Greater Wisconsin Agency on Aging Resources, Inc.

The Guardian

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The Guardian is a quarterly newsletter published by the Greater Wisconsin Agency on Aging Resources, Inc. (GWAAR), Wisconsin Guardianship Support Center (GSC).

The GSC provides information and assistance on issues related to guardianship, protective placement, advance directives, and more.

To contact the GSC—

Call: (855) 409-9410
E-mail: guardian@gwaar.org

Website: gwaar.org

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Helpline Highlights

Following is a sample of the calls received (and answers given) through the Guardianship Support Center helpline:

If a ward has a standby guardian, does the standby guardian need to be contacted in addition to the guardian for every decision? When does the standby guardian have the authority to act?

A standby guardian is on standby until the guardian is unavailable or unwilling to act. The appointment of a standby guardian becomes effective immediately upon the death, incapacity, or resignation of the initially-appointed guardian. The standby guardian notifies the court using form GN-3220 and receives new letters of guardianship. Because transferring authority from the original guardian to a standby is much easier than going through the successor guardianship process, a standby guardian should be nominated during the initial guardianship proceedings if one is available.

Does a state-authorized Certificate of Incapacity form exist for doctors to complete for purposes of activating a power of attorney for health care?

There is no standard state-issued Certificate of Incapacity form for these purposes. Individual hospitals or clinics may have their own forms or a doctor could draft their own document stating that the principal is incapacitated.

My father is terminally ill but has not executed any power of attorney document or other advance directive. I believe he would be most comfortable in hospice care for the last few months of his life. How can I make this happen?

Under Wis. Stats. §50.94, if your father does not have a valid living will or power of attorney for health care, you may be able to admit your father to hospice under the family consent rule. This rule is the only exception to the general rule that next of kin may not make health care decisions unless they are the health care agent or guardian of the person.

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Madison Office:
1414 MacArthur Road, Suite A
Madison, WI 53714
ph. 608.243.5670
fax. 866.813.0974

Brookfield Office:
125 N. Executive Drive, Suite 207
Brookfield, WI 53005

Green Bay Office:
2900 Curry Lane, Suite 414
Green Bay, WI 54311

Tribal Technical Assistance Center:
Great Lakes Inter-Tribal Council
P.O. Box 9
Lac du Flambeau, WI 54538
ph. 800.472.7207
fax. 715.588.7900

In re Mental Commitment of Aaron V.
2013AP808 (September 10, 2013)
Not Recommended for Publication

Summary: The burden of proof is placed on a county in orders of mental health commitment and involuntary medication. However, even if a patient testifies to their ability to understand their mental illness and the impact medication has on it, the court is free to consider evidence to the contrary such as testimony from case managers and psychiatrists.

Case Detail: Wis. Stat. ch. 51 describes mental health commitments and requires proof by clear and convincing evidence, that an individual has a mental illness, is a proper subject for treatment, and is dangerous. To establish that an individual is dangerous, there must be "a showing that there is a substantial likelihood, based on the subject individual's treatment record, that the individual would be a proper subject for commitment if treatment were withdrawn."

Since 2008 Aaron V. has been under a mental health commitment by Outagamie County. In 2012 the county petitioned for extension of the mental health commitment and order for involuntary medication. A psychiatrist was appointed by the court to evaluate Aaron before the extension hearing. This psychiatrist concluded that an extension of commitment was proper and that Aaron was not competent to refuse medication. The psychiatrist testified that, due to Aaron's lack of insight and denial of mental illness, he could not make an informed decision about his medication. Specifically, the psychiatrist stated that "per history, [Aaron] is substantially dangerous to others when noncompliant with recommended treatment." Aaron's case manager also recommended extension of commitment because Aaron missed treatments and doctor appointments. The circuit court granted the commitment extension and continuation of the medication.

