05AP3141

STATE OF WISCONSIN
IN SUPREME COURT

In Interest of RUBY WASHINGTON:

CITY OF MILWAUKEE,

Petitioner-Respondent,

v.

Case No. 05AP003141

RUBY WASHINGTON,

Respondent-Appellant-Petitioner.

WIS. STAT. § (RULE) 809.62 REVIEW OF DECISION OF COURT OF APPEALS, AFFIRMING CONFINEMENT ORDER FOR TUBERCULOSIS TREATMENT, ENTERED IN MILWAUKEE COUNTY CIRCUIT COURT (HON. CLARE L. FIORENZA)

BRIEF-IN-CHIEF AND APPENDIX OF RESPONDENT-APPELLANT-PETITIONER

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STATEMENT OF ISSUES

1. The circuit court pursuant to Wis. Stat. § 252.07 ordered Ruby Washington confined to jail for tuberculosis treatment until certified cured, a process that was anticipated to take, and indeed took, approximately nine months. Although the relevant statute requires that "no less restrictive alternative exist," the circuit court refused, because of presumably greater costs, to order confinement to a local hospital where she had recently and successfully received treatment; the issue is:

Whether the "no less restrictive alternative" requirement of Wis. Stat. § 252.07(9)(a)3. applies to the place

and not merely the fact of confinement; and if the former, whether the court may take into account costs in determining which placement is appropriate.

2. The trial court ordered Ruby Washington confined to jail for the purpose of assuring her compliance with prior orders for tuberculosis treatment; in so doing, the trial court explicitly and with the City's express assent invoked its authority under the tuberculosis treatment procedure authorized by Wis. Stat. § 252.07, rather than as an exercise of the court's contempt power. The court of appeals nonetheless upheld confinement as within the trial court's contempt authority; the issue is:

Whether judicial estoppel precludes consideration of contempt as a basis for upholding confinement and, if not, whether the confinement order satisfied the procedural requirements of Wis. Stat. ch. 785 for contempt sanction, given that the confinement order both conditioned Ms. Washington's release from confinement on something outside her own power to control—her certification as cured—, and also clearly exceeded the 6-months' imprisonment maximum for remedial sanction.

POSITION ON ORAL ARGUMENT AND PUBLICATION

Grant of discretionary review itself signifies the importance of the case, hence supports both oral argument and publication; this case is no exception. The issues are precedential—there are no reported cases discussing confinement in jail for the purpose of treating a tuberculosis patient—and sufficiently complex to warrant oral argument.

STATEMENT OF THE CASE

Preliminary Procedure: Issuance of Therapy Orders.

This matter commenced with orders issued by the City of Milwaukee Health Department against Ms. Washington,

for treatment of tuberculosis with directly observed therapy[1] and isolation, effective July 27, 2005. The orders were issued pursuant to the department's authority to control spread of communicable diseases, Wis. Stat. ch. 252. She had been diagnosed with TB on June 17, 2005, but after receiving initial medication failed to appear at scheduled directly observed therapy sessions. She was living in a shelter and presumed to be homeless (3:2-3).

The City subsequently commenced court action to enforce its orders, with a petition (1) filed on August 23, 2005, alleging Ms. Washington's non-compliance. The petition sought a judicial order, pursuant to Wis. Stat. § 252.07(9), that she "remain confined in Aurora Sinai" (the hospital where she was then giving birth) until she was determined to be no longer infectious (1:3).

A hearing on the petition was heard in Milwaukee County circuit court (Hon. Maxine A. White), on August 26, 2005. The parties entered into a stipulated resolution: Ms. Washington would receive in-patient tuberculosis treatment at Aurora Sinai for at least one month; if released, she would strictly adhere to tuberculosis therapy until the disease was completely ameliorated; and, the therapy would be administered under a direct observation modality (21:4-8). It was anticipated that she would live with a sister upon discharge from the hospital (*id.*:9).

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[1] "Directly observed therapy is a compliance enhancing strategy in which each dose of medication is observed by a family member, a peer advocate, a community worker, a health care or public health professional, or by any other responsible person." Lawrence O. Gostin, *The Resurgent Tuberculosis Epidemic in the Era of AIDS: Reflections on Public Health, Law, and Society*, 54 Md. L. Rev. 1, 125 (1995). It is similarly defined under Wis. Admin. Code § HFS 145.08(5): "'Directly observed therapy' means the ingestion of prescribed anti-tuberculosis medication that is observed by a health care worker or other responsible person acting under the authority of the local health department." Precisely because it is compulsory, this form of therapy is regarded as a coercive means of tuberculosis control. Carlos A. Ball and Mark Barnes, *Public health and Individual Rights: Tuberculosis Control and Detention Procedures in New York City*, 12 Yale L. & Policy Rev. 38, 47-48 (1994).

At a review date on September 27, 2005 (Hon. Clare L. Fiorenza), the following was adduced. As anticipated, Ms. Washington's recent samples had proved negative and she therefore was going to be released from the hospital (22:3-4). The parties renewed the previously negotiated agreement—she must remain under the referenced isolation / therapy orders, strictly adhere to the prescribed treatment regimen, and live with her sister (*id.*:4). Upon that stipulation, the trial court ordered Ms. Washington's release from the hospital (*id.*:21) subject to a directly observed therapy order and treatment plan (10).

Confinement Order.

Ms. Washington was released from Aurora Sinai on September 27, 2005, but failed to comply with the treatment conditions. The City filed on September 29, 2006, what it styled a "Motion of Contempt," seeking her confinement in the local jail (13). The motion was accompanied by a procedural motion to "shorten time" within which to hear the contempt motion (11). That same day but before the motion had been heard, local police officers arrested Ms. Washington at the insistence of the Milwaukee Health Department. After a medical evaluation at Aurora-Sinai, she was processed into the jail, where she was held pending a court proceeding on the City's motion.

The motion was then brought before Judge Fiorenza on October 3, 2005, but in the meanwhile the jail had mistakenly released Ms. Washington, so the matter was adjourned. Although the motion referenced "contempt," the City also asserted that "relevant statutes" permit holding a patient up to 72 hours for noncompliance with a directly observed therapy order, "and 72 hours isn't appropriate notice under the local rules for a motion" (23:2-3). The motion invoked no specific statute, but the City obviously relied on Wis. Stat. § 252.07(9)(a), which limits to 72 hours tuberculosis-treatment confinement without court order. The City thus asserted that, when Ms. Washington could be found, the City would then have "sufficient authority" to hold her in the jail for 72 hours, pending a hearing on its motion (23:7).

Ms. Washington was indeed soon found, and Judge Fiorenza conducted a hearing on the motion on October 5. The City sought her confinement "for a minimum of eight to nine months on a continuous basis, on a secure basis until ... she's cured of the disease as certified by the Milwaukee Health Department" (24:9).

The sole witness, a health department tuberculosis control manager, testified that although Ms. Washington had pulmonary tuberculosis (*id.*:11-12), she was not presently thought to be contagious (*id.*:20).[2] Nonetheless, it would take nine months for her to complete her course of treatment, and the health department would not certify her as cured before that period of time had elapsed (*id.*:26-27).

After close of testimony, Ms. Washington's counsel raised the possibility of moving "to dismiss the contempt finding (*sic*) at the end of the State's (*sic*) case" (*id.*:34). The trial court responded by ruling that this proceeding did *not* involve contempt sanction but, rather, a tuberculosis treatment proceeding under § 252.07; *the City expressly agreed* with that characterization (*id.*:34-39).

Ms. Washington did not deny non-compliance, and the sole contested issue thus became where, not whether, she should be confined pursuant to Wis. Stat. § 252.07(9). She had indisputably taken tuberculosis medication daily during her stay at the hospital and her smears were negative (*id.*:20). It is thus equally undisputed that she was fully compliant during her one-month confinement at Aurora Sinai (*id.*:32). She was, that is, non-compliant only after leaving the hospital.

The City sought confinement in jail (*id.*:55), to which Ms. Washington objected as "inappropriate because ... it's designed for people that violated the criminal code" (*id.*:56). Instead, other alternatives should be considered, including the hospital: "the Sinai situation worked." (*id.*:57).

In response, the City asserted that "it would be grossly unfair to the tax payers of this City to require that she be

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[2] Indeed, the authorities were sufficiently certain of her non-infectiousness that they cleared her to "be housed in the jail's general population" at this time (16:1-2).

placed under police guard on a 24/7 basis .... There's no necessity to impose that on our tax payers" (*id.*). The trial court agreed with the City:

> ... With respect to the order (sic) that I place a guard at the hospital and allow her to stay at the hospital for the remainder of her treatment. I refuse to require tax payers to pay 24 hours around the clock guard at her door to make sure she stays put. I don't think that's appropriate. ...

(*Id.*64-65).

The trial court's written order (15) entered at the conclusion of the October 5, 2005, hearing mandated confinement in the Milwaukee County Jail "until further order of this Court." This open-ended duration was consistent with the Wis. Stat. § 252.07(9)(c) requirement that confinement last until treatment is complete or the person no longer a threat to public health. The trial court's oral ruling was to like effect, namely that Ms. Washington remain in jail until certified as cured by the health department (24:65).

The trial court foresaw that confinement would last more than 6 months, and set a review date of April 7, 2006 (24:67-68), consistent with the statutory mandate in § 252.07(9)(c) ("If the individual is to be confined for more than 6 months, the court shall review the confinement every 6 months").[3]

Post-Appeal Procedural Developments.

Because the confinement order was entered pursuant to an exercise of authority under Wis. Stat. § 252.07(9), Ms. Washington's notice of appeal referenced that provision as the basis for the order, and also drew the court of appeals' attention to the § 252.07(9)(e) requirement that the appeal must be heard within 30 days. The Presiding Judge then

[3] As counsel subsequently informed this court, by memorandum dated May 30, 2006, Ms. Washington was released from confinement on May 29, 2006. She argues in § III that this development should not impede review.

issued two procedural orders bearing heavily on the course of this appeal and content of the briefs. By order dated December 27, 2005, the Presiding Judge required briefing on several issues, most pertinently whether "this may be an appeal from what is functionally a contempt order" rather than a § 252.07(9) confinement order.

Ms. Washington responded that the confinement order was entered pursuant to a distinct exercise of § 252.07(9) authority. The City, *despite its prior express agreement in the trial court to that very effect*, now asserted instead that "this proceeding is an appeal from a 'functional,' *de facto* contempt order satisfying the requisites of Wis. Stat. Ch. 785." (*City's Memorandum Responding to Court of Appeals' 12/27/05 Order*, p. 4; *see also id.*, pp. 4-7, developing argument in support of that contention).

The court of appeals (again through the Presiding Judge) ruled that "this is, at base, an appeal from a contempt order" (Order, 1/9/06, p. 2). Although this order had the effect of assigning disposition to a one-judge panel, the appeal was converted to a 3-judge panel, with expedited disposition (*id.*, p.3).[4] See also 2006 WI App 99, ¶9.

Court of Appeals' Opinion (published, 2006 WI App 99).

On appeal, Ms. Washington solely challenged her place (jail, as opposed to hospital) not fact of confinement.

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[4] Ms. Washington sought to have her identity masked, so as to preserve her right to patient confidentiality. The City conceded that much of the documentation in the court file was indeed confidential, but asserted that because the case had been "accorded considerable publicity" her right to confidentiality was no longer significant. Memorandum of Petitioner-Respondent, etc., filed in court of appeals 1/5/06. To emphasize the point, the City attached a copy of a newspaper account which reported the circuit court proceeding and which prominently displayed what it described as a "mug shot" of Ms. Washington. The court of appeals ruled (1/9/06 order, p. 2) "the appeal is not and should not be confidential." Although Ms. Washington respectfully disagrees with that conclusion, any further objection would be futile: revelation of her identity has been full, public and not susceptible to undoing.

She argued that *placement* must be the least restrictive alternative; that Aurora Sinai was indisputably both a suitable placement and also less restrictive than jail; and that the trial court's basis for rejecting hospital placement—fiscal concern—was inadmissible under the statute (Washington's Court of Appeals' Brief-in-Chief, pp. 26-31). The court of appeals rejected this argument, holding that the Wis. Stat. § 252.07(9)(a) confinement requirement of "no less restrictive alternative," applies only to the fact and not the nature (or place) of confinement. 2006 WI App 99, ¶12. Therefore, Ms. Washington could be placed in jail without regard to whether hospitalization was a less restrictive alternative.

The court *also* upheld the confinement as a contempt sanction, *id.*, ¶¶16-20. Judge Kessler dissented on this latter holding, ¶¶25-32.

The opinion will be discussed in more detail below.

This court granted review, Wis. Stat. § (Rule) 809.62, on June 14, 2006.

STATUTE AND CODE CONSTRUED

Wis. Stat. § 252.07 Tuberculosis:

(1g) In this section:

(a) "Infectious tuberculosis" means tuberculosis disease of the respiratory tract, capable of producing infection or disease in others as demonstrated by the presence of acid-fast bacilli in the sputum or bronchial secretions or by chest radiograph and clinical findings.

(b) "Isolate" means a population of mycobacterium tuberculosis bacteria that has been obtained in pure culture medium.

(c) "Isolation" means the separation from other persons of a person with infectious tuberculosis in a place and under conditions that prevent the transmission of the infection.

(d) "Suspect tuberculosis" means an illness marked by symptoms and laboratory tests that may be indicative of

tuberculosis, such as a prolonged cough, prolonged fever, hemoptysis, compatible roentgenographic findings or other appropriate medical imaging findings.

(1m) Infectious tuberculosis and suspect tuberculosis are subject to the reporting requirements specified in s. 252.05. Any laboratory that receives a specimen for tuberculosis testing shall report all positive results obtained by any appropriate procedure, including a procedure performed by an out-of-state laboratory, to the local health officer and to the department.

(1p) Any laboratory that performs primary culture for mycobacteria shall also perform organism identification for mycobacterium tuberculosis complex using an approved rapid testing procedure specified by the department by rule.

(1t) Any laboratory that identifies mycobacterium tuberculosis shall ensure that antimicrobial drug susceptibility tests are performed on the initial isolate. The laboratory shall report the results of these tests to the local health officer and the department.

(2) The department shall identify groups at risk for contracting or transmitting mycobacterium tuberculosis and shall recommend the protocol for screening members of those groups.

(5) Upon report of any person under sub. (1m) or (1t), the local health officer shall at once investigate and make and enforce the necessary orders. If any person does not voluntarily comply with any order made by the local health officer with respect to that person, the local health officer or the department may order a medical evaluation, directly observed therapy or home isolation of that person.

(8)

(a) The department or a local health officer may order the confinement to a facility of an individual who has a confirmed diagnosis of infectious tuberculosis or suspect tuberculosis if all of the following conditions are met:

1. The department or local health officer notifies a court in writing of the confinement.

2. The department or local health officer provides to the court a written statement from a physician that the individual has infectious tuberculosis or suspect tuberculosis.

3. The department or local health officer provides to the court evidence that the individual has refused to follow a prescribed treatment regimen or, in the case of an individual with suspect tuberculosis, has refused to undergo a medical examination to confirm whether the individual has infectious tuberculosis.

4. In the case of an individual with a confirmed diagnosis of infectious tuberculosis, the department or local health officer determines that the individual poses an imminent and substantial threat to himself or herself or to the public health. The department or local health officer shall provide to the court a written statement of that determination.

(b) If the department or local health officer orders the confinement of an individual under this subsection, a law enforcement officer, or other person authorized by the local public health officer, shall transport the individual, if necessary, to a facility that the department or local health officer determines will meet the individual's need for medical evaluation, isolation and treatment.

(c) No individual may be confined under this subsection for more than 72 hours, excluding Saturdays, Sundays and legal holidays, without a court hearing under sub. (9) to determine whether the confinement should continue.

(9)

(a) The department or a local health officer may petition any court for a hearing to determine whether an individual with infectious or suspect tuberculosis should be confined for longer than 72 hours in a facility where proper care and treatment will be provided and spread of the disease will be prevented. The department or local health officer shall include in the petition documentation that demonstrates all of the following:

1. That the individual named in the petition has infectious tuberculosis; that the individual has

noninfectious tuberculosis but is at high risk of developing infectious tuberculosis; or that the individual has suspect tuberculosis.

2. That the individual has failed to comply with the prescribed treatment regimen or with any rules promulgated by the department under sub. (11); or that the disease is resistant to the medication prescribed to the individual.

3. That all other reasonable means of achieving voluntary compliance with treatment have been exhausted and no less restrictive alternative exists; or that no other medication to treat the resistant disease is available.

4. That the individual poses an imminent and substantial threat to himself or herself or to the public health.

(b) The department or local health officer shall give the individual written notice of a hearing at least 48 hours before a scheduled hearing is to be held. Notice of the hearing shall include all of the following information:

1. The date, time and place of the hearing.

2. The grounds, and underlying facts, upon which confinement of the individual is being sought.

3. An explanation of the individual's rights specified under par. (d).

4. The proposed actions to be taken and the reasons for each action.

(c) If the court orders confinement of an individual under this subsection, the individual shall remain confined until the department or local health officer, with the concurrence of a treating physician, determines that treatment is complete or that the individual is no longer a substantial threat to himself or herself or to the public health. If the individual is to be confined for more than 6 months, the court shall review the confinement every 6 months.

(d) An individual who is the subject of a petition for a hearing under this subsection has the right to appear at the hearing, the right to present evidence and cross-

examine witnesses and the right to be represented by adversary counsel. At the time of the filing of the petition the court shall assure that the individual who is the subject of the petition is represented by adversary counsel. If the individual claims or appears to be indigent, the court shall refer the individual to the authority for indigency determinations specified under s. 977.07 (1). If the individual is a child, the court shall refer that child to the state public defender who shall appoint counsel for the child without a determination of indigency, as provided in s. 48.23 (4). Unless good cause is shown, a hearing under this subsection may be conducted by telephone or live audiovisual means, if available.

(e) An order issued by the court under this subsection may be appealed as a matter of right. An appeal shall be heard within 30 days after the appeal is filed. An appeal does not stay the order.

(10) Inpatient care for isolated pulmonary tuberculosis patients, and inpatient care exceeding 30 days for other pulmonary tuberculosis patients, who are not eligible for federal medicare benefits, for medical assistance under subch. IV of ch. 49 or for health care services funded by a relief block grant under subch. II of ch. 49 may be reimbursed if provided by a facility contracted by the department. If the patient has private health insurance, the state shall pay the difference between health insurance payments and total charges.

(11) The department may promulgate any rules necessary for the administration and enforcement of this section, including, if necessary to prevent or control the transmission of mycobacterium tuberculosis, rules that require screening of members of specific groups that are at risk for contracting or transmitting mycobacterium tuberculosis.

Wis. Admin. Code § HFS 145.06 General statement of powers for control of communicable disease:

...

(4) AUTHORITY TO CONTROL COMMUNICABLE DISEASES. When it comes to the attention of an official empowered under s. 250.02 (1), 250.04 (1) or 252.02 (4) and (6), Stats., or under s. 252.03 (1) and (2),

Stats., that a person is known to have or is suspected of having a contagious medical condition which poses a threat to others, the official may direct that person to comply with any of the following, singly or in combination, as appropriate:

...

(g) Be placed in an appropriate institutional treatment facility until the person has become noninfectious.

(5) FAILURE TO COMPLY WITH DIRECTIVE. When a person fails to comply with a directive under sub. (4), the official who issued the directive may petition a court of record to order the person to comply. In petitioning a court under this subsection, the petitioner shall ensure all of the following:

(a) That the petition is supported by clear and convincing evidence of the allegation.

