIS. STAT. ch.] 51 on someone with dementia, in that dementia is treatable in some way and this one is treated. She is not going to get cognitively better, but it's going to improve or control the aggressiveness, the physical aggressiveness that she is showing....

Helen's attorney maintained the position that the filing of a new WIS. STAT. ch. 51 petition constituted an end run around the government's failure to comply with the time limits of a prior WIS. STAT. ch. 55 proceeding. The trial court denied Helen's motion to dismiss without explanation: "I'll deny your motion."

¶10 *Probable cause hearing.* During the probable cause hearing that immediately followed the court's denial of Helen's motion to dismiss, the County presented testimony from psychiatrist Dr. Brian Christenson. Christenson treated Helen during her initial WIS. STAT. ch. 51 emergency detention at St. Agnes on April 12, 2010, and throughout the subsequent thirty-day WIS. STAT. ch. 55 emergency placement order. In Christenson's opinion, Helen suffers from "[s]enile dementia of Alzheimer's type." Christenson explained that this "progressive loss of brain function, brain deterioration" is exhibited in the following ways:

> [S]he is extremely confused and forgetful and disoriented and agitated, aggressive, uncooperative, anxious, incontinent, and unable to carry on conversations; it grossly impaired her judgment and she is unable to make any decisions regarding her own self care.

Christenson was "not certain" whether Helen's agitation and aggressiveness was related to the dementia or the urinary tract infection, but believed it was "most likely predominantly from the dementia."

¶11 With regard to whether Helen's dementia was subject to treatment, Christenson indicated "the cognitive deterioration is not treatable, but the psychiatric complications of her dementia are treatable," in that "her agitation, aggressiveness, combativeness can be treated with medications that can have some calming effects." Helen is "completely unable to understand" the advantages and disadvantages of the medication. In Christenson's opinion, Helen poses a danger to herself and others through her combativeness with treatment staff and "could harm herself inadvertently."

¶12 Christenson noted that when Helen was taken off the unit at St. Agnes, he "[did not] think she was placed anywhere." Further, Christenson acknowledged that Helen was off the unit "[n]ot very long" and that he believed she was wheeled off the unit because of a problem with the expiration of the WIS. STAT. ch. 55 thirty-day-time period. The court found sufficient probable cause to proceed.

¶13 *Final commitment hearing.* The final commitment hearing was conducted on May 28, 2010. The sole witness at the hearing, psychiatrist Dr. Robert Rawski, testified that Helen "suffers from Alzheimer's Dementia with a behavioral disturbance," that Helen "has progressive dementia" and "has been in a nursing home for the last six years." Rawski explained that Helen's "dementia has progressed to the point where she is very limited in any verbal communication" and she is "so cognitively impaired by her dementia" that she is unable to express an understanding of the advantages or disadvantages of medication.

¶14 Rawski further explained that Alzheimer's dementia can involve behavioral disturbances such as "poor judgment, aggression towards others,

periods of agitation [and] wandering." And that "[c]ognitively, [dementia] is not considered to be a treatable mental disorder. It's a progressive mental defect that is not treatable." Rawski indicated, however, that the behavioral disturbances resulting from dementia are subject to treatment. He said that treatment consists of using medications to address impulsivity, agitation, and physical combativeness.

¶15 Rawski testified that it was his opinion that Helen poses a risk of harm to others due to her impulsive combativeness and grabbing of treatment staff. Rawski said he believed, due to "her advanced age, medical issues, and dementia," Helen also poses a risk of harm to herself because she is unable to manage her daily needs. Based on Rawski's testimony, the trial court found that the grounds for a WIS. STAT. ch. 51 commitment and an involuntary medication order had been proven by clear and convincing evidence. A ch. 51 commitment order and an involuntary medication order were entered following the bench trial. Helen appeals both orders.

The Alzheimer's Challenging Behaviors Task Force Report[2]

¶16 We begin by noting that the issues raised in this case are of great public import. The number of people aged sixty-five or older with Alzheimer's disease is expected to reach 7.7 million in 2030 from the current 5.3 million. Nearly one out of two people who reach age eighty-five will develop Alzheimer's.

[2] *See Handcuffed: A Report of the Alzheimer's Challenging Behaviors Task Force*, http://www.planningcouncil.org/PDF/Alzheimers_Report_Handcuffed.pdf (last visited Apr. 17, 2011). For readability, we do not repeatedly cite to the link to our source. However, the discussion and facts are all derived from the task force report unless otherwise noted.

In Wisconsin alone, the current number of people with Alzheimer's is estimated at 110,000. All too often, instead of engaging in behavioral management techniques or careful discharge planning, facilities will use WIS. STAT. ch. 51 civil commitment procedure to immediately remove residents with challenging behaviors, many of whom suffer from Alzheimer's disease.

¶17 One way to measure the greatness of our society is to look at how we treat our weakest members, such as our growing population of people afflicted with Alzheimer's.[3] In April 2010, the Alzheimer's Challenging Behaviors Task Force was called together by the Alzheimer's Association of Southeastern Wisconsin to look into the treatment of people with Alzheimer's. The task force was called together following the tragic death of Richard Petersen. Petersen, an eighty-five-year-old gentleman with late stage dementia who exhibited challenging behaviors, was placed under emergency detention after being at two hospitals, and was eventually transferred by police to the Milwaukee County Behavioral Health Division where his family found him tied in a wheel chair with no jacket or shoes. In spite of his family's efforts to intervene, he later developed pneumonia, was transferred to a hospital, and died. The Alzheimer's Association and scores of members of the community were deeply concerned, not only about the treatment of Mr. Petersen and his family, but about others in the Milwaukee county area that are in the same or similar circumstances. The Alzheimer's Association sought and obtained support from several charitable foundations to

[3] A similar sentiment is often attributed to Mohandas Karamchand Gandhi (2 Oct. 1869-30 Jan. 1948), commonly known as Mahatma Gandhi: "A nation's greatness is measured by how it treats its weakest members." http://www.biography.com/articles/Mahatma-Gandhi-9305898 (last visited Apr. 14, 2011); Timothy A. Kelly, *Healing the Broken Mind: Transforming America's Failed Mental Health System* 1 (N.Y. University Press 2009).

partner with the Planning Council for Health and Human Services, Inc., to staff a task force and produce a report to the community.

¶18 The task force found that using WIS. STAT. ch. 51 as a vehicle to deal with challenging behaviors in persons with dementia can lead to transfer trauma, medical complications, exacerbated behaviors, and even death. The use of ch. 51 emergency detentions and the administration of psychotropic drugs, though common, are controversial strategies used to deal with challenging behaviors among people with Alzheimer's and related dementias.[4] These two controversial strategies are precisely what were used to deal with Helen's challenging behaviors.

¶19 While WIS. STAT. ch. 51 provides a means to place persons with mental illness who are considered to be a danger to themselves or others in emergency detention and to administer involuntary treatment, the task force found that a ch. 51 petition is often used for persons with Alzheimer's and related dementias. It found that the usual treatment is the involuntary administration of psychotropic drugs to reduce agitation and aggression and produce a state of sedation. "People come to us in handcuffs, they are out of their milieu, they are put on someone else's schedule, put on meds, and are surrounded by chaos. This will worsen their situation. If they weren't confused before, they will be now."

[4] Other strategies that are used to deal with challenging behaviors among people with Alzheimer's and related dementias reflect promising practices, including activities and interventions that incorporate the interaction of the person with dementia, the caregiver and the environment in which the behaviors occur. These include formal support for caregivers, training in promising methods of assessment and intervention, a culture shift toward "person-centered" care, pain management, use of the Star Method, and instituting appropriate policies and guidelines within facilities regarding the management of challenging behaviors among people with Alzheimer's disease and other dementias.

¶20 Finally, the task force found that across Wisconsin, there is variation in the way different counties apply WIS. STAT. ch. 51 to people who have Alzheimer's and related dementias. At least two counties do not believe ch. 51 should apply to this population and will not prosecute older adults with dementia under ch. 51.

Discussion and Law

¶21 Helen's case provides the opportunity to clarify the proper application of WIS. STAT. ch. 51 and eliminate the variation in ways counties apply the law to people who have Alzheimer's and related dementias.

¶22 Our consideration of the law and the parties' arguments, as well as the well-written amicus briefs[5] and task force report, lead us to conclude that Helen was not a proper subject for detainment or treatment under WIS. STAT. ch. 51 because Alzheimer's disease is not a qualifying mental condition under that chapter.

¶23 Both WIS. STAT. chs. 51 and 55 define "degenerative brain disorder" as the "loss or dysfunction of brain cells to the extent that the individual is substantially impaired in his or her ability to provide adequately for his or her own care or custody or to manage adequately his or her property or financial affairs." WIS. STAT. §§ 55.01(1v) & 51.01(4r). WISCONSIN STAT. ch. 46 specifically defines Alzheimer's disease as "a *degenerative disease* of the central nervous

[5] We are grateful to Disability Rights Wisconsin, Coalition of Wisconsin Aging Groups, and Wisconsin Counties Association for the very helpful and well-written briefs, pertinent parts of which we track in this opinion.

system characterized especially by premature senile mental deterioration, and also includes any other irreversible deterioration of intellectual faculties with concomitant emotional disturbance resulting from organic brain disorder." WIS. STAT. § 46.87(1)(a) (emphasis added). Thus, looking at the text of these closely related statutes, we are able to ascertain that Alzheimer's disease is simply one type of a degenerative brain disorder. *See* ***Kalal***, 271 Wis. 2d 633, ¶46.

¶24 We further conclude that the intended application of the term "degenerative brain disorder" in WIS. STAT. chs. 51 and 55 is unambiguous. Chapter 51's definition of the term is included only to specifically *exclude* it from the chapter's authority, whereas ch. 55's definition is used to *include* it in the scope of authority granted under ch. 55's protective placement and services laws. In ch. 51, "degenerative brain disorder" is referred to only as an exception to both the definitions of "developmental disability" and "serious and persistent mental illness." WIS. STAT. § 51.01(5)(a) & (14t). Chapter 51's definition of "mental illness" is silent on the term "degenerative brain disorder," and defines "mental illness" for purposes of involuntary commitment as "a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, but does not include alcoholism." Sec. 51.01(13)(b).

¶25 Accordingly, it would be inconsistent to include "degenerative brain disorder" in this statutory definition. Even though the definition of "mental illness" does not specifically exclude the term "degenerative brain disorder," "degenerative brain disorder" is specifically statutorily defined separately from "mental illness," thereby creating an intentional distinction between the two terms.

¶26 Contrary to WIS. STAT. ch. 51, WIS. STAT. ch. 55 specifically *includes* individuals with degenerative brain disorders when defining the scope of who may receive protective services and for whom emergency and temporary protective placements may be made. WIS. STAT. §§ 55.01(6r)(k), 55.135(1). Even more telling is each respective statutory section's initial statement of legislative policy. Chapter 51 states that "[i]t is the policy of the state to assure the provision of a full range of treatment and rehabilitation services in the state for all mental disorders and developmental disabilities and for mental illness, alcoholism and other drug abuse." WIS. STAT. § 51.001. Chapter 55 explains that "[t]he legislature recognizes that many citizens of the state, because of serious and persistent mental illness, *degenerative brain disorder*, developmental disabilities, or other like incapacities, are in need of protective services or protective placement." WIS. STAT. § 55.001 (emphasis added). Notably and repeatedly absent from ch. 51 is the term "degenerative brain disorders" and, just as notably, the term is specifically included throughout ch. 55. *See* ***Kansas v. Hendricks***, 521 U.S. 346, 359 (1997) ("[W]e have traditionally left to legislators the task of defining terms of a medical nature that have legal significance.").

¶27 Moreover, the primary purpose of WIS. STAT. ch. 51 is to provide treatment and rehabilitation services for the individuals described in ch. 51's legislative policy. WIS. STAT. § 51.001. Even if we were to assume, which we do not, that Alzheimer's disease could reasonably be classified under ch. 51's definition of "mental illness," commitment of an individual with Alzheimer's disease under ch. 51 is nonetheless not appropriate because Alzheimer's disease falls outside the scope of ch. 51's limited definition of "treatment." "Treatment" is defined by ch. 51 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." WIS. STAT. § 51.01(17).

¶28 Consequently, rehabilitation is a necessary element of treatment under WIS. STAT. ch. 51. Because there are no techniques that can be employed to bring about rehabilitation from Alzheimer's, an individual with Alzheimer's disease *cannot* be rehabilitated. Accordingly, Helen is not a proper subject for ch. 51 treatment. *See Alzheimer's Association, 2010: Alzheimer's Disease Facts and Figures*, http://www.alz.org/documents_custom/report_alzfactsfigures2010.pdf, 8 (last visited Apr. 8, 2011).

¶29 Though we could end here, we consider it relevant to note that this court has in fact distinguished the term "rehabilitation" from "habilitation" in a similar WIS. STAT. ch. 51 context. *See* ***Milwaukee Cnty. Combined Cmty. Servs. Bd. v. Athans***, 107 Wis. 2d 331, 334-35, 320 N.W.2d. 30 (Ct. App. 1982). In ***Athans***, Milwaukee County Combined Community Services Board petitioned the trial court for the involuntary commitment of Theodora Athans and Gerald Haskins pursuant to WIS. STAT. § 51.20. ***Athans***, 107 Wis. 2d at 332. The trial court found Athans mentally ill and evincing a danger to herself, but not a proper subject for treatment. ***Id.*** at 333. The trial court found Haskins developmentally disabled, but not a proper subject for treatment. ***Id.*** The trial court ordered both petitions dismissed. ***Id.***

¶30 The Board appealed, arguing that we should broadly construe the term rehabilitation to include within it habilitation in order to carry out the intent of the legislature as embodied in WIS. STAT. ch. 51. ***Athans***, 107 Wis. 2d at 335. We determined that "[o]nly if rehabilitation includes habilitation may we say that Athans and Haskins are proper subjects for treatment." ***Id.*** The two issues on

appeal then were (1) whether treatment as defined in WIS. STAT. § 51.01(17) includes habilitation as well as rehabilitation and (2) whether the findings of the trial court are against the great weight and clear preponderance of the evidence. ***Athans***, 107 Wis. 2d at 335.

¶31 In order to determine whether WIS. STAT. ch. 51 treatment included "habilitation" as well as "rehabilitation," we looked to the definitions given by and agreed upon by the two testifying doctors. ***Athans***, 107 Wis. 2d at 334, 336. "Habilitation" means "the maximizing of an individual's functioning and the maintenance of the individual at that maximum level." ***Id.*** at 334. "Rehabilitation" means "returning an individual to a previous level of functioning which had decreased because of an acute disorder." ***Id.*** We then concluded that "rehabilitation is not an ambiguous term with two or more meanings of which one meaning might include habilitation." ***Id.*** at 335. We held that because WIS. STAT. § 51.01(17) defines treatment in terms of rehabilitation *only* and because the terms habilitation and rehabilitation are separate and distinct in their meanings, Athans and Haskins—*who were unable to be rehabilitated*—were therefore not suitable for ch. 51 treatment. ***Athans***, 107 Wis. 2d at 335-37.

¶32 ***Athans*** is very much on point. Like Athans and Haskins, Helen has a condition that cannot be rehabilitated; thus, like Athans and Haskins, Helen is not suitable for WIS. STAT. ch. 51 treatment. *See* ***Athans***, 107 Wis. 2d at 335-37.

¶33 Finally, the legislative scheme concerning involuntary civil commitment supports our holding today, just as strongly as it supported our holding in ***Athans***. *See* ***id.*** at 337. WISCONSIN STAT. ch. 51 provides for active treatment for those who are proper subjects for treatment, while WIS. STAT. ch. 55 provides for residential care and custody of those persons with mental disabilities

that are likely to be permanent. *See **Athans***, 107 Wis. 2d at 337. With the ever-growing Alzheimer's population, "[t]he distinction between these two statutes must be recognized and maintained." *See **id.***

¶34 Helen is not a proper subject for treatment under WIS. STAT. ch. 51. We therefore reverse the orders and remand with instructions to proceed not inconsistently with this opinion.[6]

By the Court.—Orders reversed and cause remanded with directions.

[6] The appellants also argued that the trial court lacked competency to proceed. We need not reach this argument given our holding. *See **Walgreen Co. v. City of Madison***, 2008 WI 80, ¶2, 311 Wis. 2d 158, 752 N.W.2d 687 (noting that when resolution of one issue is dispositive, we need not reach other issues raised by the parties).

We also leave for another day the question of what is proper under the law when a person has a duel diagnosis of Alzheimer's and a WIS. STAT. ch. 51 qualifying illness.

Associates in Psychiatry and the Law
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May 26, 2010

FILED
MAY 26 2010
FOND DU LAC COUNTY
PROBATE COURT

The Honorable Richard J. Nuss
Circuit Court—Branch 3
Fond du Lac County Courthouse
160 South Macy Street
Fond du Lac, Wisconsin 54935

RE: HELEN E. F[redacted]
DOB: 02/06/1925
CASE NO: 10-ME-146

Dear Judge Nuss:

Pursuant to a court order dated May 17, 2010 and Wisconsin Statute 51.20, I evaluated Helen F[redacted]s suitability for civil commitment in Fond du Lac County.

Database: My evaluation consisted of the following:

1. A psychiatric interview conducted on May 24, 2010 at St. Agnes Hospital in Fond du Lac.

2. A review of the original petition for examination authored by St. Agnes staff dated May 14, 2010.

3. A review of Ms. F[redacted]s treatment records at St. Agnes Hospital.

Preliminary Advisement: Prior to beginning this evaluation, I attempted to inform Ms. F[redacted] of the purpose of the evaluation and limits of confidentiality. I attempted to explain that she had the legal right to remain silent and that what she told me would not be confidential, but would rather be used by the Court in determining its opinion regarding her suitability for civil commitment. I also attempted to explain that this information would be conveyed to the Court in a report with copies for the judge, the County attorney and her attorney. While Ms. F[redacted] listened to the advisement, she mumbled irrelevant questions and showed me some folded washcloths in front of her on the table. At no time did she indicate that she understood the purpose of the evaluation or the limits of confidentiality.

Collateral Record Review: Helen F[redacted] is 85-year-old Caucasian female who has resided at All About Life Nursing and Rehabilitation Center in Fond du Lac for the last six years. Ms. F[redacted] has a host of medical problems including hypertension, osteoarthritis, hyperlipidemia, anemia and chronic kidney disease. She also suffers from Alzheimer's disease which has grown progressively worse over the years. In late March and early April 2010, Ms. F[redacted] became increasingly agitated and physically struck out at caregivers at All About Life while refusing meds and meals. On April 12, 2010 she became physically aggressive toward others at the nursing home and at the emergency room at St. Agnes Hospital where she was taken for medical care. She was diagnosed with a urinary tract infection, but required restraint and intramuscular medication secondary to her degree of agitation and aggressiveness. Fond du Lac police were called and an emergency detention was filed secondary to her combative behavior. A probable cause hearing was held on April 15, 2010, at which time an order for temporary protective placement at St. Agnes for a period of up to 30 days was instituted and Ms. F[redacted]'s daughter was named temporary guardian.

Prior to her hospitalization, Ms. F[redacted] was treated with three different medications for depression, anxiety and physical aggressiveness, namely Seroquel, Celexa and Depakote. Early in her hospital course, the Depakote was increased in an attempt to reach a therapeutic blood level. Her Depakote level on admission was barely detectable, consistent with reports that she had been refusing medications prior to her hospitalization. Subsequent blood levels drawn at St. Agnes could not be located within the medical records. Secondary to confusion and periods of agitation, Ms. F[redacted] required a one-to-one sitter for the first ten days of hospital course. The sitter was discontinued during a period in which the Seroquel was being tapered secondary to unsteadiness and a fall, and a small dosage of the anti-anxiety medication Ativan was added in its place. Within one week, the sitter was reinstituted secondary to re-emergence of aggressive behavior. Possible causes for the return of aggressiveness included the discontinuation of Seroquel or the addition of Ativan which may have contributed to a disinhibition of behavior. A third possibility was the re-emergence of another urinary tract infection, ultimately diagnosed in mid-May 2010.

Ms. F[redacted] was prescribed the antipsychotic/mood-stabilizer Risperdal on May 12, 2010, the dosage of which was increased two days later. Within one week, the one-to-one sitter was again discontinued and, over the four days prior to this evaluation, she was only noted on one occasion to have been combative with staff but at least two occasions to have resisted or refused to take medications.

Treatment notes and the petition for examination detail Ms. F[redacted]'s aggressive behavior. These episodes primarily occur when assisting her to get into the bathroom or to clean her as she is unable to manage those cares on her own. She has hit or scratched caregivers, struck one nurse in the chest and another in the head, and had also been grabbing at peers as they walk by. At the time of the petition for examination dated May 14, 2010 shortly before the expiration of the 30-day temporary protective placement, Ms.

one sitter during periods in which medications used to decrease impulsivity and aggression were withdrawn. It appears that her behavior is once again improving with the treatment of a second episode of urinary tract infection and the institution of the anti-psychotic/mood-stabilizer Risperdal. Unfortunately her cognitive capacities to understand her illness and consistently cooperate with treatment remain quite impaired.

Opinions Regarding Civil Commitment: I hold the following opinions to a reasonable degree of medical certainty.

1. Helen F[redacted] suffers from a mental illness as defined by the Wisconsin State Statute 51.01(13)(b). She does not suffer from a developmental disability or drug dependence.

2. Ms. F[redacted] is a proper subject for treatment at this time. Her treatable symptoms of dementia include the behavioral disturbance characterized by irritability, mood lability, hostility, impulsive episodes of agitation, and physical combativeness, all expected to improve with the judicious use of appropriate psychotropic medications.

3. Ms. F[redacted]'s acute risk of harm to herself and others remains a daily concern given the need for treatment staff to assist her with daily cares in order to reduce the potential for morbidity and mortality associated with medical illnesses and infection. During routine cares, Ms. F[redacted] has been physically aggressive with staff including hitting them about the face and torso. She has also impulsively reached out and grabbed at other peers who walk by, raising the potential risk for an aggressive response by another individual.

4. At the current time, I believe the least restrictive and most appropriate level of treatment is inpatient treatment at St. Agnes Hospital under a civil commitment enforcing appropriate psychotropic treatment to reduce impulsive agitation and aggression while allowing staff to actively administer appropriate medical treatment and daily cares. A civil commitment will be required secondary to Ms. F[redacted]'s inconsistent cooperation with her medications secondary to the absence of insight into her behavioral difficulties.

5. Ms. F[redacted] requires medications to maintain control over her symptoms of behavioral disturbance associated with dementia so that she can be acutely stabilized and staff at St. Agnes can eventually transfer her to an outpatient setting, likely a return to the nursing home. Medications are designed to have a therapeutic value and will not impair the subject's ability to prepare or participate in any further proceedings. Ms. F[redacted] is currently prescribed the anti-psychotic/mood-stabilizer Risperdal, the anti-depressant Celexa, and the mood stabilizer Depakote.

6. Ms. F[redacted] is substantially cognitively impaired to the degree that she was unable to coherently communicate and thus is incapable of expressing an understanding of the advantages, disadvantages and alternatives to treatment, the consequences of no treatment, or apply that information to her particular situation in order to make an informed choice as to whether to accept or refuse medications to treat her mental illness. As a result, I currently believe she is incompetent to accept or refuse psychotropic medications.

Thank you very much for this referral. If I can be of further assistance, please do not hesitate to page me at 414-405-2433. Upon hearing the voicemail greeting, press 5, enter the callback number, and press #.

Sincerely,

RR MD

Robert Rawski, M.D.
Board Certified Psychiatrist
Board Certified Forensic Psychiatrist

STATE OF WISCONSIN CIRCUIT COURT FOND DU LAC COUNTY
PROBATE DIVISION

In the Matter of:

HELEN E. F[redacted]. Case No. 10-ME-146

TRANSCRIPT OF PROCEEDINGS

Proceeding: Final Hearing

Date: May 28, 2010

Before: HONORABLE RICHARD J. NUSS,
Circuit Judge, Branch 3

Appearances: WILLIAM J. BENDT
CORPORATION COUNSEL
160 S. Macy Street
Fond du Lac, Wisconsin 54935
appearing on behalf of the County;

MARGARET VINZ,
ASST. STATE PUBLIC DEFENDER
160 S. Macy Street, Third Floor
Fond du Lac, Wisconsin 54935
appearing on behalf of HELEN E. F[redacted],
who did not appear.

AnnaMaria H. Casper, RMR
Official Court Reporter

INDEX OF EXAMINATION

INDEX OF EXHIBITS

EXHIBIT	DESCRIPTION	MK'D	OFR'D	RCV'D
**None were marked				

P R O C E E D I N G S

THE COURT: The Court will call case 10-ME-146. This is in the interest of Helen F[redacted]. She does not appear in person but by Margaret Vinz. State appears by Corporation Counsel William Bendt.

We're here for a mental commitment hearing. State and County is ready to proceed. Please call the doctor.

MR. BENDT: I'm going to call Dr. Robert Rawski by telephone. And, for the record, I would agree that it would be appropriate for Helen F[redacted]'s appearance to be waived. She does have a form of dementia where she would not understand or comprehend or be able to participate meaningfully or in any way, actually, in these proceedings.

THE CLERK: Dr. Rawski, please hold. This is Judge Nuss's courtroom calling.

THE COURT: Dr. Rawski.

THE WITNESS: Good morning.

THE COURT: This is Judge Nuss. I'm presiding over this matter. Margaret Vinz, the subject's attorney, is here. Helen F[redacted] has been excused. The subject has been excused. William Bendt, Corporation Counsel, is present.

We are here for a mental commitment hearing.

You have a report of May 26, 2010. I have not invited counsel to stipulate to its admission subject to direct and cross. I will now do that.

Mr. Bendt, any objection?

MR. BENDT: No.

THE COURT: Miss Vinz.

MS. VINZ: No.

THE COURT: So your report of May 26, 2010, with regard to Helen F[redacted] is received subject to direct and cross. I'm going to have the clerk administer the oath, and Mr. Bendt can ask you questions.

ROBERT RAWSKI, M.D., called as a witness herein, having been first duly sworn, testified as follows:

THE COURT: Proceed, Mr. Bendt.

DIRECT EXAMINATION

BY MR. BENDT:

Q Please state your full name for the record.

A Robert Rawski, R-A-W-S-K-I.

Q And you are a psychiatrist; is that correct?

A Yes.

MR. BENDT: I would ask the attorney for Helen F[redacted] if she would stipulate to Dr. Rawski's credentials to testify as an expert in psychiatry for the purpose of this hearing.

THE COURT: Any objection?

MS. VINZ: Yes.

THE COURT: You have an objection?

MS. VINZ: No, I'm stipulating

THE COURT: All right. Thank you.

Doctor, you have been certified to testify. Your credentials are not being questioned.

BY MR. BENDT:

Q Dr. Rawski, you received a directive from the Fond du Lac County Circuit Court to examine the condition of Helen E. F[redacted]; is that correct?

A Yes.

Q And did you prepare a report in writing and file that with the Court?

A I did.

Q And did you review the treatment records in preparing your report?

A I did. I reviewed treatment records from St. Agnes Hospital.

Q And when did your interview take place?

A May 24, 2010.

Q Do you have an opinion concerning Helen F[redacted]'s mental condition?

A Yes.

Q What is that opinion?

A Helen F[redacted] suffers from Alzheimer's Dementia with a behavioral disturbance.

Q And can you describe the Alzheimer's Dementia?

A Alzheimer's is a progressive dementia that typically develops after the age of 60 years old. It is characterized by multiple cognitive deficits primarily involving memory impairment and associated decision-making.

Miss F[redacted] has progressive dementia, has been in a nursing home for the last six years because of memory impairment, forgetfulness, inability to learn new information, and her dementia has progressed to the point where she is very limited in any verbal communication.

Now, dementia, especially Alzheimer's, can also involve behavioral disturbances and these can include poor judgment, aggression towards others, periods of agitation, wandering. The behavioral disturbances are often accelerated by confusion. Patients can become anxious, they can become depressed. They oftentimes have disturbed sleep which can increase the behavioral disturbance. They can also become paranoid and hallucinate as well. Any medical conditions can exacerbate the behavioral disturbances as well, and Ms. F[redacted] has suffered from at least two episodes of urinary tract infection, of which preceded the original

hospitalization or at least coming to the hospital in order to get treatment and a second one was discovered a couple of weeks ago while inpatient. It can also add to the confusion in an elderly person with dementia more so than one would expect in a person who did not suffer from dementia. Cognitively, it is not considered to be a treatable mental disorder. It's a progressive mental defect that is not treatable. But the behavioral disturbances are considered to be a substantial disorder of thought, mood, or perception that grossly impairs Miss F[redacted]'s judgment, behavior, capacity to recognize reality, and the ability to meet the ordinary demands of life.

Q And is she a proper subject for treatment for the behavioral disturbances?

A Yes.

Q What would that treatment consist of?

A That treatment would consist of using medications commonly prescribed for symptoms of psychosis, mood disturbances, impulsivity, and aggression in a judicial fashion to result in improvement in impulsivity, agitation, and physical combativeness.

Q And, first of all, what is the least restrictive level of treatment consistent with her needs?

A At the current time the least restrictive level is

inpatient hospitalization on a psychiatric unit.

Q In a locked psychiatric unit?

A Yes.

Q And you mentioned medications as a treatment possibility. Could you describe that further?

A Yes. Miss f[redacted] is currently prescribed a combination of Depakote which is a mood stabilizer often used in individuals with bipolar disorder but frequently helpful in individuals with brain injuries, mental retardation, and dementia in reducing agitation and aggression. That, however, alone has not been satisfactorily sufficient in controlling periods of agitation and aggression on the inpatient unit.

More recently, the psychotic medication Seroquel that had been utilized at the nursing home and in her first weeks at St. Agnes had been discontinued and replaced with a different antipsychotic medication, Risperdal. That medication is being prescribed at low doses consistent with Miss F[redacted]'s age and medical conditions, and the early signs are an improvement in her condition evidenced by the ability to remove a one-to-one sitter that had been reinstituted for approximately 15 days the first and second week of May due to increased combativeness when the Seroquel was discontinued.

Q Did you talk to her about the advantages and

disadvantages of taking the Depakote and Risperdal?
A I tried. Miss F[redacted] did not respond coherently to most of my questions and on a couple that she did, she merely answered yes or no without offering any further details to identify to what degree she even really understood the question.
Q And you formed an opinion as to whether she is able to understand those advantages and disadvantages?
A Yes.
Q And what's that opinion?
A My opinion is that Miss F[redacted] is so cognitively impaired by her dementia that she is unable to express an understanding of the advantages and disadvantages to alternative treatment, the consequences of no treatment, to apply that situation to her particular situation, or to make an informed choice as to whether to accept or refuse medications that trigger mental illness.
Q Do you have an opinion as to whether Helen F[redacted] is a danger to herself or others as a result of the behavioral disturbances?
A Yes.
Q And what's that opinion?
A My opinion is that Miss F[redacted] does represent a risk of harm to others due to impulsive combativeness of the treatment staff, primarily of individuals who are in

harm's way. And because of her advanced age, medical issues, and dementia, she is unable to manage daily cares. Her urinary tract infections are likely the result of her inability to properly clean herself and take care of her daily needs, and staff are having some difficulty in doing that as they run the risk of being assaulted by her, as they have on a few occasions, both at the nursing home and on an inpatient basis. She has a tendency to grab out and reach at others which, both in an inpatient setting and in a nursing home, raises the risk of aggression toward her and so that also puts herself at some risk of harm due to the impaired judgment of grabbing onto other individuals.

Q You mentioned the striking out. Could you describe that in more detail? How is that occurring?

A Yes. When staff are required to assist her with getting up and going to the bathroom or cleaning her up or getting her dressed for the day and such or simply bathing or even administering medications, Miss F[redacted] has struck out at them. She has scratched one caregiver, struck another nurse in the chest, another one in the head, and also has been grabbing at peers as they walk by.

Q And this is actually impacting her ability to properly give her the cares that she needs?

A Yes. It certainly raises the risk of aggression towards staff, and her not being able to cooperate with those cares reduces the likelihood that they are going to be able to accomplish those in a safe and appropriate manner.

Q And is the goal to reduce that aggression so that she could return to a nursing home setting?

A Yes. She is likely -- her needs when she is not aggressive can be managed in a nursing home. And if properly medicated and her symptoms improve, she is likely to be able to return there so that the staff there can resume assisting her with her needs.

MR. BENDT: I don't have any further questions.

THE COURT: Cross-examination, Miss Vinz?

MS. VINZ: Thank you.

CROSS-EXAMINATION

BY MS. VINZ:

Q Doctor, when an individual, an elderly individual who has dementia also has urinary -- a urinary tract infection, that can be a source of aggression by that individual, correct?

A What it does is it raises the risk for confusion and delirium superimposed on the dementia, and that -- and confusion can increase the amount of agitation and anxiety and potential aggression in an individual with

dementia.

Q So the urinary tract infection causes confusion which in turn can cause the person to be aggressive?

A It can.

Q Now, in terms of Mrs. F[redacted], she was admitted to St. Agnes Hospital on April 12th of this year, correct?

A Yes.

Q And she was admitted with a urinary tract infection?

A Yes, in addition to other issues.

Q And you have no information that prior -- with the exception of a couple of weeks prior to April 12th that she was physically aggressive, correct?

A That is the entirety of the information that I know of her history prior to, yes.

Q So the physical aggression, as far as you know, began within about a two-week period prior to her admission on April 12th?

A I did not know that.

Q One way or the other?

A One way or the other.

Q All right.

A She was prescribed medication to treat aggression -- actually, three of them, actually, and that would indicate a history of the need to treat aggression in a demented individual.

Q Well, when you say "medication to treat aggression," you are talking about medication that is also prescribed for a number of purposes?
A Yes, for depression and for psychosis. She did not have a history of psychosis from what I understand.
Q But there could have been a history of depression.
A There could have been a history of depression and one of those medications of the three are prescribed for depression. The other two would likely be described -- or prescribed for the behavioral disturbances associated with dementia.
Q Now, since she has been at St. Agnes Hospital, that urinary tract infection has been a continuing problem.
A I understand it was treated and then they rechecked again in May and discovered that the bacteria was back again and only responded to certain antibiotics.
Q And so they were retreating it?
A Yes.
Q Now, Miss -- Mrs. F[redacted] is 85 years old?
A Right.
Q And if you could give your best estimate of her weight, it would be somewhere in the neighborhood of 100 pounds. Would that be true?
A Yes.
MS. VINZ: I have no other questions.

THE COURT: Redirect.

REDIRECT EXAMINATION

BY MR. BENDT:

Q Is it your opinion that there is -- that the behavior disturbances that you were talking about that resulted from the Alzheimer's is independent from the UTI?

A Yes.

MR. BENDT: I don't have any further questions.

THE COURT: Further recross.

MS. VINZ: No, sir.

THE COURT: Doctor, I want to thank you for your testimony. Have a nice day and have a nice weekend.

THE WITNESS: Thank you. Enjoy the weekend.

THE COURT: Thank you.

THE COURT: Further testimony.

MR. BENDT: No. I had -- Dr. Patel is available, but I think Dr. Rawski's report and his testimony were so pervasive here, I think it would be repetitive, not necessary to take up the Court's time.

THE COURT: Miss Vinz, other than argument, anything to offer?

MS. VINZ: No, sir.

THE COURT: Thank you, Mr. Bendt.

MR. BENDT: I would ask the Court find that Helen F[redacted] is a proper subject for commitment. She has

a form of Alzheimer's that has cognitive impairment that is not treatable, but there are behavioral disturbances that are associated with it that are. Those behavioral disturbances meet the statutory criteria as a substantial disorder of thought, mood, and perception that grossly impairs her judgment and behavior capacity to recognize reality.

Fortunately, she is a subject for treatment. There are medications, Depakote and Risperdal which is replacing a former medication, Seroquel, that actually, according to the doctors, shows early signs of improvement in her condition that would allow her to be less combative and able to cooperate with needed cares.

She is not able to understand the advantage and disadvantages of taking the medication, and I would ask for a medication order. She has been a danger to herself and others, especially during caregiving. She is striking out at staff. She is hitting staff in the head, chest, the arms. She reaches out and grabs at people, all of which is unintended. It has -- it's a response to her agitation and confusion but it is resulting in the inability of the nursing home to provide her care and even, to some extent, at the psychiatric unit. She still has the same need for cares, including hygiene which Dr. Rawski's starting to believe may have been part of

the reason why she has a urinary tract infection. She hasn't been allowing staff to properly bathe her and keep her clean and so she would meet the criterion for dangerousness towards others and herself, and I would ask the Court order a six-month commitment. Initially it's inpatient. I'm hoping that she gets better so she can be returned to the nursing home where she has been for at least six years and with a medication order.

THE COURT: Miss Vinz.

MS. VINZ: Thank you. As the Court is certainly aware, the County has to establish three things here. First of all, they have to establish that the individual has a mental illness or disorder. Secondly, that they have to establish that the person is dangerous connected to that mental illness or disorder. It is not enough that the person has a mental illness and then they are dangerous. There has to be a connection between those two things. And then, finally, they have to prove that that individual is treatment -- is treatable, that they are mentally ill -- or disorder is treatable.

Now, in regard to the mental illness or disorder, we acknowledge that Mrs. F[redacted] has Alzheimer's. The problem comes in the connection between that and the dangerousness. Mrs. F[redacted] has been in this nursing home for six years. The doctor has no evidence that she was

in any form dangerous to residents and staff prior to two weeks before her admission on April 12th to St. Agnes Hospital. She was admitted with a urinary tract infection. The doctor testified that urinary tract infections in individuals who have dementia can cause confusion which in turn can cause aggression. And so based on the fact that this just manifested itself, this aggression manifested itself at the same time that the urinary tract infection manifested itself, I don't believe there is that connection between the dementia and the dangerousness.

