Axley
Axley Brynelson, LLP

MEMORANDUM

TO:	Wisconsin Chapter of the American College of Emergency Physicians
FROM:	Guy DuBeau
DATE:	April 18, 2018
RE:	Act 140 - Emergency Detention Bill

Wisconsin recently enacted Act 140, which seeks to clarify the rights and responsibilities of emergency providers. Unlike many other states, providers in Wisconsin cannot, on their own, initiate emergency detentions of patients. That ability is reserved to law enforcement and county crisis staff. This arrangement has created uncertainties regarding rights, responsibilities and potential liabilities which this Act seeks to address.

The Act accomplishes three major goals toward this end. Specifically, the Act clarifies that providers acting in good faith can seek, without fear of liability, emergency detention even though the process must be formally initiated by law enforcement or county crisis workers. The Act also providers greater control over transfers in that it requires emergency providers to agree that transfer is medically appropriate before the transfer can be made by law enforcement. Lastly, the Act explicitly aligns Wisconsin law with HIPAA by noting that providers may disclose information to third parties in a good faith effort to prevent or lessen a serious and imminent threat to third parties.

It is unfortunately not uncommon for emergency providers to encounter individuals who are emotionally unstable and who are not inclined to take the necessary steps for their own well-being. When this instability appears to rise to the level of a substantial probability of physical harm to the patient or to others and the patient will not consent to evaluation and treatment, emergency detention is warranted. When a provider reaches this belief in good faith, several rights come into effect.

First, any provider acting in good faith can make several types of disclosure without fear of liability. They can contact law enforcement regarding the patient. They can contact the county department they understand to be responsible for initiating emergency detentions regarding the patient. If the provider is also an agent of the county responsible for initiating the emergency detention, they themselves can approve the detention. Lastly, they can take any other action they believe would meet the duty to warn a third person of the substantial probability that the patient

might cause them harm. If the provider does any of these things and the patient is not placed in custody or agrees to voluntary admission, then the provider has no further duty to seek involuntary treatment, emergency detention, emergency stabilization, or commitment, nor is there any duty to physically restrain the patient, prevent the patient from leaving the hospital or administer medication without the patient's consent.

If law enforcement or the county deems the patient is in need of emergency detention, then they must take the next steps to make that happen. It becomes their responsibility to arrange for a mental health provider (psychiatrist, licensed psychologist or other mental health professional) to perform a crisis assessment in order provide such an opinion. This assessment may be performed in person, telephonically, by video conferencing or a telemedicine platform. The emergency provider does not have any responsibility to make this happen, but can veto the transfer of a patient if, in the emergency provider's opinion, is not medically appropriate. In such a case, the provider can administer whatever treatment is needed to stabilize the patient for such transfer.

Additionally, sometimes it may not appear to a mental health professional that the patient meets the criteria for emergency detention. The Act clarifies that this decision is also protected and that the provider would have no liability for proceeding in conformance with that conclusion. In all, this Act provides much greater clarity to the rights and responsibilities of emergency providers and limits the potential for liability for decisions made in good faith.

FAQ's

What do providers need to do to meet the requirements of the new Act? The Act requires that providers act in good faith in making decisions about communicating with authorized initiators of emergency detentions and others who are felt to need to know. Providers can satisfy any obligation to warn a third party by doing one of three things: contacting law enforcement; contacting the county department of health charged with initiating emergency detentions; or taking any other action that is recognized as reasonable to warn a third party. There is nothing that prevents a provider from doing more than one of these things.

Do providers have any liability for releasing protected health information to law enforcement or a county crisis center? No, as long as the disclosures are made in good faith.

What is the good faith exception? Good faith is not explicitly defined by statue but is generally understood to mean a reasonable medical decision arrived at after evaluation of pertinent information. Fortunately, the good faith of a health care provider is legally presumed in this context and someone contending otherwise must effectively prove the absence of good faith by a higher legal burden.