Aaron appealed the court's decision to extend his commitment. Although Aaron conceded that he has a mental illness and is a proper subject for treatment, he argued that there was insufficient evidence that he was a proper subject for commitment if treatment were withdrawn. Specifically, Aaron stated that the record did not establish that he would be dangerous if treatment was withdrawn. Aaron also objected to the involuntary medication order. An individual can only be placed under such an order if a court determines that the person is incompetent to make such a decision. This burden is placed on the County and they must prove it by clear and convincing evidence. Aaron argues that the burden was placed on him to show that he was competent to refuse medication. He specifically points to the record where the Court said that it was not convinced that Aaron met the "threshold where he can be declared competent to refuse medications."

The court held the psychiatrist's testimony that Aaron gets threatening and aggressive and is dangerous to others when noncompliant with medication was sufficient to support the circuit court's determination. Furthermore, the Court pointed to the record where it specifically addressed the County's burden of proof and noted that it agreed with the recommendations of the psychiatrist and case manager. The court rejected Aaron's argument that because he recognized his own illness, he could understand the application of medication to his mental illness. The court went on to further say that "if a person cannot recognize that he or she has a mental illness, logically the person cannot establish a connection between his or her expressed understanding of the benefits and risks of medication and the person's own illness." Although Aaron testified to his mental illness, the Court was free to accept the psychiatrist's testimony that Aaron did not believe he had a mental illness.

In re Donna H.
2013AP80 (July 31, 2013)
Not Recommended for Publication

Summary: To establish that an involuntary medication order is necessary, medical experts must testify that a discussion of the advantages and disadvantages of medication took place. A court is not allowed to infer from a medical expert's testimony. The specific words *advantages* and *disadvantages* must be used.

Case Detail: Donna has schizophrenia that causes a significant functional impairment. In the evaluation of the need for an involuntary medication order, a doctor testified that Donna was not competent to refuse medication. Although the doctor did not specifically use the words *advantages* or *disadvantages*, the court found that the doctor clearly had a discussion with Donna about use of medication. After testimony from Donna and her doctor, the court ordered involuntary

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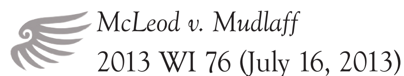
medication with a protective order.

To establish that an individual is not competent to refuse psychotropic medication, a county must show that the advantages and disadvantages of accepting medication have been explained to the individual. To establish that this occurred, medical experts must testify using the statutory terms of *advantages* and *disadvantages*. If counsel does not receive an answer from a medical expert with such terms, he or she should require the expert to expound upon their answer so the court does not have to speculate as to the meaning. Because the doctor never specifically used the words *advantages* or *disadvantages*, the lower court's ruling must be reversed. Courts are not allowed to make inferences from the testimony of medical experts regarding whether advantages or disadvantages were discussed.



McLeod v. Mudlaff
2013 WI 76 (July 16, 2013)

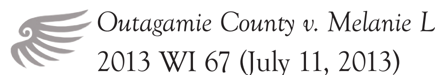
Summary: An annulment is not the exclusive remedy to challenge the validity of a marriage. A court has the authority to declare a marriage void after the death of one of the parties to the marriage.

Case Detail: Nancy and Luke Laubenheimer were married for 30 years, until Luke's death in 2001. Luke had three children from a previous marriage and Laubenheimer never adopted them. Nancy's will left the bulk of her estate to Luke. However, if Luke died before she did, the bulk of Nancy's estate was to be distributed to Luke's children.

In early 2007, Nancy suffered a debilitating stroke. In October of 2008, Nancy's doctors signed a statement of incapacitation concluding that Nancy was unable to make health care decisions. At some point, Joseph McLeod came to live with Nancy. McLeod claims this began in 2003. In 2008 McLeod removed Nancy from her nursing home on two occasions; once to obtain a marriage license and again for a marriage ceremony.