Furthermore, this is an individual who is 85 years old, weighs about a hundred pounds. The degree to which she can actually be dangerous is very limited. And then, finally, there is the issue of the treatability. We have heard that the symptoms can be treated but that is not what the law requires. The law requires treatability of the mental illness or disorder and the doctor's testimony on that point was that dementia is not treatable, so I don't believe the legal standard has been met.

THE COURT: Mr. Bendt, anything briefly in response?

MR. BENDT: Yeah. It is dangerous to be striking out at staff. You can hit them in the head, you

can hit them in the chest, you can hit them in the arm. Mostly the danger is to herself because they are not able to provide the cares that she needs. In fact, the same argument can be used against the commitment that was well stated by her attorney used to support it. She had been there six years, and they know her, you'd like to think, after six years. They are not able to care for her and that is why she was transferred to an inpatient setting. Yes, there is a UTI. They treated it. It seemed to recur fast, but Dr. Rawski believes that her lack of cooperation with cares probably helped result in her getting a UTI, and if you are not cooperating with cares for cleaning and bathing and providing whatever medication you need, you are in serious harm to yourself. Nursing homes can't do something for you if you are not cooperative to care. So I believe she is a danger, and the doctor did say that he thought that the behavioral disturbance was independent of the UTI. It's part of the illness itself which meets the statutory definition.

Even if the cognitive impairment is not treatable, the behavior is, the agitation is, the fear that results from the confusion that she needs to strike out. That would be treatable. That would help improve and control her condition which is what the statutory definition -- that's what the jury instructions say, that

you don't cure mental illness, but you improve and control it and without that, I don't believe a nursing home would even be able to handle her.

THE COURT: Anything else, Miss Vinz?

MS. VINZ: No, sir.

THE COURT: Well, we have the uncontroverted testimony of Dr. Rawski, and I found Dr. Rawski's testimony to be extremely thorough, extremely persuasive, and, quite frankly, was somewhat refreshing to hear testimony articulated the way he did it. He walked down the mental illness issue, was sensitive to recognize that this young lady has some certain cognitive problems, has a good grasp on how that interplays with behavior, talks about behavior, talks about how disruptive she is, talked about her mental illness, talked about her level of dangerousness, talked about the fact that she is treatable, and the clear and convincing evidence is what this Court has to ultimately find has been established. That's what we had. We had his testimony. We don't have any controverting testimony to present, but I find that -- I find that testimony to be extremely compelling, extremely persuasive.

We have a -- we would like to -- I think we would like to all believe that maybe the manifestations of this subject at this time are a direct result of a UTI

issue and leave it at that and say, fine, we aren't going to medicate that, any of those concerns we are just going to -- we are just going to move on.

I think what we all have to do is to live with that experience with a family member and you will quickly realize the advantages and disadvantages of medications when people have the unfortunate occasion in that maturation process to have Alzheimer's and dementia. My mother-in-law went through this exact same scenario, so this Court is extremely familiar with this type of a situation. She had a UTI issue, and I'm not sitting here passing judgment on Miss F[redacted] but suffice to say we eventually catheterized her because that was the best way of dealing with that issue. Whether or not that in fact is the end result of Miss F[redacted], I don't know. But what it has done is that coupled with her other behavioral issues have been extremely disrupting and has provoked and compromised staff and others that are commissioned, quite frankly, to care for her.

We have aa young lady 85 years old weighing about a hundred pounds that, evidently, is not able to come into court today. But under the same token, they are saying, quite frankly, she ought to be let go because there is no basis to commit her. I find that disappointing. We apparently have a feeling that there

is some lack of connection between mental illness and dangerousness. And with regard to the behavior of Miss F[redacted], I don't think that Dr. Rawski could have said it any clearer as to what that connection is, and certainly to suggest that the subject would not get the very best of care under the best of circumstances, given her unfortunate stage in life, would be, quite frankly, a judicial miscarriage.

There is little doubt in this Court's mind that the County has met its burden of clear and convincing. There is little doubt in this Court's mind that the record clearly supports a finding of mental illness, and a subject -- and a subject that is proper for treatment and that the subject -- and that she is proper subject for treatment. There is no doubt in my mind that the dangerousness standard has, in fact, been satisfied. I don't know what else has to be said. She is combative, she is very disruptive, and we might all want to think this is because of a urinary tract infection. I think that's putting the cart before the horse. She is in a nursing home not because of a UTI. She is in a nursing home because of her Alzheimer's and dementia and that has accelerated itself. Those are cognitive problems that can't be corrected, unfortunately, but they try to medicate that as best they can. It's just a tragic stage

in everybody's life.

I think it's very disappointing that we place our emphasis on the UTI side of this young lady and not on her mental illness issues. So I find, unequivocally, that the record supports the relief that the County has requested and it's so ordered. So I'll order the commitment. I find that she is not competent to refuse medications, and I find the least restrictive is an inpatient, locked psychiatric unit, and she will be committed for six months.

Anything else?

MR. BENDT: Nothing further.

MS. VINZ: Yes, sir. The Court may not fully be aware that in a situation where an individual is uncommunicative, unable to make their wishes known to a case, a default position is one one must advocate for an individual to be free of a commitment order and free of a medication order and so I'm concerned about the Court's use on two occasions of the word "disappointed." I have no choice but to advocate for a client against a commitment order when the individual is uncommunicative and unable to express their wishes. That is the law. If the Court has a concern about that aspect of the law, of course the proper place is to advocate with one's legislature, for instance. But in terms being

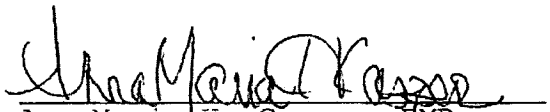
C E R T I F I C A T I O N

STATE OF WISCONSIN)
) ss.
FOND DU LAC COUNTY)

I, AnnaMaria H. Casper, hereby certify that I am a Registered Merit Reporter, and that I have been duly appointed as Official Court Reporter for Circuit Court, Branch 4, Fond du Lac County, Wisconsin.

I further certify that I reported these proceedings by means of machine shorthand, and that the foregoing is a full, complete and correct transcript of my stenographic notes in said proceedings, as prepared by me via computer-aided transcription.

Dated: August 18, 2010.



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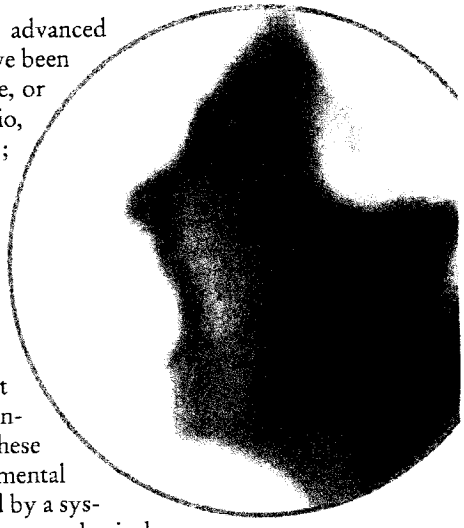
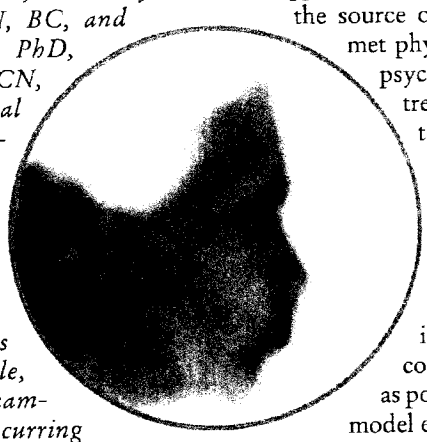
Behaviors of Nursing Home Residents with DEMENTIA

EXAMINING NURSE RESPONSES

This article is a companion piece to an article that appeared in the April issue of the Journal of Gerontological Nursing *entitled "The Serial Trial Intervention: An Innovative Approach to Meeting Needs of Individuals with Dementia" (Vol. 32, No. 4, pp. 18-25). The first article, by Christine R. Kovach, PhD, RN, Patricia E. Noonan, MSN, APRN, BC, Andrea Matovina Schlidt, MSN, GNP, Sheila Reynolds, MS, APRN, BC, and Thelma Wells, PhD, RN, FAAN, FRCN, describes the Serial Trial Intervention (STI)—an innovative approach to assessing and treating unmet needs of individuals with dementia. In this month's article, the authors examine whether recurring behaviors were predicted by variations in approaches to nursing care. The research was part of a larger study of the effectiveness of the STI as an approach to behaviors associated with advanced dementia.*





More than half of individuals with advanced dementia exhibit behaviors that have been described as challenging, disruptive, or problematic (Allen-Burge, Stevens, & Burgio, 1999; Burgio, Scilley, Hardin, & Hsu, 2001; Jackson, Spector, & Rabins, 1997). Approximately half of these behaviors involve problematic vocalizations or physical aggression (Ballard et al., 2001; Beck & Vogelpohl, 1999). Caregivers are commonly taught to respond to such behaviors using psychosocial and environmental treatments (Burgener & Twigg, 2002), based on the assumption that the source of the behavior is not unmet physical needs. However, these psychosocial and environmental treatments are not preceded by a systematic assessment to rule out physical needs, and the assumption therefore may be faulty.

The notion that behaviors may signal unmet physical needs has gained substantial support since 1996 when the Need-Driven, Dementia-Compromised Behavior (NDB) model was published (Algase et al., 1996). Although behaviors may be disruptive and ineffective, they represent the most integrated and meaningful mechanism the individual has for communicating unmet needs. Behaviors are thus conceptualized as possible symptoms of unmet need. However, although the NDB model explains the source of behaviors associated with dementia, the model does not attempt to describe the consequences of such behaviors. The Consequences of Need-Driven, Dementia-Compromised Behavior (C-NDB) theory extends this model by explaining the consequences of behavioral

CHRISTINE R. KOVACH, PhD, RN, SHERYL T. KELBER, MS, MICHELLE SIMPSON, MS, AND THELMA WELLS, PhD, RN, FAAN, FRCN

symptoms (Kovach, Noonan, Schlidt, & Wells, 2005). When the meaning of a behavior is misinterpreted, needs are left unmet and can contribute to worsening behaviors, new behaviors, and new needs. Thus, expressing needs behaviorally can set off a series of cascading effects that may lead to negative outcomes for the individual with dementia, the caregiver, and the environment.

For example, the literature suggests that the act of resistance during bathing is caused by a task-oriented approach, environmental stress, insensitivity, or power struggles (Gotell, Brown, & Ekman, 2003; Namazi & Johnson, 1996; Skovdahl, Kihlgren, & Kihlgren, 2003; Sloane et al., 1995). If, however, the behavior is actually caused by arthritic pain with movement, treatment with recommended psychological or environmental approaches would leave the primary need unmet. Untreated, the pain may contribute to a decline in function, depression, sleep problems, impaired immune function, decreased socialization, malnutrition, impaired ambulation, and increased use of health care (Chang, Dunlop, Gibbs, & Hughes, 1995; Ferrell, 1995; Liebeskind, 1991; Moss, 1997; Vines, Gupta, Whiteside, Dostal-Johnson, & Hummler-Davis, 2003; Won et al., 1999). In addition, the act of resisting care may lead to injury of the caregiver or resident, increased staff burnout, and staff turnover. Using the C-NDB framework, one can argue that both identification of behaviors as symptoms and enhanced assessment are needed prior to treatment.

As dementia advances, management of physical needs becomes increasingly the focus of concern (Volicer, 2001). Weight loss, dehydration, nutrition, and swallowing problems are common (Berkhout, Cools, & Van Houwelingen, 1998; McGillivray & Marland, 1999). Mobility problems progress to the point that the individual often becomes chairbound or bedbound (Kurlan, Richard, Papka, & Marshall, 2000). Urinary and fecal incontinence contribute to skin problems and falls. Also, changes in circadian rhythm include an increase in agitation in the late afternoon or evening, impaired nighttime sleep and more time dozing, social withdrawal, and less awareness of the surrounding environment or activities (Grace, Walker, & McKeith, 2000; Pollak & Stokes, 1997). Immobility, in turn, contributes to other problems such as constipation, pneumonia, and pressure ulcers. Immune system function is impaired, and infections are common causes of death (Kukull et al., 1994).

One would expect that decreases in verbal skill and increases in physical needs would be accompanied by increased nursing assessment of physical needs. However, the research to date has not examined relationships among resident physical need, verbal skill, and nurse physical assessment. The purpose of the study reported in this article is to examine nurse responses (i.e., assessments and treatments) to nursing home residents with advanced dementia who exhibit certain behaviors and whether recurring behaviors were predicted by variations in approaches to nursing care. The research was part of a larger study of the effectiveness of an innovative nursing assessment and treatment intervention, the Serial Trial Intervention (STI), as an approach to behaviors associated with advanced dementia. Findings on the positive effects of the STI on patient discomfort and short-term resolution of behaviors are reported elsewhere (Kovach, Logan, & Noonan, in press).

METHODS

Setting and Sample

Fourteen nursing homes in one midwestern state participated in the study. Facilities were in a mix of urban (n = 8) and suburban (n = 6) locales and were both for-profit (n = 8) and not-for-profit (n = 6). There were between 60 and 187 beds licensed for skilled care (M 115.2, SD = 43.17) and the percentage of residents receiving Medicaid reimbursement ranged from 39% to 94%. Facilities were stratified on these variables and then randomly assigned to the treatment (STI) or control condition. Consent for participation was obtained from the resident, the durable power of attorney or closest family member, and from nurse participants.

A total of 54 nurses participated in the study. The number at each nursing home ranged from 2 to 6, depending on the distribution of residents across units. Nurse participants were required to have at least 6 months of experience caring for individuals with dementia and to work the dayshift 32 hours or more per week. Attempts were made to use RNs, but at sites in which this was not possible, licensed practical nurses (LPNs) were asked to participate (RNs = 46, LPNs = 8). The ratio of RNs to LPNs at the treatment and control sites was not significantly different (chi-square = .427, $df = 1, p = .514$).

Measures of cognitive and functional status were used to determine resident eligibility criteria. The Mini-Mental State Examination (MMSE) was used to measure cognition (Folstein, Folstein, & McHugh, 1975). The MMSE has demonstrated reliability and validity, with test scores correlated with age-adjusted scores on the Wechsler Adult Intelligence Scale (Folstein et al., 1975; Zarit, 1997). Residents entered into the study had a MMSE score indicating moderate to severe cognitive impairment. The Functional Assessment Staging of Dementia (FAST), which was used to screen residents for functional ability, divides function into seven stages with higher stages indicating greater impairment (Reisberg, Ferris, & Franssen, 1985). A Guttman analysis revealed a coefficient of scalability of .98 and a coefficient of reproducibility of .99, supporting the unidimensional and cumulative qualities of the scale. A correlation of –.79 supports the concurrent validity of the FAST Stages 6 and 7 with the Ordinal Scales of Psychological Development (Sclan & Reisberg, 1992). Residents who were in Stage 6 or 7, or who were designated by a nurse as unable to clearly and consistently verbalize needs, were en-

tered into the study. Participants also had no chronic psychiatric diagnosis other than dementia-associated diagnosis and were at least 4 weeks post-admission to skilled nursing care.

Procedures

The STI uses systematic serial assessments and treatments, as well as sequential trials of treatments, to respond to behaviors of individuals with advanced dementia that are not ameliorated by basic care interventions commonly provided by ancillary staff (Kovach et al., in press). The five sequential steps of the STI response to behaviors are:

- Physical assessment followed by targeted treatment if indicated.
- Affective assessment followed by targeted non-pharmacological treatment if indicated.
- Non-pharmacological treatment trial.
- Analgesic treatment trial.
- Consultation and possible trial of psychotropic medication.

An "as needed" (pro re nata [prn]) order for analgesics was either available or obtained for each resident from the primary physician prior to the start of the study. If the step of the STI required any other changes in medication orders, physicians were consulted to obtain orders. Time frames for expected responses to common treatments were distributed to assist nurses to evaluate treatment effectiveness and to possibly begin the next step of the STI in a timely manner.

To assure that differences in outcome measures could not be explained by differences in the attention provided to staff, nurses in both control and treatment groups received an initial 45-minute introduction meeting, 7 hours of classroom instruction, and site visits twice weekly by an advanced practice nurse to answer questions and check on compliance with data collection. The curriculum used to teach nurses in the treatment group included content on behaviors, the STI process, physical, affective and environmen-

EXAMPLES OF DISMISSIVE AND REACTIVE NURSE RESPONSES TO NEEDS OF INDIVIDUALS WITH DEMENTIA

DISMISSIVE

Case A

- Behavior: Ambulating with her walker back and forth in the hall from resident's room to sitting room. Motions staff to come to her and asks, "What should I do?"
- Assessment: Kept walking for awhile, then went to lie on couch
- Treatment: None
- Percentage behavior returned to baseline*: 0%

Case B

- Behavior: Making constant little noises. "Sounds like a cat." Rubbing face throughout most of the morning
- Assessment: None
- Treatment: None
- Percentage behavior returned to baseline: 0%

REACTIVE

Case C

Day 1 Behavior: Fidgeting in wheelchair. Setting off chair alarm

- Assessment: Asked resident if she needed to go to the bathroom. She stated no
- Treatment: Snacks provided
- Assessment: Accepted crackers and juice
- Percentage behavior returned to baseline: 100%

Day 2 Behavior: Resident restless in wheel chair. Setting off chair alarm

- Assessment: Resident denies pain or need for toileting
- Treatment: One to one therapeutic communication provided and backrub given. Fluids also given
- Percentage behavior returned to baseline: 100%

Day 3 Behavior: Setting off chair alarm. Looks worried

- Assessment: None
- Treatment: One to one therapeutic communication provided and redirection given
- Assessment: Resident listened to recreational therapy activity in sitting room
- Percentage behavior returned to baseline: 100%

Case D

Day 1 Behavior: Calling out "please?"

- Assessment: Unable to state need when asked what she needs
- Treatment: Offered to assist to rest in recliner
- Assessment: Refuses direction to recliner and continues calling out "please?"
- Treatment: None
- Percentage behavior returned to baseline: 0%

Day 2 Behavior: Calling out, "Hello? Please? Where did my boys go?"

- Assessment: When asked what she wants, no special complaints or requests
- Treatment: Given cup of coffee and informed lunch will be served soon
- Percentage behavior returned to baseline: 100%

Day 3 Behavior: Calling out, "C'mon boys, please? Hello?"

- Response: Offered food, drink, toileting. Moved to recliner for position change/comfort. Continued to call out until nurse brought resident to desk
- Percentage behavior returned to baseline: 50%

**Percentage behavior returned to baseline was determined by the nurse who completed a visual analog scale.*

EXAMPLES OF STATIC NURSE RESPONSES TO NEEDS OF INDIVIDUALS WITH DEMENTIA

Case E

Day 1 Behavior: 8 a.m. urinating on floor in room

- Assessment: None
- Treatment: Redirected
- Percentage behavior returned to baseline*: 0%
- Behavior: 1 p.m. urinated on floor in front of closet
- Assessment: None
- Treatment: Redirected
- Percentage behavior returned to baseline: 0%
- Behavior: 2 p.m. urinated on floor in room. Laughs at staff attempts at redirection. Denies urinary tract infection symptoms
- Assessment: None
- Treatment: Redirected
- Percentage behavior returned to baseline: 0%
- Behavior: Urinated twice on floor during the evening shift
- Assessment: None
- Treatment: Redirected
- Percentage behavior returned to baseline: 0%

Days 2, 3, 4, 5 Behavior: 14 documented occurrences of urination in places other than toilet

- Assessment: None for all 14
- Treatment: Redirection for all 14
- Percentage behavior returned to baseline: 0%

Case F

Day 1 Behavior: Resistive to cares. Hitting, yelling, stating "get out"

- Assessment: Knees stiff with standing, incontinent of urine
- Treatment: Cares provided
- Percentage behavior returned to baseline: 100%

Day 9 Behavior: Yelling, "Leave me alone," hitting staff

- Assessment: Incontinent of urine
- Treatment: Cares given
- Percentage behavior returned to baseline: 100%

Day 20 Behavior: When approaching for toileting every 2 hours the same behavior happens—increased agitation, yelling, hitting staff

- Assessment: Incontinent of urine
- Treatment: Cares given
- Assessment: Open area noted on scrotum
- Percentage behavior returned to baseline: 100%

**Percentage behavior returned to baseline was determined by the nurse who completed a visual analog scale.*

tal assessment, non-pharmacological comfort treatments, pain management, and appropriate use of psychotropic drugs. The control nurse received a standard approach to dementia care education that included an interactive discussion of common misconceptions about aging, the physical effects of aging, reversible and irreversible causes of dementia, stages of Alzheimer's disease, and various approaches to treating behaviors and physical conditions associated with dementia.

Measurement

Nurses in both treatment and control groups were instructed to record on a daily log four observations:

- Behaviors of residents that initiated care.
- Assessments performed in response to the behavior.
- Treatments given in response to behaviors or as a result of assessment findings.
- The degree to which the behavioral symptom returned to baseline following assessments or treatments.

Recording these data in logs was started on the first day the nurse noticed a change in behavior. This change in behavior may have been observed by the nurses or brought to their attention by the certified nursing assistant. Logs were then kept daily for the next 20 weekdays.

Behaviors for which care was initiated were recorded in a specific box at the top of the daily log forms. Nurses in both groups were instructed to include vocal complaints; nonverbal vocalizations; and changes in behavior, mood, or function on the form. At treatment sites, the form for making daily recordings of assessments and treatments was divided into the five steps of the STI. The forms used at control sites had the same width and height of the page for recording assessments and treatments, but no specific procedural steps were delineated.

To obtain an effectiveness rating for each treatment, the nurse recorded the degree to which the behavioral symptom returned to the individual's baseline on a 0% to 100% visual analog scale (VAS) located on the daily log form. At sites using the STI, these scales were available for each step of the protocol. At control sites, nurses were instructed to complete a new scale whenever a new episode of assessment, treatment, or consultation was conducted. Guidelines for the time in which effects can be expected for common types of treatments were distributed during education sessions. For example, the nurse was instructed to complete the VAS within 30 minutes of massage, but to wait 2 to 3 days following antibiotic treatment for infection. Nurses were trained to

complete the VAS until interrater reliability was .85 or greater.

To teach nurses to consistently record the needed data, eight vignettes were digitally produced by the university film department using actors. Three experts in dementia care reviewed scripts prior to production to assure that the four vignettes used at the treatment sites reflected the steps of the STI and the four vignettes used at control sites reflected standard care and not the steps of the STI. Vignettes depicted the use of four treatments in response to behavioral symptoms—medication, medication and non-pharmacological treatments, verbal support only, and verbal support and another non-pharmacological treatment. Nurses were trained to record daily logs using the vignettes until interrater reliability was .85 or greater.

Analysis

Content analysis of the data included thematic analysis and development of a coding system for quantification of nurse response variables (Downe-Wamboldt, 1992). To begin uncovering themes, all 20 daily logs were analyzed for each resident. Each daily log was read multiple times and notations were made using word processing tables that described behaviors, assessments, and interventions. Next, patterns were explored by developing flow charts that tracked resident behaviors, nurse assessments, nurse treatments, and return of resident behaviors to baseline from day to day. To assist in understanding responses, return of behavior to within 50% of baseline was used as a marker for short-term effectiveness of nurse response.

Frequency counts were also recorded on flow charts to begin elucidating nurse response patterns. Four nurse response patterns emerged with initial analysis by the first author, and were described to the fourth author, who then read cases and examined flow charts. Descriptions of the patterns were clarified based on this input and patterns of nurse response were labeled as dismissive, static, responsive, and comprehensive.

A coding system was then constructed for the four types of nurse response. To code the responses, domains of assessment and treatment developed for earlier studies were used. Assessment domains included body systems, functional parameters, changes in behavior, and affect. Treatment domains included 10 pharmacological categories and 13 non-pharmacological categories (Kovach et al., in press). Three advanced practice nurses with expertise in dementia care supported the content validity of the domains. Two graduate students were trained by the first author to code data, and interrater reliability of coding for 55 daily logs was .94 for scope of assessment, 1.0 for pharmacological treatments, and .80 for non-pharmacological treatments. After interrater reliability was greater than .85, one graduate student research assistant coded all data. Data were entered into Statistical Package for the Social Sciences Version 12.0 (SPSS Inc., Chicago, IL) using a two-person cross-checking technique. Frequencies and distributions were examined for all variables.

The major independent variable in the study was care delivered in response to resident dementia behavior. Care responses were dichotomized as present or absent. A care response was considered present if it was ever used for a resident during the 20 days studied following manifestation of a behavioral symptom.

The outcome variables were short-term effectiveness and recurrence of dementia behavior within the 20-day period. Nurses' reports of return of dementia behavior to baseline were averaged to capture the short-term effectiveness of care responses to behaviors. The authors viewed recurrence of dementia behavior on subsequent days as an indicator that the underlying need represented by the dementia behavior remained. Recurrence of behavioral symptoms was given a maximum score of 20, a score reflecting the number of days a behavioral symptom was present on the daily logs.

RESULTS

Of the 112 residents studied, most were women (n = 84, 75%), and the mean age was 86.55 (SD = 6.91) years. On average, the length of stay in a skilled care facility was 23.48 (SD = 20.12) months, the educational level was 11.25 (SD = 3.04) years, and the MMSE score was 7.81 (SD = 6.20). All residents had impaired function, with the majority at Stage 6 (n = 60) of the FAST hierarchy; 46 were in Stage 7, 5 were in Stage 4, and 1 resident was in Stage 5.

A behavior symptom profile, the short form of the BEHAVE-AD, was used to describe the sample's behavioral symptoms. This 14-item scale is used to assess the occurrence of common and potentially remediable behavioral symptoms associated with dementia during the previous 14 days (Reisberg et al., 1987). Items are rated on a 3-point scale with higher scores indicating more severe behavioral symptoms. Agreement between two nurses simultaneously rating five residents using the BEHAVE-AD tool was .90 in this study.

In the week prior to the start of the intervention, 102 of the 112 residents exhibited dementia behaviors. The most frequent behaviors were agitation (n = 65, 57.5%), anxiety (n = 55, 50%), verbal outbursts (n = 54, 47.8%), and purposeless activity (n = 52, 46%). The least frequent behaviors were hallucinations (n = 13, 13.2%) and physical threats and violence (n = 18, 15.9%). No significant differences were found between the treatment and control groups on any demographic variables or on behaviors.

As noted previously, content analysis revealed that nurses responded to behavior in four ways:

- Dismissive.
- Static.
- Reactive.
- Comprehensive.

Nurses responded to 203 behavioral symptoms from the 112 residents

EXAMPLES OF COMPREHENSIVE NURSE RESPONSES TO NEEDS OF INDIVIDUALS WITH DEMENTIA

Case G

- Behavior: Complaint of pain in left temple
- Assessment: No change in activity noted past couple of days, blood pressure 120/84 mm/Hg, pulse 76 beats per minute, respirations 22 per minute, temperature 98.6° F. Complains of pain to contracted hand, able to move two digits. Also complains of bladder pain and pain to right flank. Denies burning or difficulty urinating. Lungs clear, bowel sound active. Urine dipstick negative. History of cerebrovascular accident, contractures, degenerative joint disease. No environmental stress, activities well paced
- Treatment: Lotioned hand and arm with minimal range of motion, assisted with transport to activity room
- Percentage behavior returned to baseline*: 25%
- Treatment: Acetaminophen (Tylenol) given
- Assessment: No change after 1 hour
- Treatment: Prescriber notified of new complaint of pain. Acetaminophen hydrocodone (Vicodin) ordered and given
- Percentage behavior returned to baseline: 100%

Case H

Day 1 Behavior: Agitated. Sitting at nurses station complaining of burning in leg and deep itch. "I could go down there and pull my skin off"

- Assessment: No redness, rash, physical assessment negative
- Treatment: Adjusted brace
- Percentage behavior returned to baseline: 0%
- Treatment: Provided attention
- Percentage behavior returned to baseline: 25%
- Treatment: Acetaminophen given as needed
- Percentage behavior returned to baseline: 75%
- Treatment: Physician notified. Doxepin ordered and given for possible peripheral neuropathy pain.
- Percentage behavior returned to baseline: 100%. Nurse states "Day and night difference. Much more relaxed."

**Percentage behavior returned to baseline was determined by the nurse who completed a visual analog scale.*

on the first daily log. Nonspecific vocalizations, combative and resistive behaviors, restless body movement and specific verbal complaints were the most frequent behaviors. Sidebars 1 to 3 show data from the daily logs for each type of care response.

When a dismissive care response occurred, there was no treatment provided despite recognition and documentation of a change in behavior. Dismissive responses were experienced by 13 residents, and had the lowest effectiveness rating (M = 17.91, SD = 36.79). During static care responses, the nurse continued to use the same one or two assessments or treatments over multiple days, even though they were ineffective or effectiveness lasted less than 24 hours. Static care responses were used for 60 residents, with an effectiveness rating of 45.89 (SD = 35.19).

During reactive care responses, treatments were provided without prior thorough assessment (i.e., fewer than three domains were assessed). Reactive care responses were the most frequent responses in this sample, used with 87 residents, with an effectiveness rating of 62.66 (SD = 31.20). Comprehensive care responses involved assessment of three or more domains plus one or more treatments. Comprehensive care responses were used for 55 residents with an effectiveness rating of 74.75 (SD = 29.57).

The Figure shows differences in the percentage of residents in the treatment and control groups who received a given response to their behaviors at any time during 20 days. There was no significant difference between the treatment and control group in the use of dismissive care (x^2 = .909, p = .340), but the low frequency of dismissive care may have been an artifact resulting from a directive for the nurse to not dismiss behavioral symptoms. Reactive (x^2 = 26.20, p < .001) and static (x^2 = 19.11, p < .001) care were used by significantly more control group nurses. Despite that the experimental group nurses were being taught to respond to behaviors with a comprehensive assessment, at some time during the 20 days of data collection, residents in the treatment group still received reactive care (interventions with inadequate assessment, n = 33, 57.9% of group) and static care (the same ineffective care used over multiple days; n = 19, 33.3%). As expected, residents in the treatment group received significantly more comprehensive responses than those in the control group received (x^2 = 82.40, p < .001). It is noteworthy that residents in the control group received inadequate assessment 97% of the time.

It was expected that use of the three responses not based on a reasonably thorough assessment would be associated with more recurrence of behavior. Recurrence of behavior was an indicator that nurse response had not resolved needs. To determine if data from treatment and control groups could be combined for this analysis, three separate two-way analyses of variance were run to determine if there were relationships among the total number of days behavioral symptoms were present; group membership (treat-

ment/control); and use of dismissive, reactive, or static responses to behavior at any time during the 20 days of data collection. There were no significant differences based on group membership for dismissive (F = 1.81, df = 1,108, p = .180), reactive (F = .192, df = 1,108, p = .663), or static responses (F = .204, df = 1,108, p = .652); therefore the treatment and control group were combined for regression analyses.

Hierarchical regression analysis was performed to determine the relative contribution of variables in predicting recurrence of behavior. Dismissive care responses were too infrequent to include in the regression model. As shown in the Table, reactive care, after controlling for functional status and pretest behavior symptom profile, did significantly predict behavior symptom days (ΔR^2 = .134, p < .001). Step 4 of the model showed that 20.1% of the variance in behavioral symptom days was uniquely accounted for by the use of static care responses (p < .001). Even after controlling for functional level, behavior symptom profile, and reactive care, the static care response by the nurse was the strongest predictor of recurrence of behavior.

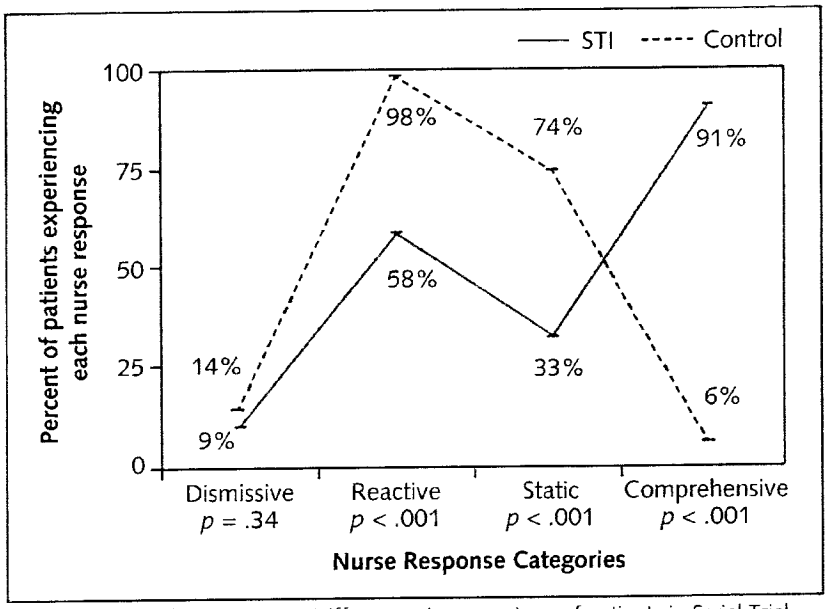


Figure. Serial Trial Intervention: Differences in percentage of patients in Serial Trial Intervention versus control receiving four care categories.

DISCUSSION

This study found an array of care responses to behaviors associated with dementia. The frequency with which these nurses treated behaviors without conducting prior assessment is worrisome. Assessment is fundamental to the nursing process, taught to all nursing students, and emphasized as the cornerstone of all care (Wilson & Giddens, 2001). Factors contributing to this breach of practice standards are unknown. Staff turnover and lack of consistent caregivers are well-documented in long-term care and may have contributed to this finding (Fitzpatrick, 2002; Harrington & Swan, 2003; Karlin, Schneider, & Pepper, 2002). However, lack of familiarity with a particular resident should lead to more rather than less assessment. Time constraints are frequently cited as reasons for suboptimal care in nursing homes and assessment takes time (Bowers, Lauring, & Jacobson, 2001; Cardona, Tappen, Terrill, Acosta, & Eusebe, 1997; Harrington et al., 2000). However, repeated ineffec-

TABLE

SUMMARY OF HIERARCHICAL REGRESSION ANALYSIS WITH BEHAVIORAL SYMPTOM DAYS AS CRITERION (N = 112)

Step and Predictor Variable	R^2	ΔR^2	β	t_{df}	p
Step 1					
Functional level	.029	.029	.170	1.80	.075
Step 2					
Functional level			.182	2.01	.047
Behavior symptom profile	.121	.092*	.304	3.36	.001
Step 3					
Functional level			.172	2.05	.043
Behavior symptom profile			.235	2.75	.007
Reactive care	.256	.134*	.373	4.37	< .001
Step 4					
Functional level			.145	2.01	.047
Behavior symptom profile			.256	3.49	.001
Reactive care			.158	1.95	.053
Static care	.457	.201*	.497	6.24	< .001

Note. $F(4,109)$ = 22.08, p < .001
**Statistically significant* p < .05

KEYPOINTS

NURSE RESPONSES TO DEMENTIA BEHAVIORS

Kovach, C.R., Kelber, S.T., Simpson, M., & Wells, T. **Behaviors of Nursing Home Residents with Dementia: Examining Nurse Responses.** *Journal of Gerontological Nursing*, 2006, 32(6): 13-21.

1. It is challenging for nurses to understand and respond to behaviors expressed by individuals with dementia.
2. Nurses in this study responded to behaviors in 4 discrete ways—with no treatment, treatment without assessment, repetitive use of ineffective treatments, and with comprehensive assessment followed by treatment.
3. Using ineffective treatments and treating without assessing were associated with recurrence of behaviors.
4. This study suggests there is a need for more assessment and critical thinking when addressing behavior change in individuals with dementia.

tive responses also take time. Souder and O'Sullivan (2003) found it took from 5.7 to 201.5 minutes (mean = 23.1 minutes, *SD* = 31.9) to manage disruptive behavior. Future research should examine the effect of the STI intervention on the time caregivers devote to behaviors that recur.

Nurses perceived comprehensive care responses to be most effective and associated with the fewest recurrences of behavior. Differences between the treatment and control groups in the use of comprehensive care suggest that nurses need more education to understand, assess, and treat behaviors associated with dementia. Also, future research should examine if other strategies, such as supervision, increased staffing, or presence of an advanced practice nurse are helpful in eliciting or sustaining comprehensive care.

Reactive and static care may reflect the nurse's learned response to a particular behavior. Static care responses are particularly troubling evidence of lack of critical thinking and evaluation of residents over time. Static care accounted for the most recurrences of behavior. The continued use of a small armamentarium of ineffective treatments observed in this study suggests that, in addition to teaching nurses and other caregivers what should be performed, there is a need to extinguish use of ineffective interventions.

Repetitive use of ineffective interventions may actually frustrate and agitate the resident while failing to meet the individual's real needs. According to the C-NDB theory (Kovach et al., 2005), failure to meet unmet needs may lead to sequelae including worsening of behavioral symptoms and new unmet needs. Further, nurses who use an ineffective static response style may develop feelings of inadequacy, decreased motivation, and burnout.

Differences in responses among nurses based on educational preparation and years of experience should be examined. In addition, it would be useful to explore the relationship of nurse responses to cost of caregiving over time, feelings of adequacy, burnout, and motivation. Outcome measures studied should be expanded to include both short- and long-term outcomes.

In this study, because nurses were requested to document a response to behaviors, dismissive responses are probably underrepresented. Souder and O'Sullivan's (2003) finding that approximately 25% of the time no nursing assessment or intervention was provided for disruptive behaviors may be more accurate. Also, perception of the effectiveness of responses may have been inflated in the study because of social desirability biases of nurses.

Recurrence of behavior was used as an indicator that a need was not met, but it could also have been an indication of a new need or a behavior that was not a symptom of unmet need. Coding of responses was reliable and dual investigators developed and refined both conceptual and operational definitions, but more methodological work is needed on all measures used in the study. Future research should examine the influence of organizational, staffing, and nurse characteristics on nurses' responses and residents' behavioral symptoms.