(b) That the respondent has been given the directive in writing, including the evidence that supports the allegation, and has been afforded the opportunity to seek counsel.

(c) That the remedy proposed is the least restrictive on the respondent which would serve to correct the situation and to protect the public's health.

...

SUBCHAPTER II TUBERCULOSIS

HFS 145.08 Definitions. In this subchapter:

(2) "Confinement" means the restriction of a person with tuberculosis to a specified place in order to prevent the transmission of the disease to others, to prevent the development of drug-resistant organisms or to ensure that the person receives a complete course of treatment.

...

HFS 145.10 Restriction and management of patients and contacts:

(6) The local health officer or the department may do any of the following:

(a) Order a medical evaluation of a person.

(b) Require a person to receive directly observed therapy.

(c) Require a person to be isolated under ss. 252.06 and 252.07 (5), Stats.

(d) Order the confinement of a person if the local health officer or the department decides that confinement is necessary and all of the following conditions are met:

1. The department or local health officer notifies a court in writing of the confinement.

2. The department or local health officer provides to the court a written statement from a physician that the person has infectious tuberculosis or suspected tuberculosis.

3. The department or local health officer provides to the court evidence that the person has refused to follow a prescribed treatment regimen or, in the case of a person with suspected tuberculosis, has refused to undergo a medical examination under par. (a) to confirm whether the person has infectious tuberculosis.

4. In the case of a person with a confirmed diagnosis of infectious tuberculosis, the department or local health officer determines that the person poses an imminent and substantial threat to himself or herself or to the public health. The department or the local health officer shall provide to the court a written statement of that determination.

(e) If the department or local health officer orders the confinement of a person under par. (d), a law enforcement officer, or other person authorized by the local public health officer, shall transport the person, if necessary, to a location that the department or local health officer determines will meet the person's need for medical evaluation, isolation and treatment.

(f) No person may be confined under par. (d) for more than 72 hours, excluding Saturdays, Sundays and legal holidays, without a court hearing under sub. (7) to determine whether the confinement should continue.

(7)

(a) If the department or a local health officer wishes to confine a person for more than 72 hours, the department or a local health officer may petition any court for a hearing to determine whether a person with infectious or suspected tuberculosis should be confined for longer than 72 hours. The department or local health officer shall include in the petition documentation that demonstrates all the following:

1. The person named in the petition has infectious tuberculosis; the person has noninfectious tuberculosis but is at high risk of developing infectious tuberculosis; or that the person has suspected tuberculosis.

2. The person has failed to comply with the prescribed treatment regimen or with any rules promulgated by the department under s. 252.07 (11), Stats.; or that the disease is resistant to the medication prescribed to the person.

3. All other reasonable means of achieving voluntary compliance with treatment have been exhausted and no less restrictive alternative exists; or that no other medication to treat the resistant disease is available.

4. The person poses an imminent and substantial threat to himself or herself or to the public health.

(b) If the department or a local health officer petitions the court for a hearing under par. (a), the department or local health officer shall provide the person who is the subject of the petition written notice of a hearing at least 48 hours before a scheduled hearing is to be held. Notice of the hearing shall include all the following information:

1. The date, time and place of the hearing.

2. The grounds, and underlying facts, upon which confinement of the person is being sought.

3. An explanation of the person's rights under sub. (8).

4. The proposed actions to be taken and the

reasons for each action.

SUMMARY OF ARGUMENT

The tuberculosis control regime, Wis. Stat. § 252.07, does not support jail as a "facility" to which a patient may be confined for treatment. Even if it did, jail would not be a suitable placement alternative in this instance because hospital confinement was available as a less restrictive alternative. The tuberculosis commitment statute, Wis. Stat. § 252.07 permits a patient to be "confined" in a "facility," for purposes of treatment, if "no less restrictive alternative exists." The most natural textual reading of this requirement is that there be "no less restrictive alternative" to the *place* and not merely the fact of confinement. Moreover, a contrary reading would result in an abdication of judicial oversight and open the statute to constitutional attack on various grounds, including due process and equal protection. The trial court ordered that Ms. Washington be confined to the local jail in preference to the indisputably suitable, less restrictive alternative of a hospital, due to presumed greater taxpayer costs. Because the statute does not permit consideration of placement costs to affect determination of the "least restrictive alternative," the trial court erred as a matter of law.

The court of appeals' separate holding—that the confinement order was sustainable as a remedial contempt sanction—should not be reached under the doctrine of judicial estoppel. In the trial court, the City expressly grounded its request for confinement on Wis. Stat. § 252.07 and expressly disavowed reliance on a theory of contempt; the trial court, in reliance on the City's assertion, entered the appealed order under § 252.07 rather than a contempt sanction. The City's argument on appeal that the order should be upheld as a contempt sanction is therefore a classic example of judicial estoppel. On the merits, the order confining Ms. Washington in jail until certified healthy was clearly defective as a remedial contempt sanction because: remedial contempt requires that satisfaction of the condition for release be within the contemnor's control and Ms. Washington did not have it

within her power to certify herself cured; and also because the duration of confinement in jail exceeded the permissible maximum for remedial contempt.

ARGUMENT

I. ALTHOUGH THE TUBERCULOSIS CONTROL REGIME PERMITS A PATIENT'S "CONFINEMENT" FOR COMPULSORY TREATMENT, JAIL IS NOT AN AUTHORIZED PLACEMENT OPTION; BUT EVEN IF JAIL PLACEMENT WERE PERMISSIBLE, THE STATUTORY SCHEME REQUIRES THAT THERE BE NO LESS RESTRICTIVE PLACEMENT ALTERNATIVE AND IN THIS INSTANCE SUCH AN ALTERNATIVE (CONFINEMENT IN A HOSPITAL) INDISPUTABLY EXISTED.

A. Standard of review: the issue presents questions of law regarding statutory construction, and is therefore reviewed non-deferentially; a statute must be construed with due regard for its entire context, taking into account related statutes, so that proper meaning may be assigned each term within the statute.

Statutory construction lies at the heart of this litigation; review is therefore non-deferential. ***Village of Cross Plains v. Haanstad***, 2006 WI 16, ¶9, 709 N.W.2d 447 ("Statutory interpretation is a question of law reviewed de novo"). In addition, the operative facts are undisputed, and the application of a given set of facts to the appropriate legal standard is a question of law reviewed independently. ***State v. Trochinski***, 2002 WI 56, ¶16, 253 Wis.2d 38, 644 N.W.2d 891.

Statutory construction focuses primarily on the language of the statute which, if plain in meaning, ordinarily stops the inquiry. ***State ex. rel Kalal v. Circuit Court for***

Dane County, 2004 WI 58, ¶¶44-45, 271 Wis. 2d 633, 681 N.W.2d 110. Statutory text must be placed in its proper context, so as to give meaning to each term. ***State v. Morford***, 2004 WI 5, ¶21, 268 Wis.2d 300, 674 N.W.2d 349 (footnotes omitted):

> Our goal in interpreting statutes is to discern and give effect to the intent of the legislature. Statutory interpretation begins with the language of the statute. Each word should be looked at so as not to render any portion of the statute superfluous. But "courts must not look at a single, isolated sentence or portion of a sentence" instead of the relevant language of the entire statute. Furthermore, a statutory provision must be read in the context of the whole statute to avoid an unreasonable or absurd interpretation. ...

Accord, ***Kalal***, ¶46:

> Context is important to meaning. So, too, is the structure of the statute in which the operative language appears. Therefore, statutory language is interpreted in the context in which it is used; not in isolation but as part of a whole; in relation to the language of surrounding or closely-related statutes; and reasonably, to avoid absurd or unreasonable results. ...

B. Overview of tuberculosis control: Delegation of broad discretion to health bureaucracy but subject to judicial scrutiny.

Given the absence of prior judicial construction, a brief overview of the legislative and administrative scheme for tuberculosis control in this state will be beneficial.

Wisconsin Statute ch. 252 and Administrative Code ch. HFS 145 assign responsibility to the local health officer for investigating and controlling communicable diseases such as TB. When someone is suspected of having a communicable disease, the local health officer is generally empowered "to direct that person to comply with" certain treatment modalities, ranging from counseling to isolation to placement "in an appropriate treatment facility until the person has become noninfectious." Administrative Code § HFS

145.06(4). If the patient fails to comply with any such directive the health officer may petition a court for a compliance order. *Id.*, § 145.06(5). The official must show, among other things, "(t)hat the remedy proposed is the least restrictive on the respondent which would serve to correct the situation and to protect the public's health." *Id.*

The foregoing controls apply generally to *all* communicable diseases, which of course includes TB. Nonetheless, there are specific tuberculosis controls, spelled out in Wis. Stat. § 252.07 and Wis. Admin. Code §§ HFS 145.08-.13. Upon a reported TB case, the local health officer may order: a medical evaluation; directly observed therapy; isolation; or confinement. *All* of these modalities are coercive, but in a graded sense: the idea is to gradually increase compulsion to ensure treatment compliance. The health bureaucracy toolbox thus contains a treatment ratchet, turned stop by stop. See, e.g., Richard J. Coker, *From Chaos to Coercion: Detention and the Control of Tuberculosis* (2000), p. 109 (Center for Disease Control advocates step by step interventions, beginning with directly observed therapy and proceeding finally to detention).

Intrusive health interventions have long been deemed constitutional exercises under a police power theory, see, e.g., ***Jacobsen v. Massachusetts***, 197 U.S. 11 (1905), but it is not to be doubted that the exercise of such extraordinarily intrusive power is subject to very careful limitations—something the judiciary is responsible for monitoring. The Wisconsin scheme, to be sure, appears to grant health officials unfettered discretion to order not only directly observed therapy, but also isolation and even confinement for 72 hours (or longer, if a weekend or holiday intervenes). But lengthier detention requires judicial approval. Thus, where confinement has been bureaucratically ordered, there must be a judicial hearing at which the patient has specified rights and the health officer must make various showings, most pertinently that voluntary compliance has been found wanting and that "no less restrictive alternative exists," Wis. Stat. § 252.07(9)(a)3.

The Wisconsin approach thus contains "features of both an administrative/public health model and a judicial/due

process model," *Symposium on Tuberculosis: Legislative Reform of Washington's Tuberculosis Law: The Tension Between Due Process and Protecting Public Health*, 71 Wash. L. Rev. 989, 1003 (1996). That is, the health bureaucracy has broad authority to issue and enforce public health orders including detention, and the judiciary in turn requires that such orders be justified at due process hearings. *Id.* The question presented by this appeal is whether the health bureaucracy can throw a non-compliant patient in jail; and, if so, whether jail-confinement is permissible when treatment can be accomplished equally in the less restrictive environment of a hospital.

C. *The plain text of Wis. Stat. § 252.07 does not authorize confinement in jail for TB treatment.*

1. The absence of express statutory authorization precludes confinement in jail for treatment purposes.

A patient may be confined "in a facility," § 252.07(9). Ms. Washington conceded below that jail qualified as a "facility." That concession was hasty, and she withdraws it.

Despite the absence of express statutory authorization to confine a tuberculosis patient in jail for treatment, the court of appeals suggested that absence of an explicit bar makes jail a permissible placement option. 2006 WI App 99, ¶12. However, the question is more properly why jail *should* be an option in the absence of express authorization. See Lawrence O. Gostin, *The Resurgent Tuberculosis Epidemic in the Era of AIDS: Reflections on Public Health, Law, and Society*, 54 Md. L. Rev. 1, 120-21 (1995), footnotes omitted):

> Confinement for the purpose of tuberculosis treatment is ostensibly nonpunitive, because the government's interest is in protecting the public health and, in most cases, the person confined has not been convicted of a criminal offense. Accordingly, the place and conditions of confinement are a relevant concern in examining the lawfulness of detention. Even in early public health cases that adopted a deferential approach

> to the review of compulsory public health measures, courts would not tolerate the use of jails or other punitive or unhealthy settings for isolation. These courts reasoned that persons who were civilly confined for treatment should neither suffer the stigma associated with the criminal justice system, nor face additional health risks.

See also *id.*, n. 703 ("*See* ***Benton v. Reid***, 231 F.2d 780, 782 (D.C. Cir. 1956) ('In the absence of specific language, we cannot lightly infer that Congress intended that a person like appellant, neither indicted for nor convicted of any crime, is to be confined in a penal institution to suffer the social stigma and bad associations resulting therefrom.'); ***State v. Snow***, 324 S.W.2d 532, 534 (Ark. 1959) (stating that the Arkansas statute addressing the isolation of recalcitrant tuberculosis patients 'is not a penal statute, but it is to be strictly construed to protect the rights of the citizen')").[5]

Note, too, the extraordinary power granted a health official, namely to order a patient's confinement for 72 hours or more without prior judicial approval, see generally Wis. Stat. § 252.07(8). It is hard to imagine that the legislature intended that a *health official* could throw a person into jail at all, let alone for a substantial period of time, without some express grant of authority.

Various provisions are irreconcilable with the idea of jail-confinement for TB treatment. Thus, a health official has express statutory authority to order "the removal of the person [in jail with a dangerous disease] to a hospital or other place of safety" for treatment, Wis. Stat. § 252.06(6)(a), yet no statute specifically allows a health officer to put someone *in* jail. Specific authority to remove a diseased person from,

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[5] Nor is incarceratiion necessarily good policy. Nationally, the rate of tuberculosis in correctional facilities is over three times the rate among the general population, Gostin, 54 Md. L. Rev. at 51. The risk of *increased* transmission of the disease in a highly congregate setting such as a local jail, especially one as overcrowded as Milwaukee's, makes such placement inapt at least as a matter of policy, *see generally id.*, pp. 50-54. Moreover, "there are strong ethical ... objections" to incarcerating TB patients. Tom Oscherwitz, et. al., *Detention of Persistently Nonadherent Patients with Tuberculosis*, 278 JAMA 846 (1997).

without correspondingly express authority to place a diseased person in, jail very strongly indicates intent to withhold authorization to confine a person in jail for treatment of a disease.

Similarly, the sheriff is responsible for medical and hospital care, Wis. Stat. § 302.336(2), and when a prisoner "needs medical or hospital care" the sheriff "may transfer the prisoner to a hospital," Wis. Stat. § 302.38(1). However, the sheriff (or superintendent) is not required "to provide or arrange for the provision of appropriate care or treatment if the prisoner refuses appropriate care or treatment," Wis. Stat. § 302.38(5). It would be nonsensical to authorize a patient's confinement to jail in order to compel treatment while at the same time withholding any obligation to provide treatment merely because the patient refuses it. Jail is simply not intended for compulsory treatment.

2. If construed to allow jail confinement, the TB control regime as written would plainly violate the fourth amendment.

Placement in jail is also antithetical to the fourth amendment requirement of judicial determination of probable cause within 48 hours of warrantless arrest. *See, generally,* ***County of Riverside v. McLaughlin***, 500 U.S. 44 (1991); ***State v. Koch***, 175 Wis. 2d 684, 696, 499 N.W.2d 152 (1993) ("We conclude that the ***Riverside*** 48-hour rule is applicable in Wisconsin. The Fourth Amendment requires that a judicial determination of probable cause be made within 48 hours of a warrantless arrest." Footnote omitted.).

Ms. Washington was arrested by the police without a warrant and incarcerated. Her "mug shot" was publicly disseminated for all to see (p. 7, fn. 4, above). She was placed in the jail's general population. If her situation was different from any garden variety criminal's it is hard to see how. She was handled like, and her fourth amendment rights were surely no less viable, than a common criminal's.

Under ***Riverside***, Ms. Washington ought to have been entitled to judicial review *within 48 hours*. Yet, the tuberculosis commitment scheme allows *pre-hearing* confinement for *at least* 72 hours, more if Saturdays, Sundays and legal holidays intervene, Wis. Stat., § 252.07(8)(c). This would violate the fourth amendment, as explicated by ***Riverside*** and ***Koch***—*if* the statutory scheme allows incarceration. On the other hand, if this court construes the statute to *disallow* incarceration in jail as a means of coercing TB treatment then ***Riverside*** simply is not implicated, and the statute not open to fourth amendment attack.[6]

3. Absurd results would flow from jail-confinement, namely incarceration of non-medicable patients and also patients with sexually transmitted diseases.

As suggested above, an integral purpose of plain-meaning analysis is avoidance of absurd results. Consider, then, this absurd result from construing the treatment scheme to allow jail confinement: a perfectly compliant but untreatable patient would be subject to indefinite incarceration. A patient is subject to confinement if her "disease is resistant to the medication prescribed" and "no other medication to treat the resistant disease is available." Wisconsin Statute §§ 252.07(9)(a)3. and 4. There is no requirement of non-compliance, only non-amenability to cure. It is inconceivable that the legislature intended to incarcerate a sick individual simply because she is presently beyond cure, but if jail is available to confine the non-compliant then it must also be available to warehouse the untreatable. And, is a drug-resistant patient to be kept in jail forever? The court of appeals suggested, firstly, that that would indeed be the case,

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[6] Whether the *entire* TB commitment scheme is subject to attack for denying the panoply of criminal procedural rights is something else, and is not raised by this appeal. The intent of the commitment scheme is undoubtedly civil, but the effect is surely punitive if Ms. Washington's experience is any guide (at least as ratified by the court of appeals). *See, generally,* ***State v. Rachel***, 2002 WI 81, 254 Wis. 2d 215, 647 N.W.2d 762, for discussion of intents-effect test for determining when putatively civil scheme imposes punitive sanction.

2006 WI App 99, ¶19 ("If, as she posits without support in the Record, she can never be assured of a cure, the remedy is not, of course, permitting her to roam our community with the real danger that she would make others very sick"). The court secondly indicated that it would not entertain such a possibility, however, because it was "grotesque" or "fanciful," *id.*). True, in the event, Ms. Washington did not prove multi-drug resistant. Yet, the phenomenon is quite real, and of on-going concern to the public health establishment. Gostin, 54 Md. L. Rev. at 15-17. Certainly, it would work an absurd statutory result to say that a patient can be jailed *indefinitely* because her condition resists treatment, yet that is the implication of the holding.

That is hardly the only absurd result. "Any court of record may commit a person with a sexually transmitted disease to any institution ...," Wis. Stat. § 252.11(5). If a jail may be deemed a "facility" for tuberculosis treatment purposes, then surely a jail may be considered an "institution" for treating a sexually transmitted disease. It is not remotely possible that the legislature intended to jail someone in order to treat his or her STD.

The balance of this argument assumes that confinement in jail is a viable option for TB treatment purposes. However, should this court rule otherwise, then the challenged confinement will not be valid for that reason alone and it will not be necessary to reach the issues discussed below.

D. *Even if permissible as a placement option, jail may not be utilized where some less restrictive alternative is available: Read as a whole, the plain text of the tuberculosis control regime requires that* placement *under a confinement order be the "(least) restrictive alternative available."*

The court of appeals' construction is discussed first. The court read § 252.07(9) to state that "(c)onfinement may not be ordered unless there is 'no less restrictive alternative'

to confinement," 2006 WI App 99, ¶12, emphasis supplied. The court reasoned that because subsec. (9)(a)3. "does not reference the *nature* of the place of confinement," the legislature did not intend "to engraft 'a least restrictive facility' dictate," *id.*, emphasis in original. Ms. Washington respectfully disagrees with this analysis.

As explained above, normative rules of construction require viewing a statutory scheme contextually and as a whole, which in this instance includes relevant Administrative Code provisions promulgated pursuant to Wis. Stat. § 252.07(11). The same principles of statutory construction apply to construction of the Code. ***State ex rel. v. Smith***, 2004 WI 36, ¶19, 270 Wis. 2d 235, 677 N.W.2d 259 ("When interpreting an administrative regulation, we generally use the same rule of interpretation as applicable to statutes").