After Nancy's death, McLeod asserted his right to a share of her estate, claiming that her will was not proper because it was executed prior to their marriage. Wis. Stat. § 853.12 provides that "if the testator married the surviving spouse . . . after the testator executed his or her will, the surviving spouse . . . is entitled to a share of the probate estate." Luke's children, however, argued that Nancy lacked the mental capacity to enter into a marriage contract. The circuit court held that the only way to invalidate a marriage is through annulment which cannot occur after the death of a party to the marriage.

In the Wisconsin Supreme Court's reversal of the circuit court's decision, it referenced Wis. Stat. §765.03(1) that prohibits marriage where a party has such want of understanding as renders him or her incapable of assenting to marriage. Furthermore, the court stated that, at common law, "when one of the parties died, such that any impediment to a valid marriage was no longer capable of being corrected, a declaration that a marriage was void was the proper remedy." This common law principle has been retained by our case law.



Outagamie County v. Melanie L
2013 WI 67 (July 11, 2013)

Summary: The Wisconsin Supreme Court reversed the decision of the Court of Appeals that affirmed the circuit court's extension of an involuntary medication order for Melanie L. The Supreme Court found that the circuit court misstated the burden of proof and failed to prove by clear and convincing evidence that Melanie was "substantially incapable of applying" an understanding of the advantages, disadvantages, and alternatives of her prescribed medication to her mental illness to make an informed choice on whether to accept or refuse the medication. The county did not overcome Melanie's presumption of competence to make an informed choice to refuse medication. The Court found that "the medical expert's terminology and recitation of facts did not sufficiently address and meet the statutory standard."

Case Detail: Melanie L. suffered from a mental illness. The court committed her for outpatient treatment and custody for six months and ordered that medication and treatment be administered to her. She did not challenge these orders. The county sought an extension of those orders for another 12 months and the court granted the extension. Melanie appealed the extension of the involuntary order for medication only. The Court of Appeals affirmed the involuntary medication order.

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Melanie argued that the examining doctor's opinion that she was incompetent to refuse medication did not satisfy the statutory standard because the doctor testified that Melanie was not "capable of applying the benefits of her medication to her advantage" rather than that she was "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." Melanie also argued that the circuit court misapplied the standard by relying too heavily on her mental illness to support the medication order even though there was evidence that she could apply an understanding of the advantages, disadvantages, and alternatives of medication to her mental illness.

In its opinion, the Supreme Court was required to interpret the controlling statute, Wis. Stats. §51.61(1)(g)4b. First, it looked to its legislative history. The Court discussed the development of involuntary medication orders in Wisconsin and the evolution of the involuntary medication standard in the state. The Court noted that this statute is located in Chapter 51, the chapter dealing with alcohol, drug abuse, mental health, and developmental disabilities. The job of Chapter 51 is to balance the role of government in providing "caring treatment (sometimes involuntarily and if necessary, by force) and the personal liberty of the individual." The Court also noted this statute is in the section of Chapter 51 that deals with *patient rights*.

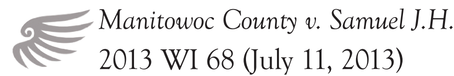
The Court then parsed the language of Wis. Stats. §51.61(1)(g)4b, the statute defining the standard for allowing involuntary medication and treatment. This statute provides in part:

4\. . . .[A]n individual is not competent to refuse medication or treatment if, because of mental illness . . . and after the advantages and disadvantages of and alternatives to accepting the particular medication or treatment have been explained to the individual, one of the following is true:

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

After analyzing the statute and applying it to Melanie's case, the Court ruled that the county did not meet its burden of proof by clear and convincing evidence. Although the case was technically moot due to her involuntary medication order having already expired, the Court determined that the issue was "of great public importance" and "was likely to arise in future cases."

The Court noted in its decision that although corporation counsel posed questions to the testifying doctor in statutory terms, he did not receive an answer in those terms. This type of answer leads to speculation in a reviewing court and as the record stood, the Court could not be certain whether the doctor was changing the standard or applying the standard. The county simply did not fulfill its burden of proof on this issue. The Court noted that, "these hearings cannot be perfunctory under the law. Attention to detail is important . . . this court does not have the option of revising the statute to make the county's work or burden easier."