The results of this study suggest that, in addition to developing the sensitivity and empathy of caregivers, there is a need for more skills and for more critical thinking when addressing behaviors of individuals with dementia. Specifically, nurses and other caregivers must understand that behaviors may be symptoms of physical, as well as other, unmet needs. Nurses need to conduct multidimensional assessments in response to behavior changes, stop using ineffective treatments, and increase their repertoire of comforting interventions.

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alzheimer's association®

Statement Regarding Treatment of Behavioral and Psychiatric Symptoms of Alzheimer's Disease

Alzheimer's disease does more than rob people of their memories; people with Alzheimer's experience other kinds of symptoms. Cognitive symptoms disrupt memory, language, and thinking. Another category is behavioral and psychiatric symptoms. These symptoms occur in many — but not all — individuals with Alzheimer's. In early stages of the disease, people may experience irritability, anxiety or depression. In later stages, a range of other symptoms may occur, including:

- Sleep disturbances
- Physical or verbal outbursts
- Emotional distress
- Restlessness, pacing, shredding paper or tissues, and yelling
- Delusions (firmly held belief in things that are not real)
- Hallucinations (seeing, hearing, or feeling things that are not there)

These types of symptoms often are extremely distressing to persons with dementia, as well as their caregivers and family members, and some symptoms can have serious consequences. Many find behavioral symptoms to be the most challenging effects of the disease, and they are often a determining factor in a family's decision to place a loved one in residential settings such as assisted living and nursing homes. These symptoms can have an enormous impact on the care and quality of life for people living in these settings. That is why recognizing behavioral and psychiatric symptoms, understanding their causes, and knowing treatment options are so important.

1. Potential Causes of Behavioral and Psychiatric Symptoms

Resident behaviors are a form of communication and expression of preference, particularly for those people who cannot communicate easily in other ways. For example, a resident refusing a certain type of food may not like it. A resident resisting entering the shower room may need another method of keeping clean. Someone who repeatedly screams may be hungry or in pain. A person who wanders or paces may be bored and need more interaction with staff or activities that are meaningful to him or her.

Medical conditions, environmental influences and some medications can cause behavioral symptoms or make them worse. These symptoms can sometimes be traced to an underlying medical condition, such as bowel impaction, infections, or untreated pain. Environmental conditions can also trigger behavioral symptoms. These conditions can include changing residences or caregivers or fear and fatigue from trying to make sense of an increasingly confusing world. Side-effects of prescription medications are another common contributing factor to behavioral symptoms. Side effects are especially likely to occur when individuals are taking multiple medications for several health conditions, as that creates the potential for drug interactions.

2. Proper Identification, Assessment and Treatment of Symptoms

With appropriate assessment and treatment, behavioral and psychiatric symptoms can be significantly reduced or stabilized. Success depends on:

1. Identifying the symptoms, symptom triggers, and the symptoms' timing and frequency. All members of the care team, including family, can provide valuable insights.

2. Using assessment to understand the symptoms' medical causes, including medication side effects, as well as caregiving or environmental causes.
3. Addressing any medical causes, including medication side effects, and adapting caregiving and the environment to remedy the situation.
4. Reassessing symptoms periodically and modifying treatments as needed.

Medical Evaluation and Treatment

A person exhibiting behavioral and psychiatric symptoms should receive a thorough medical evaluation, especially when symptoms come on suddenly. Treatment depends on identification and description of the types of behavior the person is experiencing, careful diagnosis, and determination of possible medical causes of the behavior. With proper treatment and intervention, significant reduction or stabilization of the symptoms can often be achieved. Symptoms often reflect an underlying infection or medical illness. If the symptoms are treated with a psychotropic drug without careful examination, the medication will mask the symptom, which may lead to a much more dangerous situation. For example, the pain or discomfort caused by pneumonia or a urinary tract infection or untreated pain from another chronic condition (e.g., arthritis) can result in agitation. Resolving such conditions can result in reduction or elimination of symptoms.

Caregiving and the Environment

If medical causes of symptoms have been ruled out, it is important to identify other possible causes of behavioral and psychiatric symptoms. Often, the trigger is a change in the person's care, such as change in caregiver or in living arrangements; travel; admission to a hospital; presence of houseguests; or being asked to bathe or change clothing. Assessment should also address personal comfort, pain, hunger, thirst, constipation, full bladder and fatigue. Loss, boredom and isolation should also be assessed as causes of a behavioral symptom.

An environmental assessment directed at possible irritants may also be helpful. A calm, simple environment is critical; this involves such things as maintaining a comfortable room temperature and avoiding noise, glare, and too much background distraction, including distractions such as television.

3. Use of Medications

If non-drug approaches fail after they have been applied consistently, introducing medications may be appropriate when individuals have severe symptoms or have the potential to harm themselves or others. Medications can be effective in some situations, but they must be used carefully and are most effective when combined with non-drug approaches.

Medications should target specific symptoms so their effects can be monitored. In general, it is best to start with a low dose of a single drug. Effective treatment of one core symptom may sometimes help relieve other symptoms. For example, some antidepressants may also help people sleep better. Individuals taking medications for behavioral symptoms must be closely monitored. People with dementia are susceptible to serious side effects, including stroke and an increased risk of death from antipsychotic medications. Sometimes medications can cause an increase in the symptom being treated. Without careful evaluation, some medical providers will increase rather than decrease the dose, putting the person at greater risk. Risk and potential benefits of a drug should be carefully analyzed for any individual.

When considering use of medications, it is important to understand that no drugs are specifically approved by the U.S. Food and Drug Administration (FDA) to treat behavioral and psychiatric dementia symptoms. Some of the

examples discussed here represent "off label" use, a medical practice in which a physician may prescribe a drug for a different purpose than the ones for which it is approved.

Antipsychotic Medications

Antipsychotic medications for such symptoms as hallucinations and delusions include newer "atypical" agents such as aripiprazole (Abilify), olanzapine (Zyprexa), quetiapine (Seroquel), risperidone (Risperdal) and ziprasidone (Geodon) and older first-generation drugs such as haloperidol (Haldol). The decision to use an antipsychotic drug needs to be considered with extreme caution.

A recent meta-analysis shows that atypical antipsychotics are associated with an increased risk of stroke and death in older adults with dementia.[i] The FDA has asked manufacturers to include a "black box" warning about the risks and a reminder that they are not approved to treat dementia symptoms. The warning states: "Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo."

The meta-analysis states that while risperidone and olanzapine are useful in reducing aggression and that risperidone reduces psychosis, both drugs are associated with severe side effects.[ii] The authors said that despite some efficacy, these drugs should not be used routinely with dementia patients, unless the person is in severe distress or there is a marked risk of harm.

Guidance to Nursing Home Surveyors on Antipsychotics

The Centers for Medicare & Medicaid Services, using some of this information on antipsychotics, revised surveyor guidance in 2006 governing use of medications.[iii] The guidance says that nursing facilities must ensure that antipsychotic medications are being used properly. Facilities are in compliance with federal regulations, if they do the following:

- Assess the resident to determine causes of the behavioral condition or symptoms.
- Use the assessment to determine what non-pharmacologic intervention and/or medication is needed and identify the therapeutic goals for the treatments.
- Use appropriate doses of the medications for the time necessary to treat the resident's assessed condition(s).
- Implement a gradual dose reduction and behavioral interventions for each resident receiving antipsychotic medications unless clinically contraindicated.
- Monitor the resident for progress toward the therapeutic goal(s) and for the emergence or presence of adverse consequences.
- Adjust or discontinue the dose of a medication in response to adverse consequences, unless clinically contraindicated.

The use of antipsychotics must meet additional requirements. These drugs can only be used if the resident's symptoms are due to mania or psychosis; the symptoms present a danger to residents or others; or the resident is experiencing inconsolable or persistent distress, a significant decline in function or substantial difficulty receiving needed care. Finally, antipsychotics should not be used if the only reason for them is wandering, poor self-care ... uncooperativeness, or behaviors that do not present a danger to the resident or others.

4. Conclusion

Non-pharmacologic interventions should be used first to address behavioral and psychiatric symptoms in those with dementia. The research evidence as well as governmental warnings and guidance governing use of antipyschotics show that individuals with dementia should only use these medications when their behavioral symptoms are: due to mania or psychosis; or the symptoms present a danger to the resident or others; or the resident is experiencing inconsolable or persistent distress, a significant decline in function, or substantial difficulty receiving needed care. These medications should not be used to sedate or restrain persons with dementia. The minimum dosage should be used for the minimum amount of time possible. Adverse side effects require careful monitoring. If nursing facilities, medical directors, and their staff follow current governmental guidance on use of antipsychotics, problems associated with use of these medications can be minimized.

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[i] Ballard C, Waite J, "The Effectiveness of Atypical Antipsychotics for the Treatment of Aggression and Psychosis in Alzheimer's Disease," *Cochrane Database Systematic Review* January 2006 (1) :CD003476.

[ii] Ballard C, Waite J, "The Effectiveness of Atypical Antipsychotics for the Treatment of Aggression and Psychosis in Alzheimer's Disease," *Cochrane Database Systematic Review* January 2006 (1) :CD003476.

[iii] Centers for Medicare & Medicaid Services. *State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities.* Section 483.25(1).

The Neuropsychiatric Symptoms of Dementia:

A Visual Guide to Response Considerations

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About the Guide:

This guide is a product of the collective experiences of those who have contributed to and reviewed this tool. It does not, nor could it, include all possible considerations or interventions needed to help a person with dementia. Each person with dementia brings their own history, personality, medical conditions, family, coping styles and many other issues that require attention, analysis and commitment in order to support quality of life through the disease process.

Following general definitions and information about the neuropsychiatric symptoms of dementia, subsequent sections will direct you to specific considerations. It is hoped that this guide will offer ideas and conversations to help people with dementia.

Contents:

About Dementia:

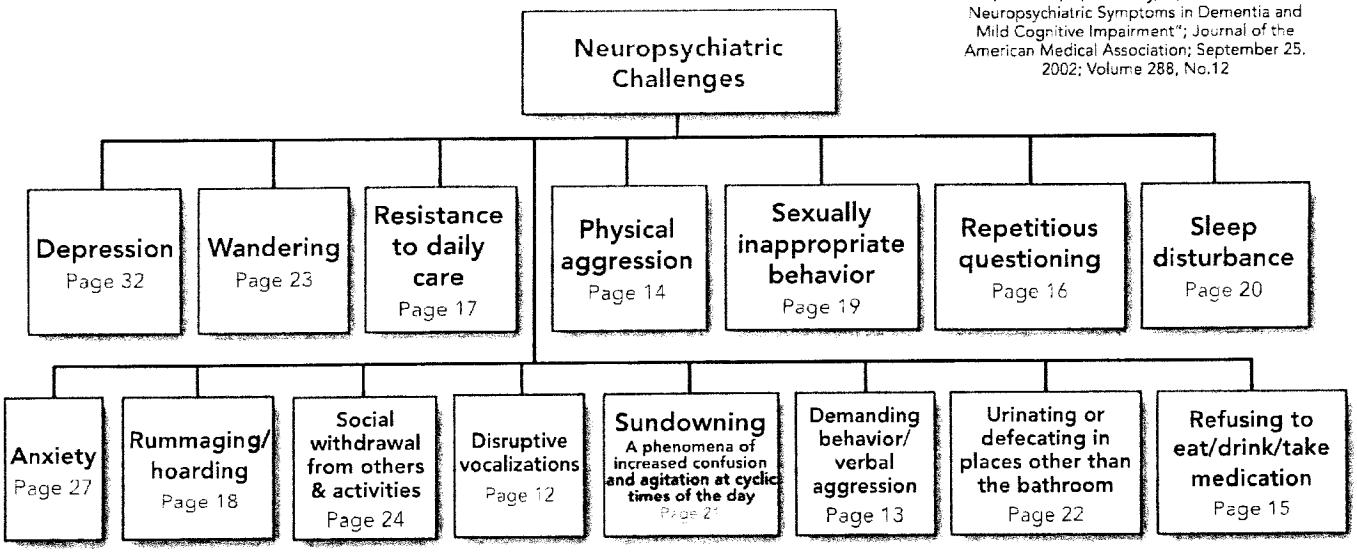
The term "dementia" simply means that a progressive neurological disease is present. There are many types of dementia. Alzheimer's disease is the most common type. While the dementias may present with some common symptoms and may result in the same conclusion, how each of these diseases move through the brain can be different and requires caregivers to be informed in the unique type of dementia present. Informed and prepared caregivers often result in reduction or avoidance of foreseeable crisis. A thorough dementia evaluation can assist in not only narrowing the type of dementia, but also preparing individuals and families in how to live with disease. It includes a brain scan, blood work, lab work, cognitive testing and a complete clinical history. Physicians may order additional tests as well. While affective and behavioral symptoms, especially depression, can occur at any time depending on the medical and environmental context, the highest risk for the neuropsychiatric symptoms occurs in the middle stages of the disease and beyond.

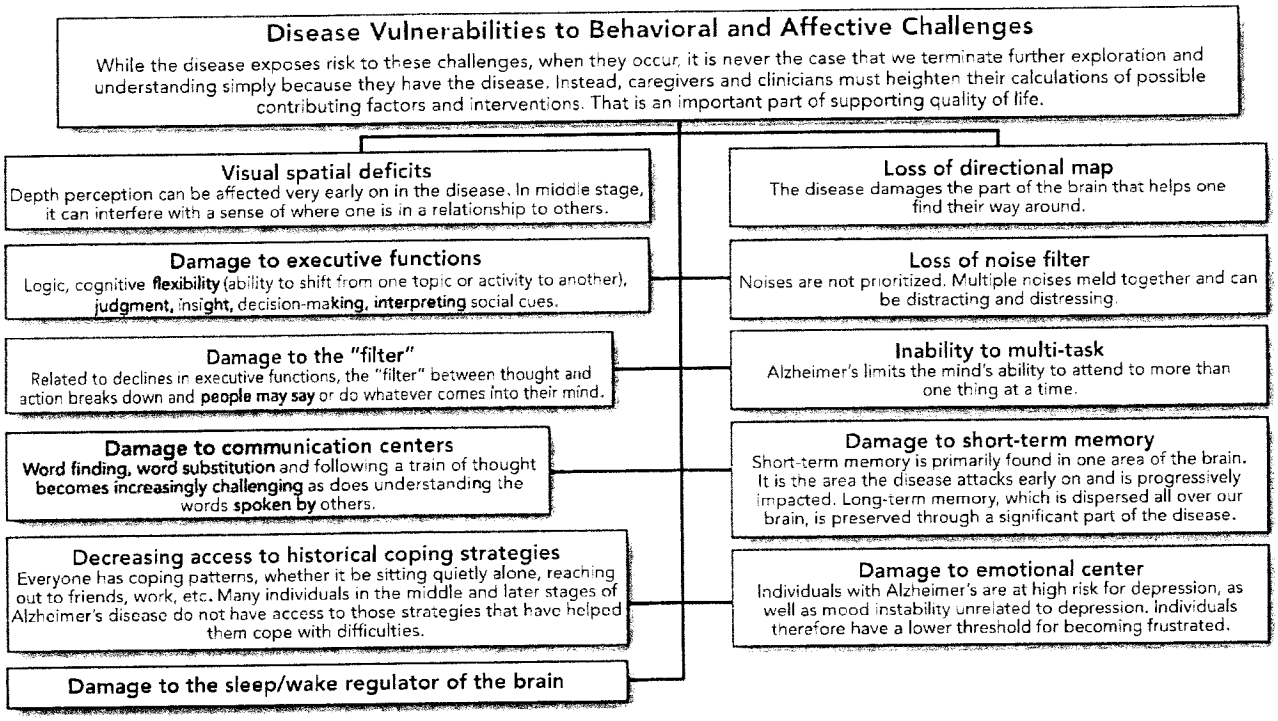
Section I

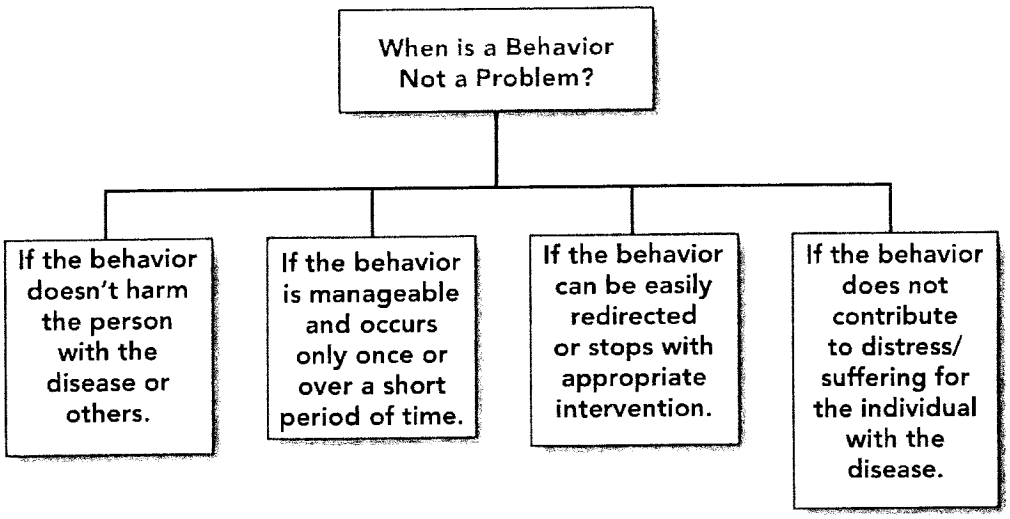
General Behavior Information

"80% of individuals with a dementia will experience neuropsychiatric (behavioral and affective) symptoms. The many serious consequences of these complications are greater impairment in activities of daily living, more rapid cognitive decline, worse quality of life, earlier institutionalization and greater caregiver depression."[1]

[1] Lyketos, C., Lopez, O., Jones, B., Fitzpatrick, A., Breitner, J., DeKosky, S.; "Prevalence of Neuropsychiatric Symptoms in Dementia and Mild Cognitive Impairment"; Journal of the American Medical Association; September 25. 2002; Volume 288, No.12




Disease Vulnerabilities to Behavioral and Affective Challenges
While the disease exposes risk to these challenges, when they occur, it is never the case that we terminate further exploration and understanding simply because they have the disease. Instead, caregivers and clinicians must heighten their calculations of possible contributing factors and interventions. That is an important part of supporting quality of life.
Visual spatial deficits
Depth perception can be affected very early on in the disease. In middle stage, it can interfere with a sense of where one is in a relationship to others.
Damage to executive functions
Logic, cognitive flexibility (ability to shift from one topic or activity to another), judgment, insight, decision-making, interpreting social cues.
Damage to the "filter"
Related to declines in executive functions, the "filter" between thought and action breaks down and people may say or do whatever comes into their mind.
Damage to communication centers
Word finding, word substitution and following a train of thought becomes increasingly challenging as does understanding the words spoken by others.
Decreasing access to historical coping strategies
Everyone has coping patterns, whether it be sitting quietly alone, reaching out to friends, work, etc. Many individuals in the middle and later stages of Alzheimer's disease do not have access to those strategies that have helped them cope with difficulties.
Damage to the sleep/wake regulator of the brain
Loss of directional map
The disease damages the part of the brain that helps one find their way around.
Loss of noise filter
Noises are not prioritized. Multiple noises meld together and can be distracting and distressing.
Inability to multi-task
Alzheimer's limits the mind's ability to attend to more than one thing at a time.
Damage to short-term memory
Short-term memory is primarily found in one area of the brain. It is the area the disease attacks early on and is progressively impacted. Long-term memory, which is dispersed all over our brain, is preserved through a significant part of the disease.
Damage to emotional center
Individuals with Alzheimer's are at high risk for depression, as well as mood instability unrelated to depression. Individuals therefore have a lower threshold for becoming frustrated.



Affective and behavioral symptoms are problematic when they interfere in quality of life, including ability to absorb enjoyable elements around them, to receive care, and to utilize the strengths and abilities that they continue to possess.

Medications

While environmental interventions and therapeutic care may reduce or negate the need for pharmacological intervention, there are times incorporating medication as part of a treatment plan for individuals going through behavioral and affective challenges is necessary. It is important to understand general types of medications utilized in order to avoid an automatic default to anti-psychotics and anxiolytics. There may be circumstances where an individual's medical status or long-term belief system precludes incorporation of pharmacological interventions. Further, all medications carry with them potential side effects. Dialogue with families about risk/benefit profile should occur around the use of any medication. When prescribing such medication, those with less potent side effects should be attempted first, often that means antidepressant trial. Careful assessment of these drugs is always important. At times primary physicians may prescribe such medications. However, in situations where multiple psychotropic medications are on board, intolerable side effects occur, or challenging behavior persists, securing opinion from a geriatric psychiatrist may be indicated. Further, medication response may change or decline over time necessitating re-evaluation of medications. The need for medications should be reevaluated on an ongoing basis.

Types of psychotropic medications include:

- ***Antidepressants***
  Antidepressants target the set of symptoms that constitute depression — such as irritability, negativity, anxiety, resistance, agitation, sadness, sleep disturbance, expressions of worthlessness/desire to die, and appetite changes. Symptoms of depression can even include paranoia and other forms of psychosis.

- ***Mood Stabilizers***
  Mood stabilizers, such as Depakote and Neurontin, are given in this population to assist in management of agitation and aggression. While evidence regarding the significance of their benefit is lacking, their use is often associated with attempts to minimize or avoid use of the antipsychotic medication.

- ***Anti-anxiety Agents***
  Anti – anxiety agents may be indicated in short-term crisis situations, in individuals who have had struggled with long standing generalized anxiety disorders in their life prior to dementia, end of life situations and in people with Parkinson's disease or other movement disorders. They can provoke paradoxical effects, increase fall risk, increase confusion, and negatively impact function.

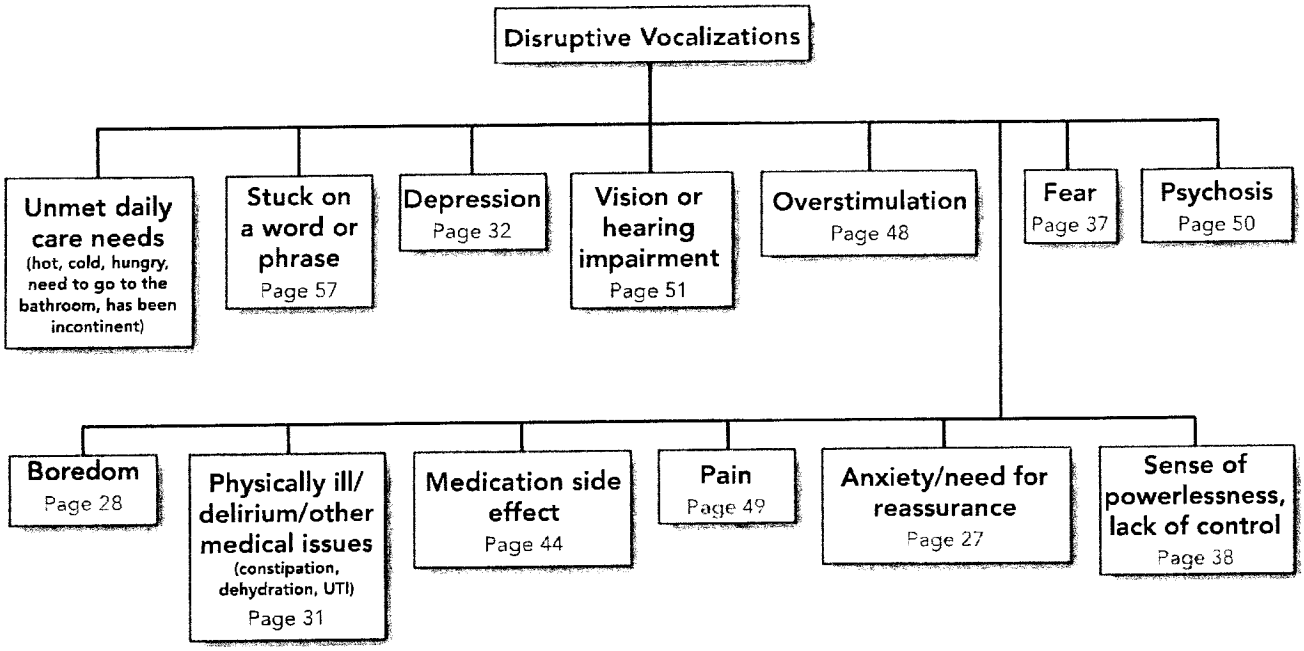
- ***Anti-psychotic Medications***
  The newer anti psychotic medication such as Risperidol, Zyprexa and Seroquel may be utilized as part of the treatment for the behavioral consequences of dementia. While their use may be unavoidable, all other possible interventions should be attempted first in order to minimize or negate use of this class of medications. They do have serious potential side effects including increased risk of death and, as with any medication, risk/benefit profile should be discussed with family.

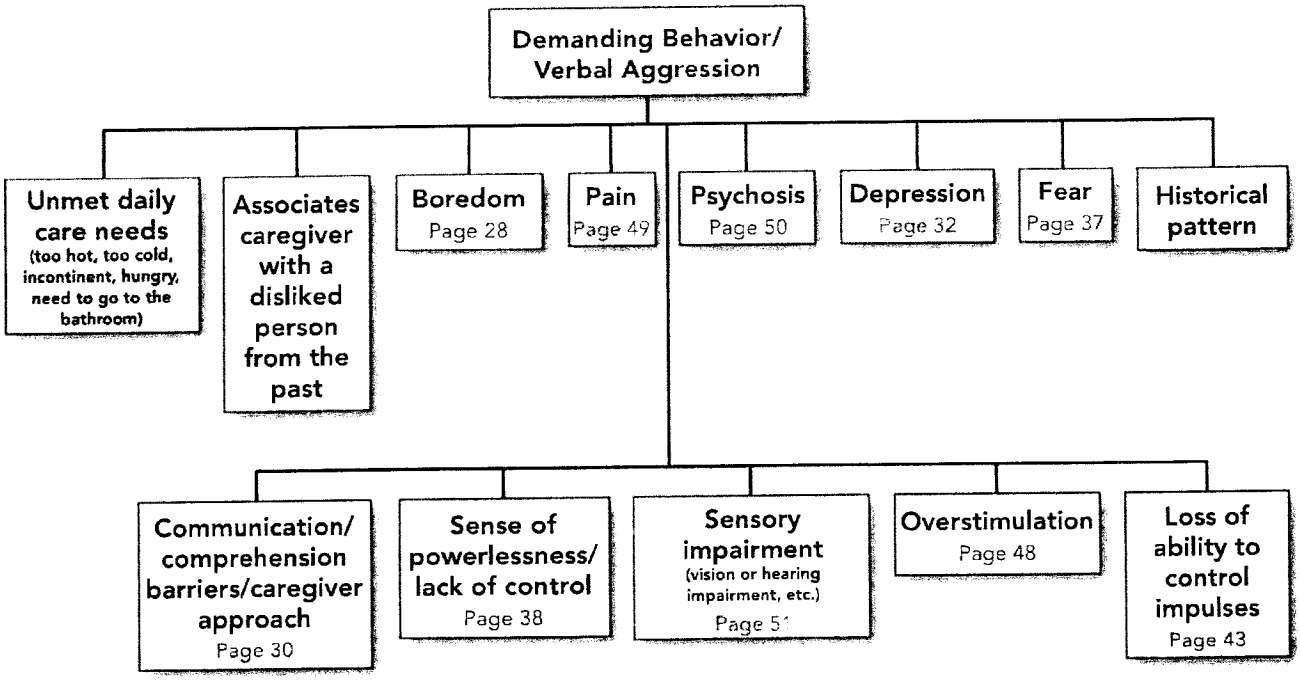
Careful monitoring of these medications is always necessary. They often require titration, many require withdrawal protocol, and they may or may not be required for extended amounts of time. Medication should not be used as a substitute for good care, for activity or for medical assessment, nor is the goal sedation. Decisions to incorporate such medication are based in the commitment to reduce suffering and improve quality of life. Incorporation of appropriate medication may extend the family's ability to care for the person at home, may reduce safety risks to the person and others and may prevent premature disability.

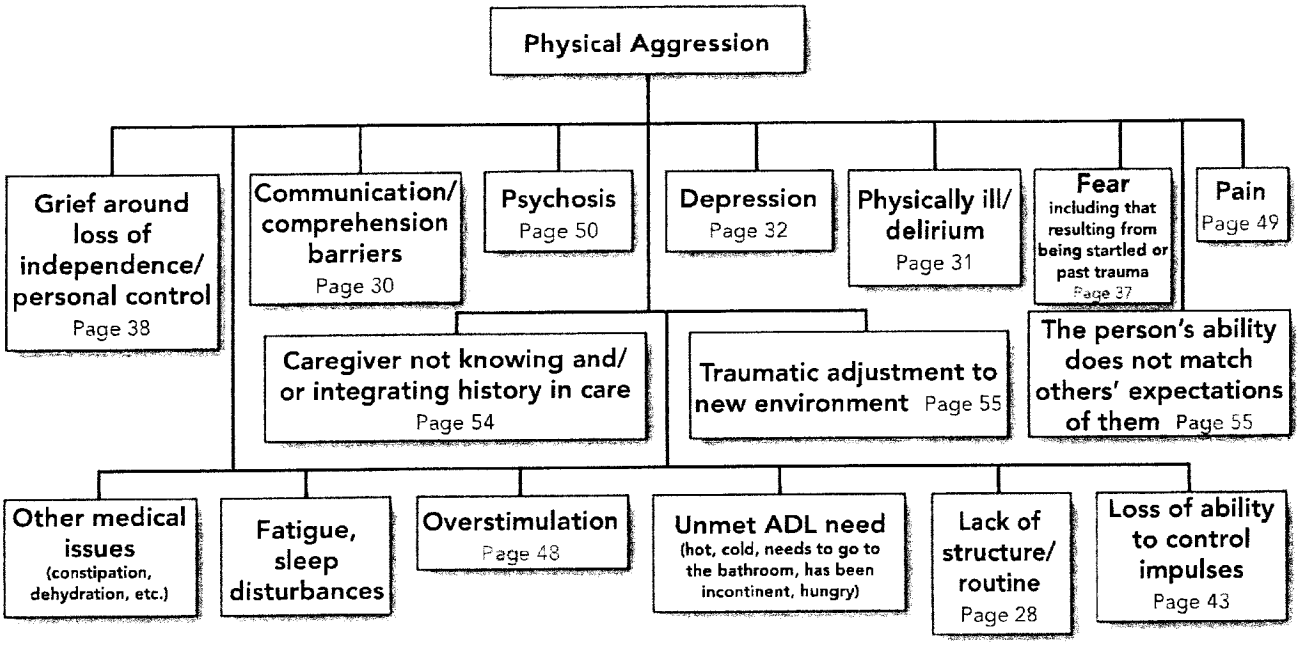
Section II

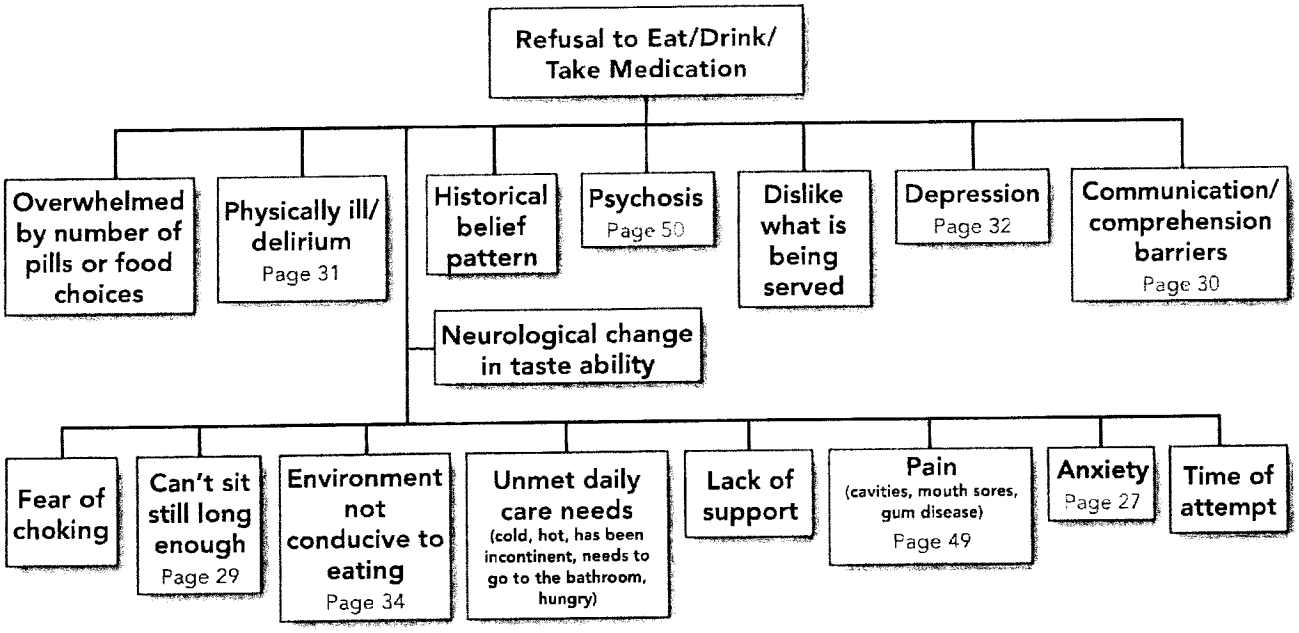
Possible Reasons for Specific Neuropsychiatric Challenges

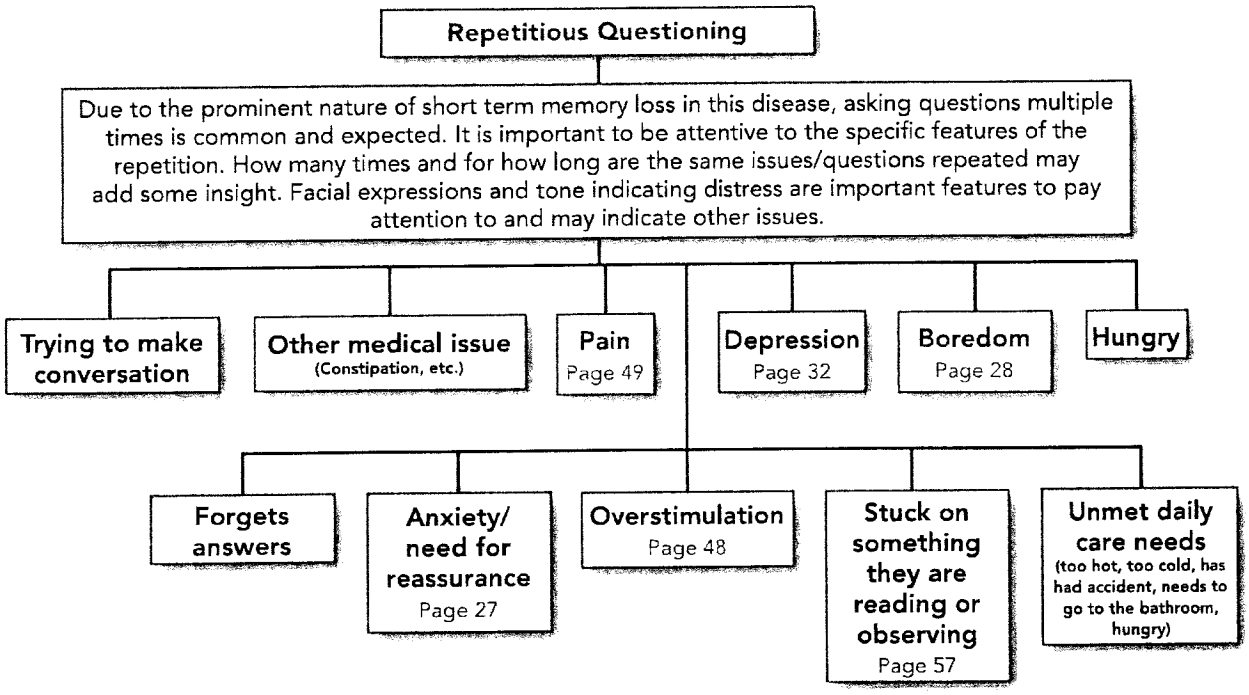
11

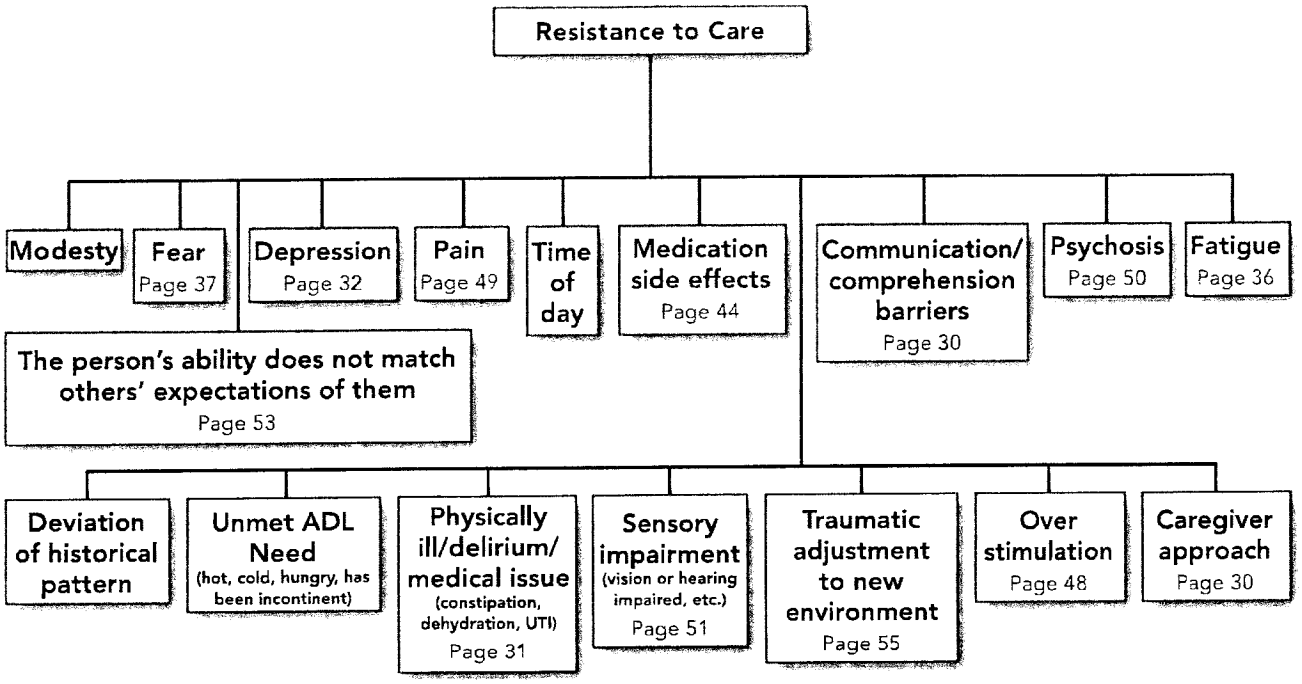

Disruptive Vocalizations
Unmet daily care needs (hot, cold, hungry, need to go to the bathroom, has been incontinent)
Stuck on a word or phrase Page 57
Depression Page 32
Vision or hearing impairment Page 51
Overstimulation Page 48
Fear Page 37
Psychosis Page 50
Boredom Page 28
Physically ill/ delirium/other medical issues (constipation, dehydration, UTI) Page 31
Medication side effect Page 44
Pain Page 49
Anxiety/need for reassurance Page 27
Sense of powerlessness, lack of control Page 38