The Code defines "confinement" to mean "the *restriction* of a person with tuberculosis *to a specified place*," Wis. Admin. Code § HFS 145.08(2), emphasis supplied. This language is clear on its face, and conclusively indicates that when a health official petitions a court for a confinement order, the official is not seeking confinement in some detached or abstract sense, but in the very concrete sense of the patient's "restriction to a specified place."

Similarly, Wis. Admin. Code § HFS 145.06(5) requires a showing "(t)hat the remedy proposed is the least restrictive on the respondent which would serve to correct the situation and to protect the public's health." In other words, when confinement is sought, the remedy proposed is restriction to a specified place and *it* must be "the least restrictive" alternative.

Analysis of § 252.07 itself must keep the foregoing provisions in mind. Ms. Washington begins with § 252.07(8), which commences the confinement process. Subsection (8)(a) grants authority to health officials to order a TB patient's "confinement to a facility." If there is any doubt about the implication, it is resolved by the Code definition of "confinement," discussed above: *the health official orders the patient's restriction to a specified place.* This action is

accompanied by written notice to a court of "*the* confinement" (emphasis supplied), which in light of the foregoing definition means the health officer notifies a court of the restriction to a specified place. If the patient is to be held more than 72 hours, there must be "a court hearing under sub. (9) to determine whether *the confinement should continue*," subsec. (8)(c), emphasis supplied.

In other words, much has occurred *before* the § 252.07(9) hearing. The patient has *already* been confined to a *specified* facility, the court has been notified of *that* placement, and the petitioner (the City in this instance) seeks to *continue* the specified restriction. The "less restrictive alternative" language naturally, necessarily and grammatically refers to the overarching issue of confinement in a specified, and therefore *identified*, "facility."

Thus, contrary to the court of appeals, at issue is not simply the fact but also the place of confinement. The executive branch, through the department or local health officer, orders temporary confinement to a specified place and the judicial branch determines whether that confinement should be continued.

Consider again the court of appeals' embellishment of the statutory language: "(c)onfinement may not be ordered unless there is 'no less restrictive alternative' *to confinement*," 2006 WI App 99, ¶12. However, fealty to the actual statutory and regulatory text would produce this more accurate rendering: "... unless there is 'no less restrictive alternative' to *continuing already-ordered restriction to a specified place*."

Contextual reading of the entire scheme is not the only basis for such a construction. By detaching "no less restrictive alternative" from the *nature of placement*, 2006 WI App 99, ¶12, the court effectively read out of the statute the express requirement that confinement "should be in a facility where proper care and treatment will be provided," Wis. Stat. § 252.07(9)(a). If, as the court of appeals says, placement is not before the TB commitment court then neither is the seeming requirement of a "proper facility." That can not be right, and

indeed it is not. Rather, it is an absurd result of the court of appeals' construction and thus another compelling indication that the "no less restrictive alternative" phrase refers to the place and not merely the fact of confinement.

Relatedly: the thrust of the holding, that the circuit court only orders *confinement* generally, not specified placement, necessarily means that once the court authorizes confinement the health bureaucracy has unfettered, unreviewable discretion to place the patient where it chooses. In Ms. Washington's instance the City explicitly sought and received approval to continue her placement in jail; but under the holding, there is nothing to prevent the City from obtaining judicial ratification of a "confinement" order and then simply putting the patient in jail or wherever else it chose, *without judicial oversight*. Nothing in the language or structure of the statute suggests in the remotest way that the legislature intended either to grant such essentially dictatorial power to the health bureaucracy or to eliminate judicial oversight of the former's discretion.

E. Extrinsic analysis bolsters the view that a least restrictive analysis applies to place and not merely fact of confinement.

1. Statutory history.

To the extent that the statutory scheme is ambiguous this court may, of course, consider ancillary sources such as legislative history. Sections 252.07(8) and (9) were promulgated as part of the 1999 Wis Act 9 budget bill. Relevant Legislative Reference Bureau analysis (see A-Ap. 157) merely elaborates the obvious: "Makes several changes to the public health laws relating to tuberculosis, including: ... Authorizing DHFS or a local health officer to order an individual with tuberculosis or a suspected case of tuberculosis to confinement in a facility for no more than 72 hours if certain conditions are met and creating a process by which a person with infectious tuberculosis or with a

suspected case of tuberculosis may be confined for more than 72 hours."

The initial drafting request (see A-Ap. 156) is similarly terse. If nothing else, though, it is noteworthy for what it does not say: it does not, for example, suggest any intent to detain a patient in jail; nor does it suggest that "least restrictive alternative" applies to "confinement" alone as opposed to place of confinement.

The prior regime authorized commitment "to a place that will provide proper care," Wis. Stat. § 252.07(4) (1997-98). Counties were at that time authorized to establish TB sanitariums, Wis. Stat. § 252.073 (1997-98), and hospitals could be certified as acute TB treatment centers, Wis. Stat. § 252.08 (1997-98); those provisions were repealed under 1999 Wis Act 9, with the result that funding for dedicated TB treatment centers was abolished.

The current scheme, among other things, substitutes "facility" for "place" and "confinement" for "commitment." These changes appear to be rhetorical rather than substantive. Nothing in the prior version remotely suggested that a patient's "place" of "commitment" could be jail.

That aside, the new procedure is certainly different, and was obviously intended to modernize the tuberculosis commitment process, which theretofore simply stated that "(a)ny court of record may commit a person infected with" TB to a place where proper treatment would be afforded, Wis. Stat. § 252.07(4) (1997-98). This prior, essentially standardless procedure for interfering with liberty interests would not have withstood judicial scrutiny.

The narrow question is whether less restrictive alternative *place of confinement* is one of these rights added by the 1999 revision. Ms. Washington discusses the constitutional implications in the succeeding subsections. But a bit of historical context may first be useful.

At one time, "the disease (TB) was endemic.... The poor were carried off by it in their millions." Richard J. Coker, *From Chaos to Coercion: Detention and the Control of Tuberculosis* (2000), p. 5. Thus arose what might be termed

the sanitarium era (isolation and detention); at its peak nationally in 1954, there were 120,000 TB sanitarium beds. Barron H. Lerner, *Contagion and Confinement: Controlling Tuberculosis along the Skid Row* (1998), p. 56. That changed, whether due to improved microbial treatment or social conditions. *See* Gostin, 54 Md. L. Rev. at 36-37. The Center for Disease Control now strongly urges step by step interventions, beginning with directly observed therapy, and ending with detention. *Coker*, p. 109. (As indicated in the Overview above, Wisconsin's TB control regime follows this model.)

We came to have, in brief, much less need for sanitariums, as reflected by current data compiled by the Department of Health and Family Services. From 2001 to 2005, the number of reported active TB cases declined statewide from 86 to 78 (disproportionately originating in Dane and Milwaukee counties, which together account for more than half the cases statewide), http://www.dhfs.state.wi.us/tb/pdf/tbcht05.pdf. Although this number is well above the elimination goal of 1 case per million, http://www.dhfs.state.wi.us/tb/pdf/TBQuickFacts.pdf, it is also probably well below the number needed to justify the expense of sanitariums dedicated to that purpose.

A graduated scheme of coercive intervention seems to be the most cost-effective mechanism for delivering treatment. Intrinsic to such a scheme is the concept of least restrictive alternative; engrafting this concept into the placement decision is perfectly consistent with the overall thrust of the scheme.

Ms. Washington undertakes discussion immediately below of the impact of several distinct theories on least restrictive placement. They each support a least restrictive placement requirement regardless of the statutory text, but they may also be taken as aids to statutory construction and thus are included in this section.

2. Due process.

"No less restrictive alternative" phraseology is not unknown to caselaw. See, e.g., ***Shelton v. Tucker***, 364 U.S.

479, 488 (1960) (breadth of "legitimate and substantial" governmental purpose trenching on "fundamental liberties ... must be viewed in the light of less drastic means for achieving the same basic purpose") for a succinct articulation of the doctrine. The phrase is found most prominently in ***Lessard v. Schmidt***, 349 F. Supp. 1078, 1096 (E.D. Wis. 1972) (mentally ill "cannot be totally deprived of their liberty if there are less drastic means for achieving the same basic goal"), *subsequent procedural history omitted*, a mental health commitment case which was eventually codified in such statutes as Wis. Stat. § 51.001 ("It is the policy of the state to ... assure all people in need of care access to the least restrictive treatment alternative appropriate to their needs"). Involuntary mental health treatment is "(t)he closest legal analogy" to involuntary TB treatment, ***Newark v. J.S.***, 279 N.J. Super 178, 652 A.2d 265, 276 (N.J. Super. Law Div. 1993), quoting with approval Annas, *Control of Tuberculosis – The Law and the Public's Health*, 328 New Eng. J. of Med. 585, 586 (1993). *Accord*, ***Greene v. Edwards***, 164 W. Va. 326, 263 S.E.2d 661, 663 (1980) (tuberculosis control and mental commitment "have like rationales"; moreover, involuntary commitment for tuberculosis treatment impinges on right to liberty, therefore, mental health commitment procedural safeguards apply to tuberculosis treatment); Carlos A. Ball and Mark Barnes, *Public health and Individual Rights: Tuberculosis Control and Detention Procedures in New York City*, 12 Yale L. & Policy Rev. 38, 51-52 (1994) (because of dearth of TB detention caselaw, guidance should be sought in developed body of mental commitment caselaw); Gostin, 54 Md. L. Rev., pp. 114-15 ("confinement of persons with mental illness under civil commitment provides an apt analogy to tuberculosis detention").

As with mental health commitment, so too with TB commitment: "The terms of confinement must minimize the infringements on liberty and enhance autonomy. ... Lesser forms of restraint must be used when they would suffice to fulfill government interests." ***J.S.***, 652 A.2d at 272, cites omitted. Thus, the following "axiom of due process" applies equally to involuntary TB treatment: "Even though the

governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgement must be viewed in the light of less drastic means for achieving the same basic purpose." ***J.S.***, *id.*, citation omitted.

Indeed, at the time our current TB control regime was enacted, "the phrase 'least restrictive alternative' (LRA) ha(d) been an essential element of mental disability law" for a quarter-century. Michael L. Perlin, *Health Care and the Americans with Disability Act*, 37 Hous. L. Rev. 99, 100 (2000). Included in the LRA concept was the idea that restriction on the patient was permissible only to the extent necessary. *Id.*, fn. 6.

The legislature undoubtedly had in mind these broader (and, more importantly, *settled*) principles when it used the phrase, "no less restrictive alternative" in § 252.07(9)(a)4. The court of appeals' citation (2006 WI App 99, ¶12) to certain provisions in ch. 51 linking "least restrictive" to "facility," as evincing legislative intent to impose such a requirement only when expressing an explicit linkage, is arbitrary. The fact is that "least restrictive" appears numerous times in different contexts within ch. 51, but the most significant usage is the statement of policy in § 51.001 quoted above which makes it clear that this phrase embodies a *general* principle. Usage of that phrase in relation to "facility" is simply a particular expression of the overarching principle. By contrast, "no less restrictive" is used but once with regard to TB commitment procedure, and it stands to reason that, as with ch. 51, the legislature intended an overarching purpose, not a narrowly concrete one.

3. Equal protection.

As the court of appeals usefully catalogs (¶12), other procedures incorporate a "least restrictive facility" requirement. In Ms. Washington's view, these provisions are all structured differently from the tuberculosis scheme, such that their distinct wording does not meaningfully impact construction of the latter. But that is not presently here or

there. Clearly, a mental health commitment must take into account the least restrictive facility; under the instant holding, a tuberculosis commitment need not: is there a "rational basis" to justify this distinction?

As noted above, the two types of commitment are closely analogous. Indeed, each is aimed at thwarting physical danger to self or public. By definition a mental health commitment subject must be demonstrably "dangerous," Wis. Stat. § 51.20(1)(a)2, and this dangerousness may be evidenced by, among other things, a substantial probability of harm to the patient herself as manifested by recent attempts at suicide or serious bodily harm, Wis. Stat. § 51.20(1)(a)2.a.; or by, "a substantial probability of physical harm to other individuals as manifested by evidence of recent homicidal or other violent behavior," Wis. Stat. § 51.20(1)(a)2.b. Confinement of a tuberculosis patient requires that the patient "pose an imminent and substantial threat to himself or herself or to the public health," Wis. Stat. § 252.07(9)(a)4.

Although ch. 51 does not use the phrase "imminent and substantial," the thrust is indistinguishable. A substantial probability of physical harm as manifested by recent homicidal behavior plainly represents an imminent and substantial threat.[7]

There is no rational basis to justify affording less-restrictive treatment to *violently* dangerous individuals incapable of controlling their behavior but not to individuals who happen to be ill. Each presents a threat to the safety of themselves or others, and it is irrational to give one class but deny the other a right of least-restrictive placement.

The same is true of juvenile miscreants—no matter how much havoc they wreak they are entitled to consideration of a less restrictive alternative than a secured correctional facility, as the court of appeals ably illustrates (2006 WI App

[7] True, this court seems to have held in ***State v. Dennis H.***, 2002 WI 104, 255 Wis. 2d 359, 647 N.W.2d 851, that imminent harm was not required for the "fifth standard" of ch. 51 commitments. But that case did not purport to discuss the other standards, including those relied on by Ms. Washington in the text above.

99, ¶12). Why should dangerous juveniles be given this benefit but not someone who is sick?

4. Americans with Disabilities Act.

As ***Newark v. J.S.*** further indicates, 652 A.2d at 273-74, a least-restrictive alternative to incarceration for TB treatment is also imposed by federal legislation, the Americans with Disabilities Act, 42 U.S.C. §§ 12101-12213. The ADA bans discrimination on the basis of disability (and affliction with TB is considered as such, ***School Board of Nassau County v. Arline***, 480 U.S. 273, 288-89 (1987)), unless necessary to avoid a risk that can not be eliminated by a reasonable accommodation. In other words, the reasonable accommodation requirement of the ADA is tantamount to a least restrictive alternative to incarceration – the ADA does not allow a TB patient to be jailed for the purpose of treatment unless a reasonable accommodation is not available

F. Determination of the "least restrictive alternative" must be made without regard to resultant costs; the trial court therefore erred in factoring costs into its determination.

The question remains whether costs may be factored into a least restrictive alternative calculus. It is enough to say that *nothing* in § 252.07 allows costs to be considered; thus, the issue is determined by ***D.E.R. v. La Crosse County***, 155 Wis. 2d 240, 248, 455 N.W.2d 239 (1990), which read Wis. Stat. § 55.06(9)(a) (1987-88) to mean that protective placement may not be driven by fiscal concerns: "The legislature has not expressly limited the county's responsibility in ch. 55 to make placements to the least restrictive environment to funds available from state or federal sources and county matching funds," *id.*, at 252. The same principle applies here: nothing in the tuberculosis commitment scheme evinces any legislative intent whatsoever to countenance costs as a factor. Therefore, a least restrictive alternative may not be rejected on fiscal grounds.

The court of appeals' discussion on this point (2006 WI App 99, ¶¶14-15) is deeply problematic. The court noted, first, that post-***D.E.R.*** legislation now allows consideration of costs to guide protective placement, and that this "change reflects legislative concerns" pertinent to TB placement. This is clearly incorrect, for the legislature has *not* added any similar provision to § 252.07. Moreover, even as to protective placement, this court interpreted the legislative change narrowly in ***Dunn County v. Judy K.***, 2002 WI 87, ¶28, 254 Wis. 2d 383, 647 N.W.2d 799 ("the county must show it has made a good faith, reasonable effort to find and fund an appropriate placement").

Second, the court of appeals reduced the argument to an absurdity, raising an alarm that Ms. Washington's preference (needless to say, one she never stated) for "being under a guard-enforced confinement at the Pfister Hotel or some other luxury facility would be 'less restrictive'" still. 2006 WI App 99, ¶15. The court of appeals' transparent disdain for Ms. Washington's plight does throw into relief one long-recognized *historical* truth about tuberculosis control: "From a multicausal and social perspective, tuberculosis is caused by poverty, overcrowding, malnutrition, and social inequity. It is a measure of social justice, hence its fascination." Coker, p. 209. Ms. Washington has never sought preferential treatment; rather, she seeks the *minimal* dignity accorded *any* patient.

This is not, of course, to make light of the problems presented by a "persistently nonadherent" TB patient, see, e.g., Tom Oscherwitz, et. al., *Detention of Persistently Nonadherent Patients with Tuberculosis*, 278 JAMA 843-46 (1997); Gostin, 54 Md. L. Rev at 115 n. 672 (*most* patients fail to take their medication after release from short-term detention). But ultimately, both problem and solution are social-political rather than law enforcement in nature.

Reasons for noncompliance are variegated, but unsurprisingly include homelessness, financial barriers, mental illness, and substance abuse, Ball, 12 Yale L. & Policy Rev. at 46—unsurprising because the disease does have a social origin, with a "demonstrable and striking correlation

between tuberculosis and poverty, race, homelessness, and the deterioration of the public health and health care systems," Gostin, 54 Md. L. Rev at 37. (Ms. Washington if nothing else exemplifies this correlation quite well.) See also *id.*, at 12-13 ("the distribution of the disease among the population is strikingly unequal, with the epidemic affecting substantially greater numbers of poor persons and ethnic minorities").

> ... Virtually every official publication by governmental or international agencies attribute the low rate of treatment success to "nonadherence," "noncompliance", "recalcitrance", or "failure" on the part of patients. Blaming the person who is ill rather than accepting the responsibility of health agencies masks the problems that truly affect treatment completion.

Id., at 28, footnotes omitted.

Jailing the nonadherent, then, is not exactly a pragmatic policy, but instead merely kicks the can down the road. There is, in other words, a "growing consensus" that deteriorating social conditions are critical to the resurgence of TB. Gostin, 54 Md. L. Rev., at 37. Aiming compulsory measures at those such as Ms. Washington "who are economically disadvantaged and socially marginalized [and who] face formidable barriers outside of their control ... is certainly easier than requiring government to provide a comprehensive network of social services and incentives to complete treatment." *Id.*, at 109, 110. But to the extent it encourages the government to overlook comprehensive services it is in the end not necessarily the most cost-effective let alone equitable approach.

A blunt-speaking high plains doctor put it succinctly nearly a century ago: "Tuberculosis is a respectable business if you have money, but without it, it is a mean low-down business." Coker, p. 40, quoting Denver physician Henry Sewall. Ms. Washington never claimed entitlement to luxurious quarters; nor did she deserve arrest, jailing, and widespread dissemination of her mug shot on account of her illness.

All that said, *whether* hospital confinement would be costlier, and if so by how much, is simply unknown. What seems to be true is that while the City would have to pay for hospital confinement jail costs will be borne by the county.

G. Aurora Sinai Medical Center was indisputably a "less restrictive alternative" than jail, and its rejection on the inadmissible ground of costs must be reversed.

It is undisputed that Aurora Sinai hospital was both a suitable treatment facility for Ms. Washington, and also less restrictive than incarceration in jail. She had been compliant while at the hospital. The sole basis for rejecting placement at the hospital was not that it was less restrictive than the jail or that it was not suitable to her treatment needs but, rather, that it would cost too much. Because this was an inadmissible ground under the statute, Ms. Washington's placement in jail was erroneous as a matter of law.