If a patient has overdosed on opiates in order to get "high" as opposed to consciously trying to inflict self-harm, can providers make contact with family members under the Act on the theory that the patient is at substantial future risk of self-harm? The Act provides a potential safe harbor for doing so but the provider would need to be able to articulate their reason for doing so in terms specific to the patient. A good rule of thumb is that if a provider could justify contacting

law enforcement or the county and would expect an emergency detention to ensue, then they may also consider contacting family. This could be couched as a medical decision made in good faith for which there is protection under the Act.

Do providers need to do anything special to make sure they are protected by the Act's immunity provisions? No, but it is always a good idea to clearly document the rationale for any medical decision in the patient's chart and to similarly note the individuals whom they have contacted.

Does this new law create a greater obligation to reach out to law enforcement or the county? No. Under sec. 51.15 (11) any good faith determination that "an individual has or does not have mental illness or evidence or does not evidence a substantial probability of harm (to others)" is not liable for any action taken in good faith." Accordingly, if a provider legitimately concludes that a patient is not in need of emergency detention, then the provider is not liable for that determination. It is always good practice for providers to document their thought process in this regard.

What is the scope of the immunity provided by the Act? The Act uses very broad language to provide this immunity. It notes that a provider "is not liable for any actions taken in good faith" regarding the need for a patient's emergency detention. The Act also makes clear that a provider satisfies his or her duty – a key legal concept – by making at least one of the three notifications noted above. The concepts of "not liable" and the clear articulation of how to satisfy a legal duty, make these strong immunity provisions.

If law enforcement or the county do not place a patient on an emergency detention hold after being contacted by the provider, does the provider have any liability for harm that patient causes? No. Section 51.17(3)(b) makes clear that a provider who contacts law enforcement or the county about a hold "has no further duty to any person to seek involuntary treatment, emergency detention, emergency stabilization, or commitment of the individual; to physically restrain the individual; to prevent the individual from leaving the hospital; or to provide treatment or medication without the individual's consent." Any duty to warn a third person is satisfied by the act of warning law enforcement or the county; this does not prevent a provider from warning a third party directly, but there is no affirmative legal duty to do so.

Do these rules apply only to physicians? No, disclosures can be made by any "health care provider" as that term is defined in statute. This encompasses over 25 licensed providers including physicians, physician assistants, nurses, therapists, ambulance providers, and emergency medical responders to name a few.

Can providers share their concerns with family member? It depends and this will always be a case-by-case evaluation. The law allows providers to take any action they believe a reasonable provider would take to prevent harm to a third person. If a family member is the target of a patient's apparent aggression, then they can certainly be informed. If a family member seems to be the most reasonable option for communicating information to an intended target, then that too would likely be deemed reasonable. If the family member is simply concerned with the patient but not seen as having a special relationship to an intended victim, then normal disclosure rules would apply. Again, providers have the benefit of the good faith presumption in this regard.

What if law enforcement is insistent on removing a patient when the provider feels that doing so is not medically appropriate? First and foremost, the provider should try to work with law enforcement to explain the provider's position. In extreme circumstances, the provider can petition for an emergency hearing in front of a judge to resolve the legal rights governing the patient. It is important to note that law enforcement need only get the opinion of any hospital employee or medical staff member treating the patient to say that transfer is medically appropriate so it is important that all involved in the patient's care are all on the same page on this issue.

If a provider feels involuntary commitment is against the patient's best interests, can they decline to allow the transfer as not being medically appropriate? Maybe, but this would be at most a case by case determination and arguably the provider would not have the right to make that call. Providers cannot initiate an emergency detention nor are they the ones who make the determination that doing so is appropriate. To block a transfer in the situation would require the provider to second guess the mental health professional who made the call. In such a situation, a conversation between the provider and mental health professional would be necessary and if agreement cannot be reached, then court intervention would be necessary.

What if a patient is insistent on leaving the hospital before law enforcement or county agents become involved? The law is written in such a fashion that, as long as the provider has notified law enforcement, the county or an appropriate third party, then the provider has no duty to restrain the patient or prohibit their leaving the hospital.

GJD:dmr

cc: Eric Jensen