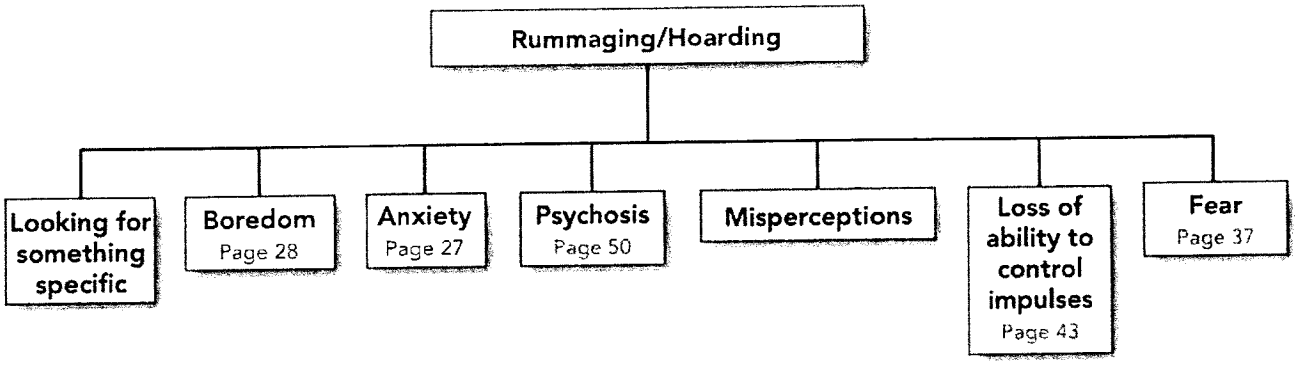

Demanding Behavior/ Verbal Aggression
Unmet daily care needs (too hot, too cold, incontinent, hungry, need to go to the bathroom)
Associates caregiver with a disliked person from the past
Boredom Page 28
Pain Page 49
Psychosis Page 50
Depression Page 32
Fear Page 37
Historical pattern
Communication/ comprehension barriers/caregiver approach Page 30
Sense of powerlessness/ lack of control Page 38
Sensory impairment (vision or hearing impairment, etc.) Page 51
Overstimulation Page 48
Loss of ability to control impulses Page 43

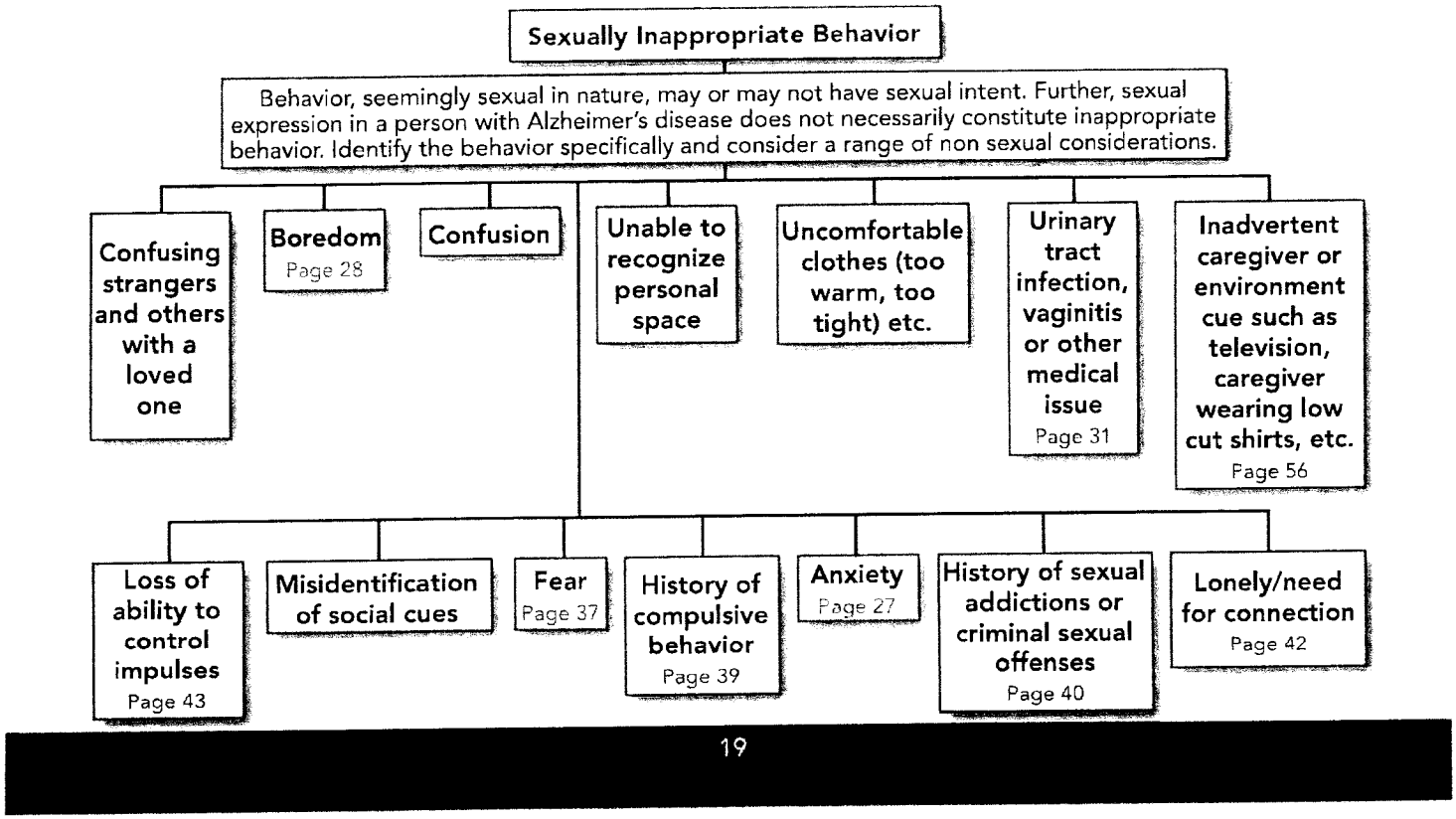

Physical Aggression
Grief around loss of independence/ personal control
Page 38
Communication/ comprehension barriers
Page 30
Psychosis
Page 50
Depression
Page 32
Physically ill/ delirium
Page 31
Fear
including that resulting from being startled or past trauma
Page 37
Pain
Page 49
Caregiver not knowing and/ or integrating history in care
Page 54
Traumatic adjustment to new environment
Page 55
The person's ability does not match others' expectations of them
Page 55
Other medical issues
(constipation, dehydration, etc.)
Fatigue, sleep disturbances
Overstimulation
Page 48
Unmet ADL need
(hot, cold, needs to go to the bathroom, has been incontinent, hungry)
Lack of structure/ routine
Page 28
Loss of ability to control impulses
Page 43

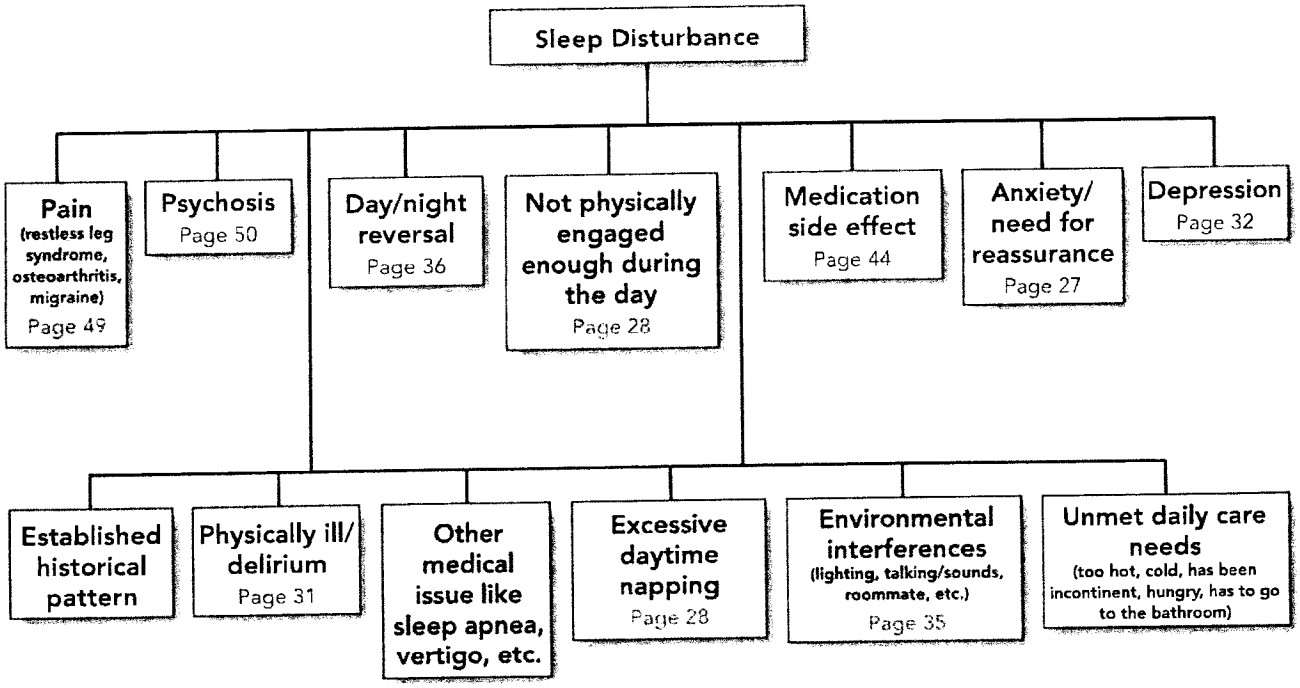

Refusal to Eat/Drink/ Take Medication
Overwhelmed by number of pills or food choices
Physically ill/ delirium
Page 31
Historical belief pattern
Psychosis
Page 50
Dislike what is being served
Depression
Page 32
Communication/ comprehension barriers
Page 30
Neurological change in taste ability
Fear of choking
Can't sit still long enough
Page 29
Environment not conducive to eating
Page 34
Unmet daily care needs
(cold, hot, has been incontinent, needs to go to the bathroom, hungry)
Lack of support
Pain
(cavities, mouth sores, gum disease)
Page 49
Anxiety
Page 27
Time of attempt

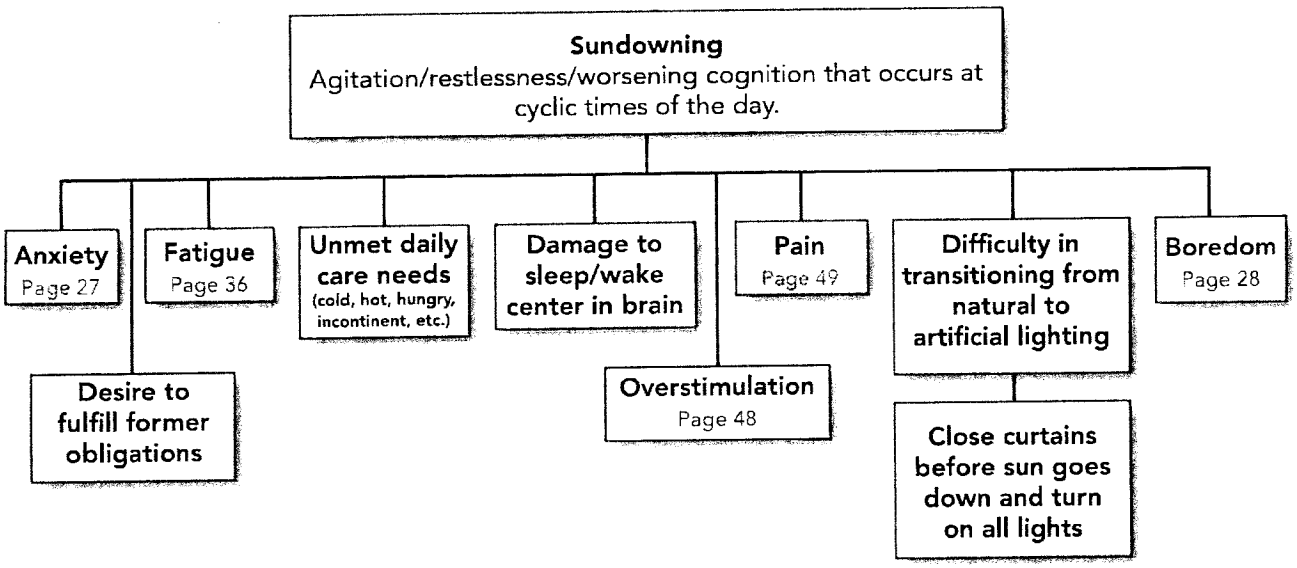

Repetitious Questioning
Due to the prominent nature of short term memory loss in this disease, asking questions multiple times is common and expected. It is important to be attentive to the specific features of the repetition. How many times and for how long are the same issues/questions repeated may add some insight. Facial expressions and tone indicating distress are important features to pay attention to and may indicate other issues.
Trying to make conversation
Other medical issue (Constipation, etc.)
Pain Page 49
Depression Page 32
Boredom Page 28
Hungry
Forgets answers
Anxiety/ need for reassurance Page 27
Overstimulation Page 48
Stuck on something they are reading or observing Page 57
Unmet daily care needs (too hot, too cold, has had accident, needs to go to the bathroom, hungry)

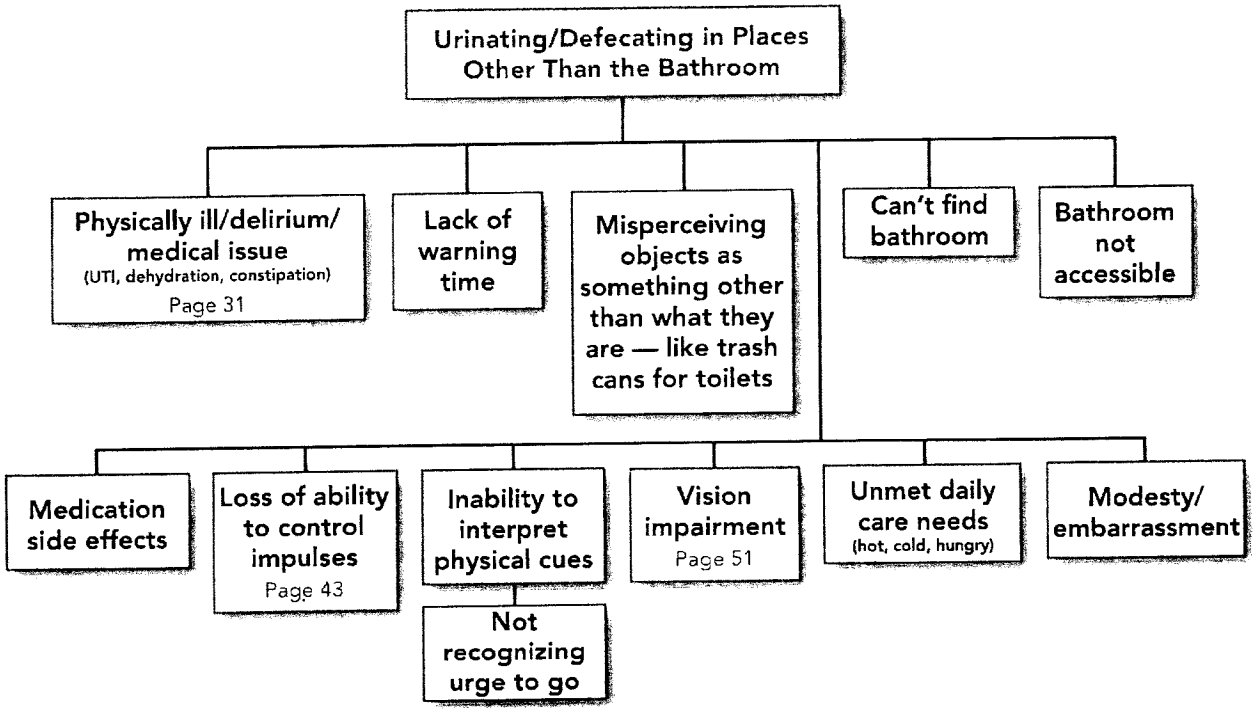

Resistance to Care
Modesty
Fear
Page 37
Depression
Page 32
Pain
Page 49
Time of day
Medication side effects
Page 44
Communication/ comprehension barriers
Page 30
Psychosis
Page 50
Fatigue
Page 36
The person's ability does not match others' expectations of them
Page 53
Deviation of historical pattern
Unmet ADL Need
(hot, cold, hungry, has been incontinent)
Physically ill/delirium/ medical issue
(constipation, dehydration, UTI)
Page 31
Sensory impairment
(vision or hearing impaired, etc.)
Page 51
Traumatic adjustment to new environment
Page 55
Over stimulation
Page 48
Caregiver approach
Page 30

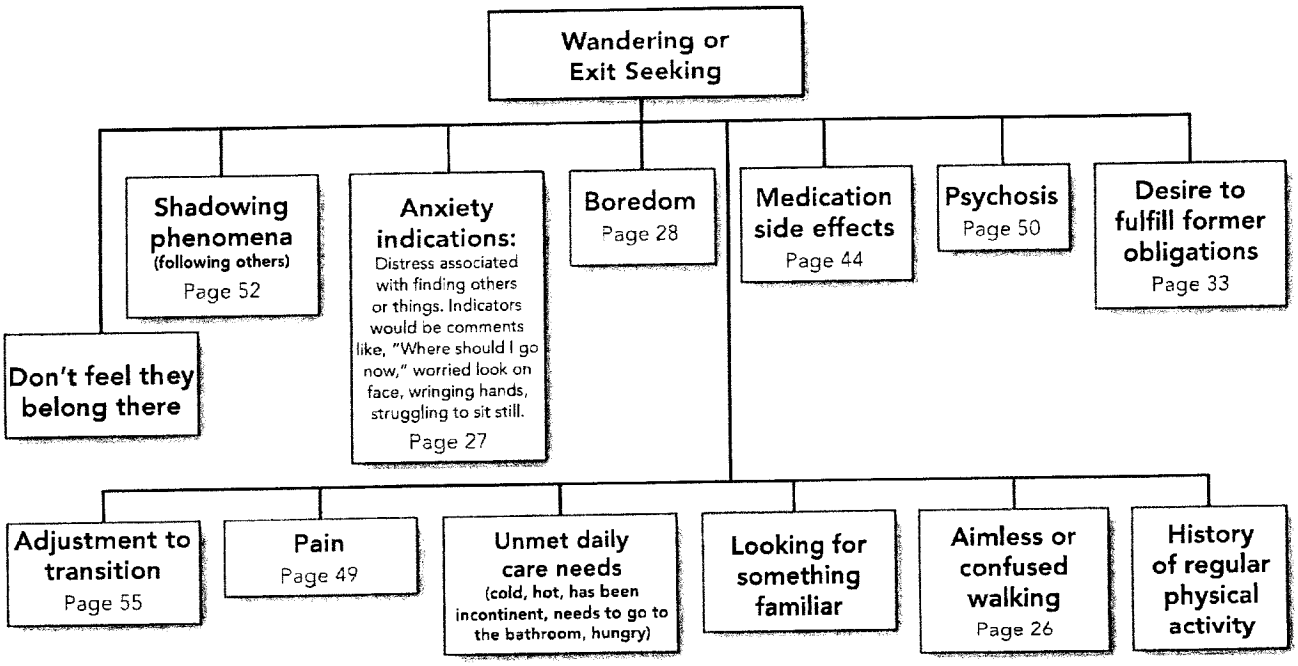

Rummaging/Hoarding
Looking for something specific
Boredom
Page 28
Anxiety
Page 27
Psychosis
Page 50
Misperceptions
Loss of ability to control impulses
Page 43
Fear
Page 37


Sexually Inappropriate Behavior
Behavior, seemingly sexual in nature, may or may not have sexual intent. Further, sexual expression in a person with Alzheimer's disease does not necessarily constitute inappropriate behavior. Identify the behavior specifically and consider a range of non sexual considerations.
Confusing strangers and others with a loved one
Boredom
Page 28
Confusion
Unable to recognize personal space
Uncomfortable clothes (too warm, too tight) etc.
Urinary tract infection, vaginitis or other medical issue
Page 31
Inadvertent caregiver or environment cue such as television, caregiver wearing low cut shirts, etc.
Page 56
Loss of ability to control impulses
Page 43
Misidentification of social cues
Fear
Page 37
History of compulsive behavior
Page 39
Anxiety
Page 27
History of sexual addictions or criminal sexual offenses
Page 40
Lonely/need for connection
Page 42
19

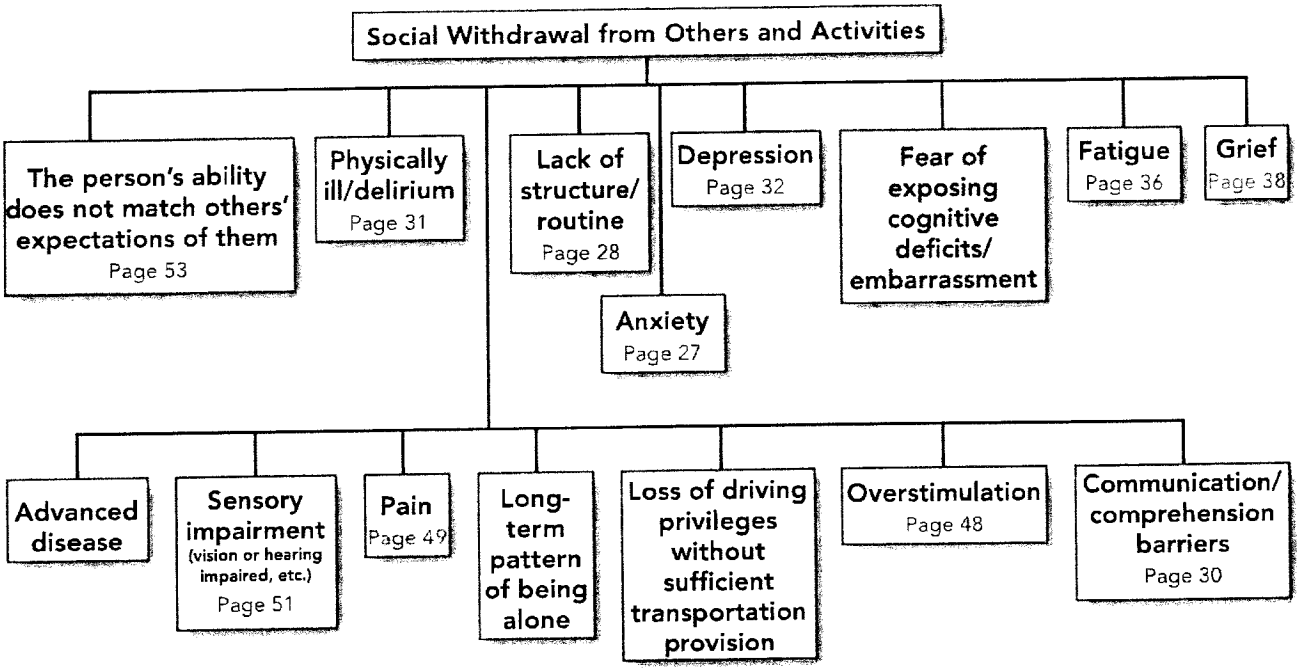

Sleep Disturbance
Pain
(restless leg syndrome, osteoarthritis, migraine)
Page 49
Psychosis
Page 50
Day/night reversal
Page 36
Not physically engaged enough during the day
Page 28
Medication side effect
Page 44
Anxiety/ need for reassurance
Page 27
Depression
Page 32
Established historical pattern
Physically ill/ delirium
Page 31
Other medical issue like sleep apnea, vertigo, etc.
Excessive daytime napping
Page 28
Environmental interferences
(lighting, talking/sounds, roommate, etc.)
Page 35
Unmet daily care needs
(too hot, cold, has been incontinent, hungry, has to go to the bathroom)


Sundowning
Agitation/restlessness/worsening cognition that occurs at cyclic times of the day.
Anxiety
Page 27
Fatigue
Page 36
Unmet daily care needs
(cold, hot, hungry, incontinent, etc.)
Damage to sleep/wake center in brain
Pain
Page 49
Difficulty in transitioning from natural to artificial lighting
Boredom
Page 28
Desire to fulfill former obligations
Overstimulation
Page 48
Close curtains before sun goes down and turn on all lights

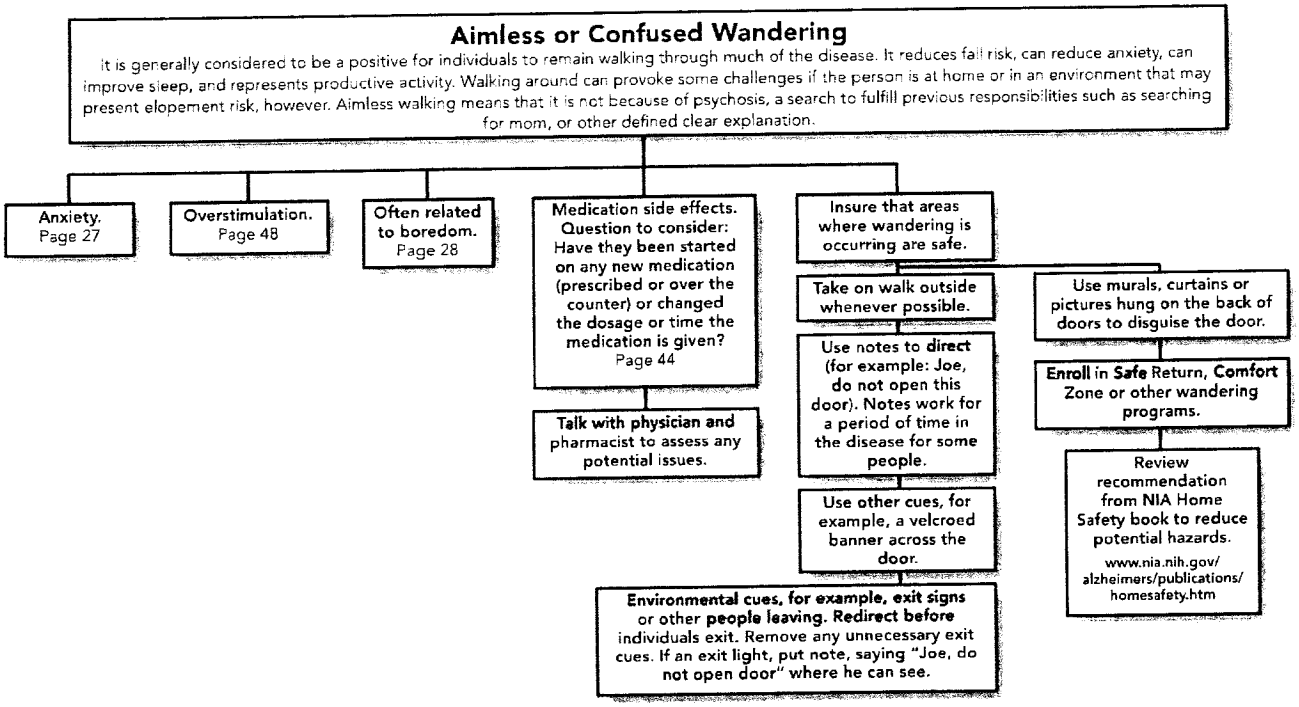

Urinating/Defecating in Places Other Than the Bathroom
Physically ill/delirium/ medical issue
(UTI, dehydration, constipation)
Page 31
Lack of warning time
Misperceiving objects as something other than what they are — like trash cans for toilets
Can't find bathroom
Bathroom not accessible
Medication side effects
Loss of ability to control impulses
Page 43
Inability to interpret physical cues
Not recognizing urge to go
Vision impairment
Page 51
Unmet daily care needs
(hot, cold, hungry)
Modesty/ embarrassment

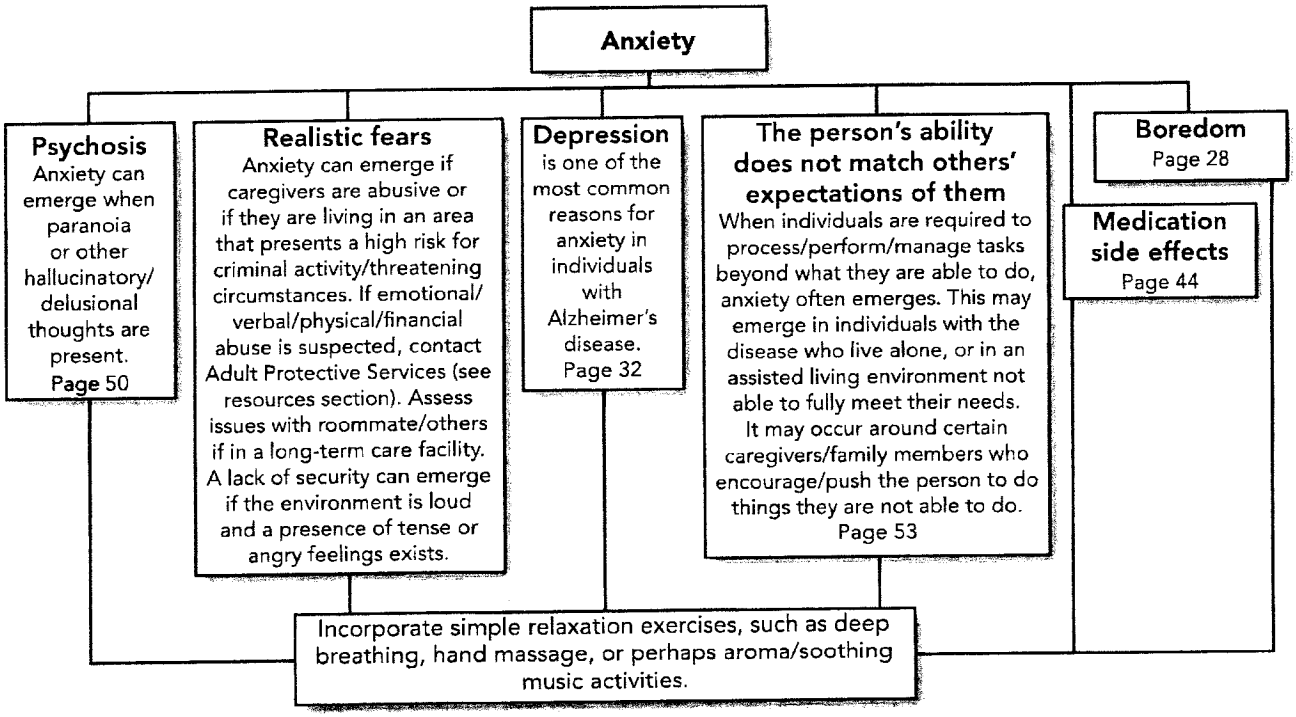

Wandering or Exit Seeking
Shadowing phenomena (following others) Page 52
Anxiety indications: Distress associated with finding others or things. Indicators would be comments like, "Where should I go now," worried look on face, wringing hands, struggling to sit still. Page 27
Boredom Page 28
Medication side effects Page 44
Psychosis Page 50
Desire to fulfill former obligations Page 33
Don't feel they belong there
Adjustment to transition Page 55
Pain Page 49
Unmet daily care needs (cold, hot, has been incontinent, needs to go to the bathroom, hungry)
Looking for something familiar
Aimless or confused walking Page 26
History of regular physical activity

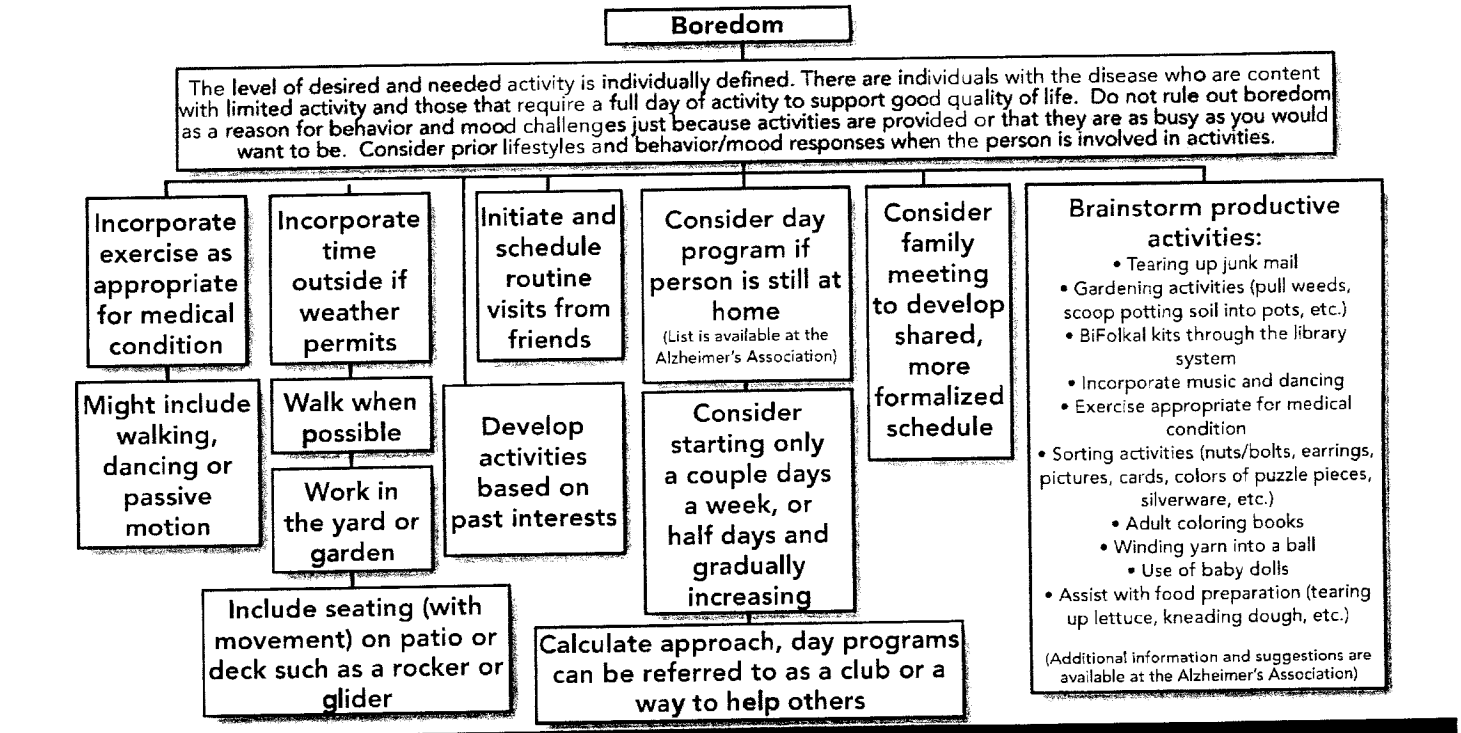
23

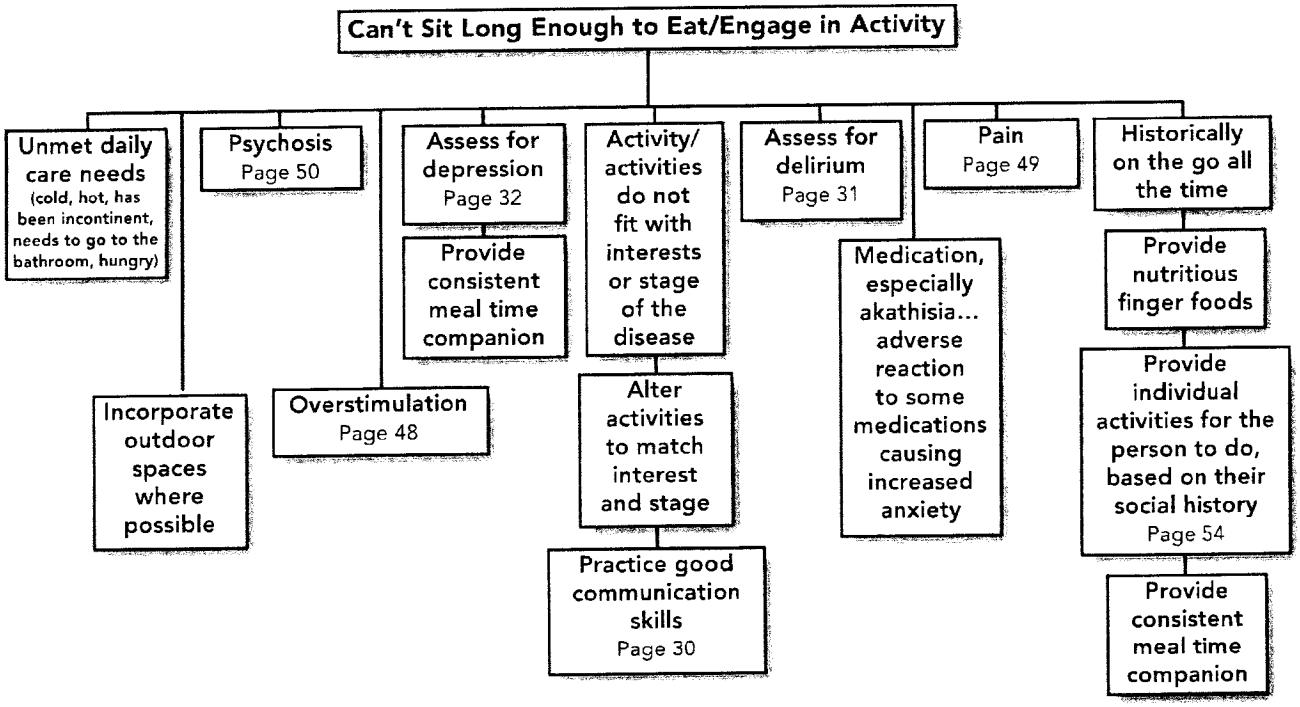

Social Withdrawal from Others and Activities
The person's ability does not match others' expectations of them
Page 53
Physically ill/delirium
Page 31
Lack of structure/ routine
Page 28
Depression
Page 32
Anxiety
Page 27
Fear of exposing cognitive deficits/ embarrassment
Fatigue
Page 36
Grief
Page 38
Advanced disease
Sensory impairment
(vision or hearing impaired, etc.)
Page 51
Pain
Page 49
Long-term pattern of being alone
Loss of driving privileges without sufficient transportation provision
Overstimulation
Page 48
Communication/ comprehension barriers
Page 30