II. MS. WASHINGTON'S CONFINEMENT TO JAIL IS NOT SUPPORTABLE AS A CONTEMPT SANCTION: JUDICIAL ESTOPPEL BARS CONSIDERATION OF THIS THEORY; ON THE MERITS, THE CONDITION FOR RELEASE—CERTIFICATION BY THE HEALTH DEPARTMENT THAT SHE IS CURED—IS NOT WITHIN HER POWER TO BRING ABOUT, AND THUS CLEARLY VIOLATES THE REQUIREMENT THAT ABILITY TO PURGE THE CONDITION BE WITHIN THE CONTROL OF THE CONTEMNOR; AND, ITS DURATION EXCEEDS THE PERMISSIBLE LIMIT FOR REMEDIAL CONTEMPT.

A. Introduction: the City's inconsistent argumentation—one result of which was to induce the court of appeals to hold that the confinement order was, contrary to the trial court's ruling and the City's express agreement below, a contempt order—establishes a judicial estoppel bar against opposing the relevance of contempt procedure.

Right or wrong, upholding confinement under Wis. Stat. § 252.07(9) should have concluded discussion. Nonetheless, the court of appeals proceeded to hold *separately* that the confinement was *also* proper under the circuit court's contempt power. 2006 WI App 99, ¶¶16-19.

Not only was it unnecessary for the court to discuss contempt, the discussion should have been barred by notions of judicial estoppel. The City did initially seek to invoke the circuit court's authority to confine Ms. Washington as a contempt sanction (for violating the order to cooperate with treatment as an out-patient), *but it expressly abandoned that ground in preference to reliance on the TB control procedure*:

> THE COURT: ... And *that statute does allow the Court to confine a person for the treatment of the tuberculosis*. What the Court-- What the statute requires

> is that if I'm going to order a person in confinement more than six months, I have to have a review every six months if I'm going to order her confined. I don't know if that's the--.
>
> MR. MUKAMAL: *That's exactly how we're proceeding.*
>
> THE COURT: *This is the only way I know how to proceed is under the statute because it's a specific statute if someone has tuberculosis.*
>
> MR- MUKAMAL: *That's what I'm asking the Court proceed under. This statute, no other.*
>
> ...
>
> THE COURT: ... And I just kind of view it as continuing jurisdiction, of the Court with respect to this case. And what's happened is it has been brought to my attention that there's been violations -- alleged violations regarding the order. So that's why this matter is before the Court today. *I don't need to find contempt. ...*
>
> ...
>
> THE COURT: ... So anyways, I think I have continued jurisdiction under the statute. And the statute does allow the Court to confine a person for treatment. ... And *I believe 252.03(9)(c)* (sic, 252.07(9)(c)) *provides that the Court orders confinement under this subsection ... So I think that's the authority I'd be proceeding under, sir.*

(24:34-39 emphasis supplied).

Note, too, that *Ms. Washington was arrested and brought to court for the confinement proceeding pursuant to the specific authority granted by § 252.07(8)(a).* The reason, after all, the City sought to shorten the time for hearing its motion was precisely because that section does not allow an individual to be confined on the department's say-so for more than 72 hours. Wisconsin Section 252.07(8)(c). The City may have initially styled its motion as being in the nature of remedy for contempt, but it expressly abandoned that theory in preference to reliance on § 252.07.

The City nonetheless argued on appeal that the confinement order was within the trial court's contempt authority. However, bedrock notions of judicial estoppel should have barred the City's argument, and should have inhibited the court of appeals from reaching it. ***State v. Petty***, 201 Wis. 2d 337, 347-48, 548 N.W.2d 817 (1996) (doctrine of judicial estoppel intended to prevent litigant from playing fast and loose with court by asserting inconsistent positions; elements include: later position "clearly inconsistent" with former position; unchanged facts; convincing first court to adopt party's former position); ***State v. English-Lancaster***, 2002 WI App 74, ¶22, 252 Wis. 2d 388, 642 N.W.2d 627 ("classic" judicial estoppel where party's argument induced trial court action but party then took clearly inconsistent position on appeal).

The City's argumentation fulfills the elements of judicial estoppel. The City explicitly asserted in the trial court that this matter was proceeding under the tuberculosis commitment procedure and was *not* in contempt. As a result, the trial court followed the tuberculosis procedure *instead of* contempt. This is not an instance of merely seeking to affirm a ruling on an alternative theory, which is of course both routine and permissible, ***State v. Scheidell***, 230 Wis.2d 189, 601 N.W.2d 284 (1999) (party prevailing in trial court may on appeal defend the ruling by "an attack upon the reasoning of the lower court or an insistence upon matter overlooked or ignored by it"). Rather, the City is attempting to resurrect a theory expressly eschewed by the trial court precisely because expressly abandoned by the City. This is indeed classic judicial estoppel.

If this court imposes a judicial estoppel bar then further discussion will be unnecessary. The balance of the argument assumes that the court will reach the merits of the issue.

B. When a contempt sanction is meted out, statutory requirements (of remedial contempt in this instance) must be followed.

Contempt sanction must be imposed in accordance

with legislatively prescribed procedure, else is not sustainable. *See, generally,* ***Evans v. Luebke***, 2003 WI App 207, ¶17, 267 Wis. 2d 596, 671 N.W.2d 304:

> Contempt power is recognized as an "inherent" judicial power, that is, one that does not necessarily derive from legislative mandate and which inheres in the definition of a court. *See* ***State v. Cannon,*** 196 Wis. 534, 536-37, 221 N.W. 603 (1928); ***State ex rel. Attorney General v. Circuit Court for Eau Claire County,*** 97 Wis. 1, 8, 72 N.W. 193 (1897). For over one hundred twenty years, however, the Wisconsin Supreme Court has recognized legislative regulation of the contempt power, and the court has proscribed the exercise of this power outside of the statutory scheme. "[T]he power to punish for contempt was not conferred in the first instance by statute ... [however, this court] holds that whenever a statute prescribes the procedure in a prosecution for contempt, or limits the penalty, the statute controls." ***State ex rel. Lanning v. Lonsdale***, 48 Wis. 348, 367, 4 N.W. 390 (1880); *see also* ***Douglas County v. Edwards***, 137 Wis. 2d 65, 87-88, 403 N.W.2d 438 (1987).

There is no dispute that Ms. Washington's contempt—assuming that it may be so characterized—was civil and remedial. 2006 WI App 99, ¶17. Remedial contempt is limited by the sanctions authorized in Wis. Stat. § 785.04(1), which are pertinently as follows:

> **Remedial sanction.** A court may impose one or more of the following remedial sanctions:
>
> ...
>
> (b) Imprisonment if the contempt of court is of a type included in s. 785.01 (1) (b), (bm), (c) or (d). The imprisonment may extend only so long as the person is committing the contempt of court or 6 months, whichever is the shorter period.
>
> ...
>
> (d) An order designed to ensure compliance with a prior order of the court.
>
> (e) A sanction other than the sanctions specified in pars. (a) to (d) if it expressly finds that those sanctions would be ineffectual to terminate a continuing

contempt of court.

The court of appeals upheld confinement under both subsecs. (d) and (e). 2006 WI App 99, ¶19. Ms. Washington respectfully disagrees with the court's analysis for several reasons.

C. The requirement of a least restrictive alternative would be absorbed into contempt sanction.

The least restrictive alternative to jail confinement pertinent to the tuberculosis commitment scheme would be absorbed into an order entered in contempt to enforce that very scheme. *See, e.g.,* ***Interest of D.L.D.***, 110 Wis. 2d 168, 182, 327 N.W.2d 682 (1983) (contempt sanction to enforce juvenile court order incorporates "limitations" of children's code, one of which is that less restrictive alternatives are considered). Ms. Washington therefore incorporates the same arguments she made in Argument § I above.

D. Ms. Washington did not have it within her power to purge the condition of her confinement—health department certification of her cure—and therefore remedial contempt could not support the sanction.

Remedial contempt requires that the contemnor be able to purge the sanction, something simply impossible under the confinement order. As has often been said, "(t)he purge provision must clearly spell out what the contemnor must do to be purged, *and that the action must be within the power of the person.*" ***State ex rel N.A. v. G.S.***, 156 Wis. 2d 338, 342, 456 N.W. 2d 867 (Ct. App. 1990), emphasis supplied. *Accord,* ***Diane K.J. v. James L.J.***, 196 Wis. 2d 964, 968-69, 539 N.W.2d 703 (Ct. App. 1995) ("Remedial contempt is imposed to ensure compliance with court orders. ... The sanction must be purgeable through compliance with the original court order.") *Ms. Washington's confinement order was not remedial in nature because it imposed a condition quite outside her capabilities, namely a clean bill of health.*

The court of appeals nonetheless held that her contempt would be purged "by complying with the treatment regimen *for the medically required time*." 2006 WI App 99, ¶19, emphasis supplied. This is slippery, at best; the circuit court specifically ordered: "The health department has to certify that she's no longer a threat and that she's been cured. So that's the only way that she's going to be able to get released it appears, once that's obtained." (24:65) It was not within Ms. Washington's power to certify a cure; it was not within her power to effectuate a cure. Re-casting the order *from* certification of good health *to* compliance for the required time changes nothing. "The medically required time" is, indeed, however long it took to be cured.

This is therefore not, by any reckoning, a remedial order of contempt. (Nor was it intended to be; as noted, the circuit court wisely grounded its order in the procedure specifically devised for this sort of situation, § 252.07(9) – but this is merely to repeat that the court of appeals never should have taken up the issue of contempt.) See also dissent, 2006 WI App 99, ¶¶29-31.

E. The confinement order exceeded the maximum length of imprisonment for contempt.

Finally, the confinement order exceeded the 6-month imprisonment time limit authorized by Wis. Stat. § 785.04(1) ("imprisonment may extend only so long as the person is committing the contempt of court or 6 months, whichever is the shorter period"). Ms. Washington's imprisonment indisputably lasted longer than six months. The court of appeals nonetheless relied on the general authority provided by Wis. Stat. § 785.04(1)(e), which authorizes a court to impose "(a) sanction other than the sanctions specified in pars. (a) to (d) if it expressly finds that those sanctions would be ineffectual to terminate a continuing contempt of court." 2006 WI App 99, ¶19. Because the trial court did not ground its order in contempt it had no occasion to make the express finding required by this section. That aside, if the idea was indeed to compel submission to treatment, then once Ms. Washington began receiving treatment, albeit in jail, *she was*

no longer in continuing contempt of court. See Judge Kessler's dissenting opinion, *id.*, ¶29.

Judge Kessler's dissent eloquently explains why contempt should not be available where authorities already have a specific, detailed mechanism to obtain the desired end. Indeed, in the context of sexually transmitted diseases, the legislature has explicitly conferred authority to proceed in contempt where a "person fails to appear or fails to accept commitment without reasonable cause," Wis. Stat. § 252.11(5). No such express authority is conferred with regard to the tuberculosis control regime.

But even if contempt is available to coerce TB treatment through incarceration, it is a power that ought to be used sparingly, *see, e.g.,* ***International Union v. Bagwell***, 512 U.S. 821, 831-832 (U.S. 1994) ("But the contempt power also uniquely is liable to abuse. ... and its fusion of legislative, executive, and judicial powers summons forth . . . the prospect of the most tyrannical licentiousness," quote marks and cites omitted).

Indeed, the implications of granting the judiciary this "tyrannical, licentious" power to incarcerate someone deemed a public health hazard are quite vast, more than sufficient to give great pause—especially where its invocation is casually invoked well after the fact, and where the trial judge has been thoughtful and cautious enough to disdain its use.

III. THE CASE SHOULD NOT BE DISMISSED AS MOOT EVEN THOUGH MS. WASHINGTON HAS BEEN RELEASED FROM JAIL.

Ms. Washington was released from jail during the pendency of this appeal. Although a ruling would therefore not have any immediate impact on her, this appeal nonetheless falls within settled exceptions to the mootness doctrine. ***Fond du Lac County v. Elizabeth M.P.***, 2003 WI App 232, ¶28 n. 4, 267 Wis.2d 739, 758, 672 N.W.2d 88:

> We understand that the commitment order terminated on November 3, 2002, and that this issue

> may be moot. "An issue is moot when its resolution will have no practical effect on the underlying controversy." ***State ex rel. Olson v. Litscher***, 2000 WI App 61, ¶3, 233 Wis.2d 685, 608 N.W.2d 425. However, an appellate court may consider a moot issue if one of the following conditions is met: (1) it has great public importance; (2) a statute's constitutionality is involved; (3) a decision is needed to guide the trial courts; or (4) where the situation is likely to be repeated but seems to evade review because it is resolved before the completion of the appellate process. *Id.* This court has also determined that an issue is of great public importance when it affects the liberty interests of all persons subject to an involuntary commitment in Wisconsin. ***Shirley J.C. v. Walworth County***, 172 Wis.2d 371, 375, 493 N.W.2d 382 (Ct. App. 1992) (examining an involuntary commitment pursuant to Wis. Stat. § 51.20).
>
> Here, Elizabeth has appealed from the denial of her motion to release her from inpatient treatment under the commitment order and return her to outpatient status. Therefore, we are satisfied that such relief asked for by Elizabeth in her appeal should be addressed. This opinion addresses that seminal issue ....

See also, ***State v. Michael S.***, 2005 WI 82, ¶6 ("A court may decide a moot issue when the issue is of great public importance; occurs frequently and a definitive decision is necessary to guide the circuit courts; is likely to arise again and a decision of the court would alleviate uncertainty; or will likely be repeated, but evades appellate review because the appellate review process cannot be completed or even undertaken in time to have a practical effect on the parties.")

This appeal satisfies each of the four ***Elizabeth M.P.*** conditions, for reasons sufficiently obvious to require little if any elaboration. In-patient jail confinement is a matter of great public importance, no less (and arguably even more because of the incarcerating aspect) than in-patient hospital treatment under a mental health commitment; as argued above, the court of appeals' construction renders the TB commitment statute vulnerable to constitutional attack on various grounds; relatedly, guidance to trial courts is necessary to deal with such attacks; and, the issue of the court

of appeals' construction of the TB-treatment confinement scheme is likely to evade review, especially if health officials employ their new-found contempt authority, which will be processed as an ordinary appeal and will generally take much longer than the duration of any given confinement.

CONCLUSION

The trial court erred as a matter of law in ordering Ms. Washington's confinement to jail for purposes of tuberculosis treatment. The statutory and regulatory tuberculosis control regime does not authorize confinement to jail. Even if it does, such confinement must be the least restrictive alternative available, without regard to costs. In this instance, a less restrictive alternative indisputably existed, Aurora Sinai Medical Complex, and the trial court therefore erred as matter of law in rejecting that alternative solely because of greater presumed costs. Nor is the confinement to jail sustainable as a (remedial) contempt sanction, because it was not within Ms. Washington's power to purge the condition (health department certification of her cure), and also because the duration of confinement exceeded the statutorily permissible maximum. This court should therefore overrule the court of appeals on both these issues.

Respectfully submitted,

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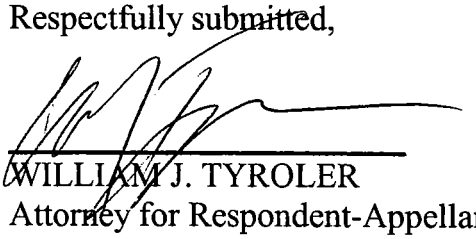
CERTIFICATION

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 300 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. The text is 13 point type and the length of the brief is 10,166 words.

Respectfully submitted,



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APPENDIX

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2006 WI APP 99

COURT OF APPEALS
DECISION
DATED AND FILED

March 28, 2006

Cornelia G. Clark
Clerk of Court of Appeals

Appeal No. 2005AP3141 Cir. Ct. No. 2005CV7563

STATE OF WISCONSIN IN COURT OF APPEALS

IN THE INTEREST OF RUBY WASHINGTON:

CITY OF MILWAUKEE,

PETITIONER-RESPONDENT,

V.

RUBY WASHINGTON,

RESPONDENT-APPELLANT.

APPEAL from an order of the circuit court for Milwaukee County: CLARE L. FIORENZA, Judge. *Affirmed.*

Before Wedemeyer, P.J., Fine and Kessler, JJ.

¶1 FINE, J. Ruby Washington appeals from the trial court's order directing that she be confined under WIS. STAT. § 252.07(9) for tuberculosis treatment. The only issue on appeal is where she should be confined. We affirm.[1]

I.

¶2 The facts in this case are not disputed. Washington has pulmonary tuberculosis, which if not treated properly is not only dangerous to the infected person but also is dangerous to others, who can inhale the bacteria expelled by an infected person. And it does not take much to get tuberculosis bacteria into the air from which others can be infected. The City of Milwaukee tuberculosis program manager testified at a hearing before the trial court that tuberculosis can get into the air by an infected person "[c]oughing, laughing, singing, talking, sneezing." Although a person suffering from pulmonary tuberculosis who is on appropriate drug-therapy may be non-communicable, that person can become communicable unless he or she completes the course of treatment. WISCONSIN STAT. § 252.07 sets out procedures designed to protect both the public and those afflicted with the disease.

¶3 Washington did not cooperate with attempts to help her overcome her pulmonary tuberculosis and to keep her from infecting others. She was living in a homeless shelter on June 17, 2005, when she was first diagnosed as having the disease. As recounted in an affidavit executed by a tuberculosis-control-clinic public-health nurse, Washington was started on medication for her tuberculosis on June 21, 2005, and was given bus tickets so she could go to the tuberculosis clinic

[1] The trial court's order was entered on October 5, 2005. Ruby Washington's notice of appeal was filed on December 21, 2005.

and take her medication "under direct observation" of the clinic staff. This did not work, however, because Washington missed two appointments and "disappeared from public view."

¶4 On August 22, 2005, Washington was found at the Aurora Sinai Medical Center, where she had gone to give birth. When she threatened to leave the hospital despite her tuberculosis, she was kept at the hospital in inpatient confinement against her will until, several days later, she and the City of Milwaukee stipulated that she would stay at the medical center for at least one month or until she was no longer contagious, and that after her release she would continue a course of supervised treatment for some nine months to ensure that she was cured.

¶5 On September 27, 2005, the trial court issued an order permitting Washington's release from the hospital, "but only on the condition that she strictly comply" with City orders that she fulfill and complete her course of treatment, and that this compliance be assured by having public-health staff see Washington take her prescribed medications. The order also required that Washington live with her sister, at whose home Washington "shall continuously reside and remain available for contact at that address until such time as in the judgment of the City of Milwaukee Health Department, her treatment is complete and she is cured of the disease of tuberculosis." Further, the order recited that if Washington "fails to fully and completely comply with the provisions of this Order, she may be subject to imprisonment, to renewed isolation and inpatient confinement pursuant to WIS.

STAT. §§ 252.07(8) and (9) and/or to such other and additional sanctions for contempt of court as this Court may determine."[2]

---

[2] WISCONSIN STAT. § 252.07(8), referenced by the trial court's order of September 27, 2005, provides:

> (a) The department or a local health officer may order the confinement to a facility of an individual who has a confirmed diagnosis of infectious tuberculosis or suspect tuberculosis if all of the following conditions are met:
>
> 1. The department or local health officer notifies a court in writing of the confinement.
>
> 2. The department or local health officer provides to the court a written statement from a physician that the individual has infectious tuberculosis or suspect tuberculosis.
>
> 3. The department or local health officer provides to the court evidence that the individual has refused to follow a prescribed treatment regimen or, in the case of an individual with suspect tuberculosis, has refused to undergo a medical examination to confirm whether the individual has infectious tuberculosis.
>
> 4. In the case of an individual with a confirmed diagnosis of infectious tuberculosis, the department or local health officer determines that the individual poses an imminent and substantial threat to himself or herself or to the public health. The department or local health officer shall provide to the court a written statement of that determination.
>
> (b) If the department or local health officer orders the confinement of an individual under this subsection, a law enforcement officer, or other person authorized by the local public health officer, shall transport the individual, if necessary, to a facility that the department or local health officer determines will meet the individual's need for medical evaluation, isolation and treatment.
>
> (c) No individual may be confined under this subsection for more than 72 hours, excluding Saturdays, Sundays and legal holidays, without a court hearing under sub. (9) to determine whether the confinement should continue.