Manitowoc County v. Samuel J.H.
2013 WI 68 (July 11, 2013)

Summary: Samuel J.H. was committed to the care and custody of Manitowoc County Human Services Department and initially placed in outpatient care. Several months later, the department transferred him to an inpatient facility due to erratic and delusional behavior. Samuel petitioned the circuit court for a review of his transfer, arguing that he was entitled to a hearing within ten days of his transfer to the inpatient facility per Wis. Stats. §51.35(1)(e) and Fond du Lac County v. Elizabeth M.P., 2003 WI App 232, 267 Wis. 2d 739, 672 N.W. 2d 88. He also petitioned for transfer back to outpatient status due to the court's failure to hold the review hearing within 10 days of his transfer.

The circuit court denied Samuel's petition concluding that, according to the statute, a patient is entitled to a hearing within 10 days of his transfer to a more restrictive placement under §51.35(1)(e)3 only when the transfer is based on "a violation of treatment conditions." In this case, transfer was based on "reasonable medical and clinical judgment," not on

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a violation of treatment conditions. The Supreme Court affirmed the circuit court's ruling.

Case Detail: On May 31, 2011, Samuel was committed to the care and custody of Manitowoc County Human Services Department and was initially placed at an outpatient group home. On September 22, 2011, the department transferred him from an outpatient to an inpatient facility. The transfer form stated the reason for the transfer: "Samuel has been presenting as increasingly delusional. Today he was chanting and punched his wall and door, putting a hole through the door. His thoughts are confused and he is agitated. He repeatedly said he put a hole in the door because 'someone was shot down and should be taken care of.' He states he is at [Holy Family Medical Center] because he is a 'person of interest.'"

The same day he was transferred, Samuel received a form titled, "Written Notice of Wis. Stats. §51.35(1)(e)1 Rights" The form reflected that Samuel was being transferred from outpatient to inpatient status and the department must inform Samuel of his rights including "the right to petition a court in the county in which the patient is located or the committing court for a review of the transfer." Soon after his inpatient transfer, Samuel wrote Judge Fox in Manitowoc County Circuit Court a letter stating, "I am disturbed that my outpatient status was changed to inpatient without due procedure."

Manitowoc County took the position that Samuel was entitled to a review hearing by the circuit court because his transfer was based on reasonable medical and clinical judgment but that he was not entitled to an administrative hearing within 10 days of the transfer because he was not transferred for a violation of treatment conditions under §51.35(1)(e)2.-3.

Through is public defender, Samuel filed a petition for review of transfer and a petition to transfer from inpatient to outpatient treatment for failure to hold a timely review hearing. He argued that under Wis. Stats. §51.35(1)(e) and Elizabeth M.P., a patient is entitled to a review hearing within 10 days of transfer when the transfer is to a more restrictive setting and lasts for more than five days — regardless of the reason for transfer. He argued that due to the lack of a timely hearing, he must be returned to an outpatient status.

Events

12th Annual FOCUS Conference
Kalahari Resort & Convention Center — Wisconsin Dells

Special Session - Tuesday, November 19, 2013
"The Art and Science of Dementia Care Without Drugs"

Conference - Wednesday, November 20, 2013
"Teach, Learn, Collaborate"

Register online at:
www.uwsp.edu/conted/ConfWrkShp/Pages/Focus/default.aspx

The court found the reason for his transfer was his delusional behavior not a violation of his treatment conditions and interpreted §51.35(1)(e) as requiring a hearing within 10 days only when a transfer is made for a violation of treatment conditions. However, the court concluded that language in Elizabeth M.P. could be interpreted as requiring a hearing within 10 days regardless of the reason for transfer. That case states, "Transfers pursuant to §51.35(1)(e) require a hearing within ten days." The court noted that other language in that case differentiated between the two types of transfers.