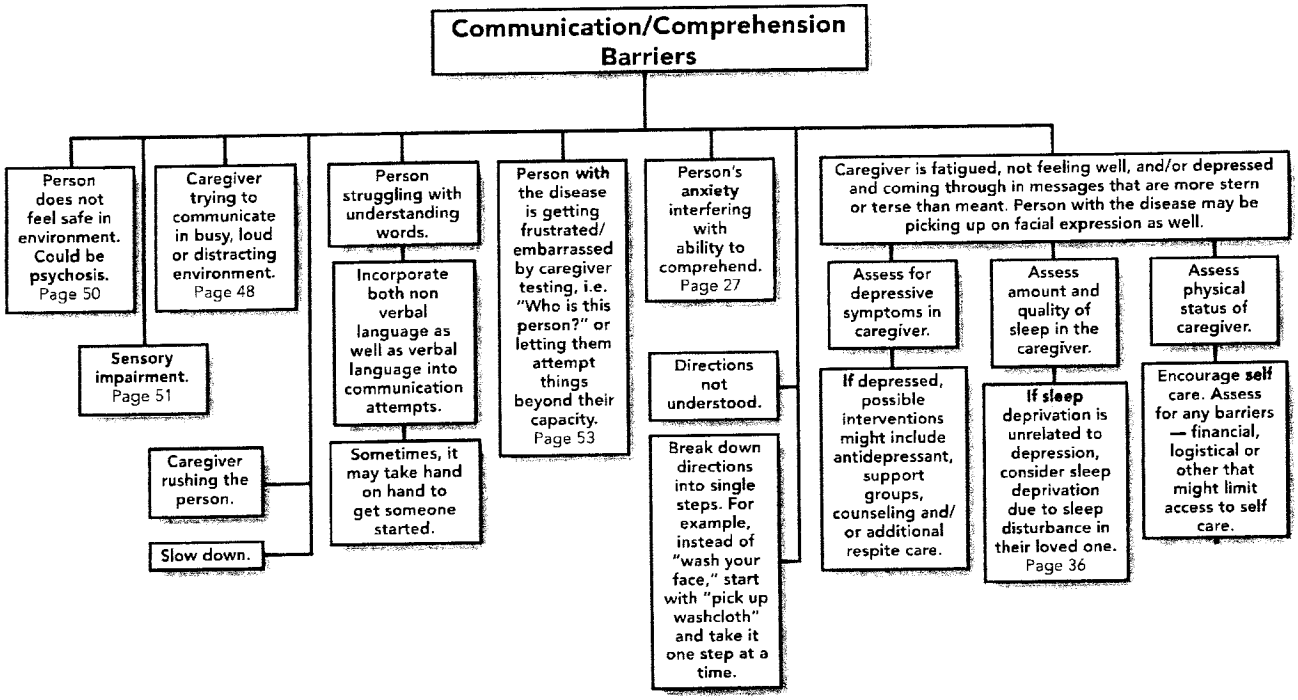
Section III
Interventions

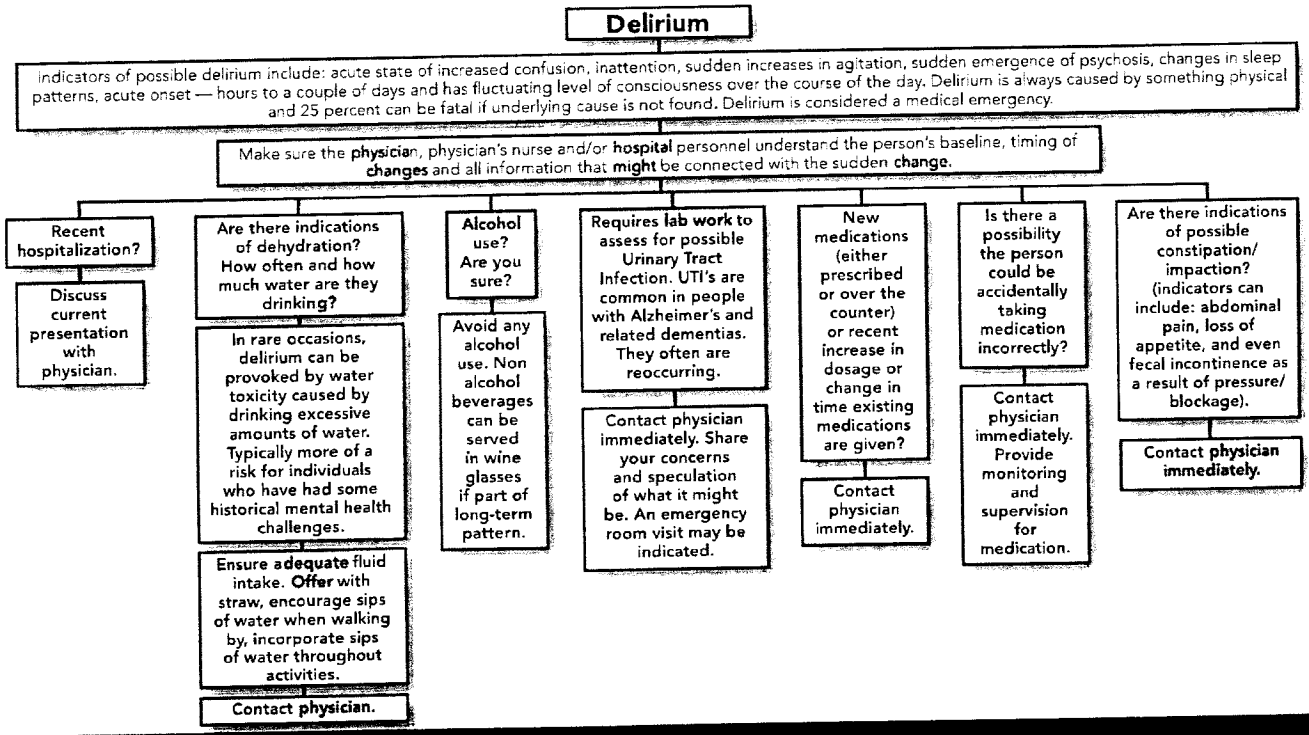

Aimless or Confused Wandering
It is generally considered to be a positive for individuals to remain walking through much of the disease. It reduces fall risk, can reduce anxiety, can improve sleep, and represents productive activity. Walking around can provoke some challenges if the person is at home or in an environment that may present elopement risk, however. Aimless walking means that it is not because of psychosis, a search to fulfill previous responsibilities such as searching for mom, or other defined clear explanation.
Anxiety. Page 27
Overstimulation. Page 48
Often related to boredom. Page 28
Medication side effects. Question to consider: Have they been started on any new medication (prescribed or over the counter) or changed the dosage or time the medication is given? Page 44
Talk with physician and pharmacist to assess any potential issues.
Insure that areas where wandering is occurring are safe.
Take on walk outside whenever possible.
Use notes to direct (for example: Joe, do not open this door). Notes work for a period of time in the disease for some people.
Use other cues, for example, a velcroed banner across the door.
Environmental cues, for example, exit signs or other people leaving. Redirect before individuals exit. Remove any unnecessary exit cues. If an exit light, put note, saying "Joe, do not open door" where he can see.
Use murals, curtains or pictures hung on the back of doors to disguise the door.
Enroll in Safe Return, Comfort Zone or other wandering programs.
Review recommendation from NIA Home Safety book to reduce potential hazards.
www.nia.nih.gov/alzheimers/publications/homesafety.htm

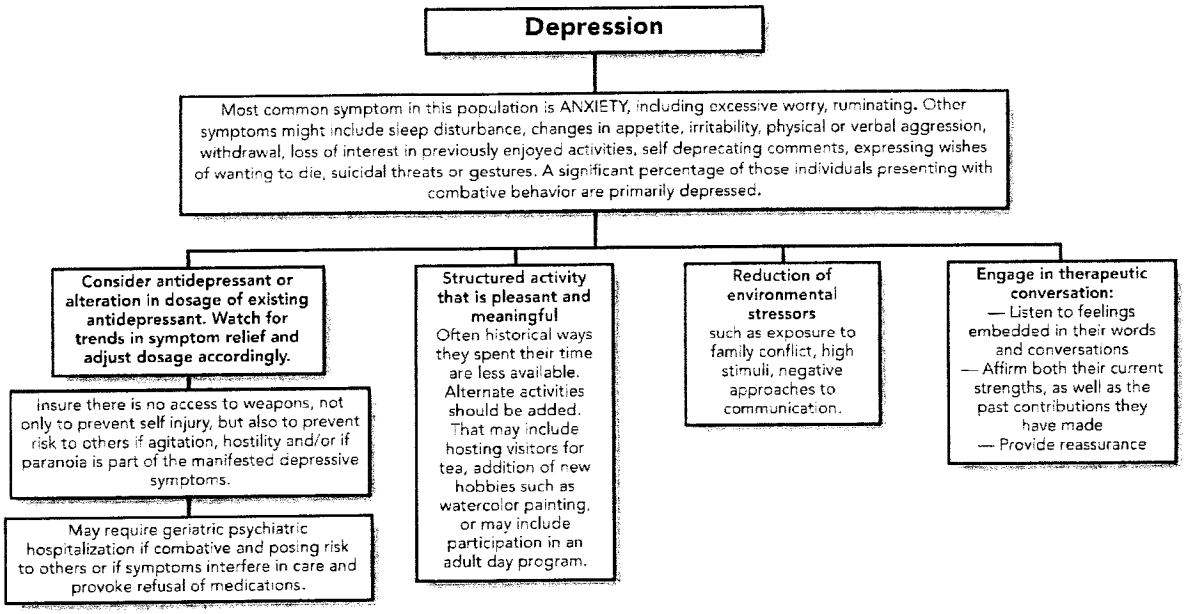

Anxiety
Psychosis
Anxiety can emerge when paranoia or other hallucinatory/ delusional thoughts are present.
Page 50
Realistic fears
Anxiety can emerge if caregivers are abusive or if they are living in an area that presents a high risk for criminal activity/threatening circumstances. If emotional/ verbal/physical/financial abuse is suspected, contact Adult Protective Services (see resources section). Assess issues with roommate/others if in a long-term care facility. A lack of security can emerge if the environment is loud and a presence of tense or angry feelings exists.
Depression
is one of the most common reasons for anxiety in individuals with Alzheimer's disease.
Page 32
The person's ability does not match others' expectations of them
When individuals are required to process/perform/manage tasks beyond what they are able to do, anxiety often emerges. This may emerge in individuals with the disease who live alone, or in an assisted living environment not able to fully meet their needs. It may occur around certain caregivers/family members who encourage/push the person to do things they are not able to do.
Page 53
Boredom
Page 28
Medication side effects
Page 44
Incorporate simple relaxation exercises, such as deep breathing, hand massage, or perhaps aroma/soothing music activities.

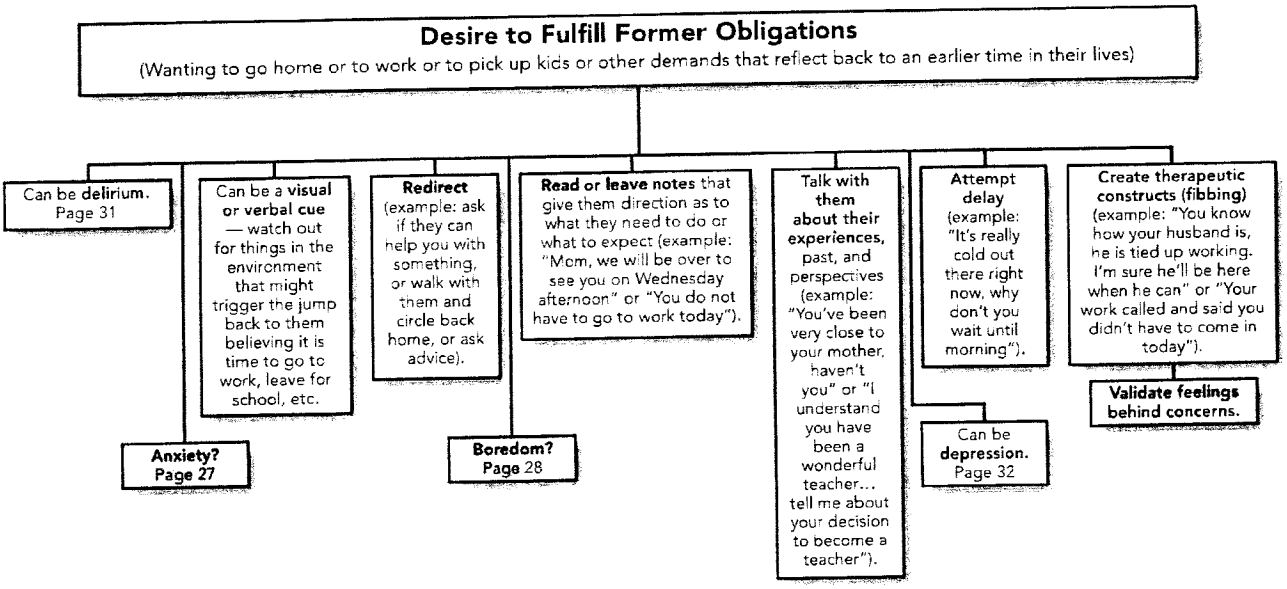

Boredom
The level of desired and needed activity is individually defined. There are individuals with the disease who are content with limited activity and those that require a full day of activity to support good quality of life. Do not rule out boredom as a reason for behavior and mood challenges just because activities are provided or that they are as busy as you would want to be. Consider prior lifestyles and behavior/mood responses when the person is involved in activities.
Incorporate exercise as appropriate for medical condition
Might include walking, dancing or passive motion
Incorporate time outside if weather permits
Walk when possible
Work in the yard or garden
Include seating (with movement) on patio or deck such as a rocker or glider
Initiate and schedule routine visits from friends
Develop activities based on past interests
Consider day program if person is still at home
(List is available at the Alzheimer's Association)
Consider starting only a couple days a week, or half days and gradually increasing
Calculate approach, day programs can be referred to as a club or a way to help others
Consider family meeting to develop shared, more formalized schedule
Brainstorm productive activities:
• Tearing up junk mail
• Gardening activities (pull weeds, scoop potting soil into pots, etc.)
• BiFolkal kits through the library system
• Incorporate music and dancing
• Exercise appropriate for medical condition
• Sorting activities (nuts/bolts, earrings, pictures, cards, colors of puzzle pieces, silverware, etc.)
• Adult coloring books
• Winding yarn into a ball
• Use of baby dolls
• Assist with food preparation (tearing up lettuce, kneading dough, etc.)
(Additional information and suggestions are available at the Alzheimer's Association)

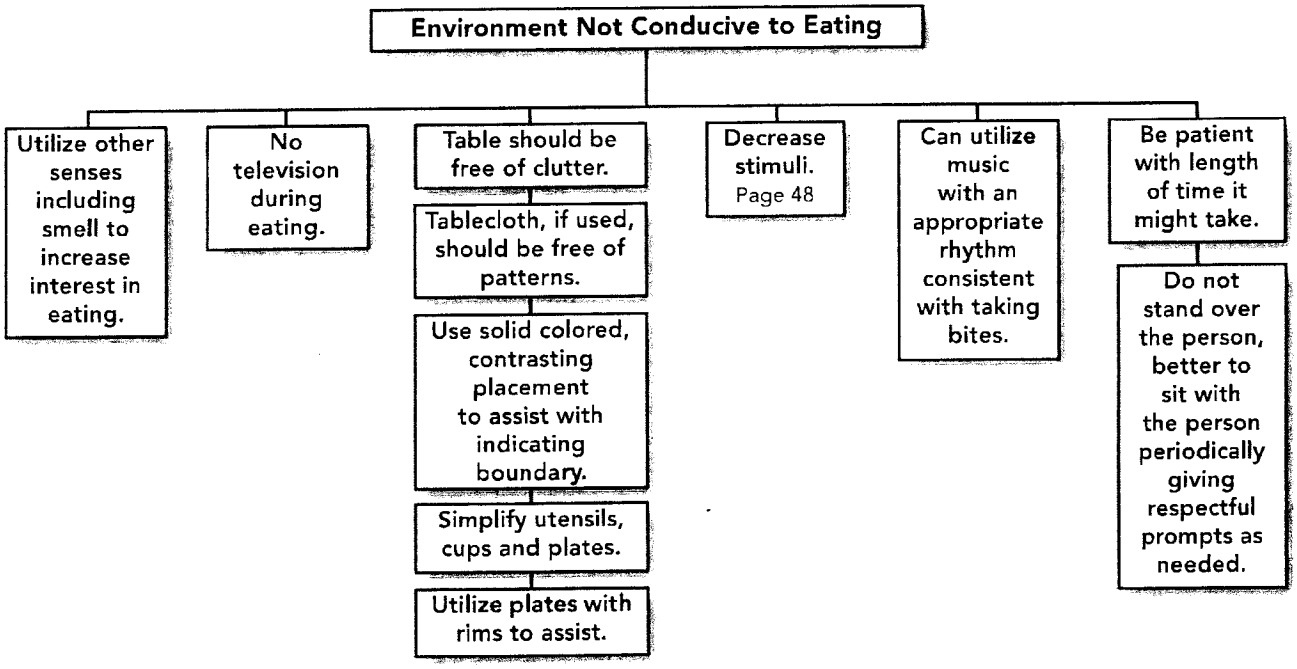

Can't Sit Long Enough to Eat/Engage in Activity
Unmet daily care needs (cold, hot, has been incontinent, needs to go to the bathroom, hungry)
Incorporate outdoor spaces where possible
Psychosis Page 50
Overstimulation Page 48
Assess for depression Page 32
Provide consistent meal time companion
Activity/ activities do not fit with interests or stage of the disease
Alter activities to match interest and stage
Practice good communication skills Page 30
Assess for delirium Page 31
Medication, especially akathisia... adverse reaction to some medications causing increased anxiety
Pain Page 49
Historically on the go all the time
Provide nutritious finger foods
Provide individual activities for the person to do, based on their social history Page 54
Provide consistent meal time companion

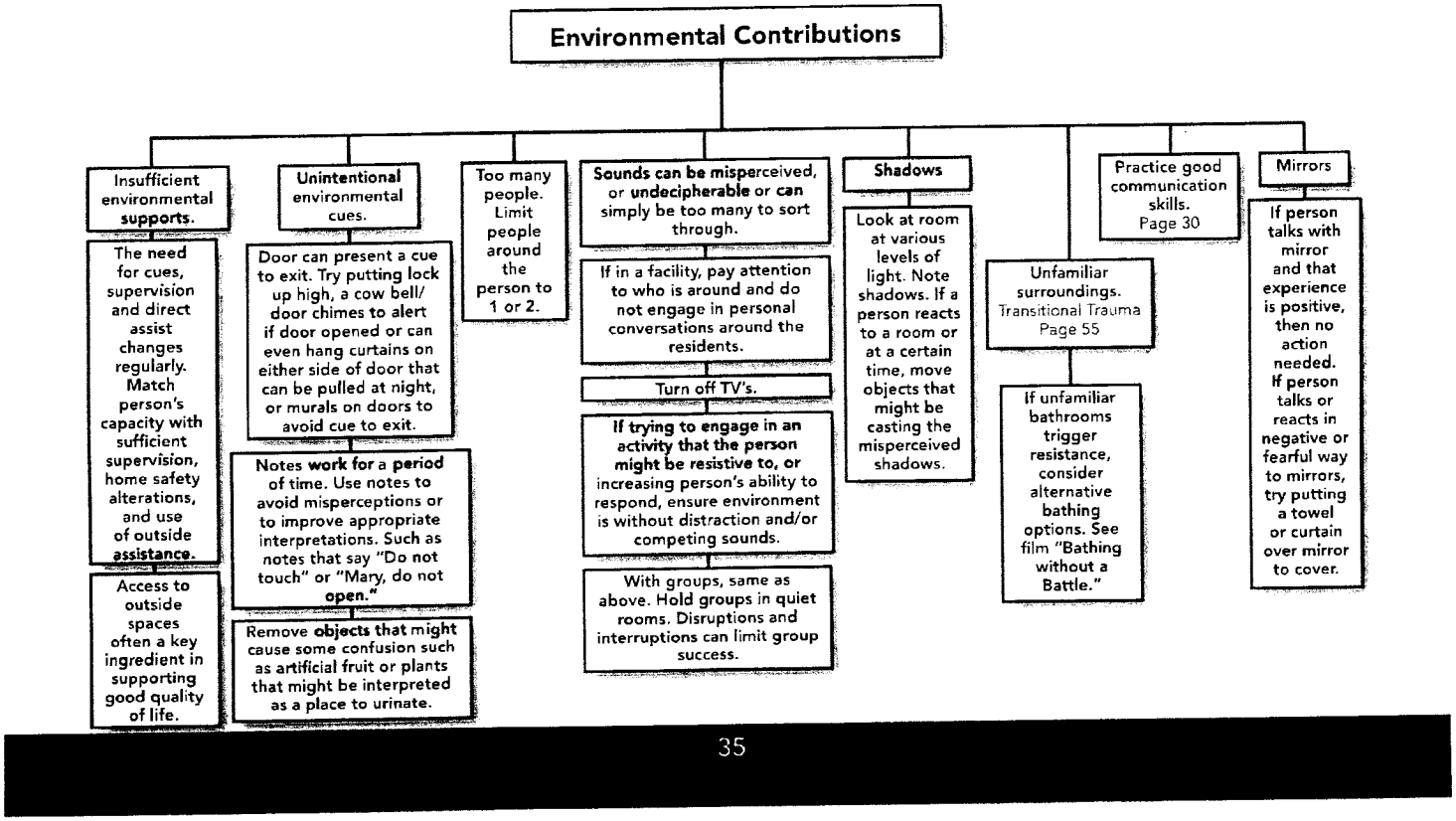

Communication/Comprehension Barriers
Person does not feel safe in environment. Could be psychosis. Page 50
Sensory impairment. Page 51
Caregiver trying to communicate in busy, loud or distracting environment. Page 48
Caregiver rushing the person.
Slow down.
Person struggling with understanding words.
Incorporate both non verbal language as well as verbal language into communication attempts.
Sometimes, it may take hand on hand to get someone started.
Person with the disease is getting frustrated/ embarrassed by caregiver testing, i.e. "Who is this person?" or letting them attempt things beyond their capacity. Page 53
Person's anxiety interfering with ability to comprehend. Page 27
Directions not understood.
Break down directions into single steps. For example, instead of "wash your face," start with "pick up washcloth" and take it one step at a time.
Caregiver is fatigued, not feeling well, and/or depressed and coming through in messages that are more stern or terse than meant. Person with the disease may be picking up on facial expression as well.
Assess for depressive symptoms in caregiver.
If depressed, possible interventions might include antidepressant, support groups, counseling and/ or additional respite care.
Assess amount and quality of sleep in the caregiver.
If sleep deprivation is unrelated to depression, consider sleep deprivation due to sleep disturbance in their loved one. Page 36
Assess physical status of caregiver.
Encourage self care. Assess for any barriers — financial, logistical or other that might limit access to self care.

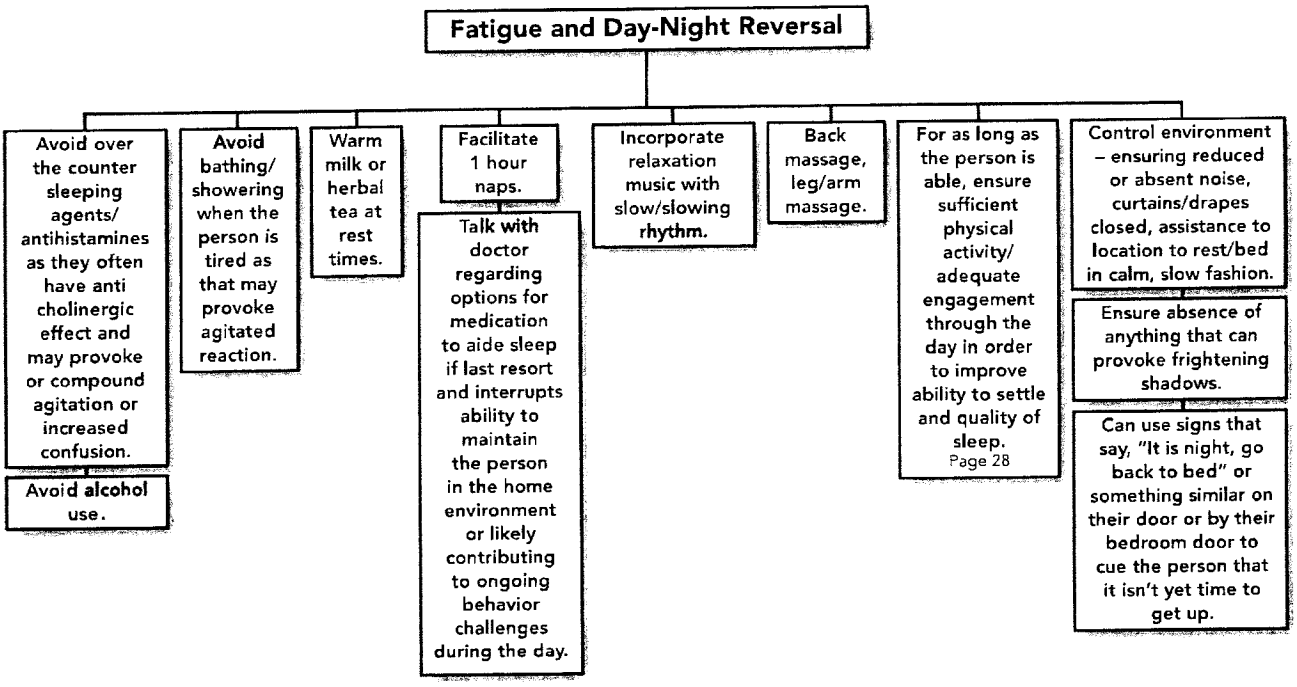

Delirium
indicators of possible delirium include: acute state of increased confusion, inattention, sudden increases in agitation, sudden emergence of psychosis, changes in sleep patterns, acute onset — hours to a couple of days and has fluctuating level of consciousness over the course of the day. Delirium is always caused by something physical and 25 percent can be fatal if underlying cause is not found. Delirium is considered a medical emergency.
Make sure the physician, physician's nurse and/or hospital personnel understand the person's baseline, timing of changes and all information that might be connected with the sudden change.
Recent hospitalization?
Discuss current presentation with physician.
Are there indications of dehydration? How often and how much water are they drinking?
In rare occasions, delirium can be provoked by water toxicity caused by drinking excessive amounts of water. Typically more of a risk for individuals who have had some historical mental health challenges.
Ensure adequate fluid intake. Offer with straw, encourage sips of water when walking by, incorporate sips of water throughout activities.
Contact physician.
Alcohol use? Are you sure?
Avoid any alcohol use. Non alcohol beverages can be served in wine glasses if part of long-term pattern.
Requires lab work to assess for possible Urinary Tract Infection. UTI's are common in people with Alzheimer's and related dementias. They often are reoccurring.
Contact physician immediately. Share your concerns and speculation of what it might be. An emergency room visit may be indicated.
New medications (either prescribed or over the counter) or recent increase in dosage or change in time existing medications are given?
Contact physician immediately.
Is there a possibility the person could be accidentally taking medication incorrectly?
Contact physician immediately. Provide monitoring and supervision for medication.
Are there indications of possible constipation/ impaction? (indicators can include: abdominal pain, loss of appetite, and even fecal incontinence as a result of pressure/ blockage).
Contact physician immediately.

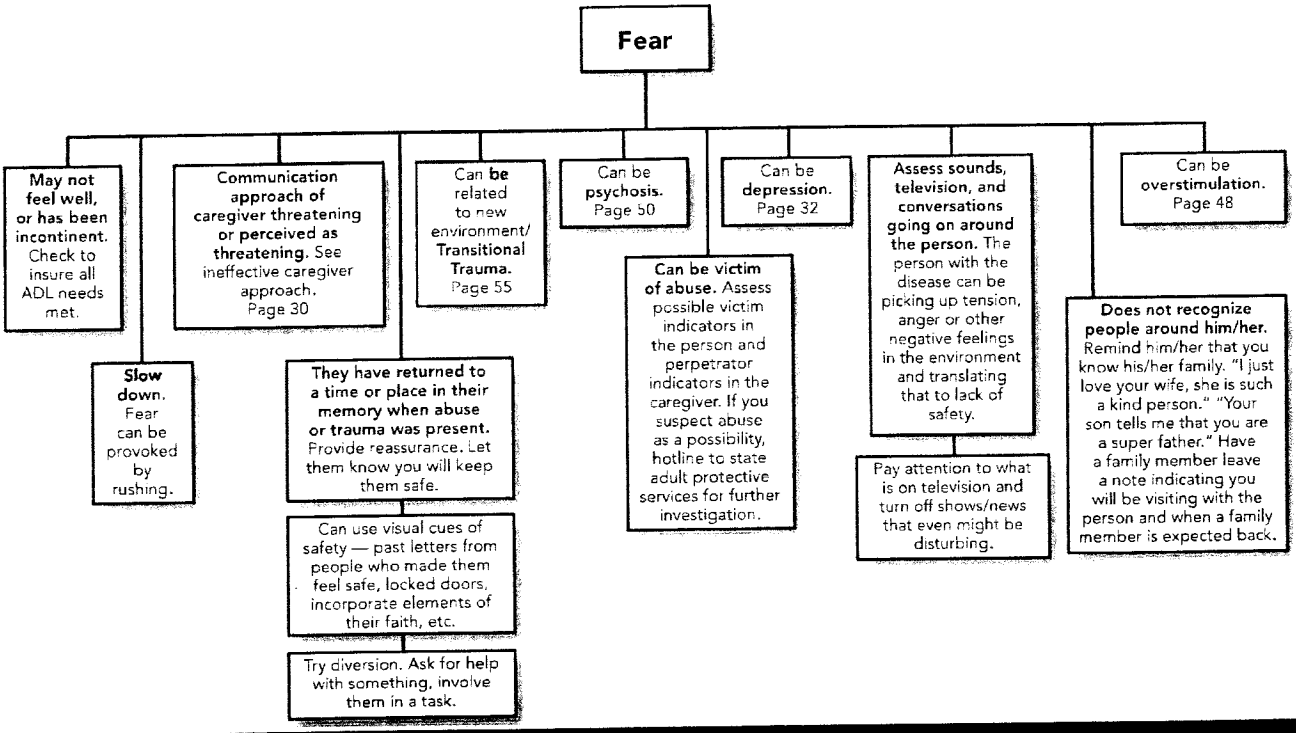

Depression
Most common symptom in this population is ANXIETY, including excessive worry, ruminating. Other symptoms might include sleep disturbance, changes in appetite, irritability, physical or verbal aggression, withdrawal, loss of interest in previously enjoyed activities, self deprecating comments, expressing wishes of wanting to die, suicidal threats or gestures. A significant percentage of those individuals presenting with combative behavior are primarily depressed.
Consider antidepressant or alteration in dosage of existing antidepressant. Watch for trends in symptom relief and adjust dosage accordingly.
Insure there is no access to weapons, not only to prevent self injury, but also to prevent risk to others if agitation, hostility and/or if paranoia is part of the manifested depressive symptoms.
May require geriatric psychiatric hospitalization if combative and posing risk to others or if symptoms interfere in care and provoke refusal of medications.
Structured activity that is pleasant and meaningful
Often historical ways they spent their time are less available. Alternate activities should be added. That may include hosting visitors for tea, addition of new hobbies such as watercolor painting, or may include participation in an adult day program.
Reduction of environmental stressors
such as exposure to family conflict, high stimuli, negative approaches to communication.
Engage in therapeutic conversation:
— Listen to feelings embedded in their words and conversations
— Affirm both their current strengths, as well as the past contributions they have made
— Provide reassurance

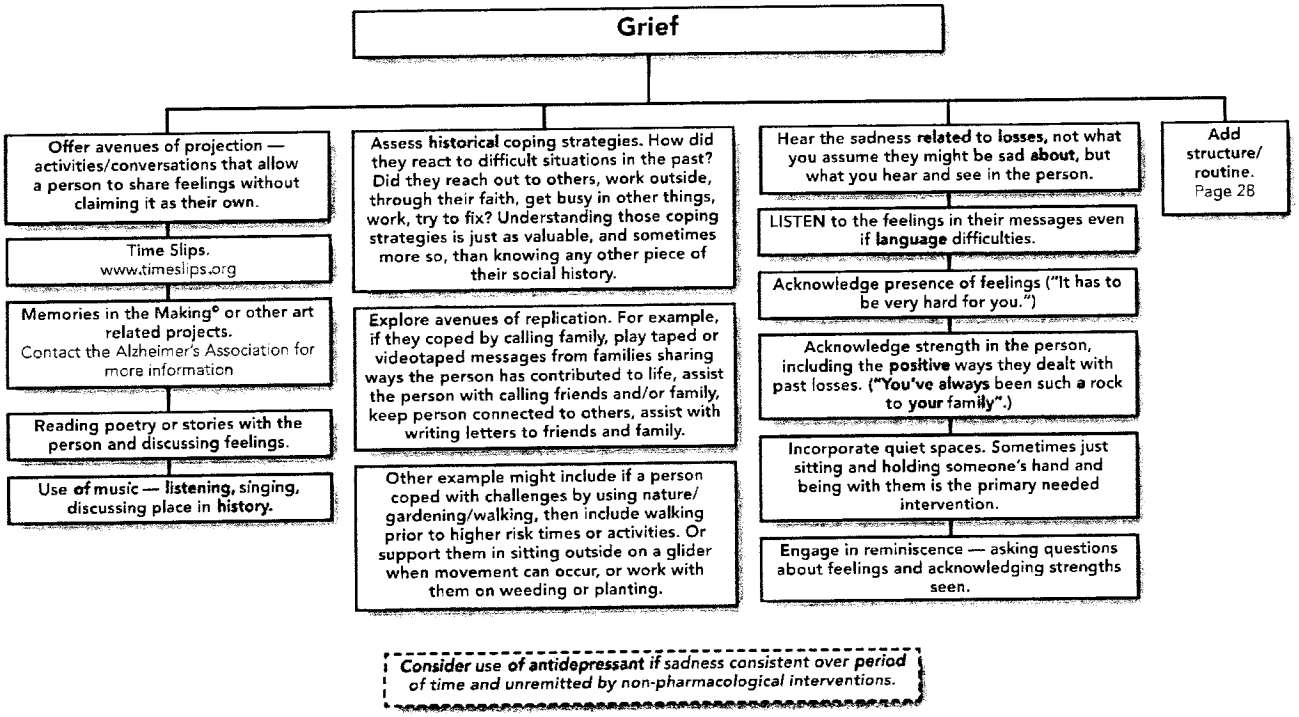

Desire to Fulfill Former Obligations
(Wanting to go home or to work or to pick up kids or other demands that reflect back to an earlier time in their lives)
Can be **delirium.** Page 31
Can be a **visual or verbal cue** — watch out for things in the environment that might trigger the jump back to them believing it is time to go to work, leave for school, etc.
Redirect (example: ask if they can help you with something, or walk with them and circle back home, or ask advice).
Read or leave notes that give them direction as to what they need to do or what to expect (example: "Mom, we will be over to see you on Wednesday afternoon" or "You do not have to go to work today").
Talk with **them about their experiences,** past, and perspectives (example: "You've been very close to your mother, haven't you" or "I understand you have been a wonderful teacher... tell me about your decision to become a teacher").
Attempt delay (example: "It's really cold out there right now, why don't you wait until morning").
Create therapeutic constructs (fibbing) (example: "You know how your husband is, he is tied up working. I'm sure he'll be here when he can" or "Your work called and said you didn't have to come in today").
Validate feelings behind concerns.
Anxiety? Page 27
Boredom? Page 28
Can be **depression.** Page 32

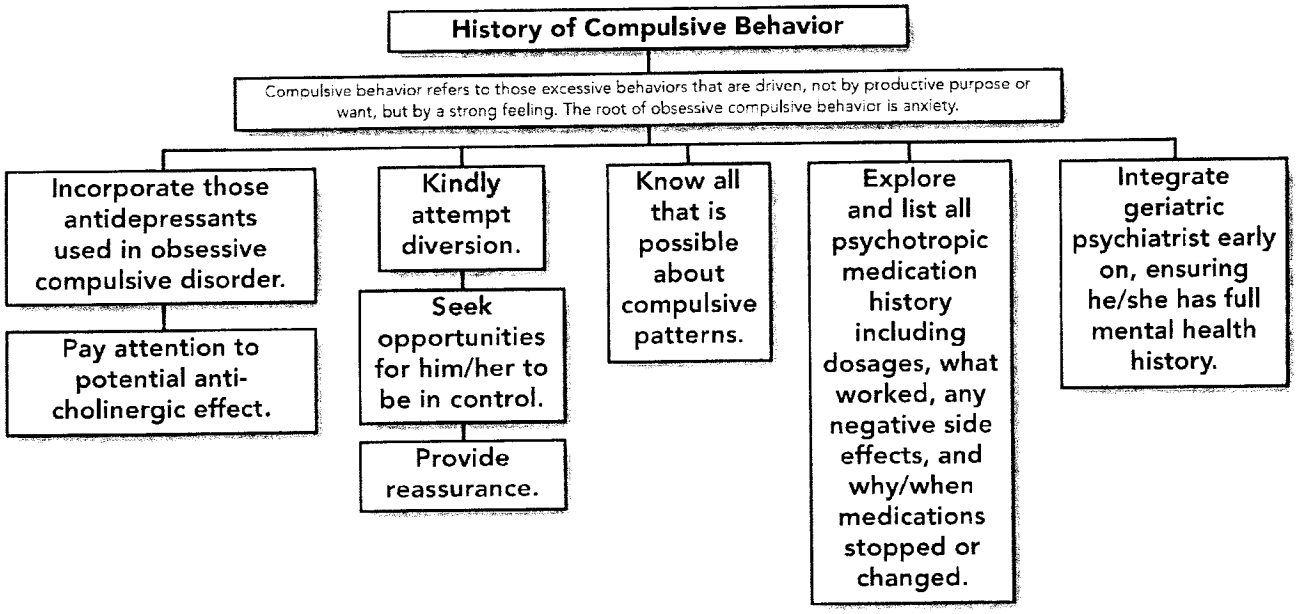

Environment Not Conducive to Eating
Utilize other senses including smell to increase interest in eating.
No television during eating.
Table should be free of clutter.
Tablecloth, if used, should be free of patterns.
Use solid colored, contrasting placement to assist with indicating boundary.
Simplify utensils, cups and plates.
Utilize plates with rims to assist.
Decrease stimuli.
Page 48
Can utilize music with an appropriate rhythm consistent with taking bites.
Be patient with length of time it might take.
Do not stand over the person, better to sit with the person periodically giving respectful prompts as needed.