Section 252.07(9), referenced by the trial court's order of September 27, 2005, provides:

(a) The department or a local health officer may petition any court for a hearing to determine whether an individual with infectious or suspect tuberculosis should be confined for longer than 72 hours in a facility where proper care and treatment will be provided and spread of the disease will be prevented. The department or local health officer shall include in the petition documentation that demonstrates all of the following:

1. That the individual named in the petition has infectious tuberculosis; that the individual has noninfectious tuberculosis but is at high risk of developing infectious tuberculosis; or that the individual has suspect tuberculosis.

2. That the individual has failed to comply with the prescribed treatment regimen or with any rules promulgated by the department under sub. (11); or that the disease is resistant to the medication prescribed to the individual.

3. That all other reasonable means of achieving voluntary compliance with treatment have been exhausted and no less restrictive alternative exists; or that no other medication to treat the resistant disease is available.

4. That the individual poses an imminent and substantial threat to himself or herself or to the public health.

(b) The department or local health officer shall give the individual written notice of a hearing at least 48 hours before a scheduled hearing is to be held. Notice of the hearing shall include all of the following information:

1. The date, time and place of the hearing.

2. The grounds, and underlying facts, upon which confinement of the individual is being sought.

3. An explanation of the individual's rights specified under par. (d).

4. The proposed actions to be taken and the reasons for each action.

(c) If the court orders confinement of an individual under this subsection, the individual shall remain confined until the department or local health officer, with the concurrence of a treating physician, determines that treatment is complete or that the individual is no longer a substantial threat to himself or herself or to the public health. If the individual is to be confined

¶6 Washington was released from Aurora Sinai Medical Center on September 27, 2005, and, on that very day, left her sister's home. Further, she did not comply with the required treatment-regimen. On September 29, 2005, Washington was arrested for violating the trial court's order, and, after being assessed at Aurora Sinai Medical Center, was taken to the Milwaukee County Criminal Justice Facility. On October 1, 2005, she was released from the Facility because of an apparent bureaucratic mix-up. The City found Washington on October 5, 2005, and she was again taken into custody.

¶7 The trial court held a hearing on October 5, 2005, and, on that day, issued the order from which Washington appeals. The order directed that Washington "be confined in the Milwaukee County Criminal Justice Facility" unless otherwise ordered, and directed that Washington "shall fully comply" with her treatment regimen. Uncontradicted testimony at the October 5 hearing

---

for more than 6 months, the court shall review the confinement every 6 months.

(d) An individual who is the subject of a petition for a hearing under this subsection has the right to appear at the hearing, the right to present evidence and cross-examine witnesses and the right to be represented by adversary counsel. At the time of the filing of the petition the court shall assure that the individual who is the subject of the petition is represented by adversary counsel. If the individual claims or appears to be indigent, the court shall refer the individual to the authority for indigency determinations specified under s. 977.07 (1). If the individual is a child, the court shall refer that child to the state public defender who shall appoint counsel for the child without a determination of indigency, as provided in s. 48.23 (4). Unless good cause is shown, a hearing under this subsection may be conducted by telephone or live audiovisual means, if available.

(e) An order issued by the court under this subsection may be appealed as a matter of right. An appeal shall be heard within 30 days after the appeal is filed. An appeal does not stay the order.

established that the required treatment and observation would take "nine cumulative months" from October 5. If that were not done, the City's tuberculosis program manager told the trial court that both the public and Washington would suffer serious consequences:

> [Washington's] personal consequences could include death, could include severe illness. She would again become incapacitated at some point, probably very weak and debiled, not feel very well at all. The consequences for the public would be transmission of tuberculosis to people.

The order also set April 7, 2006, for trial-court review of Washington's condition and circumstances.

¶8 As noted, Washington does not dispute either that she has pulmonary tuberculosis or that she must complete her course of treatment to get fully well and not be a danger to others in the community. She contended before the trial court, however, and argues on appeal, that she should not be at the criminal-justice facility, but, rather, at the hospital or some other non-jail-type facility, even if that required that she be guarded twenty-four hours a day. The trial court rejected that contention:

> There [has been] non-compliance and the risk of the community is way too high to allow her to just walk out the door today. Now, [addressing Washington's trial lawyer], I have -- I do not know where else I can place your client but in the jail at this point for confinement. ... [I]f you can find some other locked facility for your client that would agree to take her, the Court would be happy to order her placed somewhere else, and I'm sure the City would agree. The problem is that I need to have a locked facility where she's going to stay put. ... With respect to the [suggestion] that I place a guard at the hospital and allow her to stay at the hospital for the remainder of her treatment[,] I refuse to require tax payers to pay [for] 24 hour around the clock guard at her door to make sure she stays put. I don't think that's appropriate. Miss Washington was given an opportunity to receive treatment in the community and she failed to do that.

We agree.

II.

¶9 This appeal comes to us in two interconnected postures. First, an appeal from the trial court's order, in which the trial court specifically did not invoke its contempt power. Second, by virtue of an order issued by this district's motions judge on January 9, 2006, that nevertheless characterized the trial court's order as "at base, an appeal from a contempt order." *See* WIS. CT. APP. IOP VI(3)(c) (authority of the motions judge). The practical effect of the January 9, 2006, order is that it makes inapplicable the declaration in WIS. STAT. § 252.07(9)(e) that appeals from trial-court orders issued under § 252.07(9) "shall be heard within 30 days after the appeal is filed." Although appeals from contempt orders are one-judge appeals under WIS. STAT. § 752.31(2)(h), this appeal was immediately transformed into a three-judge appeal by this court's chief judge. *See* § 752.31(3). The January 9 order also directed that this appeal be expedited, which it has been. Irrespective of whether this appeal is seen as one from an order founded on § 252.07(9), or one based on the trial court's power to enter orders of contempt under WIS. STAT. ch. 785, the result is the same—the trial court's order is lawful.

¶10 This appeal presents only issues of law: the proper interpretation of statutes to facts that are uncontested. Thus, our review is *de novo*. *See* ***Rebernick v. Wausau Gen. Ins. Co.***, 2005 WI App 15, ¶5, 278 Wis. 2d 461, 466, 692 N.W.2d 348, 351, *aff'd*, 2006 WI 27, ___ Wis. 2d ___, 711 N.W.2d 621. We look at WIS. STAT. § 252.07(9) and WIS. STAT. ch. 785 in turn.

A. *WISCONSIN STAT. § 252.07(9).*

¶11 WISCONSIN STAT. § 252.07(9)(a)1–3 is set out in full in footnote 2, and, when read together, empowers the trial court to order confined a person who either has "infectious tuberculosis" or "has noninfectious tuberculosis but is at high risk of developing infectious tuberculosis," and who "has failed to comply with the prescribed treatment regimen," if "all other reasonable means of achieving voluntary compliance with treatment have been exhausted and no less restrictive alternative exists." Washington argues that under § 252.07(9)(a)3, she must be placed at a facility that is the least restrictive of her freedom. We disagree.

¶12 We apply statutes as they are written. ***State ex rel. Kalal v. Circuit Court***, 2004 WI 58, ¶44, 271 Wis. 2d 633, 662, 681 N.W.2d 110, 123–124. As we have seen, WIS. STAT. § 252.07(9)(a)3 reads, as material: "That all other reasonable means of achieving voluntary compliance with treatment have been exhausted and no less restrictive alternative exists." This subsection has two parts. Confinement may not be ordered unless:

(1) attempts at "voluntary compliance with treatment have been exhausted," and

(2) there is "no less restrictive alternative" to confinement.

As the City cogently points out, the section does not reference the *nature* of the place of confinement. Certainly, if the legislature intended to engraft a "least restrictive facility" dictate, it could have easily done so in § 252.07(9)(a)3 as it has elsewhere. *See* WIS. STAT. § 51.20(9)(b) ("Such recommendation shall include the level of inpatient facility which provides the *least restrictive environment* consistent with the needs of the individual.") (emphasis added); WIS. STAT. § 51.30(4)(b)5 ("to determine whether the person should be transferred *to a less*

restrictive or more appropriate treatment modality or *facility*") (emphasis added); WIS. STAT. § 51.35(1)(d)1 ("[T]he department may ... transfer any patient from a state treatment facility or other inpatient facility to an approved treatment *facility which is less restrictive of the patient's personal freedom.*") (emphasis added); WIS. STAT. § 55.06(9)(a) ("Placement by the appropriate board or designated agency is subject to s. 46.279 and shall be made *in the least restrictive environment* consistent with the needs of the person to be placed and with the placement resources of the appropriate board specified under s. 55.02.") (emphasis added); WIS. STAT. § 938.33(a) ("[T]he report shall indicate that a less restrictive alternative *than placement in a secured correctional facility*, a secured child caring institution or a secured group home is not appropriate.") (emphasis added); WIS. STAT. § 938.355(1) ("[T]hat determination shall be prima facie evidence that a *less restrictive alternative than placement in a secured correctional facility*, a secured child caring institution, or a secured group home is not appropriate.") (emphasis added); WIS. STAT. § 938.357(4)(c)1 ("If a juvenile is placed in a Type 2 secured correctional facility ... and it appears that a *less restrictive placement* would be appropriate for the juvenile, the department, after consulting with the child welfare agency ... may place the juvenile in a less *restrictive placement.*") (emphasis added). Indeed, as Washington points out, the California legislature has decreed that persons like her may not be held "in correctional facilities." CAL. HEALTH & SAFETY CODE § 121358(a) ("Notwithstanding any other provision of law, individuals housed or detained through the tuberculosis control, housing, and detention program shall not reside in correctional facilities, and the funds available under that program with regard to those individuals shall not be disbursed to, or used by, correctional facilities. This section shall not be interpreted to prohibit the institutionalization of criminals with tuberculosis in correctional facilities.").

Wisconsin, however, has not followed that course, and the proper respect we owe the legislature prevents us from doing so by judicial "legislation."

¶13 Further, Washington does not present any authority other than a one-sentence reference to a 1995 law review article to support her passing assertion that she has constitutional entitlement to hospital versus correctional-facility confinement.[3] We will not address arguments that are not developed or briefed adequately. *See* ***Vesely v. Security First Nat'l Bank of Sheboygan Trust Dep't***, 128 Wis. 2d 246, 255 n.5, 381 N.W.2d 593, 598 n.5 (Ct. App. 1985). Nevertheless, this country has long recognized that the Constitution does not bar enforced quarantine. *See* ***Compagnie Francaise de Navigation a Vapeur v. Louisiana Bd. of Health***, 186 U.S. 380, 387 (1902).

¶14 As the trial court recognized, government spending is a zero-sum endeavor—money spent on giving Washington the type of confinement she prefers would, per force, have to be diverted from other more worthwhile societal endeavors, such as both helping persons who want but cannot afford medical treatment, and who will *cooperate* with that treatment. And, as the trial court pointed out, taxpayer-funded cisterns, from which all government expenditures flow, are not bottomless; taxpayers, too, are entitled to consideration so they can use more of their hard-earned money as *they* see fit. Moreover, although Washington cites ***D.E.R. v. La Crosse County***, 155 Wis. 2d 240, 248, 455 N.W.2d 239, 243 (1990), for the proposition that under WIS. STAT. § 55.06(9)(a) (1987–88) taxpayer cost was an impermissible consideration, the provision now

[3] Washington explains: "Given the accelerated processing of this appeal, the constitutional grounding of Ms. Washington's argument will not be developed more fully." As we have seen, the trial court's order from which this appeal is taken was entered on October 5, 2005, and Washington's notice of appeal was filed on December 21, 2005. Her appellate brief was filed with this court on January 26, 2006.

unambiguously provides that taxpayer cost *is* a consideration: "Placement by the appropriate board or designated agency is subject to s. 46.279 and shall be made in the least restrictive environment consistent with the needs of the person to be placed *and with the placement resources* of the appropriate board specified under s. 55.02." Sec. 55.06(9)(a) (2003–04) (emphasis added). The change reflects legislative concerns similar to those expressed by the trial court and with which we agree.

¶15 As the trial court pointed out, Washington's jail-type confinement was necessitated by what *she* did. Moreover, taking to the next logical step her contention that she prefers being under a guard-enforced confinement in a hospital rather that in the Criminal Justice Facility, being under guard at the Pfister Hotel or some other luxury facility would be "less restrictive" than either a hospital or the justice facility. She is not entitled to choose the place of her confinement.

B. *WISCONSIN STAT. § 785.04.*

¶16 Although the trial court specifically struck all references to contempt in the proposed order before it signed the order, we also address Washington's contention that confining her for more than six months is prohibited by WIS. STAT. § 785.04(1)(b).

¶17 Both parties and we agree that if the trial court's October 5, 2005, order was an order finding Washington in contempt, it was an order of remedial contempt, and that the applicable sanctions are limited by WIS. STAT. § 785.04(1), which provides:

> REMEDIAL SANCTION. A court may impose one or more of the following remedial sanctions:

> (a) Payment of a sum of money sufficient to compensate a party for a loss or injury suffered by the party as the result of a contempt of court.
>
> (b) Imprisonment if the contempt of court is of a type included in s. 785.01 (1) (b), (bm), (c) or (d). The imprisonment may extend only so long as the person is committing the contempt of court or 6 months, whichever is the shorter period.[4]
>
> (c) A forfeiture not to exceed $2,000 for each day the contempt of court continues.
>
> (d) An order designed to ensure compliance with a prior order of the court.
>
> (e) A sanction other than the sanctions specified in pars. (a) to (d) if it expressly finds that those sanctions would be ineffectual to terminate a continuing contempt of court.

(Footnote added.)

¶18 As we have seen, the trial court's October 5, 2005, order directed that Washington "be confined" in the justice facility "until further order of this Court," and that although the trial court set review for April 7, 2006, everyone envisions that Washington's enforced treatment regimen will last some nine months. As we have also seen, Washington argues that this is three months longer than the maximum period permitted by WIS. STAT. § 785.04(1)(b). Although a trial court's contempt powers are circumscribed by WIS. STAT. ch. 785, ***Evans v. Luebke***, 2003 WI App 207, ¶17, 267 Wis. 2d 596, 611, 671 N.W.2d 304, 313, its remedial powers—powers necessary to compel compliance with lawfully issued orders—are not as limited as Washington contends.

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[4] WISCONSIN STAT. § 785.01(1), as material to WIS. STAT. § 785.04(1)(b), provides: "'Contempt of court' means intentional: ... (b) Disobedience, resistance or obstruction of the authority, process or order of a court."

¶19 First, under WIS. STAT. § 785.04(1)(d) the trial court was empowered to fashion an order to "ensure compliance with a prior order," and the legislature properly left the scope of such an ensure-compliance order to the trial court's discretion, without micro-managing legislative directive. Second, and perhaps even more important, the expansive scope of the trial court's power to fashion an appropriate remedy is specifically recognized by § 785.04(1)(e), which, *in haec verba*, authorizes the trial court to customize a remedial order that does not fall within subsections "(a) to (d)." Here, the trial court fully explained why confinement for more than six months was necessary to ensure Washington's compliance with her treatment regimen; namely, that the six-month limitation would "be ineffectual to terminate" Washington's continuing failure to comply with its September 27, 2005, order, which directed, upon the parties' stipulation, Washington to voluntarily complete her course of treatment. And, contrary to Washington's contention that she cannot "purge" her contempt by using keys to freedom in her possession, all she need do is comply with the required course of treatment. *See* ***State ex rel. N.A. v. G.S.***, 156 Wis. 2d 338, 342, 456 N.W.2d 867, 869 (Ct. App. 1990) ("sanction must be purgeable through compliance").. She "purges" her contempt by complying with the treatment regimen for the medically required time. After that purge, she will no longer be confined. If, as she posits without support in the Record, she can *never* be assured of a cure, the remedy is not, of course, permitting her to roam our community with the real danger that she would make others very sick. In any event, that supposition is far from being ripe for either argument or decision. *See* ***U.S. Bank Nat'l Ass'n v. City of Milwaukee***, 2003 WI App 220, ¶17, 267 Wis. 2d 718, 737, 672 N.W.2d 492, 500 ("'Grotesque or fanciful situations, such as those supposed, will have to be dealt with when they arise.'") (quoting ***Gaines v. City of New York***, 109 N.E. 594, 596 (N.Y. 1915) (Cardozo, J.)).

III.

¶20 In sum, the trial court's order of October 5, 2005, was lawful, whether considered under WIS. STAT. § 252.07(9) or under WIS. STAT. § 785.04(1). Accordingly, we affirm.

By the Court.—Order affirmed.

¶21 KESSLER, J. (*concurring in part, dissenting in part*). Because I agree with the Majority's conclusion that under the circumstances of this case Washington was properly confined, I concur in the result the Majority reaches in Part II.A. of its opinion. I write separately to clarify what I understand is permitted by WIS. STAT. §§ 252.07(8) and (9) in the context of depriving a person of her liberty. I dissent from Part II.B. of the Majority opinion because I do not agree that this case involved a finding of contempt under WIS. STAT. ch. 785, and I therefore believe that we should not be addressing that issue. I also disagree with the Majority's conclusion that the contempt statutes provide a basis for jailing a person confined for treatment under the authority of § 252.07(9).

I. Public health confinement

¶22 WISCONSIN STAT. §§ 252.07(8) and (9) set out the scheme that gives public health departments the authority to compel persons with contagious tuberculosis to accept treatment for the disease. If the infected person refuses to comply with treatment, the person may be confined and treatment compelled until the person is cured. Confinement may be enforced under the terms of § 252.07(9)(a) when the health department establishes all of the following: (1) the person has infectious tuberculosis; (2) the person has failed to follow the treatment regimen; (3) other means of compelling treatment have been exhausted and no less restrictive alternative exists; and (4) the infected person poses an imminent and substantial threat to herself or the health of the general public. ***Id.*** I agree with the

Majority that "no less restrictive alternative" in § 252.07(9)(a)3. refers to the method of providing treatment, not to the location of the confinement. *See* Majority op., ¶12.

¶23 WISCONSIN STAT. § 252.07(5) authorizes home isolation to provide treatment for the infected person and to reduce the public's exposure to the disease. That alternative was initially ordered here, but Washington refused to comply. The existence of the elements required by WIS. STAT. § 252.07(9)(a) to permit confinement to effect treatment were not disputed. The question before the court was only where the confinement for treatment would occur. The Majority's emphasis on the legislature's failure to describe the *place* of confinement by a "least restrictive" standard might be incorrectly understood to imply that a correctional facility is always an acceptable alternative. *See* Majority op., ¶¶12-13. I write to clarify why I believe such a reading would be an incorrect interpretation of the statutes and of the Majority opinion.

¶24 When a trial court finds under WIS. STAT. § 252.07(9)(c) that confinement is the least restrictive method necessary to ensure treatment, it has both the discretion to consider alternative places of confinement and the obligation every six months to review the continuing necessity of confinement. Here, the trial court was presented with only two confinement location alternatives: a twenty-four hour guard for Washington in a hospital room, or medication delivered to Washington in a jail cell. The trial court appropriately considered all of the options presented. It also stated that it was open to other suggestions. No other suggestions appear in the record. With only two alternatives, and no detailed cost analysis, it was not unreasonable for the court to conclude that jail was a more cost-effective location to confine Washington for treatment.