On March 27, 2012, Samuel filed a notice of appeal from the circuit court's order. The court of appeals certified the question of whether Elizabeth M.P.'s statement (requiring a hearing within 10 days for transfers made under Wis. Stats. §51.35(1)(e)) is contrary to the plain language of the statute. The court noted the inconsistency in the case, and stated it was powerless to address the inconsistency. Therefore, the Supreme Court accepted the court of appeals' certification.

After analyzing and relying mainly on the plain language of the statute, the Supreme Court held that Wis. Stats. §51.35(1)(e) doesn't require a hearing to be conducted within 10 days of a transfer when the transfer is based on reasonable medical and clinical judgment under §51.35(1)(e)1. The Court also withdrew any language from Elizabeth M.P. to the contrary. It further held that a hearing must be conducted within 10 days of a transfer when (1) the transfer "results in a greater restriction of personal freedom for the patient for a period of more than five days" or is "from outpatient to inpatient status for a period of more than five days," and (2) the transfer is based on "an alleged violation of a condition of a transfer to less restrictive treatment" under §51.35(1)(e)2.-3. ❑

Helpline Highlights, continued from page 1

Under this rule, you must be a spouse/domestic partner, adult child, adult sibling, or parent of the patient. A physician must certify that your father is incapacitated, has a terminal condition, and you are being given authority under this law to act in accordance with your father's views. You must sign an informed consent to receive hospice care on behalf of your father and certify that you believe to the best of your knowledge that your father would choose hospice care. A close friend or relative may also admit your father into hospice under these terms if that person is at least 18 years old, has exhibited special care and concern for your father, and has had regular contact with him so as to be familiar with his activities, health, and beliefs. The person who has authority under this family consent law is able to make all health care decisions relating to the patient's receipt of hospice care.

The guardian is the daughter-in-law of the ward who was determined competent to make a will in his 2009 guardianship proceeding. Recently, the guardian had the ward evaluated by a psychologist who found that the ward still retained competency to change his will. The ward then executed a new will, with assistance from a reputable elder law attorney, adding the guardian as his beneficiary. Did the guardian in this case violate any of her powers or duties by becoming a beneficiary under her ward's will?

Probably not, assuming no undue influence argument can be made. As guardian, the daughter-in-law may be doing a lot of work for her ward, so it could be reasonable for the ward to add her as a beneficiary in his will. This right was retained by him in the guardianship proceeding. Presumably, because a reputable attorney was involved in this transaction, the attorney would have been sure to discuss the ward's wishes with him and without the guardian present. The fact that there was another competency evaluation performed is extra protection against any potential challenge of the will modification.

An individual's POA-HC was activated, but now his condition has improved. The agent still refuses to allow the principal to make his own medical decisions. What can the principal do?

Section 155.40 (1) of the statutes states that a principal may revoke his or her power of attorney for health care (POA-HC) *at any time*. This means the document can be revoked by the principal after it has been activated. If the principal was still clearly unable to make his own health care decisions, his authority to revoke a POA after incapacity would create problems because a decision-maker is still needed, so a guardian would need to be appointed. However, this principal can terminate the agent's authority immediately by revoking the POA-HC. There are several ways to do this including:

- Burning, writing *void* on each page, or otherwise destroying the POA-HC
- Directing another person to destroy it in the presence of the principal
- Signing a document expressing the principal's intent to revoke the document
- Verbally expressing the principal's intent to revoke the POA-HC document before two witnesses
- Executing a new POA-HC

A document titled, "Revoking a Power of Attorney for Health Care" may be found at:
www.gwaar.org/images/stories/GSC/AD-POAHealthCare/POAHCRevocationPacket.pdf

Any revocation document or new POA-HC should be distributed as needed to doctors and others. Once the document is revoked, the agent loses all authority to make medical decisions on behalf of the ward. ❑