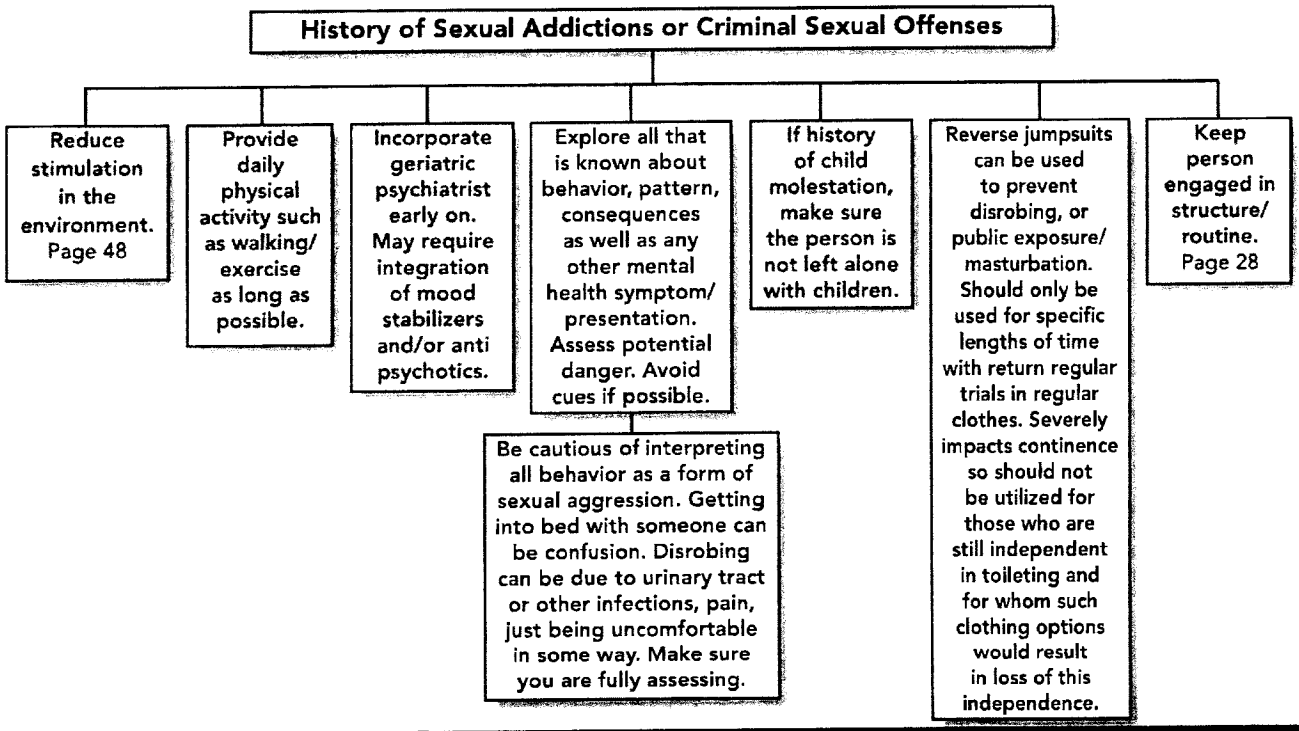

Environmental Contributions
Insufficient environmental supports.
The need for cues, supervision and direct assist changes regularly. Match person's capacity with sufficient supervision, home safety alterations, and use of outside assistance.
Access to outside spaces often a key ingredient in supporting good quality of life.
Unintentional environmental cues.
Door can present a cue to exit. Try putting lock up high, a cow bell/ door chimes to alert if door opened or can even hang curtains on either side of door that can be pulled at night, or murals on doors to avoid cue to exit.
Notes work for a period of time. Use notes to avoid misperceptions or to improve appropriate interpretations. Such as notes that say "Do not touch" or "Mary, do not open."
Remove objects that might cause some confusion such as artificial fruit or plants that might be interpreted as a place to urinate.
Too many people. Limit people around the person to 1 or 2.
Sounds can be misperceived, or undecipherable or can simply be too many to sort through.
If in a facility, pay attention to who is around and do not engage in personal conversations around the residents.
Turn off TV's.
If trying to engage in an activity that the person might be resistive to, or increasing person's ability to respond, ensure environment is without distraction and/or competing sounds.
With groups, same as above. Hold groups in quiet rooms. Disruptions and interruptions can limit group success.
Shadows
Look at room at various levels of light. Note shadows. If a person reacts to a room or at a certain time, move objects that might be casting the misperceived shadows.
Unfamiliar surroundings. Transitional Trauma Page 55
If unfamiliar bathrooms trigger resistance, consider alternative bathing options. See film "Bathing without a Battle."
Practice good communication skills. Page 30
Mirrors
If person talks with mirror and that experience is positive, then no action needed. If person talks or reacts in negative or fearful way to mirrors, try putting a towel or curtain over mirror to cover.
35

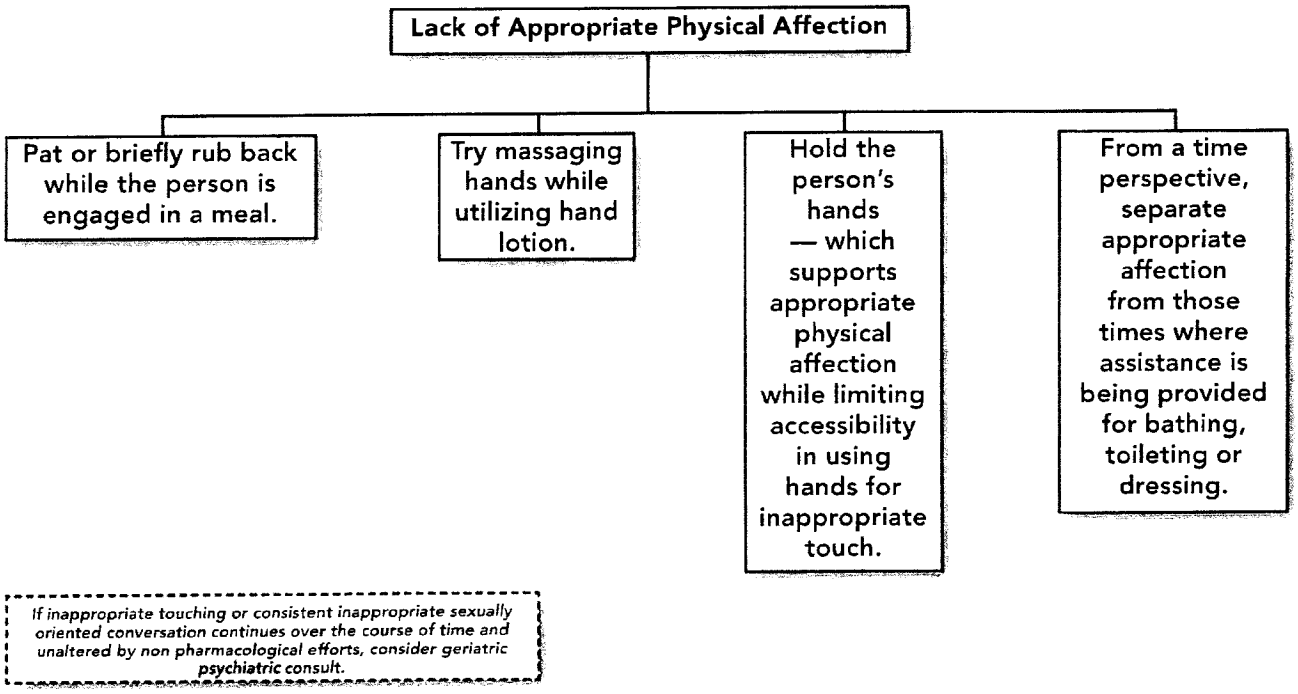

Fatigue and Day-Night Reversal
Avoid over the counter sleeping agents/ antihistamines as they often have anti cholinergic effect and may provoke or compound agitation or increased confusion.
Avoid alcohol use.
Avoid bathing/ showering when the person is tired as that may provoke agitated reaction.
Warm milk or herbal tea at rest times.
Facilitate 1 hour naps.
Talk with doctor regarding options for medication to aide sleep if last resort and interrupts ability to maintain the person in the home environment or likely contributing to ongoing behavior challenges during the day.
Incorporate relaxation music with slow/slowing rhythm.
Back massage, leg/arm massage.
For as long as the person is able, ensure sufficient physical activity/ adequate engagement through the day in order to improve ability to settle and quality of sleep.
Page 28
Control environment – ensuring reduced or absent noise, curtains/drapes closed, assistance to location to rest/bed in calm, slow fashion.
Ensure absence of anything that can provoke frightening shadows.
Can use signs that say, "It is night, go back to bed" or something similar on their door or by their bedroom door to cue the person that it isn't yet time to get up.

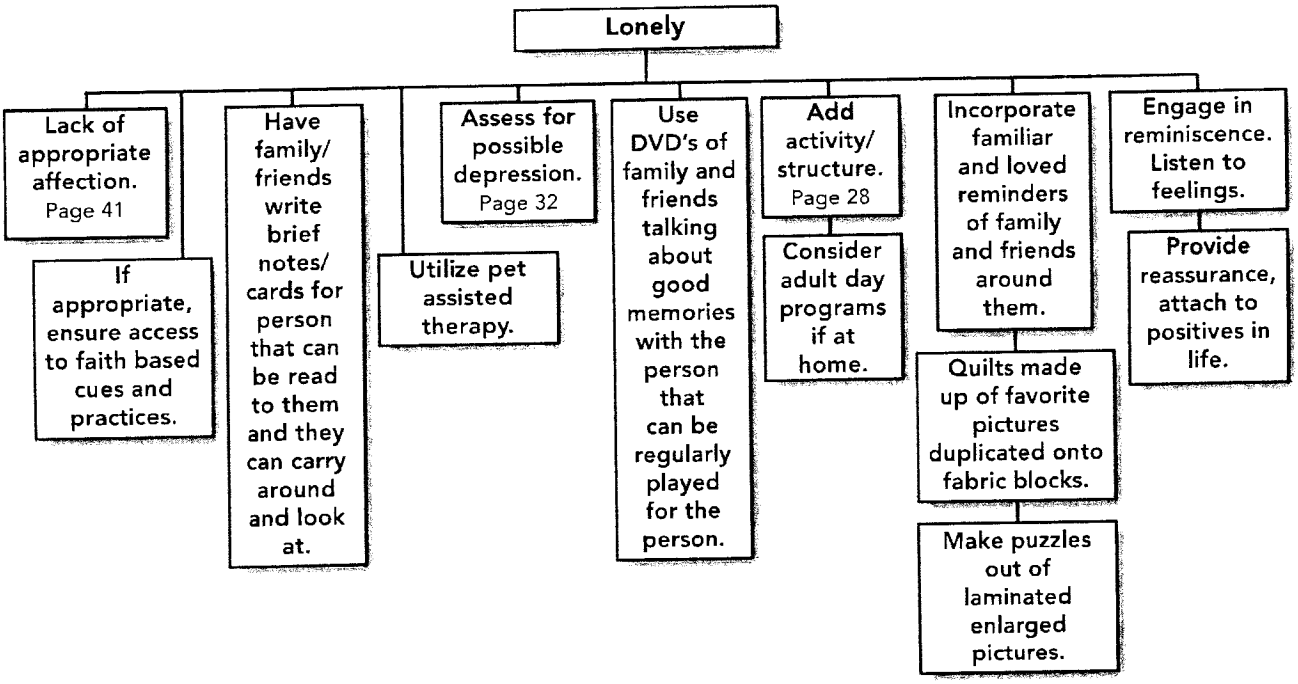

Fear
May not feel well, or has been incontinent. Check to insure all ADL needs met.
Slow down. Fear can be provoked by rushing.
Communication approach of caregiver threatening or perceived as threatening. See ineffective caregiver approach. Page 30
Can be related to new environment/ Transitional Trauma. Page 55
They have returned to a time or place in their memory when abuse or trauma was present. Provide reassurance. Let them know you will keep them safe.
Can use visual cues of safety — past letters from people who made them feel safe, locked doors, incorporate elements of their faith, etc.
Try diversion. Ask for help with something, involve them in a task.
Can be psychosis. Page 50
Can be depression. Page 32
Can be victim of abuse. Assess possible victim indicators in the person and perpetrator indicators in the caregiver. If you suspect abuse as a possibility, hotline to state adult protective services for further investigation.
Assess sounds, television, and conversations going on around the person. The person with the disease can be picking up tension, anger or other negative feelings in the environment and translating that to lack of safety.
Pay attention to what is on television and turn off shows/news that even might be disturbing.
Can be overstimulation. Page 48
Does not recognize people around him/her. Remind him/her that you know his/her family. "I just love your wife, she is such a kind person." "Your son tells me that you are a super father." Have a family member leave a note indicating you will be visiting with the person and when a family member is expected back.

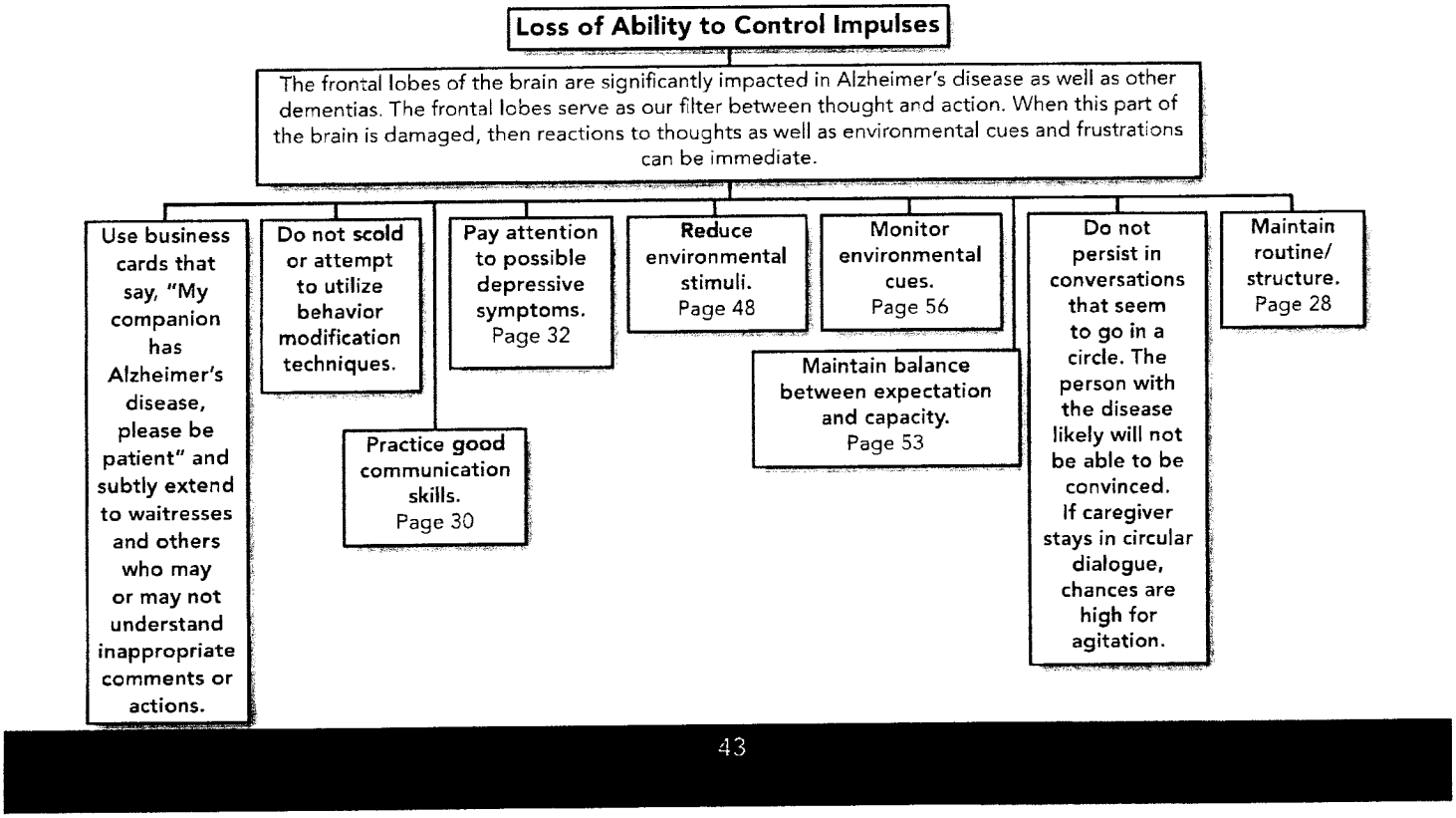

Grief
Offer avenues of projection — activities/conversations that allow a person to share feelings without claiming it as their own.
Time Slips. www.timeslips.org
Memories in the Making® or other art related projects. Contact the Alzheimer's Association for more information
Reading poetry or stories with the person and discussing feelings.
Use of music — listening, singing, discussing place in history.
Assess historical coping strategies. How did they react to difficult situations in the past? Did they reach out to others, work outside, through their faith, get busy in other things, work, try to fix? Understanding those coping strategies is just as valuable, and sometimes more so, than knowing any other piece of their social history.
Explore avenues of replication. For example, if they coped by calling family, play taped or videotaped messages from families sharing ways the person has contributed to life, assist the person with calling friends and/or family, keep person connected to others, assist with writing letters to friends and family.
Other example might include if a person coped with challenges by using nature/ gardening/walking, then include walking prior to higher risk times or activities. Or support them in sitting outside on a glider when movement can occur, or work with them on weeding or planting.
Hear the sadness related to losses, not what you assume they might be sad about, but what you hear and see in the person.
LISTEN to the feelings in their messages even if language difficulties.
Acknowledge presence of feelings ("It has to be very hard for you.")
Acknowledge strength in the person, including the positive ways they dealt with past losses. ("You've always been such a rock to your family".)
Incorporate quiet spaces. Sometimes just sitting and holding someone's hand and being with them is the primary needed intervention.
Engage in reminiscence — asking questions about feelings and acknowledging strengths seen.
Add structure/ routine.
Page 28
Consider use of antidepressant if sadness consistent over period of time and unremitted by non-pharmacological interventions.

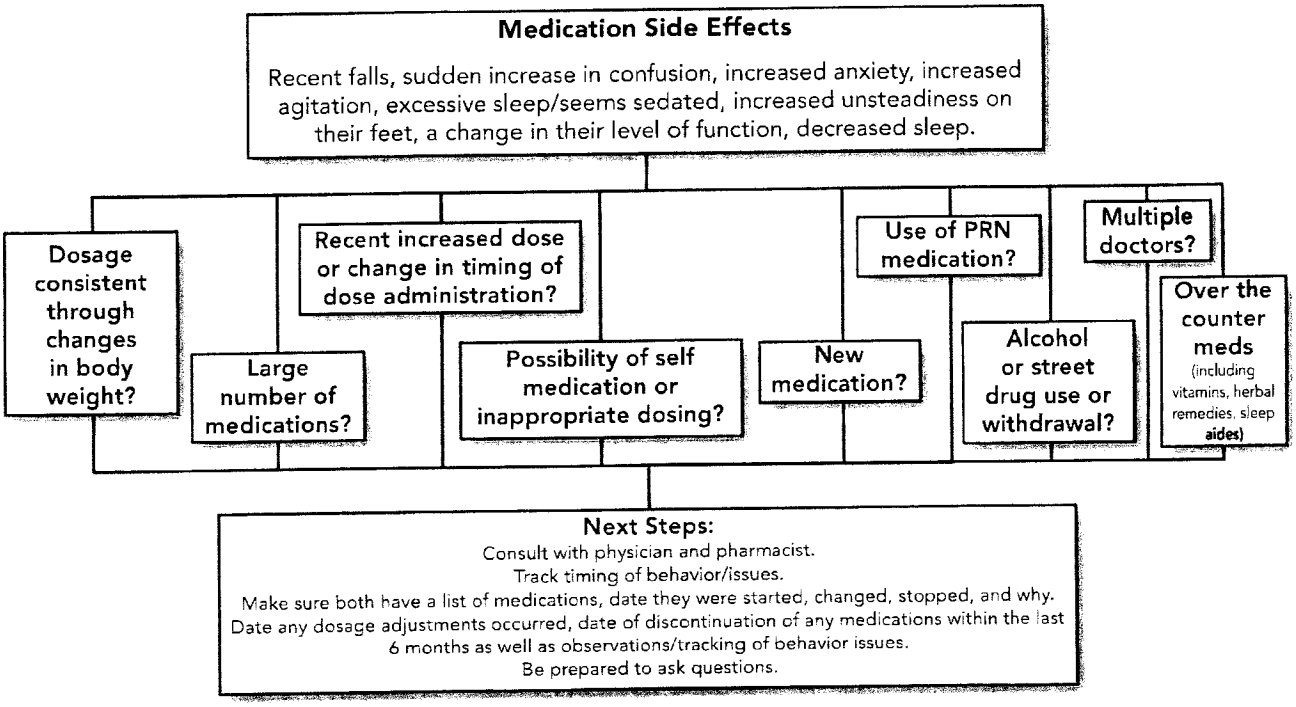

History of Compulsive Behavior
Compulsive behavior refers to those excessive behaviors that are driven, not by productive purpose or want, but by a strong feeling. The root of obsessive compulsive behavior is anxiety.
Incorporate those antidepressants used in obsessive compulsive disorder.
Pay attention to potential anti-cholinergic effect.
Kindly attempt diversion.
Seek opportunities for him/her to be in control.
Provide reassurance.
Know all that is possible about compulsive patterns.
Explore and list all psychotropic medication history including dosages, what worked, any negative side effects, and why/when medications stopped or changed.
Integrate geriatric psychiatrist early on, ensuring he/she has full mental health history.

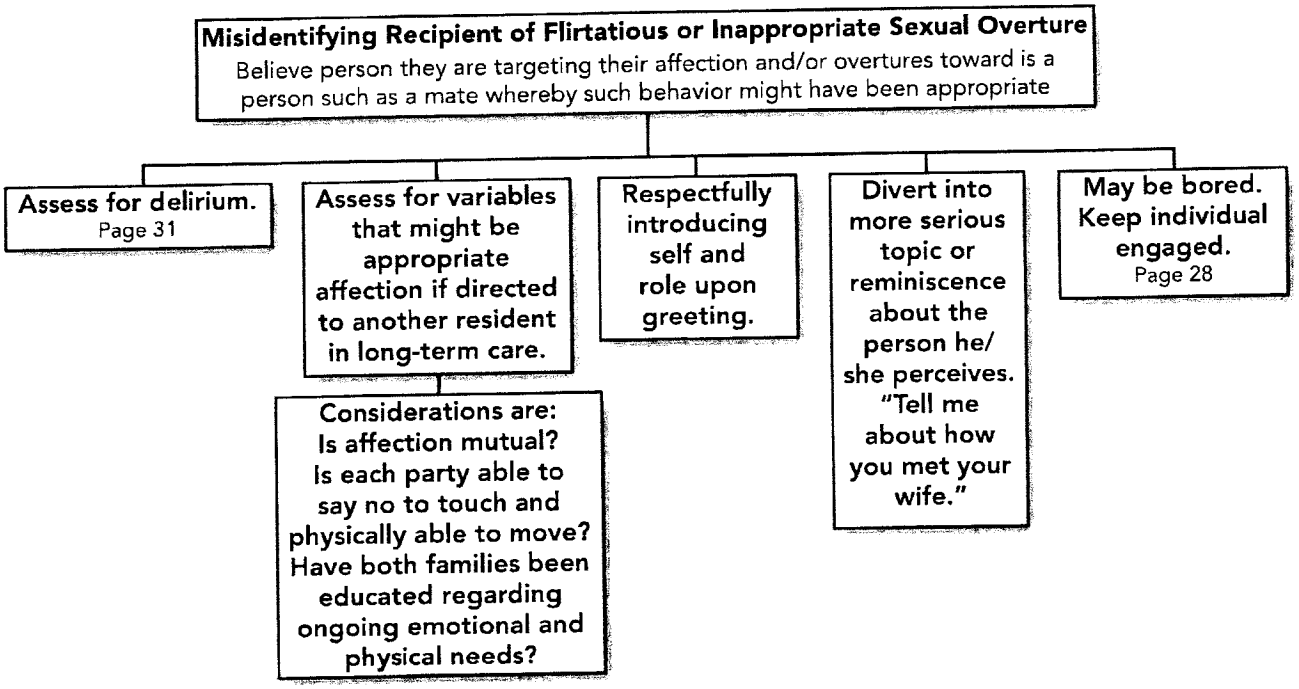

History of Sexual Addictions or Criminal Sexual Offenses
Reduce stimulation in the environment. Page 48
Provide daily physical activity such as walking/ exercise as long as possible.
Incorporate geriatric psychiatrist early on. May require integration of mood stabilizers and/or anti psychotics.
Explore all that is known about behavior, pattern, consequences as well as any other mental health symptom/ presentation. Assess potential danger. Avoid cues if possible.
Be cautious of interpreting all behavior as a form of sexual aggression. Getting into bed with someone can be confusion. Disrobing can be due to urinary tract or other infections, pain, just being uncomfortable in some way. Make sure you are fully assessing.
If history of child molestation, make sure the person is not left alone with children.
Reverse jumpsuits can be used to prevent disrobing, or public exposure/ masturbation. Should only be used for specific lengths of time with return regular trials in regular clothes. Severely impacts continence so should not be utilized for those who are still independent in toileting and for whom such clothing options would result in loss of this independence.
Keep person engaged in structure/ routine. Page 28

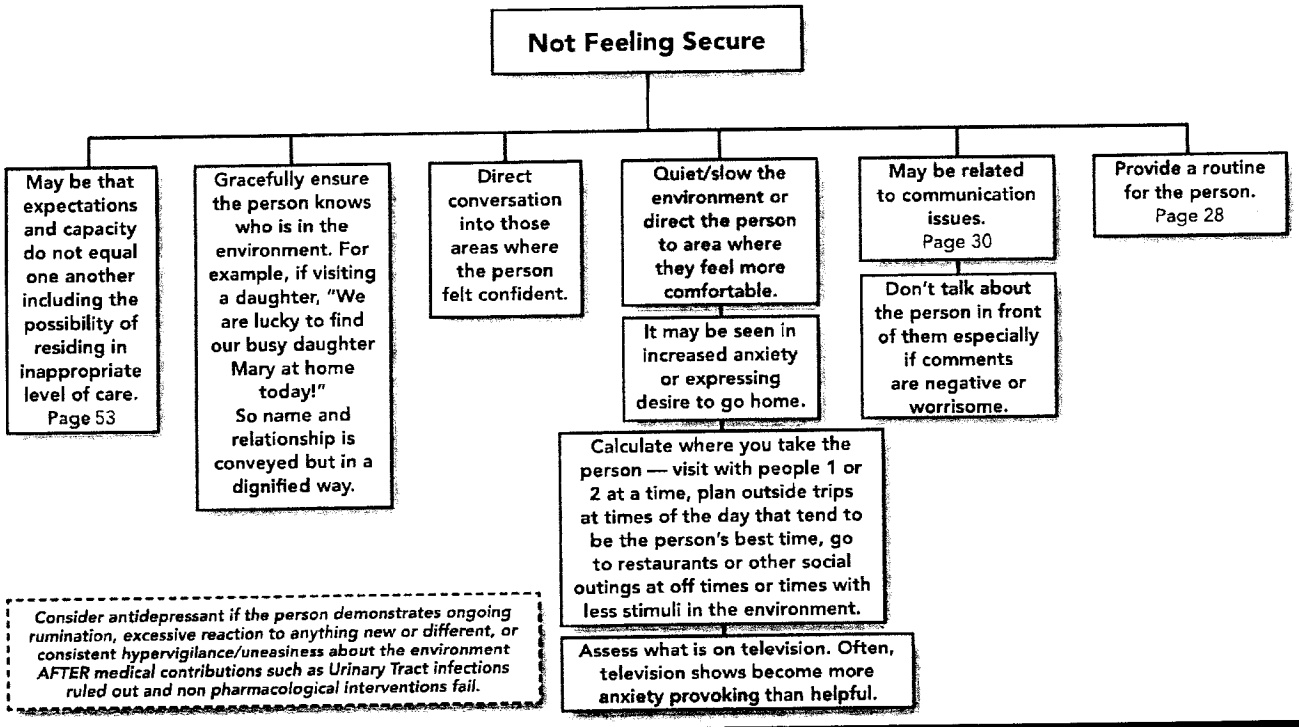

Lack of Appropriate Physical Affection
Pat or briefly rub back while the person is engaged in a meal.
Try massaging hands while utilizing hand lotion.
Hold the person's hands — which supports appropriate physical affection while limiting accessibility in using hands for inappropriate touch.
From a time perspective, separate appropriate affection from those times where assistance is being provided for bathing, toileting or dressing.
If inappropriate touching or consistent inappropriate sexually oriented conversation continues over the course of time and unaltered by non pharmacological efforts, consider geriatric psychiatric consult.

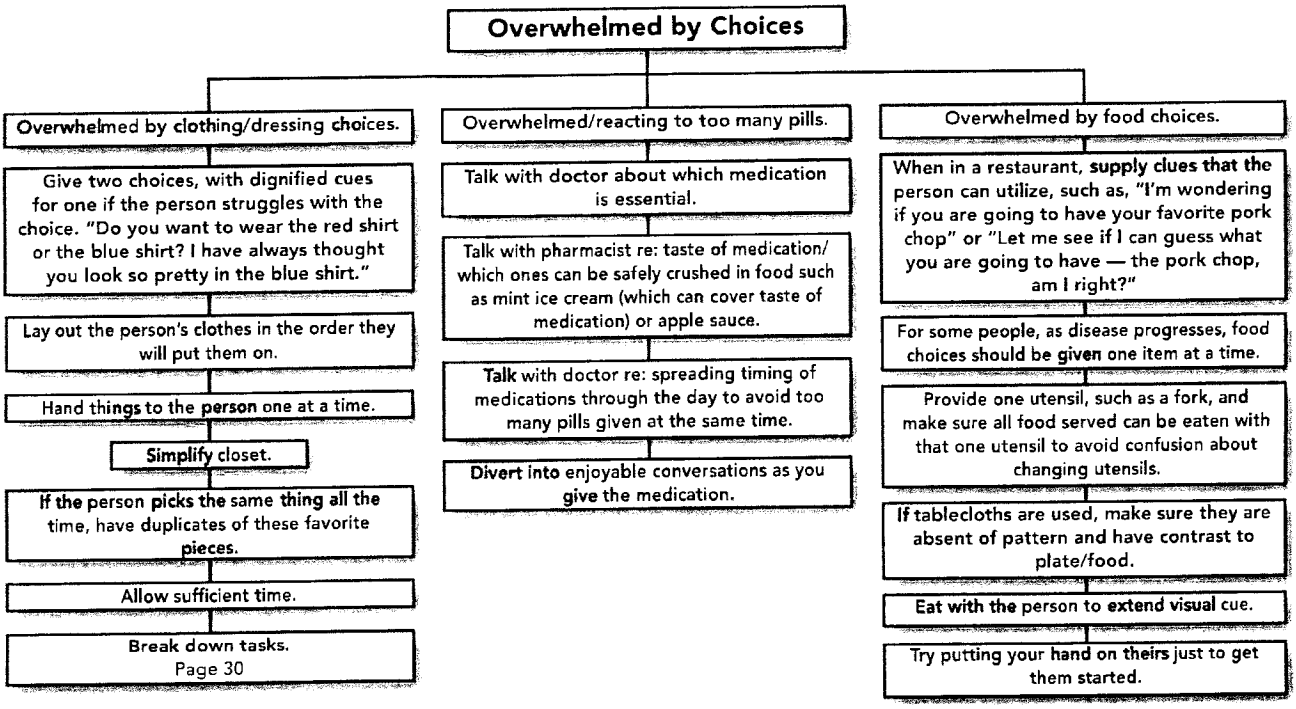

Lonely
Lack of appropriate affection.
Page 41
If appropriate, ensure access to faith based cues and practices.
Have family/ friends write brief notes/ cards for person that can be read to them and they can carry around and look at.
Assess for possible depression.
Page 32
Utilize pet assisted therapy.
Use DVD's of family and friends talking about good memories with the person that can be regularly played for the person.
Add activity/ structure.
Page 28
Consider adult day programs if at home.
Incorporate familiar and loved reminders of family and friends around them.
Quilts made up of favorite pictures duplicated onto fabric blocks.
Make puzzles out of laminated enlarged pictures.
Engage in reminiscence. Listen to feelings.
Provide reassurance, attach to positives in life.