II. Contempt confinement

¶25 Having concluded that the trial court had the authority to confine Washington for treatment under WIS. STAT. § 252.07(9), the Majority proceeds to decide the case on the alternative basis of statutory contempt of court under WIS. STAT. ch. 785. I disagree with the decision to address this issue, because, as this court recognized in ***State v. Blalock,*** 150 Wis. 2d 688, 703, 442 N.W.2d 514 (Ct. App. 1989), cases should be decided on the "narrowest possible ground." In addition, I disagree with the Majority's conclusion because it adds to the statutory tuberculosis treatment program a remedy that is not only unnecessary on the facts of this case, but is also an alternative that the legislature could have easily included in treatment program but did not.

¶26 The trial court made clear that it was not conducting a contempt proceeding. As the Majority observes, the trial court struck all references to contempt before signing the order on which this appeal is based. *See* Majority Op., ¶16. Because the order appealed from was not based on a finding of contempt, we should not decide whether the trial court *could* have ordered Washington confined on that basis.

¶27 The fact that in a preliminary order this court erroneously described this case as "at base, an appeal from a contempt order," *see* Majority Op., ¶9, does not mean that we should address a legal issue on appeal that was never a part of the order appealed from. The order appealed from is no more nor less than an order pursuant to WIS. STAT. § 252.07(9) confining a person infected with contagious tuberculosis to a facility for treatment. The power of the court to enter that order is the only issue we should address.

¶28 Furthermore, I disagree with the Majority's conclusion in Part II.B., *see* ¶¶16-19, that WIS. STAT. §§ 785.03 and 785.04, governing imprisonment for contempt, are available as an alternate basis for confining a person for treatment of tuberculosis. The Majority discusses the definitions of sanctions under § 785.04. It does not discuss the alternative procedures in § 785.03 that are required to impose those sanctions. In view of the significant powers provided to the trial court in WIS. STAT. § 252.07, a close review of the process set out by the legislature by which a trial court may impose contempt sanctions compels the conclusion that contempt is not an appropriate alternative vehicle to order the tuberculosis treatment because the civil liberties safeguards connected with compelled *treatment* are not a part of contempt *punishment*.

¶29 The trial court could not have ordered imprisonment as a remedial sanction for contempt under WIS. STAT. § 785.03(1)(a) because Washington cannot rid herself of the contempt (*i.e.*, not taking her medicine) by terminating the offending conduct (*i.e.*, taking her medicine) and thus gain release from imprisonment. If the Majority were correct in applying WIS. STAT. ch. 785 to this case, Washington would have to be released from the correctional facility as soon as she began taking her medicine. WISCONSIN STAT. § 785.04(1)(b) permits imprisonment for "only so long as the person is committing the contempt of court...." Obviously, that would be an absurd result when long-term tuberculosis treatment is needed. One suspects the inapplicability of contempt proceedings to tuberculosis treatment was not lost on the legislature when it crafted the more detailed and specific treatment enforcement program of WIS. STAT. § 252.07(9).

¶30 Other provisions in WIS. STAT. ch. 785 likewise fail to fit the situation here. This was not a punitive sanction contempt proceeding under WIS. STAT. § 785.03(1)(b) because it was neither referred to the district attorney for

prosecution nor separately prosecuted. This was not a summary procedure under § 785.03(2) because it did not involve action committed in the presence of the trial court.

¶31 Had the legislature wished to provide contempt under WIS. STAT. § 785.04 as an alternative means of compelling tuberculosis treatment, it could easily have done so. It did not. WISCONSIN STAT. § 252.07(9) makes no reference to the contempt statutes. The legislature, instead, developed an elaborate and detailed system to protect the public from, provide treatment for, and protect the civil liberties of, individuals with contagious tuberculosis. The legislature has concluded that the statutory system of regulation, and enforcement, provides adequate tools to protect the public and to treat the infected. The key to release from confinement under § 252.07(9) is becoming tuberculosis-free. The key to release from imprisonment for contempt, however, is either to complete the specific time imposed as punishment or to end the conduct that resulted in the contempt finding. Neither method of contempt release is available to a person infected with tuberculosis. This court should not engraft an entire additional body of contempt law onto a carefully designed treatment system solely because of an improvident statement earlier made by this court before it had the opportunity to review the complete record.

¶32 Because the parameters of WIS. STAT. ch. 785 add nothing to the tuberculosis treatment sanctions provided by the legislature, and because ch. 785 was not incorporated by the legislature in WIS. STAT. §§ 252.07(8) and (9), I respectfully dissent from Part II.B. of the Majority opinion.

the most favorable light on it. But I think that any alternative other than the jail should be explored. The Sinai situation worked. The Court could order her there for a period while other alternatives are explored. But I think incarcerating a person because of their health, and I also acknowledge it's a violation of the things, an extreme measure that shouldn't be taken without exploring other alternatives.

MR. MUKAMAL: Your Honor, if I might respond to that in part. We've already addressed the shortcomings of the mental health complex. The City strongly opposes returning her to Mount Sinai Hospital. Strongly. Number one, the hospital security staff doesn't have the authority to detain her nor should they be asked to do so. Secondly, it would be grossly unfair to the tax payers of this City to require that she be placed under police guard on a 24/7 basis, which would be required for a period of nine months. The jail already has security. It would not cost our tax payers any more. There's no necessity to impose that burden upon our tax payers, particularly under the circumstances of this case. We would really be quite -- quite opposed to any suggestion that she be returned to Mount Sinai. This is a custodial issue as much as a medical one.

THE COURT: Okay. Thank you. Anything

further, Mr. Rohlich?

MR. ROHLICH: No. I just don't think the tax thing is an appropriate consideration. And I think that the primary consideration is the public health, and that can be accomplished at the hospital. And it could result in additional cost. I don't think that's an appropriate consideration.

THE COURT: All right. Well, when this matter first came to my court on August 23rd, I knew nothing about any type of isolation order or what the authority of the Court was with respect to a person with active TB. And I guess I've learned a lot in the last few months. But this matter was before the Court in August where there was an agreement for Miss Washington to stay at the hospital to get the initial doses until she was not actively contagious. And we had a hearing then in September. September 27th, where the Court contacted Miss Washington at the hospital and counsel was here. I should state that when this case first came before this Court, I read the chapter with respect to TB and I arranged to have counsel appointed for Miss Washington because the statute provides for that. So that's how Mr. Rohlich -- Mr. Rohlich's here. I contacted the State Public Defender's office. I wanted to make sure that she was represented by counsel. But putting that aside. She is

represented by counsel. We had a hearing on the 27th and the record is very clear. I don't have a transcript in front of me, I don't know if one was ordered, but it's very clear that I discussed where Miss Washington had to reside and it was with her sister. There is a huge threat to our community if Miss Washington is walking around our community not taking her medicine for tuberculosis. What concerns me is that the health department first discovered that there could be an issue in May and took some samples. And I think the testimony is six to eight weeks later -- four to six or six to eight weeks later the health department found out that she was active for TB and set up a plan for treatment. And Miss Washington took, I believe, five doses of medicine and she disappeared from the face of the earth as well as -- as far as the health department was concerned. Health department tried to locate her, contacted at least some area hospitals advising the hospital, I take it, that if this person shows up, call us. And they were called in August when Miss Washington gave birth to a child. There's nothing in this record to show that she would have voluntarily turned herself in to start taking her medicine again. She disappeared. And she gave birth to a child and then there was this hearing and she agreed to stay in the hospital to get the initial about four weeks of doses to make her

uncontagious, and there were the tests done and the City was convinced that she wasn't contagious at that point and we had a hearing on the 27th and it was agreed by stipulation that Miss Washington could get treatment in a less confined situation, which was in the community. She would have to take medicine twice a week. She was to reside with her sister at her residence, and the address is 2200, I think, North 20 -- 2200 North 42nd Street. And that was a condition. I've heard testimony from the health department with respect to tuberculosis. And I frankly was not aware how tuberculosis progresses. And I now know it is a long treatment, but I've been advised that treatments I think it was a minimum of nine months. And there is a risk if a person starts treatment and stops treatment-- And that's obviously what we have here. We've started and stopped and then started back up in August. And the Court heard testimony that TB can become resilient to medications. Miss Reitl testified, she's the TB program manager, and she testified with respect to actually how TB can be, what's the word I'm thinking of, transferred in the community by coughs, by someone sneezing, by someone singing, by someone laughing. It's an air born disease. And it's very contagious if you're -- if you're with a person who has active TB. And if someone goes off treatment, they potentially become

resistant to medications. And clearly that's a huge risk for Miss Washington. But I think an adult can do whatever they want in their life. She's an adult, she can make decisions for herself. But by her not taking medication, she's making decisions for other people in our community. She's becoming a huge health risk, and I'm very concerned about the fact that she's not -- that she was -- that she violated the Court order in the past. I have no confidence that Miss Washington, if I let her walk out today and say, Miss Washington -- I slap her on the wrist and say, Miss Washington, you should have abided by the Court order. I'll give you another chance. I don't think she's going to do it.

THE DEFENDANT: I will.

THE COURT: It slipped her mind, I think is what she told me. That it slipped her mind that she was supposed to take her medicine yesterday. I am truly concerned about the health and the welfare of the community if Miss Washington is released just to go in the community. Now, I don't know where she'd stay if her sister doesn't want her to stay with her. Putting that aside, I'm very concerned that Miss Washington cannot comply with Court orders.

THE DEFENDANT: I will.

THE COURT: We had a very pointed

conversation on the phone on the 27th. I was very concerned with Miss Washington complying. Because the Court wants her to comply with everything. I don't want to issue an order incarcerating her for up to nine months. I don't take pleasure in taking away someone's liberty. But if the public is at risk because of your actions, I have no alternative but to do that, ma'am.

The Court's satisfied that there have been violations of the agreement. Miss Washington was disputing it. When I asked her, if I call your sister, would she say you slept there every night. She said no, she didn't. She did not reside there. That was a condition of the order. And then another condition is that she take her medication. And the--, I just wanted to make sure that the documents that were part of the order said it was on Tuesday and Friday before noon. It clearly sets forth that in the tuberculosis treatment plan for Ruby D. Washington that's dated September 26th. I have those exact dates. I wanted to make sure that-- You know, there was some misunderstanding, but it clearly says Tuesdays and Fridays. She didn't take her medicine yesterday. I clearly understand Friday she was incarcerated so that's not an issue, but Tuesday she didn't take it. I listened to the testimony of the -- of Miss Reitl where she testified when she saw Miss

Washington she wasn't totally coherent. I know she's not an expert with respect to drug use or anything like that, but she is a nurse, she's an RN. And I'm very concerned that there could have been some type of drug use. I don't know for sure. But I clearly recall from our hearing on the 27th that it was acknowledged that Miss Washington had some issues regarding controlled substances, that's why the City actually had found a treatment program for her that was supposed to start, I think, October 13th. There was an evaluation scheduled for her.

MR. MUKAMAL: That was the date, Your Honor.

THE COURT: Because of the cocaine problem that she has. This is not an easy thing for the Court to do, but I don't know what else to do. I'm very concerned about the public safety. Having said all that, I believe I have the authority under Chapter 252 of the Wisconsin Statutes, particularly Section 252.07, to confine Miss Washington. Clearly I have to consider other means of providing medication to Miss Washington other than confining her while she takes her medication, but I note the initial non-compliance with medications when she was first discovered back in May after the summer months she didn't comply with it. I note that the only way that the City found her is that she was in the hospital and someone

from the hospital called, contacted. I note that she was released on the 27th and on the 29th a health department official finds her on the street not, well, coherent. She was mistakenly released from jail on Saturday. She did not take her medicine on Tuesday and was found again in someone else's residence earlier today. There is non-compliance and the risk of the community is way too high to allow her to just walk out the door today. Now, Mr. Rohlich, I have -- I do not know where else I can place your client but in the jail at this point for confinement. If-- This is what I'm going to state, sir. Mr. Rohlich, if you can find some other locked facility for your client that would agree to take her, the Court would be happy to order her placed somewhere else, and I'm sure the City would agree. The problem is that I need to have a locked facility where she's going to stay put. If your client for whatever reason would qualify to go to the mental health complex, that's fine with me, but I'm not ordering that she be placed there. I don't have-- I don't know what the qualifications are for somebody to be placed there, and I have none of that information in front of me. At this point the only place that I know where I can put her in a confined setting would be at the CJF, in jail. And that's what I'm ordering at this time--

THE DEFENDANT: Please, Your Honor.

THE COURT: --that she be placed. With respect to the order that I place a guard at the hospital and allow her to stay at the hospital for the remainder of her treatment. I refuse to require tax payers to pay 24 hour around the clock guard at her door to make sure she stays put. I don't think that's appropriate. Miss Washington was given an opportunity to receive treatment in the community and she failed to do that. But, Mr. Rohlich, if you find some other place that she can be placed, I'll be happy to place her in a less-- I'll be happy to place her some place other than the jail if you can come up with some alternative that would accept her, sir. I have no problem in doing that. Actually I'd welcome that. But I don't know of any other facility at this time. So I am ordering that she be confined for treatment. Now, I've been advised the course of treatment is about nine months. She has about a month -- over a month under her belt of treatment. I don't know. So it might be about eight months more treatment, I don't know, but that's a minimum. She has to test. The health department has to certify that she's no longer a threat and that she's been cured. So that's the only way that she's going to be able to get released it appears, once that's obtained. Now, I retain jurisdiction on this case. If any kind of change of circumstances come up, you bring

the matter and I'll hear this matter, you know, upon agreement of counsel, on very short notice and I'll accommodate counsel. If you find some other place to have her placed, you want me to order something, sir, I'll be happy to look at whatever you have found. Or if the City comes up with some other place for the -- for Miss Washington to reside while she's getting treatment, I'll definitely consider that. So at this time I'm ordering that she be confined. There are two Milwaukee police officers in my courtroom, they can take her into custody and take her over to the CJF with respect to this.

THE DEFENDANT: Your Honor, can I say something?

THE COURT: I am setting this matter for review. The statutes require that the Court review confinement every six months. I'll put the matter on for six months. But with the understanding that if you want me to hear this earlier, if there's any change of circumstance, I would be happy to hear it any time in very short notice. All right. We'll set a date in six months. If the Court -- Actually, if the parties want an earlier review at this point, I'd be happy to set an earlier review.

MR. ROHLICH: I'd prefer an earlier review if you could.

proceeding where I would like to at this point make a motion to dismiss the contempt finding at the end of the State's case and then have the opportunity, based on the Court's ruling, to present evidence.

THE COURT: Well, actually, you know, I was reading over the statute as to this type of hearing because it is an unusual type of action. It's under 252.05 of the statutes regarding tuberculosis. And that statute does allow the Court to confine a person for the treatment of the tuberculosis. What the Court-- What the statute requires is that if I'm going to order a person in confinement more than six months, I have to have a review every six months if I'm going to order her confined. I don't know if that's the--

MR. MUKAMAL: That's exactly how we're proceeding.

THE COURT: This is the only way I know how to proceed is under the statute because it's a specific statute if someone has tuberculosis.

MR. MUKAMAL: That's what I'm asking the Court proceed under. This statute, no other.

THE COURT: Yeah. And I don't know -- really know if the Court has to find contempt per se. There's a separate statute on contempt that I've dealt with in the past, but I don't think that-- You know, this

statute allows for the Court to confine an individual. That's how I read the statute, Mr. Rohlich.

MR. MUKAMAL: That's how I would read it, Your Honor. The only reason that I brought it in the form of a contempt was because we did have a prior order that we contend was violated. But in the alternative, even if that weren't the case, if the case is serious enough, I believe -- I think it's 252.07(8) and (9) would be sufficient.

MR. ROHLICH: Well, I guess that-- I think that answers my question. I'm-- I would argue that the City has not met its burden on the contempt on either the three issues that counsel cited in the beginning. I can address that if the Court wants me to. If the Court feels that it's not necessary to find her in contempt, then I guess I wouldn't argue that and I would argue more about-- Although I think it does have a bearing on the Court's decision, but I'd be happy to proceed just to argue about precisely where she should be confined if the Court feels that's necessary.

THE COURT: Counsel, I don't think the Court has to make an order with respect to contempt in order to have Miss Washington confined.

MR. ROHLICH: No.

THE COURT: Just reading the statute.

MR. ROHLICH: Yes.

THE COURT: And I will--

MR. ROHLICH: No. I agree with you.

THE COURT: --plead my ignorance as well, having never faced this issue, and hopefully judges don't have to face issues with live TB in the community. But under 252.07(9)(a) it talks about the department petitioning the Court for a hearing to determine whether an individual with infectious tuberculosis should be confined for longer than 72 hours in a facility where proper care and treatment will be provided. And it sets forth how you can petition. That's how this matter originally got before the Court.

MR. ROHLICH: Right.

THE COURT: And so that's the case that I have pending in front of me. Now, what happened is there was an order and a stipulation actually that Miss Washington agreed to be confined for that-- My understanding is it was a stipulation. That's how the order read.

MR. MUKAMAL: That's correct, Your Honor.

THE COURT: That she be confined at Aurora for the 30 days when she got the initial doses so she wouldn't be contagious in the community at large. And then we had that hearing on the 27th where we -- it was

asked of the Court that I release her from the hospital and that I order directly observed therapy and this continuing treatment for tuberculosis. And I understand-- We had a conversation with Miss Washington. I understand she was at the hospital on the phone, but I asked her some very pointed questions with respect to complying with these conditions and then she was released and I signed this order. And I just kind of view it as continuing jurisdiction of the Court with respect to this case. And what's happened is it has been brought to my attention that there's been violations -- alleged violations regarding the order. So that's why this matter is before the Court today. I don't need to find contempt. I think that this case -- the statutes require that, you know, there be all other reasonable means of achieving voluntary compliance. And clearly I think that there have been attempts to -- from what I have in front of me. And your client, I have not heard from her yet, Mr. Rohlich. If she wants to dispute what's been said, I haven't heard her side. What I have in front of me right now is -- it appears that your client tested positive from some May specimens and the health department tried to get her into a regimented program and she -- what I've been told-- Like I said, it's one side of the story. I haven't heard from Miss Washington yet. But she took five doses

sporadically and then she disappeared. And it appears the only way the City found out about where she was is when she gave birth to a child and the City had contacted all the -- had contacted some local hospitals on a -- to be aware that they're looking for this individual. Is that a correct statement?

THE WITNESS: Correct.

THE COURT: And then the health department got a phone call saying she's here and that's how this whole case started up. She didn't voluntarily turn herself in saying I'm sorry, I missed some treatments. But she got caught when -- You know, she got caught. She got found when she was giving birth to a child. We had this conversation with Miss Washington on the phone as to what she needed to do, how important it was for her to take her medicine, how important it was for her not to do drugs. And frankly, I was concerned at the hearing when she said she didn't have a drug problem. And I said, you know, being in felony drug court for three and a half years that troubled me when she's saying she didn't have a drug problem when she had used cocaine is my understanding. So anyways, I think I have continued jurisdiction under the statute. And the statute does allow the Court to confine a person for treatment. And obviously I want to insure all other reasonable means of

achieving voluntary compliance of treatment have been exhausted. I clearly want that before I would take someone's liberty away and confine them. And I believe 252.03(9)(c) provides that the Court orders confinement of an individual under this subsection, the individual shall remain confined until the department or local health officer with the concurrence of a treating physician determines that treatment is completed or that the individual is no longer a substantial threat to himself -- or herself or to the public health. If the individual is to be confined for more than six months, the Court shall review the confinement every six months. So I think that's the authority I'd be proceeding under, sir.