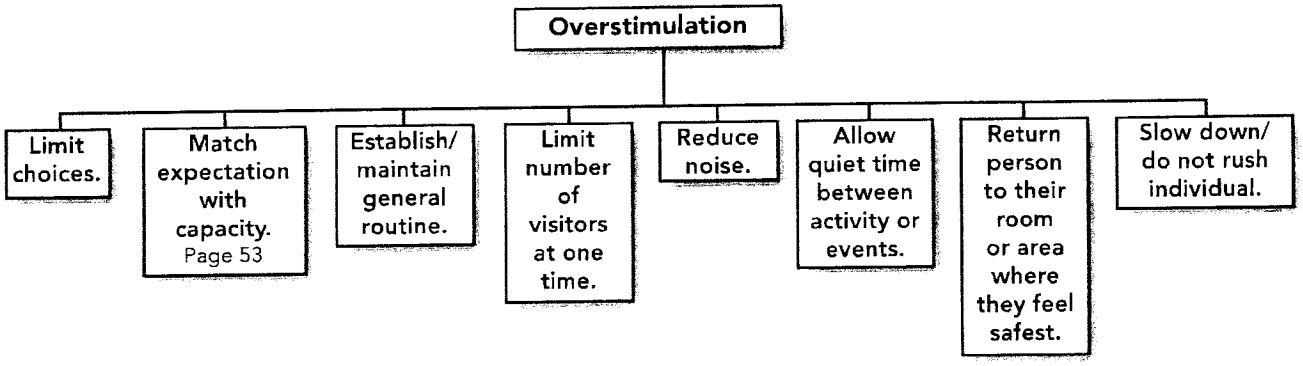

Loss of Ability to Control Impulses
The frontal lobes of the brain are significantly impacted in Alzheimer's disease as well as other dementias. The frontal lobes serve as our filter between thought and action. When this part of the brain is damaged, then reactions to thoughts as well as environmental cues and frustrations can be immediate.
Use business cards that say, "My companion has Alzheimer's disease, please be patient" and subtly extend to waitresses and others who may or may not understand inappropriate comments or actions.
Do not scold or attempt to utilize behavior modification techniques.
Practice good communication skills. Page 30
Pay attention to possible depressive symptoms. Page 32
Reduce environmental stimuli. Page 48
Maintain balance between expectation and capacity. Page 53
Monitor environmental cues. Page 56
Do not persist in conversations that seem to go in a circle. The person with the disease likely will not be able to be convinced. If caregiver stays in circular dialogue, chances are high for agitation.
Maintain routine/ structure. Page 28

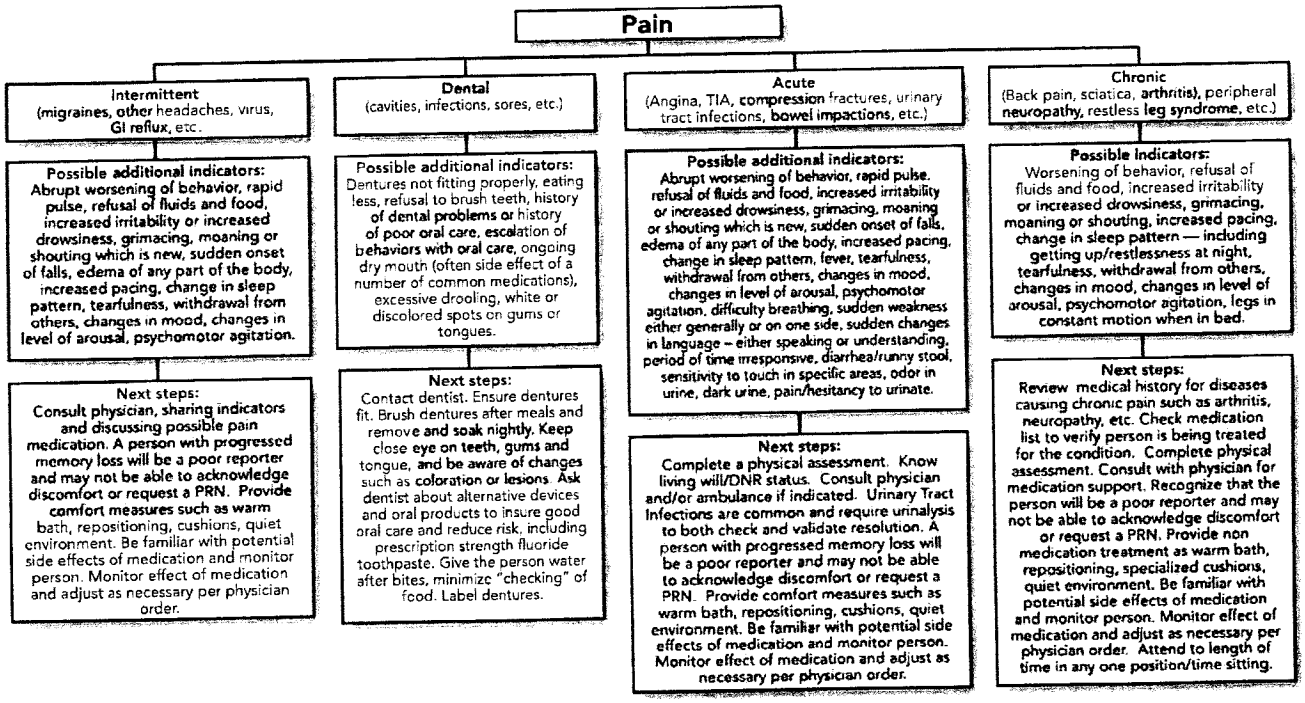

Medication Side Effects
Recent falls, sudden increase in confusion, increased anxiety, increased agitation, excessive sleep/seems sedated, increased unsteadiness on their feet, a change in their level of function, decreased sleep.
Dosage consistent through changes in body weight?
Large number of medications?
Recent increased dose or change in timing of dose administration?
Possibility of self medication or inappropriate dosing?
New medication?
Use of PRN medication?
Alcohol or street drug use or withdrawal?
Multiple doctors?
Over the counter meds (including vitamins, herbal remedies, sleep aides)
Next Steps:
Consult with physician and pharmacist.
Track timing of behavior/issues.
Make sure both have a list of medications, date they were started, changed, stopped, and why.
Date any dosage adjustments occurred, date of discontinuation of any medications within the last 6 months as well as observations/tracking of behavior issues.
Be prepared to ask questions.

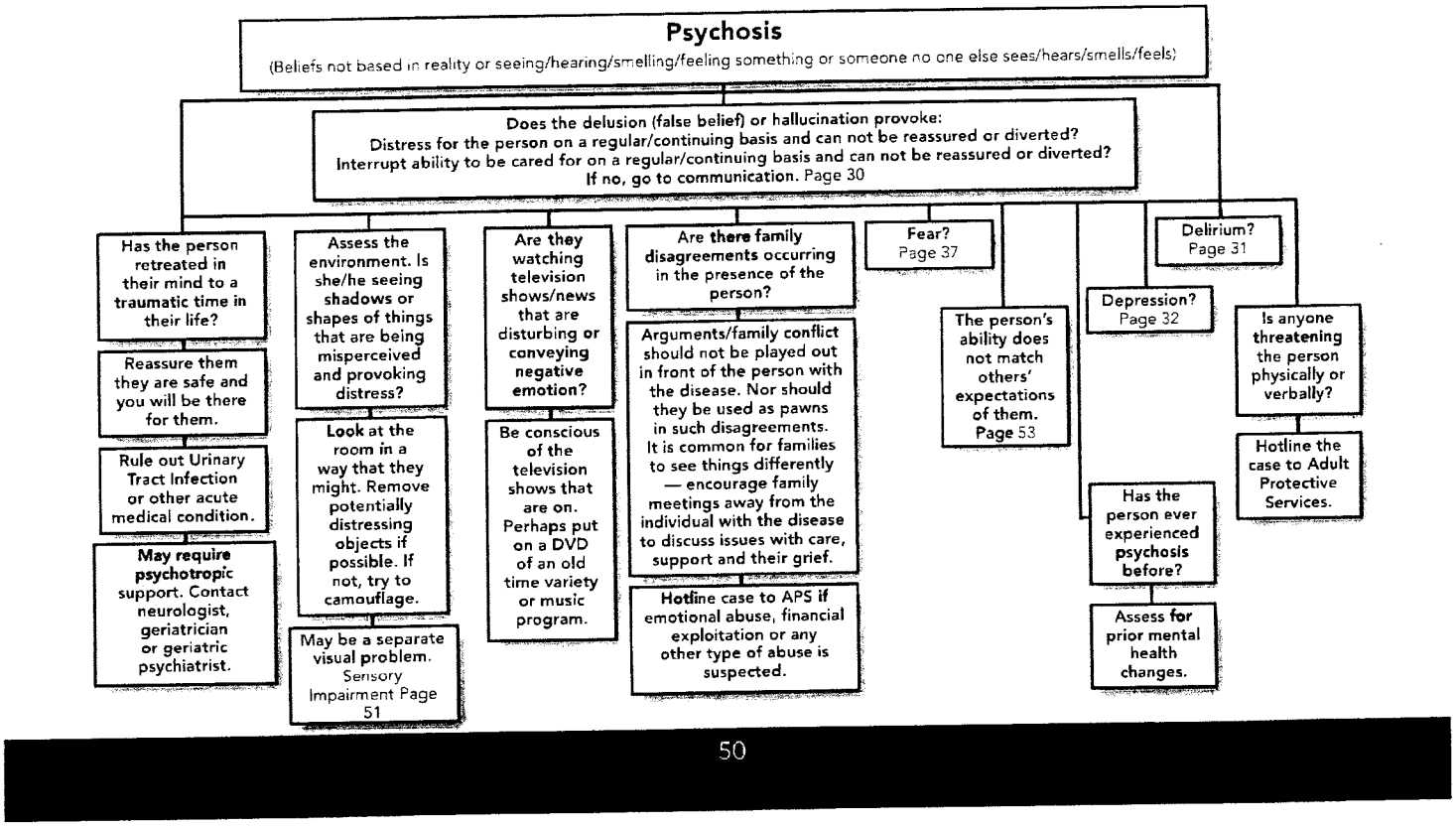

Misidentifying Recipient of Flirtatious or Inappropriate Sexual Overture
Believe person they are targeting their affection and/or overtures toward is a person such as a mate whereby such behavior might have been appropriate
Assess for delirium.
Page 31
Assess for variables that might be appropriate affection if directed to another resident in long-term care.
Considerations are: Is affection mutual? Is each party able to say no to touch and physically able to move? Have both families been educated regarding ongoing emotional and physical needs?
Respectfully introducing self and role upon greeting.
Divert into more serious topic or reminiscence about the person he/she perceives. "Tell me about how you met your wife."
May be bored. Keep individual engaged.
Page 28

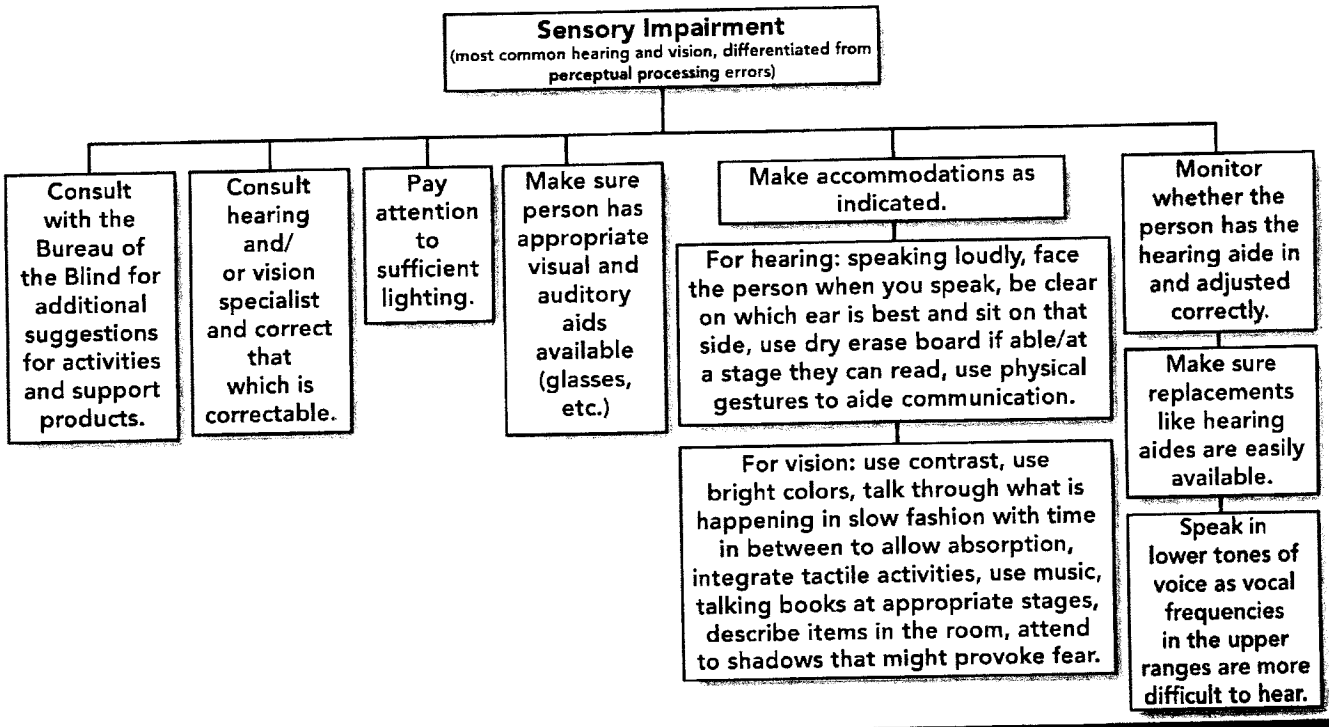

Not Feeling Secure
May be that expectations and capacity do not equal one another including the possibility of residing in inappropriate level of care.
Page 53
Gracefully ensure the person knows who is in the environment. For example, if visiting a daughter, "We are lucky to find our busy daughter Mary at home today!"
So name and relationship is conveyed but in a dignified way.
Direct conversation into those areas where the person felt confident.
Quiet/slow the environment or direct the person to area where they feel more comfortable.
It may be seen in increased anxiety or expressing desire to go home.
Calculate where you take the person — visit with people 1 or 2 at a time, plan outside trips at times of the day that tend to be the person's best time, go to restaurants or other social outings at off times or times with less stimuli in the environment.
Assess what is on television. Often, television shows become more anxiety provoking than helpful.
May be related to communication issues.
Page 30
Don't talk about the person in front of them especially if comments are negative or worrisome.
Provide a routine for the person.
Page 28
Consider antidepressant if the person demonstrates ongoing rumination, excessive reaction to anything new or different, or consistent hypervigilance/uneasiness about the environment AFTER medical contributions such as Urinary Tract infections ruled out and non pharmacological interventions fail.

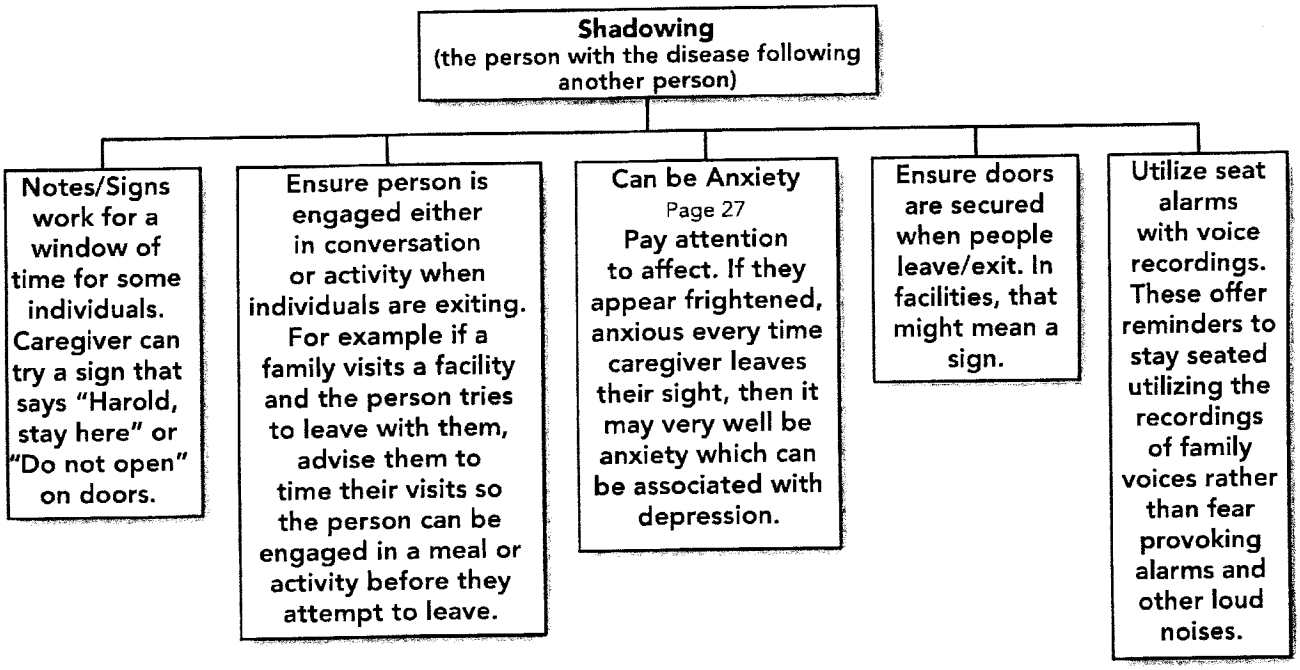

Overwhelmed by Choices
Overwhelmed by clothing/dressing choices.
Give two choices, with dignified cues for one if the person struggles with the choice. "Do you want to wear the red shirt or the blue shirt? I have always thought you look so pretty in the blue shirt."
Lay out the person's clothes in the order they will put them on.
Hand things to the person one at a time.
Simplify closet.
If the person picks the same thing all the time, have duplicates of these favorite pieces.
Allow sufficient time.
Break down tasks.
Page 30
Overwhelmed/reacting to too many pills.
Talk with doctor about which medication is essential.
Talk with pharmacist re: taste of medication/ which ones can be safely crushed in food such as mint ice cream (which can cover taste of medication) or apple sauce.
Talk with doctor re: spreading timing of medications through the day to avoid too many pills given at the same time.
Divert into enjoyable conversations as you give the medication.
Overwhelmed by food choices.
When in a restaurant, supply clues that the person can utilize, such as, "I'm wondering if you are going to have your favorite pork chop" or "Let me see if I can guess what you are going to have — the pork chop, am I right?"
For some people, as disease progresses, food choices should be given one item at a time.
Provide one utensil, such as a fork, and make sure all food served can be eaten with that one utensil to avoid confusion about changing utensils.
If tablecloths are used, make sure they are absent of pattern and have contrast to plate/food.
Eat with the person to extend visual cue.
Try putting your hand on theirs just to get them started.

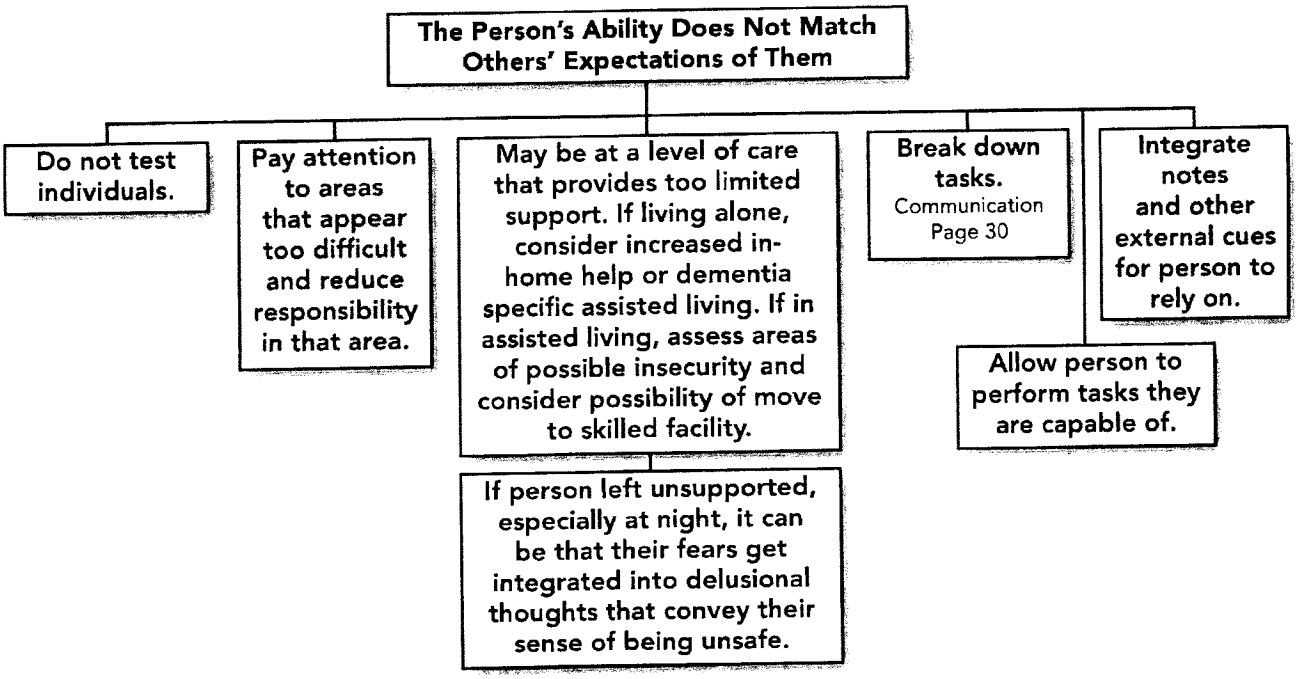

Overstimulation
Limit choices.
Match expectation with capacity.
Page 53
Establish/ maintain general routine.
Limit number of visitors at one time.
Reduce noise.
Allow quiet time between activity or events.
Return person to their room or area where they feel safest.
Slow down/ do not rush individual.

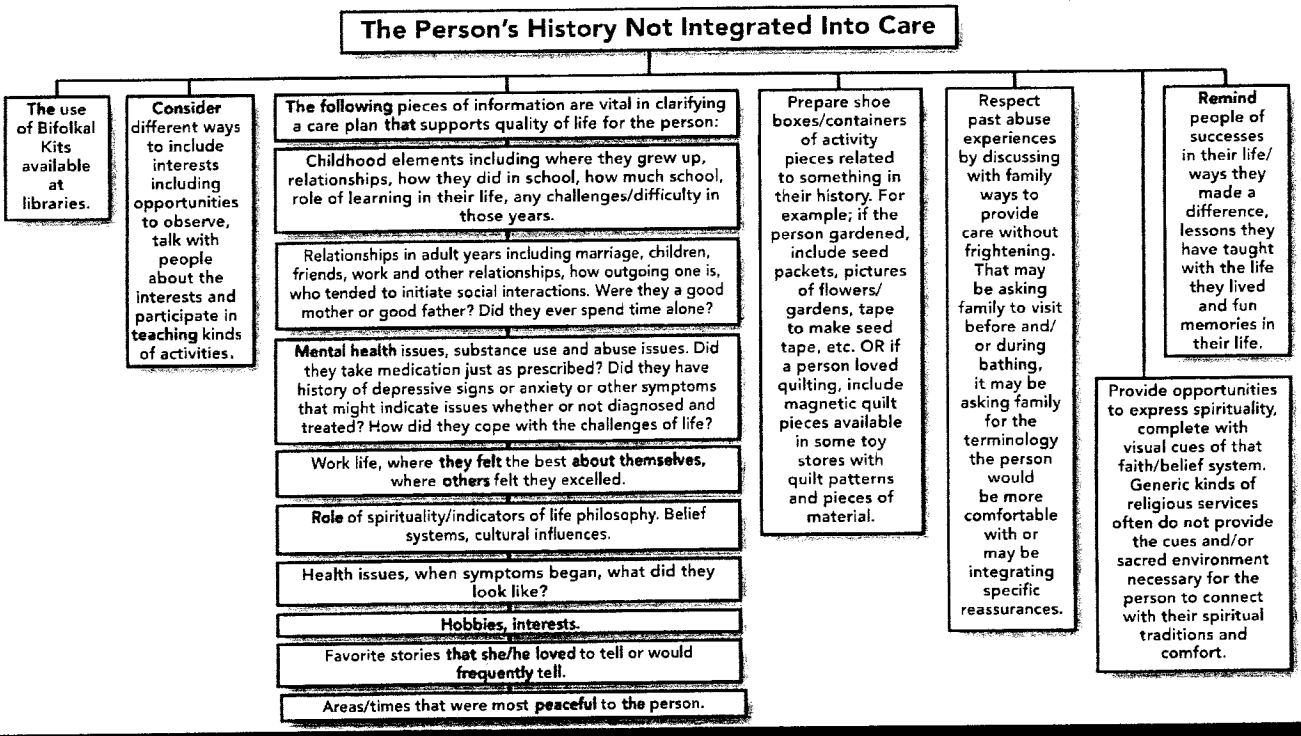

Pain
Intermittent
(migraines, other headaches, virus, GI reflux, etc.
Possible additional indicators:
Abrupt worsening of behavior, rapid pulse, refusal of fluids and food, increased irritability or increased drowsiness, grimacing, moaning or shouting which is new, sudden onset of falls, edema of any part of the body, increased pacing, change in sleep pattern, tearfulness, withdrawal from others, changes in mood, changes in level of arousal, psychomotor agitation.
Next steps:
Consult physician, sharing indicators and discussing possible pain medication. A person with progressed memory loss will be a poor reporter and may not be able to acknowledge discomfort or request a PRN. Provide comfort measures such as warm bath, repositioning, cushions, quiet environment. Be familiar with potential side effects of medication and monitor person. Monitor effect of medication and adjust as necessary per physician order.
Dental
(cavities, infections, sores, etc.)
Possible additional indicators:
Dentures not fitting properly, eating less, refusal to brush teeth, history of dental problems or history of poor oral care, escalation of behaviors with oral care, ongoing dry mouth (often side effect of a number of common medications), excessive drooling, white or discolored spots on gums or tongues.
Next steps:
Contact dentist. Ensure dentures fit. Brush dentures after meals and remove and soak nightly. Keep close eye on teeth, gums and tongue, and be aware of changes such as coloration or lesions. Ask dentist about alternative devices and oral products to insure good oral care and reduce risk, including prescription strength fluoride toothpaste. Give the person water after bites, minimize "checking" of food. Label dentures.
Acute
(Angina, TIA, compression fractures, urinary tract infections, bowel impactions, etc.)
Possible additional indicators:
Abrupt worsening of behavior, rapid pulse, refusal of fluids and food, increased irritability or increased drowsiness, grimacing, moaning or shouting which is new, sudden onset of falls, edema of any part of the body, increased pacing, change in sleep pattern, fever, tearfulness, withdrawal from others, changes in mood, changes in level of arousal, psychomotor agitation, difficulty breathing, sudden weakness either generally or on one side, sudden changes in language – either speaking or understanding, period of time irresponsive, diarrhea/runny stool, sensitivity to touch in specific areas, odor in urine, dark urine, pain/hesitancy to urinate.
Next steps:
Complete a physical assessment. Know living will/DNR status. Consult physician and/or ambulance if indicated. Urinary Tract Infections are common and require urinalysis to both check and validate resolution. A person with progressed memory loss will be a poor reporter and may not be able to acknowledge discomfort or request a PRN. Provide comfort measures such as warm bath, repositioning, cushions, quiet environment. Be familiar with potential side effects of medication and monitor person. Monitor effect of medication and adjust as necessary per physician order.
Chronic
(Back pain, sciatica, arthritis), peripheral neuropathy, restless leg syndrome, etc.)
Possible Indicators:
Worsening of behavior, refusal of fluids and food, increased irritability or increased drowsiness, grimacing, moaning or shouting, increased pacing, change in sleep pattern — including getting up/restlessness at night, tearfulness, withdrawal from others, changes in mood, changes in level of arousal, psychomotor agitation, legs in constant motion when in bed.
Next steps:
Review medical history for diseases causing chronic pain such as arthritis, neuropathy, etc. Check medication list to verify person is being treated for the condition. Complete physical assessment. Consult with physician for medication support. Recognize that the person will be a poor reporter and may not be able to acknowledge discomfort or request a PRN. Provide non medication treatment as warm bath, repositioning, specialized cushions, quiet environment. Be familiar with potential side effects of medication and monitor person. Monitor effect of medication and adjust as necessary per physician order. Attend to length of time in any one position/time sitting.

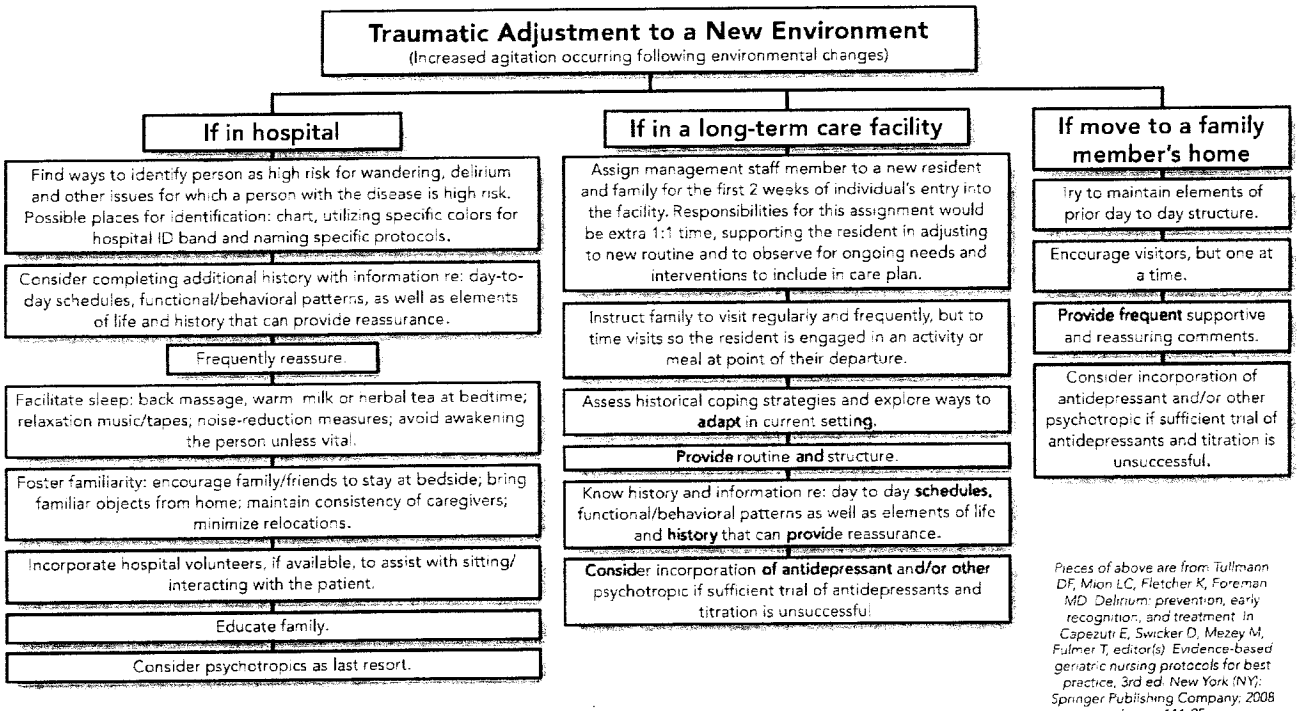

Psychosis
(Beliefs not based in reality or seeing/hearing/smelling/feeling something or someone no one else sees/hears/smells/feels)
Does the delusion (false belief) or hallucination provoke:
Distress for the person on a regular/continuing basis and can not be reassured or diverted?
Interrupt ability to be cared for on a regular/continuing basis and can not be reassured or diverted?
If no, go to communication. Page 30
Has the person retreated in their mind to a traumatic time in their life?
Reassure them they are safe and you will be there for them.
Rule out Urinary Tract Infection or other acute medical condition.
May require psychotropic support. Contact neurologist, geriatrician or geriatric psychiatrist.
Assess the environment. Is she/he seeing shadows or shapes of things that are being misperceived and provoking distress?
Look at the room in a way that they might. Remove potentially distressing objects if possible. If not, try to camouflage.
May be a separate visual problem. Sensory Impairment Page 51
Are they watching television shows/news that are disturbing or conveying negative emotion?
Be conscious of the television shows that are on. Perhaps put on a DVD of an old time variety or music program.
Are there family disagreements occurring in the presence of the person?
Arguments/family conflict should not be played out in front of the person with the disease. Nor should they be used as pawns in such disagreements. It is common for families to see things differently — encourage family meetings away from the individual with the disease to discuss issues with care, support and their grief.
Hotline case to APS if emotional abuse, financial exploitation or any other type of abuse is suspected.
Fear? Page 37
The person's ability does not match others' expectations of them. Page 53
Depression? Page 32
Has the person ever experienced psychosis before?
Assess for prior mental health changes.
Delirium? Page 31
Is anyone threatening the person physically or verbally?
Hotline the case to Adult Protective Services.


Sensory Impairment
(most common hearing and vision, differentiated from perceptual processing errors)
Consult with the Bureau of the Blind for additional suggestions for activities and support products.
Consult hearing and/ or vision specialist and correct that which is correctable.
Pay attention to sufficient lighting.
Make sure person has appropriate visual and auditory aids available (glasses, etc.)
Make accommodations as indicated.
For hearing: speaking loudly, face the person when you speak, be clear on which ear is best and sit on that side, use dry erase board if able/at a stage they can read, use physical gestures to aide communication.
For vision: use contrast, use bright colors, talk through what is happening in slow fashion with time in between to allow absorption, integrate tactile activities, use music, talking books at appropriate stages, describe items in the room, attend to shadows that might provoke fear.
Monitor whether the person has the hearing aide in and adjusted correctly.
Make sure replacements like hearing aides are easily available.
Speak in lower tones of voice as vocal frequencies in the upper ranges are more difficult to hear.


Shadowing
(the person with the disease following another person)
Notes/Signs work for a window of time for some individuals. Caregiver can try a sign that says "Harold, stay here" or "Do not open" on doors.
Ensure person is engaged either in conversation or activity when individuals are exiting. For example if a family visits a facility and the person tries to leave with them, advise them to time their visits so the person can be engaged in a meal or activity before they attempt to leave.
Can be Anxiety
Page 27
Pay attention to affect. If they appear frightened, anxious every time caregiver leaves their sight, then it may very well be anxiety which can be associated with depression.
Ensure doors are secured when people leave/exit. In facilities, that might mean a sign.
Utilize seat alarms with voice recordings. These offer reminders to stay seated utilizing the recordings of family voices rather than fear provoking alarms and other loud noises.


The Person's Ability Does Not Match Others' Expectations of Them
Do not test individuals.
Pay attention to areas that appear too difficult and reduce responsibility in that area.
May be at a level of care that provides too limited support. If living alone, consider increased in-home help or dementia specific assisted living. If in assisted living, assess areas of possible insecurity and consider possibility of move to skilled facility.
If person left unsupported, especially at night, it can be that their fears get integrated into delusional thoughts that convey their sense of being unsafe.
Break down tasks.
Communication Page 30
Allow person to perform tasks they are capable of.
Integrate notes and other external cues for person to rely on.


The Person's History Not Integrated Into Care
The use of Bifolkal Kits available at libraries.
Consider different ways to include interests including opportunities to observe, talk with people about the interests and participate in teaching kinds of activities.
The following pieces of information are vital in clarifying a care plan that supports quality of life for the person:
Childhood elements including where they grew up, relationships, how they did in school, how much school, role of learning in their life, any challenges/difficulty in those years.
Relationships in adult years including marriage, children, friends, work and other relationships, how outgoing one is, who tended to initiate social interactions. Were they a good mother or good father? Did they ever spend time alone?
Mental health issues, substance use and abuse issues. Did they take medication just as prescribed? Did they have history of depressive signs or anxiety or other symptoms that might indicate issues whether or not diagnosed and treated? How did they cope with the challenges of life?
Work life, where they felt the best about themselves, where others felt they excelled.
Role of spirituality/indicators of life philosophy. Belief systems, cultural influences.
Health issues, when symptoms began, what did they look like?
Hobbies, interests.
Favorite stories that she/he loved to tell or would frequently tell.
Areas/times that were most peaceful to the person.
Prepare shoe boxes/containers of activity pieces related to something in their history. For example; if the person gardened, include seed packets, pictures of flowers/ gardens, tape to make seed tape, etc. OR if a person loved quilting, include magnetic quilt pieces available in some toy stores with quilt patterns and pieces of material.
Respect past abuse experiences by discussing with family ways to provide care without frightening. That may be asking family to visit before and/ or during bathing, it may be asking family for the terminology the person would be more comfortable with or may be integrating specific reassurances.
Remind people of successes in their life/ ways they made a difference, lessons they have taught with the life they lived and fun memories in their life.
Provide opportunities to express spirituality, complete with visual cues of that faith/belief system. Generic kinds of religious services often do not provide the cues and/or sacred environment necessary for the person to connect with their spiritual traditions and comfort.



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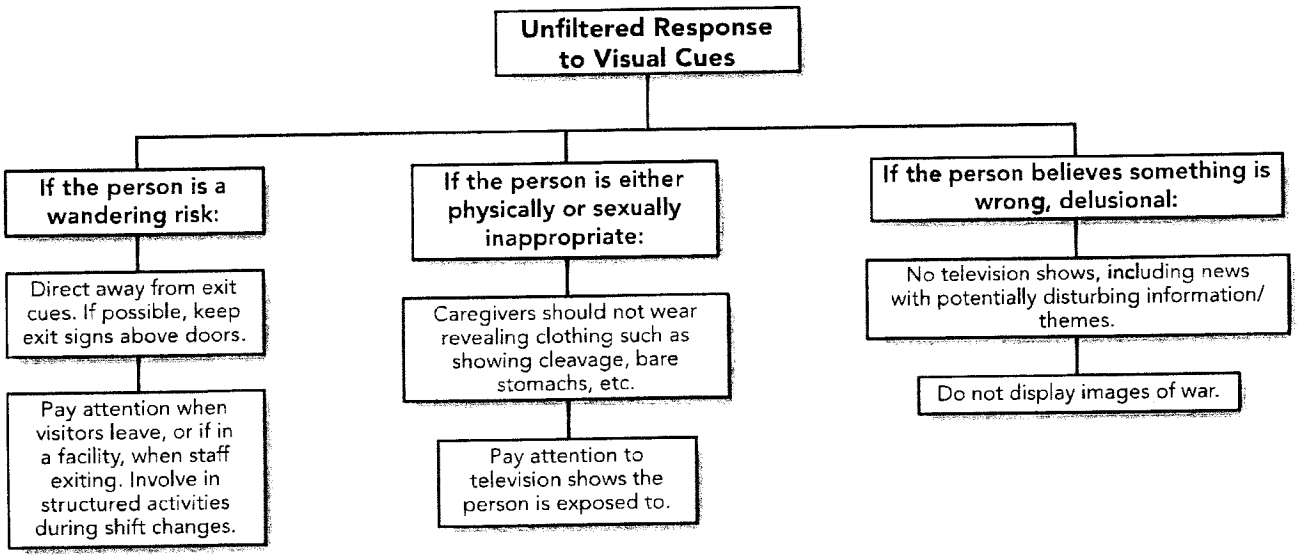
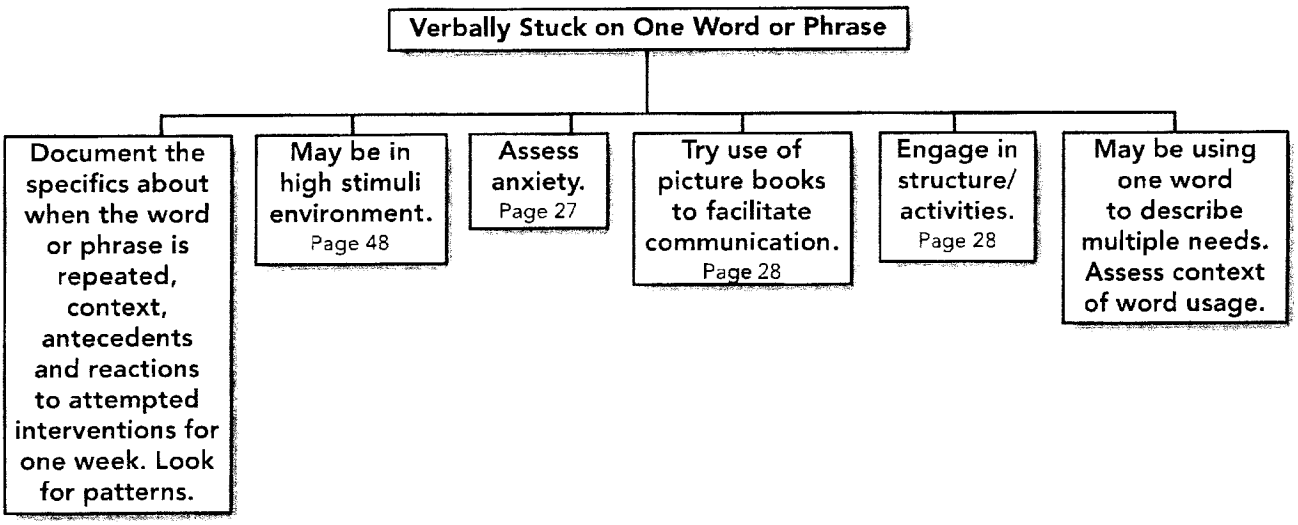

Unfiltered Response to Visual Cues
If the person is a wandering risk:
Direct away from exit cues. If possible, keep exit signs above doors.
Pay attention when visitors leave, or if in a facility, when staff exiting. Involve in structured activities during shift changes.
If the person is either physically or sexually inappropriate:
Caregivers should not wear revealing clothing such as showing cleavage, bare stomachs, etc.
Pay attention to television shows the person is exposed to.
If the person believes something is wrong, delusional:
No television shows, including news with potentially disturbing information/ themes.
Do not display images of war.