MR. ROHLICH: My-- My point was that we did enter into an agreement, and the City's alleging a violation of the agreement. And at the end of the City's case, I was going to argue -- or I am going to argue that they haven't established either of the three violations that they allege. The first one, the failure to reside at her sister's house. There's been no testimony other than the hearsay which the City attorney acknowledged was not being offered for the truth of the matter as to whether she resided at her sister's house. And second, the failure to adhere to a continuous course of treatment. This initial meeting was scheduled for Friday of last week

and she didn't make it, but she was in the custody of the City and I don't think she can be held responsible for missing that meeting when the City did have her in custody and knew where she was. Third, there's been no testimony as to any alcohol or cocaine abuse, and that was the third allegation of the City. And so I would argue that the City has failed to establish with clear and convincing evidence either of the three violations of the agreement that they've alleged here.

THE COURT: Attorney Mukamal, were you going to have the sister come to court? I thought there was some arrangement not for today's hearing but on--

MR. MUKAMAL: Not for today's hearing, Your Honor.

THE COURT: But on Monday was she--

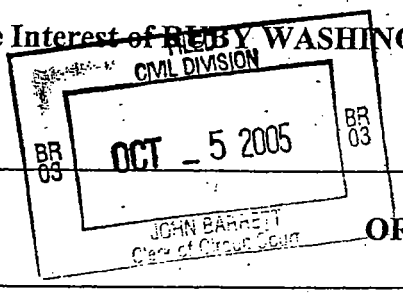
MR. MUKAMAL: I didn't make any such arrangement. She would have been free to. But no, that was not something that I would participate in.

THE COURT: I think you told the Court she was going to come last-- I thought that was told to me on Monday, that she was going to come. But maybe I'm wrong.

MR. MUKAMAL: She came to the other hearing. Wait a minute, wait a minute. She was here for one hearing. She was here on the 27th. I didn't know whether she was going to come on Monday. And it wasn't

STATE OF WISCONSIN **CIRCUIT COURT** **MILWAUKEE COUNTY**

In the Interest of RUBY WASHINGTON



Case No. 05-CV-007563
Code No. 30703

ORDER

WHEREAS, the above matter having come before the Court for hearing on Monday, October 3, 2005 at approximately 2:00 p.m., on the petitioner's Motion seeking an Order for Contempt dated September 29, 2005,

WHEREAS, the petitioner, the City of Milwaukee and its Health Department, by Stuart S. Mukamal, Assistant City Attorney and the respondent, Ruby Washington having appeared in person/by use of a telephone,

WHEREAS, the Court having reviewed the information in the petitioner's Motion for Contempt and accompanying Affidavit of Irmine Reitl;

NOW, THEREFORE, IT IS HEREBY ORDERED, as follows:

1. That the respondent, Ruby Washington, ~~is in contempt of this Court for~~ is and remains a threat to the public health and safety as a consequence of her failure to comply with having ~~disobeyed~~ its previous ORDER FOR ENFORCEMENT OF DIRECTLY OBSERVED THERAPY ORDER AND FOR CONTINUING TREATMENT FOR TUBERCULOSIS dated September 27, 2005;

2. That the respondent, Ruby Washington, be confined in the Milwaukee County Criminal Justice Facility, 949 North 9th Street, Milwaukee, Wisconsin 53233 until further order of this Court;

3. That while confined in the Milwaukee County Criminal Justice Facility, respondent, Ruby Washington, shall fully comply with the provisions of the Directly Observed Therapy Order issued by the Milwaukee Health Department on July 27, 2001 and served upon her on August 22, 2005.

Dated at Milwaukee, Wisconsin, this 5th day of October, 2005.

BY THE COURT

Clare L. Fiorenza

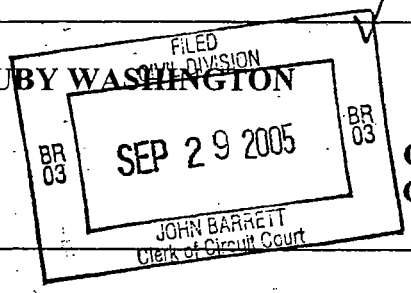
CLARE L. FIORENZA, Branch 3
Circuit Court Judge

1084-2005-2307:97304
Version A

4. That this matter shall be reviewed by the Court on Friday April 7, 2006 at 9:00 A.M. (CLF)

STATE OF WISCONSIN **CIRCUIT COURT** **MILWAUKEE COUNTY**

In the Interest of RUBY WASHINGTON



Case No.: **05-CV-007563**
Code No. **30703**

AFFIDAVIT OF IRMINE REITL IN SUPPORT OF ORDER FOR ENFORCEMENT OF DIRECTLY OBSERVED THERAPY ORDER AND FOR CONTINUING TREATMENT FOR TUBERCULOSIS

STATE OF WISCONSIN)
)ss.
MILWAUKEE COUNTY)

IRMINE REITL, being first duly sworn upon oath, deposes and says:

1. I am a duly authorized officer of the Milwaukee Health Department entrusted with protecting the public health under Chapters 251 and 252 of the Wisconsin Statutes.

2. I am employed by the City of Milwaukee as Communicable and Infectious Disease Program Supervisor. Presently, I am the Program Manager of the Milwaukee Health Department's Tuberculosis Control Clinic ("Clinic"), which is located at the Keenan Health Center, 3200 North 36th Street, Milwaukee, Wisconsin 53216. I have been employed with the Milwaukee Health Department since April, 1984. My job duties entail managing and supervising public health nurses and other support staff in the TB Control Clinic. Among the responsibilities of the TB Control Clinic are to ensure that: (a) individuals infected with tuberculosis adhere to their prescribed therapy; and (b) providing culturally sensitive outreach activities to the community concerning the treatment and suppression of tuberculosis.

3. Attached to this Affidavit as Exhibit 1 and incorporated herein by reference is a true, correct and complete copy of the ORDER FOR ENFORCEMENT OF DIRECTLY

OBSERVED THERAPY ORDER AND FOR CONTINUING TREATMENT FOR TUBERCULOSIS issued by the Court to respondent Ruby Washington on September 27, 2005, including attachments. This Order directs, among other things, that Ruby Washington continuously reside with her sister, Alwiller T. Washington at 2200 North 42nd Street, Milwaukee, Wisconsin 53208 for the entire duration of her treatment and recovery from the disease of tuberculosis and that she fully comply with the provisions of the "Directly Observed Therapy Order" and appended treatment plan issued by the Milwaukee Health Department on July 27, 2005 and served upon her on August 22, 2005, upon her admission to Aurora Sinai Medical Center. A true, correct and complete copy of this "Directly Observed Therapy Order" is attached as page 3 of Exhibit 1 and is incorporated by reference.

4. The respondent, Ruby Washington was released from Aurora Sinai Medical Center on September 27, 2005. Since her release from Aurora Sinai Medical Center, the respondent, Ruby Washington has failed to comply with the provisions of the ORDER FOR ENFORCEMENT OF DIRECTLY OBSERVED THERAPY ORDER AND FOR CONTINUING TREATMENT FOR TUBERCULOSIS referred to in paragraph 3 of this Affidavit, specifically in the following respects:

a. On Thursday, September 29, 2005, at approximately 9:15 a.m., Ruby Washington's sister, Alwiller T. Washington telephoned me to report that her sister, Ruby, had left her residence on Tuesday, September 27, 2005 shortly after being released from Aurora Sinai Medical Center and had not yet returned, to her residence.

b. In our telephone conversation this morning, Alwiller T. Washington relayed to me that she received a telephone call from Ms. Peggy Hobbs, who is a friend of the family, at approximately 9:00 a.m. on Thursday, September 29, 2005. Ms. Hobbs is employed at the Jewel/Osco store on North 35th Street and West North Avenue in the City of Milwaukee and stated to Alwiller that Ruby had come to the Jewel/Osco. Ms. Hobbs then stated she saw Ruby enter an apartment building across the street from the Jewel/Osco.

c. I then contacted Assistant City Attorney, Stuart S. Mukamal and advised him of my conversation with Alwiller T. Washington. Mr. Mukamal directed me to contact the Milwaukee Police Department and have Ruby arrested and taken into custody for failure to adhere to the Order of this Court dated September 27, 2005.

d. I presented myself at the 7th District Police Station located at 36th Street and Fond du Lac Avenue. I explained I needed the assistance of a police officer to obtain a person in violation of a court order, and asked to have an officer meet me in the Jewel/Osco parking lot. An officer was dispatched to meet me at that location.

e. I then returned to the Jewel/Osco store and spoke with Ms. Hobbs who pointed out Ruby, who was now walking in the parking lot south toward North Avenue. I caught up with Ruby and we sat and talked for a few minutes on the curb. During that conversation Ruby said many things that I was unable to understand and seemed less than coherent in her thoughts. Ruby also stated that her lawyer told her all she had to do was come to the clinic on Friday to receive her tuberculosis medication.

f. A Milwaukee Police Department squad car then arrived in the parking lot in front of the Jewel/Osco and Ruby again began to walk south toward North Avenue. I requested that she walk back toward the store with me, but she continued to walk in the opposite direction. I waved to the squad car to join me. As I explained the situation to the officer, I saw Ruby enter a convenience store on the southeast corner of 36th Street and North Avenue.

g. Due to the officer's reluctance to intervene, I presented the officer with the Order signed by this Court on September 27, 2005. I believe that the officer called for additional squads because two more squad cars arrived. Ruby was crying and yelling while the police spoke to her. After a few minutes, Ruby was handcuffed and placed in a squad car. While in the police car, she continued to be agitated and was kicking her feet out of the squad car window and kicking the inside roof of the squad car, all the while loudly screaming, yelling and crying.

h. Ruby was transported to Aurora Sinai Medical Center Emergency Room for a medical assessment prior to being taken to the Milwaukee County Criminal Justice Facility.

i. At approximately 11:00 a.m. today, I met the officers at the Aurora Sinai Medical Center Emergency Room and provided them with a copy of the Order issued by this Court on September 27, 2005.

5. I firmly and verily believe that Ruby Washington's arrest and confinement in a secure detention facility is necessary for the protection of the public health and welfare and to assure that she receives necessary and appropriate treatment for a disease of tuberculosis. I

further firmly and verily believe that no measure short of her arrest and confinement in a secure facility would be sufficient for these purposes.

Dated at Milwaukee, Wisconsin this 29th day of September, 2005.

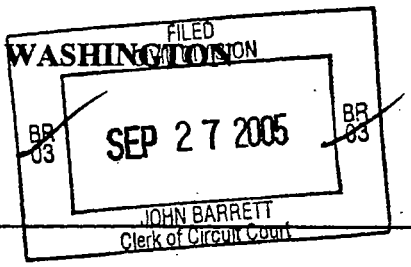
IRMINE REITL

Subscribed and sworn to before me this 29th day of September, 2005.

Notary Public, State of Wisconsin
My commission expires: 4-9-06
1084-2005-2307

STATE OF WISCONSIN **CIRCUIT COURT** **MILWAUKEE COUNTY**

In the Interest of RUBY WASHINGTON



Case No. **05-CV-007563**
Case Code **30703**

ORDER FOR ENFORCEMENT OF DIRECTLY OBSERVED THERAPY ORDER AND FOR CONTINUING TREATMENT FOR TUBERCULOSIS

WHEREAS, the above matter having come before the Court for rehearing on September 27, 2005 at 9:00 a.m., in accordance with the Court's Temporary Order issued following the prior hearing conducted in this matter on August 26, 2005; and

WHEREAS, the petitioner, the City of Milwaukee Health Department, by Stuart S. Mukamal, Assistant City Attorney and the respondent, Ruby Washington having appeared by Public Defender Karl O. Rohlich and in person by use of a telephone; and

WHEREAS, the Court having reviewed the files and records of this matter and the presentations of the parties concerning the current status of this matter; and

WHEREAS, the Court is satisfied that the respondent, Ruby Washington, may be released from inpatient confinement at Aurora Sinai Medical Center but only on the condition that she strictly comply with the petitioner's DIRECTLY OBSERVED THERAPY ORDER concerning her treatment for the disease of tuberculosis issued to her by the City of Milwaukee Health Department on August 22, 2005, and with other measures incidental to that ORDER as prescribed by the City of Milwaukee Health Department until her treatment is complete and she is cured of that disease.

NOW, THEREFORE, IT IS HEREBY ORDERED, as follows:

EXHIBIT 1

1. That the respondent, Ruby Washington, may be released from her confinement in Aurora Sinai Medical Center for treatment of infectious tuberculosis

2. That following her release from Aurora Sinai Medical Center, respondent Ruby Washington fully comply with the terms and conditions of the DIRECTLY OBSERVED THERAPY ORDER issued to her by the City of Milwaukee Health Department on August 22, 2005 and shall fully comply with such further and incidental measures as may be prescribed by the City of Milwaukee Health Department to monitor the progress of her recovery and to assure the continuing effectiveness of treatment, until such time as in the judgment of the City of Milwaukee Health Department, her treatment is complete and she is cured of the disease of tuberculosis.

3. That, following her release from Aurora Sinai Medical Center, respondent Ruby Washington shall reside with her sister, Alwiller T. Washington at 2200 North 42nd Street, Milwaukee, Wisconsin 53208 and shall continuously reside and remain available for contact at that address until such time as in the judgment of the City of Milwaukee Health Department, her treatment is complete and she is cured of the disease of tuberculosis.

4. That in the event that respondent, Ruby Washington fails to fully and completely comply with the provisions of this Order, she may be subject to imprisonment, to renewed isolation and inpatient confinement pursuant to Wis. Stat. §§252.07(8) and (9) and/or to such other and additional sanctions for contempt of court as this Court may determine.

Dated at Milwaukee, Wisconsin, this 2nd day of September, 2005.

BY THE COURT

CLARE L. FIORENZA

CLARE L. FIORENZA, Circuit Judge
Branch 3, Milwaukee County Circuit Court

1084-2005-2307:97115

City of Milwaukee
Health Department

Tom Barrett
Mayor

Bevan K. Baker, CHE
Commissioner of Health

Vivian T. Chen, MSW, MCD
Health Operations Director

Family and Community Health Services

Keenan Health Center @ 3200 N 36th Street @ Milwaukee, WI 53216

web site: www.milwaukee.gov

DIRECTLY OBSERVED THERAPY ORDER

TO: Ruby Washington
DOB: 02/03/1967

I have been informed and have confirmed that you have been diagnosed with infectious tuberculosis.

Wisconsin Statutes Chapter 252 and Wisconsin Administrative Code Chapter HFS 145 regulate the control of infectious diseases, including tuberculosis. For the protection of the public health, you are required to follow a specific plan of proper medical treatment for your disease. Proper treatment includes:

- taking prescribed medication;
- other medical treatment as prescribed for your infectious disease;
- no public contact while infectious; and
- other specific measures as noted below to protect the public health.

Therefore, as authorized by the Public Health Officer for Milwaukee, Wisconsin, and by the Statutes and Rules noted above, I am ordering you to have the ingestion of your tuberculosis medications directly observed by a medical professional. If you are in the hospital this observation may be done by your hospital nurses; otherwise, I am ordering you to meet with a Public Health Nurse designated by me, at times and places designated by the nurse, to have the ingestion of your tuberculosis medications directly observed.

You are further ordered to comply with these directly observed therapy orders until such time as I have medical verification that you have completed your course of treatment are no longer considered a public health risk.

This order is effective as of this date, July 27, 2005, and is to stay in effect until I withdrawn this order. A violation of this order will result in a request to the courts for appropriate orders to protect the public health and may result in possible criminal violations of the Wisconsin Public Health Statues and Rules.

Dated at Milwaukee, Wisconsin, this July 27, 2005.

MD

Geoffrey R. Swain, MD, MPH
Associate Medical Director

Ruby D Washington
Client's Signature

8/22/05
Date

City of Milwaukee
Health Department

Tom Barrett
Mayor

Bevan K. Baker, CHE
Commissioner of Health

Vivian T. Chen, MSW, ScD
Health Operations Director

Family and Community Health Services

web site: www.milwaukee.gov

TB Control Clinic * 3200 N 36th Street * Milwaukee, WI 53216 * 414-286-8630

September 26, 2005

To: Whom it may concern

From: Daniel Herrell, MD
Medical Consultant, TB Control Clinic
Milwaukee Health Department

Re: Tuberculosis treatment plan for Ruby D. Washington (2/3/1967)

Medications: Isoniazid (INH), Rifampin (RIF), Pyrazinamide (PZA) and Ethambutol (EMB), dosages based on client weight and American Thoracic Society, Center for Disease Control & Infectious Disease Society of America guidelines as published in "Treatment of Tuberculosis" MMWR, Vol.52, June 2003.

- PZA for 8 weeks
- EMB until sensitivities are known.
- INH,RIF and B-6 (vitamin) for the full length of treatment

Length of Treatment: At minimum, 39 weeks of intermittent twice weekly DOT (directly observed therapy).

Field delivered DOT: DOT will be administered under supervision of Milwaukee Health Department/TBCC personnel. It will be necessary for the patient to be available at 2200 N. 42nd St., Milwaukee, WI 53208 on 2 mornings each week to ingest medications until treatment is completed. (At this time the plan is DOT for Tuesdays and Fridays before 12 noon.)

Intake appointment at TBCC: Ms. Washington is to report to the TBCC on **Friday September 30, 2005 at 9:45am** to complete assessment and intake procedures necessary for continuation of care. As part of the appointment Ms. Washington will receive her dose of TB medications. (Bus fare to come the appointment has been issued for the patient care of Ms. Washington sister Ms. Alwiller "Sheena" Washington. Additional bus fare will be provided to the patient at the conclusion of the appointment.)

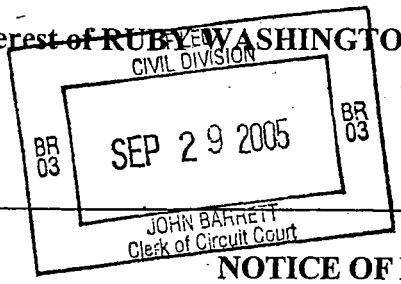
Follow-up at TB Control Clinic (TBCC):
The patient will need to come to the TBCC for necessary lab work (blood tests) and x-rays. The patient will be asked to submit sputum samples.

The standard care plan includes:

- Chest x-ray: Per TB Clinic protocol with a minimum of a posterior-anterior (PA) film every other month, and 4 views at the end of treatment, including PA, left lateral, right and left anterior oblique.
- Sputum Collection: Per TB Clinic protocol with a minimum of monthly collection until sputum conversion (documentation of negatives smear and negative cultures).
- Blood Collection: Per TB Clinic protocols with a minimum of monthly liver enzyme ALT monitoring, Creatinine every 3 months while on EMB. Serum uric acid if signs and symptoms of adverse reactions to PZA develop.
- Vision Monitoring: Per TB Clinic protocol with a minimum of baseline Ishihara and Snellen, followed by monthly Snellen and red-green color discrimination.