Verbally Stuck on One Word or Phrase
Document the specifics about when the word or phrase is repeated, context, antecedents and reactions to attempted interventions for one week. Look for patterns.
May be in high stimuli environment. Page 48
Assess anxiety. Page 27
Try use of picture books to facilitate communication. Page 28
Engage in structure/ activities. Page 28
May be using one word to describe multiple needs. Assess context of word usage.

Section IV

Resources, References and Reviewers

Resources and References

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Section V
Alzheimer's Association Information

The Alzheimer's Association is the leading, global voluntary health organization in Alzheimer's care and support, and the largest private, nonprofit funder of Alzheimer's research. Our vision is a world without Alzheimer's , and since our founding in 1980, we have moved toward this goal by advancing research and providing support, information and education to those affected by Alzheimer's and related dementias.

There are many chapters of the Alzheimer's Association throughout the United States. The Heart of America Chapter serves 66 counties including 29 in Missouri and 37 in Kansas. The Chapter offers a variety of services including support groups, family consultations both in the home and in each of the five regional offices, a 24-hour information and support line, early stage programs, educational materials and programs as well as advocacy efforts for all those who are directly impacted by Alzheimer's disease and related dementias. The Chapter also has dementia crisis coordinators who participate in the quest to figure out the elements of neuropsychiatric challenges, problem solve possible interventions and to support the individual, family and the professionals working through these difficult elements of the disease.

For more information contact:
1.800.272.3900 or 913.831.3888

This guide is part of a grant funded by the Administration on Aging and administered through the Kansas Department on Aging.

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CERTIFICATION RELATED TO APPENDIX

I hereby certify that filed with this brief, either as a separate document or as a part of this brief, is an appendix that complies with s. 809.19(2)(a) and that contains, at a minimum: (1) a table of contents; (2) the findings or opinion of the circuit court; (3) a copy of any unpublished opinion cited under s. 809.23(3) (a) or (b) **[not applicable to this brief]**; and (4) portions of the record essential to an understanding of the issues raised, including oral or written rulings or decisions showing the circuit court's reasoning regarding those issues.

I further certify that if this appeal is taken from a circuit court order or judgment entered in a judicial review of an administrative decision, the appendix contains the findings of fact and conclusions of law, if any, and final decision of the administrative agency.

I further certify that if the record is required by law to be confidential, the portions of the record included in the appendix are reproduced using first names and last initials instead of full names of persons, specifically including juveniles and parents of juveniles, with a notation that the portions of the record have been so reproduced to preserve confidentiality and with appropriate references to the record.

Dated this 14th day of November, 2011.

Signed: Maren Beermann

Maren Beermann
State Bar No. 1065893

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STATE OF WISCONSIN
SUPREME COURT
Appeal No. 2010 AP 2061

In the Matter of the Mental Commitment of Helen E.F.

FOND DU LAC COUNTY,

Petitioner-Respondent-Petitioner,

v.

HELEN E.F.,

Respondent-Appellant.

On Petition for Review of the Decision of the Wisconsin Court of Appeals, District II, Reversing an Order for Commitment and Order for Involuntary Medication, Entered in the Circuit Court, Fond du Lac County, The Honorable Richard J. Nuss, Presiding

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BRIEF OF *AMICUS CURIAE* DISABILITY RIGHTS WISCONSIN

DISABILITY RIGHTS WISCONSIN
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INTEREST OF THE AMICUS

Disability Rights Wisconsin ("DRW") as the statewide non-profit organization designated by the Governor to act as the congressionally-mandated protection and advocacy agency for Wisconsin citizens with disabilities[1], has promoted the legal and human rights of people with disabilities and challenging discrimination in virtually every aspect of the lives of people with disabilities since the early 1980's. DRW's interest in this litigation is twofold: first, DRW is concerned that the procedural maneuvering in Helen E.F.'s commitment, if condoned by this Court, would make a significant and impermissible inroad into the constitutional due process rights afforded individuals facing restriction of their liberty through the Mental Health Act commitment process.

Secondly, DRW believes that the Chapter 51 commitment process is currently being used inconsistently, as well as over used and inappropriately used, by congregate living facilities as a

[1] See: Wis Stats. §51.62, 29 USC §794e, 42 USC §15041 et. seq., and 42 USC §§10801 et. seq.

substitute for addressing the increasing need for appropriate care and supportive services in the least restrictive setting for individuals with dementia. As currently written, Chapter 51's involuntary commitment process and the mental health service system is not generally equipped, nor intended to deal with the treatment of Alzheimer's as a mental illness, often resulting in cruel and harsh results for a vulnerable patient.

ARGUMENT

I. Condoning the Clear Attempt To Circumvent the Lapsed Time Line of a Prior Commitment Petition Would Undercut the Fundamental Guaranty of Meaningful Due Process Embedded in Wisconsin's Chapter 51 Mental Health Act.

Although the Appellate Court never reached this issue, perhaps the narrowest ruling by this Court would be to hold that Helen E.F. did not receive the due process protection to which she was entitled under both the Wisconsin and United States Constitutions. The brief on behalf of Helen E.F. delineates the long line of precedent demanding strict compliance with the

statutory time limits of civil commitment proceedings. The United States Supreme Court has unequivocally established that the civil commitment process represents a significant deprivation of personal liberty giving rise to due process protections, *Addington v. Texas,*441 U.S. 418, 425 (1979); *Humphrey v. Cady*, 405 U.S.504,509 (1972). The State of Wisconsin has echoed this, holding repeatedly that an individual has a liberty interest in being free from involuntary detention, and this interest is protected by state and federal due process rights. *See, e.g., Mental Commitment of Stevenson.L.J.,* 320 Wis.2d 194,(2009). Chapter 51's time line requirements are Wisconsin's statutory expression of the fundamental due process protections afforded under both § 1 of the Wisconsin Constitution and the 14th Amendment to the U.S. Constitution.

The goal of statutory interpretation and application is to give effect to the intent of the legislature. Here, the intent of the legislature was to give meaningful, not merely technical, implementation of constitutionally guaranteed due process protections to individuals involuntarily detained under Chapter 51.

This intent can be best understood from the historical context of the enactment of the relevant portions of Wisconsin's current commitment laws. Prior to enacting these specific time lines, portions of Wisconsin's civil commitment law had been held unconstitutional on due process grounds. *Lessard v. Schmidt,* 349 F.Supp. 1078 (E.D. Wis 1972), *vacated and remanded on procedural grounds,* 414 U.S. 957 (1975), *judgement reentered,* 379 F.Supp 1376 (1974) *vacated and remanded on procedural grounds,* 421 U.S. 957 (1975), *judgement reentered, 413 F. Supp. 1318 (1976).* The *Lessard* court based these due process violations on a statutory scheme which did not contain any reasonable time limitation on how long someone could be held between the probable cause hearing and final commitment proceeding. In direct response to *Lessard*, the legislature created the specific Chapter 51 time lines we now have, the clear intent of which was to bring Wisconsin's statutory commitment process into compliance with the mandates of due process. Therefore, it is only reasonable to imbue these time lines with all those elements and restrictions necessary to give meaningful due process rights to

individuals caught up in the commitment process as required by *Lessard*.

In this case, both the uncontroverted facts support the conclusion that Helen E.F. was "wheeled off the unit" for a matter of minutes for the sole purpose of attempting to evade the consequences of a lapsed Chapter 51 time line. Furthermore, the record is devoid of any indication that the staff of the hospital where E.F. was being held, county human services department or potential nursing home placement, engaged in any discharge planning, alternative placement arrangements or other hint of an intent to terminate the original detention. After E.F. spent a few minutes parked in the hall, in her wheelchair, she was wheeled back onto the unit, and a new petition initiated. This is not meaningful due process. In fact, the sole purpose of the maneuver was to create a facade of adherence to the rules, in order to evade actual, meaningful due process. If the "due process clock" can be restarted simply by having a detainee leave the unit for a few minutes, then there would be no longer be any practical limitation on the time an individual could be detained without a hearing. In

other words, Wisconsin would return to the exact situation that the legislature strove to correct after the *Lessard* decision. Statutory time limitations even when violated would be meaningless since the physical act of leaving the unit for the front door would create the very circumstance that would reset of the clock for a new detention before the individual even hit the door. If this practice is expressly or impliedly deemed by this Court to be sufficient to comply with the intent of Wis Stats. §51.20, it would eviscerate the due process protections that Wisconsin and the United States Constitution guarantee to individuals facing potential civil commitment under Chapter 51.

The basic fact underlying this case is that there was no hearing on the prior Chapter 51 petition or Chapter 55 conversion. Attempting to obscure that fact by changing the date and updating the facts and thereby characterize the subsequent petition as "new" instead of simply a refilling of the prior petition may be creative, but it is a gossamer attempt at due process at best, and must fall under its own weight. Allowing this practice to continue would deprive all individuals subject to Chapter 51 commitment

proceedings of the meaningful due process to which they are entitled. This Court countenance such a diminishment of the fundamental constitutional liberty interest underlying these statutory time limits by petitioners in civil commitment through procedural maneuvering which merely plays lip service to the technicality of compliance.

II. Chapter 51 Commitments Are an Ineffective Legal Framework to Provide Treatment or Rehabilitation to Individuals with a Diagnosis of Dementia, such as Alzheimer's.

The legislative policy for Chapter 51 is to "... assure the provision of a full range of treatment and rehabilitation services in the state for all mental disorders . . . and mental illness. *Wis Stats §51.001(1).* Furthermore, the overarching legislative policy behind Wisconsin's civil commitment laws is to protect the personal liberties of individuals so that "...no person who can be treated adequately outside the hospital... may be involuntarily treated in such a facility."*Wis Stats §51.001(2)* Therefore, given a choice of options, the commitment statutes should read to promote

treatment alternatives that support the individuals in their current environment.

The definition of Alzheimer's disease as a "degenerative disease of the central nervous system ... [which] includes ...irreversible deterioration of intellectual faculties with concomitant emotional disturbance resulting from organic brain disorder." *Wis Stats. §46.87(1)(a)* is incorporated by reference into Chapter 51's definitions. Chapter 51 defines the term "degenerative brain disorder" as meaning ". . .the loss of or dysfunction of brain cells to the extent the individual is substantially impaired in his or her ability to provide adequately for his or her own care or custody . . ." *Wis Stats.51.01(4r).* It seems clear that the definition of Alzheimer's disease qualifies as a degenerative brain disorder under Chapter 51, however, Chapter 51 is more noteworthy for what it doesn't make clear about how Alzheimer's disease and other types of dementia fit into the involuntary commitment scheme of this chapter. As a degenerative brain disorder it is specifically excluded from the definitions of brain injury (*Wis Stats.51.01(2g) (b)*), serious and persistent mental illness *Wis Stats. §51.01(14t),* and developmental disability *(Wis Stats. §55.01(1v).* While there is debate in the medical community as to whether Alzheimer's disease should

constitute a mental illness for treatment purposes, the statutory definition of mental illness for the purposes of involuntary commitment, as a "...substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgement, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life..." *Wis Stats. §51.01(13)(b)*, is so broad it can't be said to categorically rule out much of anything, including dementia.

Instead of focusing on the definition of mental illness, which is fully addressed by the parties and other *Amic*i, this brief will focus on the more pragmatic issues surrounding the second element of the commitment standard; namely, that the individual must also be found to be a proper subject for treatment. *Wis Stats. §51.20(1)(a)*(1) Chapter 51 defines "treatment" as "those psychological, educational, social, chemical, medical or somatic techniques designed to bring about rehabilitation of the mentally ill..." *Wis Stats. §51.01(17).* Rehabilitation for the purposes of mental health commitment is not defined in Chapter 51, but the concept was explored in *In the Matter of Theodora Athans*, 107 Wis.2d 331, 320 N.W.2d 30 (Wis. App. 1982) which recognized the specific clinical meaning of rehabilitation as "...returning an individual to a previous level of functioning which had decreased

because of an acute disorder." (at 334) The court further distinguished "rehabilitation" from "habilitation" which is excluded from the mental commitment criteria, noting that the two terms, although not defined in this Chapter, were juxtaposed in Wis. Stats. §51.437(1), indicating that the legislature could be inferred to understand the difference between the two terms.

Several years later, another Wisconsin Appellate court put a finer point on the concept of rehabilitation by recognizing that there may be situations where the prior level of functioning is not realistic because of the nature of the disease. *In the Matter of the Mental Condition of C.J.* 120 Wis. 2d 355, 360, 354 N.W.2d 219 (Ct App 1984). In that case C.J. had a more "traditional" mental illness diagnosis of schizophrenia and the question raised was whether there was a treatment benefit in continued institutionalization beyond custodial care, so as to make C.J. a proper subject of treatment. However, in the case of many dementia patients with symptoms severe enough to warrant undertaking a Chapter 51 commitment, the question of control through continued institutionalization is not at issue. The individual is already a patient of a nursing home or community based residential facility (CBRF) which has access to the legal tools it needs "...to control the disorder and its symptoms" as the

court in *C.J.* defined rehabilitation. There is nothing to be gained in access to treatment modalities by putting the individual through the Chapter 51 commitment process.

At the time that Helen E.F.'s case arose, another main objective for initiating a Chapter 51 petition for an individual with Alzheimer's was obtain an order for the involuntary administration of psychotropic medications. There are no psychotropic medications approved by the FDA for the treatment of Alzheimer's, and most of these drugs carry a "black box" warning regarding use in elderly patients with dementia. Among the nursing home population (which has a high ratio of advanced stage cases) the prevalence of behavioral and psychological symptoms of dementia have been found exist for anywhere from 40 to 90% of residents. [See: CK Beck and VM Shue, "*Interventions for Treating Disruptive Behaviour in Demented Elderly People*" Alzheimer's Disease (1994): 143-155; Malaz Boustani, M.D., et. Al., "*Characteristics Associated with Behavioral Syptoms Related to Dementia in Long-Term care Residents"* The Gerontologist, 45 (2005) 56-61.]

In fact, the medical experts testifying in this case admitted that the order for involuntary medication was being sought to manage behaviors, not directly treat Helen E.F.'s Alzheimer's. Under

Chapter 51, the involuntary administration of any medication is allowed only when necessary to prevent serious physical harm to the patient or to others. *Wis Stats §51.61(1)(g).* Under federal regulations applying to facilities receiving federal medicaid dollars, the use of medications to *control behavior* or restrict the patient's freedom of movement, which are not a standard treatment for the patient's medical or psychological condition is considered a form of chemical restraint, subject to the restrictions for federal regulations of restraint and seclusion. [*See:* 42 USC 290ii, 290ii-1, 290ii-2, 290jj, 290jj-1, 290jj-2, 42 CFR 482.13 et seq.; and 42 CFR 483.350]

Notwithstanding these federal definitions, in 2010 Wisconsin made the administration of psychotropic drugs to residents of nursing homes much easier under *Wis Stat. §50.08*, Which allows for the administration of psychotropic drugs with the informed consent of a Health Care Agent. Moreover, Chapter 55 provides for involuntary administration of psychotropic medication as a protective service with the consent of the guardian. The purposes of involuntary medication under Chapter 55 are much broader and, for better or worse, more accommodating for medical professionals treating Alzheimer patients than the strict prevention of serious harm standard of Chapter 51. Under *Wis.*

Stats. §55.14 (1)(d) psychotropic medication is defined as "a prescription drug. . . used to treat *or manage* a psychiatric symptom or challenging behavior. Notwithstanding the dangerousness of these drugs for elderly patients with dementia, managing symptoms and behavior is much closer to the mark of what is actually intended in these situations. The plan for Helen E.F. was to return her to her nursing home after her behaviors were able to be managed through a court order for involuntary administration of psychotropic medication. This does not met the standard of "treatment" or "rehabilitation" under Chapter 51.

Unfortunately, the reality is that due to the very nature of the disease, for an individual with Alzheimer's exhibiting aggressive or challenging behaviors, a goal of restoration of that individual to previous level of functioning which has decreased because of an acute disorder can be an elusive one. Therefore, as argued by the Coalition of Wisconsin Aging Groups and Elder Law Section of the State Bar, in their respective *amici* briefs, the Chapter 55 protective placement system, nursing home provision of Chapter 50 as well as the healthcare power of attorney provisions of Chapter 155 provide a more efficacious legal framework to deal with treatment issues, as well as the added oversight of a guardian required under Chapter 55 or health care

agent under Chapter 155.

Because the line between managing symptoms of dementia in the context of custodial care under Chapter 50 and 55 and treatment under Chapter 51 is so unclear, these individuals increasingly find themselves caught up in the involuntary commitment process under Chapter 51 with sometimes tragic outcomes. The involuntary detention process often begins in the individual's long term care facility. Under the provision of Chapter 51, law enforcement is called to transport the patient to the appropriate detention facility. Sadly, many times this includes handcuffs and a disorienting ride in a squad car, the exact kind of activity that increases the stress and agitation level of most Alzheimer's patients.

Therefore, it is incumbent on this Court to go beyond simply endorsing a definition of rehabilitation for purposes of Wis. Stats. §51.07(17) in considering whether an individual with dementia such as Alzheimer's is the proper subject for treatment withing the Chapter 51 system. The reality of the mental health system is that commitment, and specifically the emergency detention process is increasingly used to remove a nursing home resident, rather than put the resources into effectively dealing with the individual's treatment needs. The emergency detention stage does not require

an assessment as whether the individual to be detained is a proper subject of treatment. Wis. Stats. §51.15(1). However, before transport under an emergency detention, law enforcement is required to receive approval from the county department of community programs. Wis Stats. §51.15(2). In many cases, the individual swept up by law enforcement into commitment proceedings are already residents of a nursing homes or other large congregate living setting, and if a commitment order does not result, the sending facility will often close the bed or accept an administrative fine for improper discharge rather than readmit the individual to what had become their home. Therefore, a clear message is needed to the authorizing county agencies regarding whether an individual such as Helen E.F. should be approved for emergency detention transport as a proper subject for treatment under the commitment law. Otherwise, given the likelihood of transfer trauma, increased symptomology and the deplorable practice of some residential care facilities to employ a Chapter 51 emergency detention to remove a troublesome patient from their facility, damage to the individual is often already significant at the emergency detention stage of the process.

There are other legal avenues already available to achieve the desired treatment outcome without subjecting the patient to the

stress and confusion of the emergency detention and commitment process. Although in some instances specific set of facts may exist for a Chapter 51 commitment, (for example a patient who has both a serious and persistent mental illness in addition to Alzheimer's) in most cases, there is no treatment benefit to the patient with dementia, while there exists the potential for great harm under Chapter 51 commitment process.

CONCLUSION

For the foregoing reasons, DRW urges this Court to affirm the decision of the Court of Appeals.

Dated this 14th day of November 2011.

Respectfully submitted,

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FORM AND LENGTH CERTIFICATION

I hereby certify that this brief conforms to the rules contained in §809.19(8)(b) and (c) for a brief produced with a proportional serif font. The length of this brief is 2981 words.

CERTIFICATION OF COMPLIANCE WITH RULE 809.19(12)(f)

I hereby certify that I have submitted an electronic copy of this brief which is identical to the text of the paper copy of this brief.

Dated this 14th day of November, 2011.

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STATE OF WISCONSIN
SUPREME COURT
Appeal No. 2010 AP 2061

In the matter of the mental commitment of Helen E. F.:

FOND DU LAC COUNTY,

Petitioner-Respondent-Petitioner

v.

HELEN E. F.,

Respondent-Appellant

On Certiorari From the Wisconsin Court of Appeals, District II, Reversing an Order for Commitment and Order for Involuntary Medication, Entered in the Circuit Court, Fond du lac County, the Honorable Richard J. Nuss Presiding

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BRIEF OF *AMICUS CURIAE* WISCONSIN COUNTIES ASSOCIATION

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I. INTRODUCTION

It has been long recognized that the responsibility for defining what mental conditions qualify for involuntary commitments is the province of state legislatures, not the courts. State legislatures must be free to develop solutions to address the complex scientific and treatment issues involving mental conditions and the potential dangers that those suffering from such conditions pose to their own health and safety and the health and safety of others. When a legislature undertakes to act in this area, courts are not to rewrite legislation to achieve what the court believes to be a more socially desirable or just result. In the absence of a constitutional infirmity, the court must defer to the legislature's judgment and wisdom.

In the present case, the Court of Appeals disregarded these fundamental precepts, determined that Alzheimer's dementia patients can never be the subject of an involuntary commitment and rewrote Chapter 51 to achieve its own desired result. Musing that "one way to measure the greatness of our society is to look at how we treat our weakest members…" the court usurped the authority of the legislature and concluded that those who suffer from Alzheimer's and exhibit behaviors which pose a risk of physical harm to themselves and others must be kept in a protective residential setting regardless of the consequences to residential facilities, caregivers and residents. The court further impermissibly disregarded the undisputed psychiatric testimony that Helen E.F.'s Alzheimer's and associated

mental disorders qualified as a "mental illness" under the legislature's broad definition of the term in Chapter 51.

It was not within the province of the Court of Appeals to legislate in this fashion or to disregard the undisputed psychiatric evidence before it. If the language of Chapter 51 is to be changed to limit the scope of involuntary commitments based on purported advancements in the treatment of Alzheimer's, it is the responsibility of the legislature, not courts, to evaluate the merits of that science and make any necessary statutory changes.

Equally troubling in this case was the willingness of the Court of Appeals to base its decision on a task force report and various internet resources which were not introduced into evidence before the trial court, were contrary to the undisputed psychiatric testimony in the record and which were not subjected to scientific scrutiny. By introducing a task force report and internet publications into the record for the first time on appeal, the Court of Appeals deprived the County of an opportunity to challenge the foundation of these publications, address them with the treating psychiatrists or balance the information in these reports against the County's obligation to protect Helen E.F. and those around her from physical harm.

The goals advanced by the Court of Appeals and the advocacy groups that support its decision may indeed be laudable. But such objectives do not justify rewriting existing law regarding involuntary commitments or overriding the obligations of county governments to protect caregivers and residents in

residential facilities from the dangers posed by combative individuals who qualify for involuntary commitment under Chapter 51. Any change in this process must be made by the legislature, not the courts. The decision of the Court of Appeals must be reversed.

II. ARGUMENT

A. The Wisconsin Legislature, Not The Court Of Appeals, Is Responsible For Defining The Scope Of Involuntary Commitment Proceedings Under Chapter 51

The United States Supreme Court has recognized that legislatures are in the best position to address the complex scientific, medical and legal issues associated with striking the balance between protecting the rights of the individual while providing for a system of involuntary commitment which protects caregivers and others from those who suffer from mental illness and other mental disorders. *State v. Post*, 197 Wis.2d 279, 304, 541 N.W.2d 115 (1995); *Addington v. Texas,* 441 U.S. 418, 425-426, 99 S.Ct. 1804, 60 L.Ed.2d 323 (1979). In striking this balance, the Court has not required that legislatures adopt a single definition that must be used as the mental condition sufficient to warrant an involuntary commitment. *Post*, 197 Wis. 2d at 304. Rather, the Court has left the responsibility of defining the mental conditions that qualify for involuntary mental commitment to legislatures. *Id.* In so doing, the Court has recognized that when a legislature "undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad and courts should be cautious not to rewrite legislation." *Id.* at 304.

Consistent with this philosophy, the Wisconsin legislature crafted Chapter 51 broadly so as to ensure that the full range of treatment and rehabilitation services are available to individuals who pose a risk of physical harm to themselves or others and whose condition may be improved through treatment. This approach is reflected in the legislature's broad definition of "mental illness" for purposes of involuntary commitment, which provides that mental illness is:

> …a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, but does not include alcoholism.

Wis. Stat. 51.01(13)(b).

Section 51.01(13)(b) does not limit the disorders which may constitute a mental illness provided that they meet the criteria of the definition. Individuals who suffer from physical illnesses, mental illnesses, degenerative brain disorders or other illness (other than alcoholism) which are, or result in, "substantial disorders of thought, mood, perception, orientation, memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life" meet the definition of "mental illness" and are potentially subject to involuntary commitment provided that the requirements for an involuntary commitment in Chapter 51 are otherwise satisfied.

The legislature's broad definition of "mental illness" reflects a policy determination that there may be individuals who suffer from a qualifying mental illness who pose a substantial risk of harm to themselves and others and who require safeguards and treatment not found in residential or home settings. It

recognizes that caregivers and others around these patients may not be capable of controlling those with "mental illness" or meeting their treatment needs. Chapter 51 is designed to meet the needs of both individuals and treatment facilities in this circumstance by providing for involuntary hospitalization and administration of medications required to improve the quality of life for these individuals and allow them to safely return to less restrictive environments.

B. Undisputed Psychiatric Testimony Established That Helen E.F. Suffered From "Mental Illness" Under Chapter 51 As Defined By The Wisconsin Legislature

Under the broad definition of "mental illness" adopted by the legislature, there is no doubt that individuals with Alzheimer's who exhibit mental disorders such as self-harm, combativeness, anxiety, and aggressiveness qualify for involuntary commitment under Chapter 51. This result is confirmed by undisputed medical testimony of the psychiatrists who evaluated Helen E.F., who concluded that her condition satisfied the statutory criteria of a mental illness under Chapter 51. *See R3:2; R.9:11; R.11:2-3; see also R.16:7.*

Helen E.F.'s involuntary commitment under Chapter 51 occurred as designed by the legislature. As a result of her Alzheimer's dementia, Helen E.F. became progressively disoriented, depressed, agitated, aggressive and uncooperative which caused her to strike out at her caregivers and refuse necessary nutrition, hygienic care and medical treatment. *See R.9:11-13, 15-16; R.10:1-2; R.16:9-11.* Three treating psychiatrists examined her and ultimately determined that the mental disorders which Helen E.F. was experiencing satisfied

the definition of a "mental illness" under Wis. Stat. 51.01(13)(b), i.e., she suffered from "a substantial disorder of thought, mood, perception, orientation, or memory" which grossly impaired her "judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life." *See R3:2; R.9:11; R.11:2-3; see also R.16:7.*

The opinions of Helen E.F.'s treating psychiatrists were not only consistent with the definition of "mental illness" in Chapter 51 but with diagnostic guidelines for mental disorders in the psychiatric community. In this regard, Alzheimer's disease and its symptoms are recognized by the Diagnostic and Statistical Manual, 4th edition, of the American Psychiatric Association (DSM-IV) as a mental illness. *See Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, § 290.10, *et seq*. (American Psychiatric Association ed., 4th ed. 1994). The DSM-IV is the main tool used by clinicians and psychiatrists to diagnose mental illness. *Post*, 197 Wis. 2d at 305 (recognizing that the DSM-IV is "the primary tool of clinical diagnosis in the psychiatric field").

It is likewise undisputed that the behavioral disorders associated with Alzheimer's are proper subjects of treatment through involuntary mental commitment. As determined by the psychiatrists who examined Helen E.F. and testified in this case, short-term hospitalization and administration of psychotropic medications can result in improved quality of life for Alzheimer's patients, result in decreased patient anxiety, depression and agitation and allow for the

development of behavioral support plans and a safe return to less restrictive environments. *See R.3:2; R.9:14; R.16:7-8, 11.*

C. The Court Of Appeals Impermissibly Narrowed The Scope Of Involuntary Commitments Under Chapter 51

1. Degenerative Brain Disorders Are Not Per Se Excluded From The Definition Of "Mental Illness" Under Chapter 51

Based on its erroneous finding that Alzheimer's is, *per se*, a degenerative brain disorder, the Court of Appeals concluded that Alzheimer's could not also qualify as a "mental illness" for purposes of the commitment statute. *In re Helen E. F.*, 2011 WI App 72*,* ¶*25.* The court's conclusion is contradicted by the classification of Alzheimer's as a mental illness under the DSM-IV. More importantly, the court's conclusion is belied by the definition of "mental illness" adopted by the Wisconsin legislature for purposes of involuntary commitment in Chapter 51.

The legislature did not preclude a finding of "mental illness" for those who suffer from degenerative brain disorders, nor did it limit the definition of "mental illness" to any particular type of disorder. In this case, all three psychiatrists who examined Helen E.F. determined that her mental disorders consisting of, among other things, depression, anxiety, agitation and physical aggressiveness fell within the criteria of a "mental illness" under Chapter 51.

2. Alzheimer's Is Not Defined As A Degenerative Brain Disorder Under Wisconsin Statutes

The Court of Appeals found that Alzheimer's is a "degenerative brain disorder" which does not, as a matter of law, fall within the scope of Chapter 51. There is, however, no language in Chapter 51 which supports this result. The definition of the term "degenerative brain disorder" in Chapter 51 does not include Alzheimer's disease. In fact, in defining "brain injury," under Chapter 51, the legislature expressly distinguished "degenerative brain disorder" from "Alzheimer's disease" compelling the conclusion that the two conditions are different:

> (b) "Brain injury" does not include alcoholism, Alzheimer's disease as specified under s. 46.87 (1) (a), or degenerative brain disorder, as defined in s. 55.01 (1v).

Wis. Stat. §51.01(2g)(b).

The only definition of Alzheimer's disease appears in Wis. Stat. § 46.87. Again, however, the statute does not define Alzheimer's as a degenerative brain disorder but, rather, defines Alzheimer's as a degenerative condition of the central nervous system:

> "Alzheimer's disease" means a degenerative disease of the central nervous system characterized especially by premature senile mental deterioration, and also includes any other irreversible deterioration of intellectual faculties with concomitant emotional disturbance resulting from organic brain disorder.

Wis. Stat. § 46.87(1)(a). Fundamentally, if the legislature had intended to equate Alzheimer's disease to a "degenerative brain disorder" it would have included the

disease within the definition of a "degenerative brain disorder" rather than distinguishing Alzheimer's disease from it.

Perhaps due to the absence of any statutory basis for its conclusion that Alzheimer's is a "degenerative brain disorder" excluded from the scope of Chapter 51, the Court of Appeals turned to the internet to reach its desired result. *In re Helen E. F.*, 2011 WI App 72*,* ¶*2,* fn. 2. The court concluded in a footnote and based on the internet site *www.medterms.com*, that "Alzheimer's disease is a degenerative brain disorder, causing irreversible decline." *Id.* at fn. 2.

The court's selective use of an internet definition of Alzheimer's is a fatal flaw in its analysis. By relying on one definition on the internet to the exclusion of all others, the court disregarded available information in the psychiatric and medical community, such as the DSM-IV, which suggests that Alzheimer's disease is a mental illness. Equally important, the court disregarded the broad range of disorders that may constitute a "mental illness" for purposes of involuntary commitment under Chapter 51.

The legislature's broad definition of mental illness, together with the DSM-IV's classification of Alzheimer's as a mental illness, mandates a finding that Alzheimer's patients may be involuntary committed under Chapter 51 provided that the other criteria for commitment are met. At a minimum, their existence forecloses the Court of Appeals' conclusion that individuals afflicted with Alzheimer's disease as a matter of law "do not suffer from a qualifying mental condition" under Chapter 51. *See In re Helen E. F.*, 2011 WI App 72, ¶2.

3. The Court Of Appeals Improperly Substituted Its Medical Judgment For Those Of The Psychiatrists Who Evaluated Helen E.F.

The Court of Appeals also erred by rejecting the testimony of Helen E.F.'s treating psychiatrists and substituting its own belief that neither Alzheimer's nor its associated mental disorders constitute a treatable mental illness under Chapter 51. It is well settled that whether a person is mentally ill is a *medical judgment* made by applying the definition of "mental illness" in Wis. Stat. § 51.01(13)(b) to the particular circumstances of a case. *In re Commitment of Dennis H.* 255 Wis. 2d 359, 375-376, 647 N.W.2d 851 (2002); *see also Humphrey v. Cady,* 405 U.S. 504, 509, 92 S.Ct. 1048, 31 L.Ed.2d 394 (1972).

In the present case, the only medical judgment in the record was that of the psychiatrists who personally examined Helen E.F. and observed her behaviors. Based upon their observations, the psychiatrists opined that Helen E.F.'s condition constituted a mental illness as defined in Wis. Stat. § 51.01(13)(b) and that her condition was treatable. There was no other evidence in the record which supports the Court of Appeals' conclusions to the contrary.

The Court of Appeals' reliance on its previous decision in *Matter of Athans*, 107 Wis. 2d 331, 320 N.W.2d 30 (Ct. App. 1982) to support its conclusion that Alzheimer's is not treatable is misplaced. In *Athans*, unlike the present case, the experts testified that neither of the persons named in the petitions was a proper subject of treatment for purposes of Chapter 51. *Athans* 107 Wis.2d at 333-34, 320 N.W.2d at 31-32.

The controlling authority in this case was the Court of Appeals' own decision in *Matter of C.J.*, 120 Wis. 2d 355, 354 N.W.2d 219 (Ct. App. 1984) which the Court of Appeals did not distinguish or even cite. In *Matter of C.J.*, the Court of Appeals found that an individual suffering from chronic paranoid schizophrenia was a proper subject for a Chapter 51 commitment even though treatment would only improve his aggressive behaviors and delusions, but would not cure his underlying schizophrenic disorder. *Matter of C.J.*, 120 Wis. 2d at 359-361. In reaching its decision, the court emphasized that an individual with an incurable mental illness or disease may nonetheless be considered capable of rehabilitation and subject to treatment under Chapter 51 when such treatment goes beyond custodial care and allows the symptoms of the underlying disease to be controlled and ameliorated. *Id.* at 360-361.

The undisputed medical evidence in this case, like that in *Matter of C.J.*, was that the psychiatric complications associated with Helen E.F.'s mental illness resulting from her Alzheimer's could be alleviated and her condition improved through involuntary commitment and administration of psychotropic medications regardless of the fact that her Alzheimer's could not be cured. Based on *Matter of C.J.*, the Court of Appeals erred in disregarding this medial testimony and substituting its own judgment that Helen E.F.'s condition was untreatable.

4. The Court Of Appeals Inappropriately Relied On Materials Outside Of The Record

The Court of Appeals liberally referred to resources outside of the record in concluding that individuals suffering from Alzheimer's disease are not proper subjects of Chapter 51 involuntary proceedings. While Wis. Stat. § 902.01 provides for the recognition of certain adjudicative facts through judicial notice, it does not permit recognition of such facts when they are in dispute. The Court of Appeals impermissibly sought out and relied upon internet publications and studies supporting its beliefs regarding Alzheimer's which contradicted the undisputed medical opinions and testimony presented to the trial court.

The Court of Appeals' indiscretion in relying upon matters outside of the record is best exemplified by its reliance upon an Alzheimer's advocacy group publication entitled *Handcuffed: A Report Of Alzheimer's Challenging Behaviors Task Force.* The Court of Appeals relied upon this report to support the position that Chapter 51 commitments are inappropriate for individuals with Alzheimer's.

By introducing and relying upon the report for the first time on appeal, the Court of Appeals effectively precluded examination of the report's scientific reliability or applicability to the case of Helen E.F. Importantly, none of the psychiatrists who evaluated and treated Helen E.F. were provided with the opportunity to address the report or explain why they concluded that hospitalization of Helen E.F. and control of her behaviors with psychotropic

medications was the appropriate course of treatment for her. Likewise, the County was deprived of an opportunity to challenge the foundation of the report.

Equally troubling, the Court of Appeals again impermissibly invaded the province of the legislature by giving weight to the report and using it as the basis to limit the scope of Chapter 51. As noted in *Post*, it is the responsibility of the legislature, not the courts, to define the appropriate scope of involuntary commitments based on existing scientific and medical evidence. *Post*, 197 Wis. 2d at 304.

III. CONCLUSION

Based on the foregoing, the Wisconsin Counties Association respectfully requests that the Court reverse the decision of the Court of Appeals.

Dated this 21st day of November, 2011.

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CERTIFICATION

I certify that this Brief conforms to the rules contained in Wis. Stat. § 809.19(8)(b) and (c) for a brief produced with a proportional serif font. This brief contains 13 point font size for body text and 11 point font size for footnotes. The length of this brief is 2,976 words. This certification is made in reliance on the word count feature of the word processing system used to prepare this brief.

I further certify that I have submitted an electronic copy of this brief, excluding the appendix, if any, which complies with the requirements of Wis. Stat. § 809.19(12). I further certify that this electronic brief is identical in content and format to the printed form of the brief filed as of this date. A copy of this certification has been served with the paper copies of this brief filed with the Court and served on all opposing parties.

Dated this 21st day of November, 2011.

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SUPREME COURT
Appeal No. 2010 AP 2061

In the matter of the mental commitment of Helen E. F.:

FOND DU LAC COUNTY,

Petitioner-Respondent-Petitioner

v.

HELEN E. F.,

Respondent-Appellant

CERTIFICATE OF MAILING

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