STATE OF WISCONSIN CIRCUIT COURT MILWAUKEE COUNTY

In the Interest of RUBY WASHINGTON



Case No. 05-CV-007563
Code No. 30703

NOTICE OF MOTION AND MOTION OF CONTEMPT AGAINST RESPONDENT RUBY WASHINGTON

PLEASE TAKE NOTICE that on Monday, October 3, 2005, at 2:00 p.m., the petitioner in the above-referenced matter, City of Milwaukee and its Health Department, will appear before the Honorable Clare L. Fiorenza, Milwaukee County Circuit Judge, or whoever is sitting in her place, Branch 3, Room 402, Milwaukee County Courthouse, 901 North 9th Street, Milwaukee, Wisconsin 53233, to present its motion of contempt against Ruby Washington, and for the issuance of a bench warrant/capias ordering her arrest and confinement in the Milwaukee County Criminal Justice Facility for violating the ORDER FOR ENFORCEMENT OF DIRECTLY OBSERVED THERAPY ORDER AND FOR CONTINUING TREATMENT FOR TUBERCULOSIS issued by the Court in this matter on September 27, 2005.

The petitioner, City of Milwaukee and its Health Department, by City Attorney Grant F. Langley, by Assistant City Attorney Stuart S. Mukamal, brings this motion of contempt against the respondent, Ruby Washington, pursuant to Chapter 785 of the Wisconsin Statutes and other applicable provisions of law, for violating the ORDER FOR ENFORCEMENT OF DIRECTLY OBSERVED THERAPY ORDER AND FOR CONTINUING TREATMENT FOR TUBERCULOSIS issued by the Court in the above-captioned matter on September 27, 2005.

In support of this Motion, the petitioner will present evidence that Ruby Washington violated the forgoing ORDER FOR ENFORCEMENT OF DIRECTLY OBSERVED THERAPY

ORDER AND FOR CONTINUING TREATMENT FOR TUBERCULOSIS by failing and refusing to reside continuously at the residence of her sister, Alwiller T. Washington at 2200 North 42nd Street, Milwaukee, Wisconsin 53208, but instead returning to the streets. The Petitioner will additionally present evidence that, unless Respondent, Ruby Washington, is not arrested and confined in the Milwaukee County Criminal Justice Facility, she will fail and refuse to receive regular and periodic treatment for the disease of tuberculosis under the direct observation by representatives of the Milwaukee Health Department in accordance with that Department's "Directly Observed Therapy Order" dated July 27, 2005, issued to her on August 22, 2005, and associated treatment plan, which have been enforced by the aforementioned ORDER of this Court.

Further grounds for this Motion are set forth in the accompanying affidavit of Irmine Reitl.

Dated at Milwaukee, Wisconsin, this 29th day of September, 2005.

GRANT F. LANGLEY
City Attorney

Stuart S. Mukamal

STUART S. MUKAMAL
Assistant City Attorney
State Bar No. 01016992
Attorneys for Petitioner
City of Milwaukee and its Health Department

P.O. ADDRESS:
800 City Hall
200 East Wells Street
Milwaukee, WI 53202
Telephone: (414) 286-2601
1084-2005-2307:97300

City of Milwaukee
Health Department

Tom Barrett
Mayor

Bevan K. Baker, CHE
Commissioner of Health

Vivian T. Chen, MSW, ScD
Health Operations Director

Family and Community Health Services

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October 6, 2005

Clare L. Fiorenza, Branch 3
Circuit Court Judge
901 N. 9th St., Room 402
Milwaukee, WI 53233

Re: Ruby D. Washington (DOB 2-3-67)

Dear Judge Fiorenza,

It is the opinion of the City of Milwaukee Health Department Tuberculosis Control Clinic (MHD TBCC) that Ms. Ruby D. Washington's tuberculosis is not communicable to others at this time. This opinion is based on analysis of treatment received to date and evaluation of laboratory information. Ms. Washington would become a threat to the public health if she does not strictly adhere to treatment for her tuberculosis until it is completion.

On Wednesday morning 10/5/05, while in the custody of the Milwaukee Police Department, Ms. Washington was evaluated at the Aurora Sinai Medical Center (ASMC) and was "medically cleared" by the Emergency Department's treating physician. This clearance indicates there is no need for admission or additional emergency medical care. A copy of that report is included with this fax and has been faxed to health services at the Milwaukee County Jail to the attention of John P. Riegert, RN Nursing Supervisor.

The following laboratory information along with the clinical record provides substantiation for the opinion that Ms. Washington is able to remain in the general population of the Milwaukee County Criminal Justice Facility.

Since the confirmatory culture of tuberculosis on a sample collected on 5/19/05, Ms. Washington has had several follow up samples analyzed. Samples from 5/20/05 and 5/24/05 were smear negative for the presence of acid-fast bacilli (AFB) and culture negative for TB. (AFB are organisms that retain certain stains, even after being washed with acid alcohol. Most acid-fast organisms are mycobacteria. When AFB are seen on a stained smear of sputum or other clinical specimen, a diagnosis of TB should be considered a possibility.)

Samples were also collected during Ms. Washington's stay at ASMC. The sample from 8/23/05 showed no AFB and the mycobacterium direct test (MTD), was negative. (MTD is a test used to rapidly detect the presence of TB DNA in a sample. The test was

completed by the Wisconsin State Laboratory of Hygiene in Madison.) The cultures for the 8/23/05 sample remain negative as of 10/3/05. The sample collected on 8/24/05 showed rare AFB and the MTD test was negative. Culture results for the 8/24/05 sample remain negative as of 10/3/05. The 8/25/05 sample is negative for AFB and the culture is negative as of 10/3/05.

The sample collected 8/31/05 is smear negative and the culture grew *Mycobacterium Avium complex* (MAC). MAC is found in the environment and is not transmissible between humans. It is possible and not uncommon to find both TB and Avium in an individual patient. Avium can also be found in healthy people.

Samples collected 9/1/05 and 9/2/05 at ASMC are smear negative and remain culture negative. Final cultures are expected in mid to late October.

Ms. Washington received anti-TB medications at ASMC as inpatient from 8/26/05 through 9/27/05 when she was released from ASMC. Ms. Washington also received anti-TB medications on 9/30/05 and 10/1/05 at the County Correctional facility during her stay. In order for her to remain non-contagious she must continue taking her anti-TB medications according the regimen prescribed in her treatment plan.

Based on the analysis of Dr. Daniel Herrell, medical consultant for the MHD/TBCC, and the expertise of the public health nurses of the MHD/TBCC Ms. Washington's hospital treatment for TB combined with laboratory information currently available for Ms. Washington does not require continued isolation.

The same conclusion for the scenario described above would apply to any patient with pulmonary TB and would lead to their release from isolation. It is the special circumstances of this case i.e., noncompliance and being unavailable for treatment that have led to necessary action of confinement to assure treatment is completed.

After the court hearing on Oct 5, 2005 at about 5:45pm I spoke with John P. Riegert, RN Nursing Supervisor, Sheriff's Department, County of Milwaukee, 949 N. 9th St. (226-7142). Nurse Reigert was provided information regarding Ms. Washington's anti-TB medications and was advised that she was not considered infectious at this time and could be housed in the jail's general population. The only special instructions to Nurse Reigert were that Ms. Washington receives directly observed therapy to assure ingestion of her prescribed anti-TB medications.

Please call if I can be of any additional assistance.

Sincerely,

Irmine Reitl, MSN RN
Communicable and Infectious Disease Program Supervisor
TB/CD Manager

Keenan Health Center/Tuberculosis Control Clinic
3200 N. 36th St.
Milwaukee, WI 53216-3716

Office: 414-286-8555
Cell: 414-324-1676

Cc: Stuart Mukamal, Assistant City Attorney
Karl Rohlich, State Public Defender Office 10930 W. Potter Rd. # D, Wauwatosa, WI 53226-3450 (fax: 414-266-1217)
Paul Biedrzycki, Milwaukee Health Department Disease Control and Prevention Manager
Mat Wolters, Milwaukee Health Department

Aurora Sinai Medical Center

Emergency Department

945 North 12th Street
Milwaukee, WI 53233
T (414) 219-6666
F (414) 219-6650

WASHINGTON, RUBY D
DOB: 02/03/1967 38Y F
ATT:EMPEC, X
ADM:EMPEC, X

M: 269572
F: 5466244
REG: 10/05/05
ED

STANDARD DISCHARGE INSTRUCTIONS

Medically Clear

You have been evaluated by our Emergency Department Staff and have received **Emergency Care Only. Your condition may change and require you to be seen again.**

Diagnosis: Poor compliance TB medication

☐ Follow up with your own doctor

_____.

☐ Call your physician or insurance provider for referral for follow up and/or further treatment if no improvement after taking prescribed medications or treatment.

Return to Emergency Dept. if you feel worse before being able to follow up with your doctor/clinic.

Other Instructions: Patient is medically cleared at any acute medical condition

Call Dr Horwitz at PCS if need their services 257-7260

Care Instructions Sheets Given:

☐ Asthma	☐ Pelvic inflammatory disease	☐ Nausea/Vomiting/Diarrhea
☐ Asthma Education 414-219-6221	☐ Sexually transmitted disease	☐ _____
☐ Fever/Otitis/Cold	☐ Urinary tract infection	☐ _____
☐ Head Injury	☐ Wound Care	☐ _____

Self-Care or Learning Needs:

☐ None ☐ See Emergency Dept. chart for comments ☐ Interpreter Used

Discharged per: ☐ Ambulatory ☐ W/C ☐ Crutches ☐ Ambulance

Staff Initial: MS Discharge Time: 11:20 Date: 12/5/05

Accompanied By: Police + Health Dept

White - Medical Records / Yellow - Patient

STATE OF WISCONSIN CIRCUIT COURT Branch 3 MILWAUKEE COUNTY

In Interest of RUBY W.:

CITY OF MILWAUKEE,

Petitioner-Respondent,

v.

RUBY W.,

Respondent-Appellant.

NOTICE OF APPEAL
Case No. 05-CV-007563

2005 DEC 21 PM 1:59
OFFICE OF CITY ATTORNEY
CITY OF MILWAUKEE RECEIVED

TO: Clerk of Circuit Court (Milwaukee) City Attorney

Above Ruby W., by her attorney, William J. Tyroler, hereby appeals to the Court of Appeals, District I, from the whole of the Order (confinement for tuberculosis treatment, Wis. Stat. § 252.07(9)), entered on October 5, 2005, (Hon. Clare L. Fiorenza).

This appeal is not within Wis. Stat § 752.31(2). Although the appeal is not entitled to *preference* under Wis. Stat (Rule) § 809.10(1)(b)4., **the appeal must be accelerated under Wis. Stat. § 252.07(9)(e) ("An appeal shall be heard within 30 days after the appeal is filed").**

Dated: December 21, 2005.

WILLIAM J. TYROLER,
State Bar No. 1016229
Assistant State Public Defender

735 North Water Street, Room 912
Milwaukee, WI 53202
Telephone: (414) 227-4134

Attachment: Order Appointing Counsel

cc: Cornelia Clark, Clerk of Court of Appeals

COPY

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JOHN BARRETT
Clerk of Circuit Court

TAY

To Be Drafted

[redacted]	DHFS	[redacted]	90
[redacted]	Matt Tompach	[redacted]	
		[redacted]	☐

[redacted]

Chapter 252 of the state statues is devoted to tuberculosis. Many of these sections were drafted when treatment for TB was not as advanced as it is now and are consequently outdated.

This amendment provides the following updates to CH 252:

Require the laboratories that perform primary culture for mycobacteria also perform organism identification for M. tuberculosis complex and that laboratories that identify M. tuberculosis assure that antimicrobial drug susceptibility tests are performed;

Permit local health officers to issue an emergency detention order;

Expand s. 252.973 (commitment) to describe under what circumstances a local health officer or the department may petition the court to order the commitment of a person, under what circumstances the commitment may be terminated and what the rights of the committed person, including right to appeal, are;

Insert the phrase "by court order" after the word "isolated" in s. 252.08 (3);

Delete obsolete language related to TB sanitariums and TB acute treatment centers;

Delete certain language related to reimbursable services for public health dispensaries and include that language in the administrative rule. Add language allowing any local health department to request public health dispensary certification.

[redacted]

None

[redacted]

DHFS. Update Chapter 252 of the state stautes, relating to tuberculosis.

Health and Social Services- continued

PUBLIC HEALTH

Act 9 *(AB-133)* makes various changes to the laws relating to public health. The act:

1. Creates a Tobacco Control Board and requires the board to distribute funds to programs designed to promote the cessation and prevention of tobacco use.

2. Creates a tobacco control fund from which may be spent moneys received as part of the state's settlement agreement with the tobacco industry.

3. Authorizes DHFS to contract with local health departments to conduct unannounced investigations of retail outlets where tobacco products are sold to survey levels of compliance with the prohibitions against selling tobacco products to minors. The act permits minors who are at least 15 years of age to buy, or attempt to buy, tobacco products as part of an investigation if certain conditions are met.

4. Requires DHFS to award grants for activities to improve the health status of economically disadvantaged minority groups and to establish several initiatives designed to address the health care concerns of minority groups.

5. Makes several changes to the public health laws relating to tuberculosis, including:

a. Eliminating the authority of counties to establish and maintain public health dispensaries for persons with tuberculosis or other pulmonary diseases and instead authorizing DHFS to certify counties meeting specified criteria to establish public health dispensaries.

b. Authorizing DHFS or a local health officer to order an individual with tuberculosis or a suspected case of tuberculosis to confinement in a facility for no more than 72 hours if certain conditions are met and creating a process by which a person with infectious tuberculosis or with a suspected case of tuberculosis may be confined for more than 72 hours.

c. Requiring a laboratory that tests for tuberculosis to report to the local health officer and DHFS all positive test results and specifying that these laboratories use certain procedures and perform certain types of tests when testing for tuberculosis.

6. Requires DHFS to conduct a study of the electronic benefits system of the Supplemental Food Program for Women, Infants and Children (WIC), under which supplemental food, nutrition education and other services are provided to women, infants and children.

OTHER HEALTH AND SOCIAL SERVICES

Act 8 *(AB-449)* postpones from October 1, 1999, to February 1, 2000, the effective date of the caregiver background check law as applied to current employees of certain health care facilities and of entities that provide care for children.

Act 9 *(AB-133)* changes various other laws relating to health and social services. The act:

1. Creates Family Care (see *HIGHLIGHTS*).

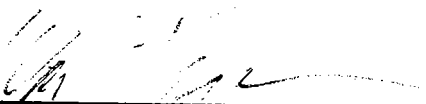
2. Eliminates the authority of the Department of Commerce to regulate sources of ionizing and nonionizing radiation (former law authorized DHFS and the Department of

Certification of Appendix

I hereby certify that filed with this brief, either as a separate document or as a part of this brief, is an appendix complying with Rule 809.19(2)(a) and containing: (1) table of contents; (2) relevant trial court record entries; (3) the findings or opinion of the trial court; and (4) portions of the record essential to an understanding of the issue raised, including oral or written rulings or decisions showing the trial court's reasoning regarding those issues.

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 person, 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.

Respectfully submitted,



WILLIAM J. TYROLER
Attorney for Respondent-Appellant-Petitioner
SB No. 1016229

IN THE SUPREME COURT
FOR THE STATE OF WISCONSIN

In the Interest of Ruby Washington

CITY OF MILWAUKEE,

Petitioner-Respondent,

v.

RUBY WASHINGTON,

Respondent-Appellant-Petitioner.

BRIEF OF THE PETITIONER-RESPONDENT CITY OF MILWAUKEE CIRCUIT COURT CASE NO. 05CV007563 APPEAL NO. 2005-AP-3141

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ISSUES PRESENTED FOR REVIEW

1. Respondent-appellant-petitioner, Ruby Washington ("Washington") was: (a) an individual diagnosed with active tuberculosis, who; (b) was uncooperative and repeatedly refused to comply with her prescribed treatment plan; (c) posed an imminent and substantial danger to the public health; (d) escaped and disappeared from public view rather than submit to treatment for her disease; and (e) had no medical need for hospitalization. Under such circumstances, does Wisconsin's tuberculosis-control statute, Wis. Stat. § 252.07(9) permit a circuit court to order confinement of Washington in a secure correctional facility to assure treatment for her disease and to prevent its spread among the public?

Answered by the Court of Appeals: Yes.

2. Did Washington's confinement in a secure correctional facility for the duration of her

treatment for tuberculosis violate the Fourth Amendment to the United States Constitution, the Due Process or Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution, or the Americans With Disabilities Act?

Answered by the Court of Appeals: The Court of Appeals did not address these contentions because they were either not raised or developed by Washington.

3. Did the willful violation by Washington of the Circuit Court's order of September 27, 2005, entered upon stipulation, concerning treatment for her disease of tuberculosis and her residential arrangements during the course of treatment constitute a *de facto* "functional" contempt of court, permitting imposition against her of those remedial sanctions specified in Wis. Stat. §§ 785.04(1) and (a) through (e) as an additional justification for her confinement in a secure

correctional facility? If so, did the Court of Appeals follow applicable statutory contempt provisions?

Answered by the Court of Appeals: Yes to both inquiries.

STATEMENT OF THE CASE[1]

A. Washington's Tuberculosis.

Washington had active pulmonary tuberculosis, a dangerous and highly communicable disease that threatens public health, safety, and welfare. Washington was first suspected of carrying tuberculosis because of a chest x-ray dated April 7, 2005, and laboratory analysis of her sputum culture provided to the Milwaukee Health Department ("Department") on May 19, 2005 (R. 2, ¶ 3; R. 3, ¶¶ 7-8, R. 16, 17, R. 24 pp. 17-18). The Department confirmed its diagnosis on June 17, 2005 (3:¶ 8 and Ex. 1). It was

[1] Citations to "X:Y" refer to the appeal record in Appeal No. 2005-AP-3141 with "X" denoting the appeal document number and "Y" denoting page(s) within that document. Citations to "P-Br. pp. __" refer to Petitioner's (Washington's) Brief to the Supreme Court and citations to "App. pp. __" refer to the Appendix attached to that Brief.

confirmed again when a smear from a sputum sample obtained from Washington on August 24, 2005 showed the presence of acid fast bacilli (AFB), a tuberculosis "marker" (16; 17; 24:18-19).

Drug therapies have been developed for the treatment and cure of tuberculosis (24:12). These therapies, however, are extremely regimented, vary depending upon the patient's physical condition, and must be strictly followed for their entire course to assure effectiveness. The effects of tuberculosis and the course of its treatment are unique, as described in *City of Newark v. J.S.*, 279 N.J. Super. 178, 186-188, 652 A.2d 265, 268-269 (1993):

> TB is a communicable disease caused by a bacteria or bacilli complex, mycobacterium (M.) tuberculosis. One of the oldest diseases known to affect humans, it was once known as consumption or the great "white plague" because it killed so many people. Human infection with M. tuberculosis was a leading cause of death until antituberculous drugs were introduced in the 1940s.
>
> * * *
>
> Typical symptoms of *active* TB include fatigue, loss of weight and appetite, weakness, chest

pain, night sweats, fever, and persistent cough. Sputum is often streaked with blood; sometimes massive hemorrhages occur if TB destroys enough lung tissue. Fluid may collect in the pleural cavity. Gradual deterioration occurs. If *active* TB is not treated, death is common.

Only persons with *active* TB are contagious. That active state is usually easily treated through drugs. Typically a short medication protocol will induce a remission and allow a return to daily activities with safety. A failure to continue with medication may lead to a relapse and the development of MDR-TB (multiple drug resistant TB), a condition in which the TB bacilli do not respond to at least two (isoniazid and rifampin) of the primary treatments, so that the active state is not easily cured and contagiousness continues for longer periods.

* * *

Active TB of the lungs is considered contagious and requires immediate medical treatment, involving taking several drugs. Usually, after only a few days of treatment, infectiousness is reduced markedly. After two or four weeks of treatment, most people are no longer contagious and cannot transmit TB to others even if they cough or sneeze while living in close quarters. ... To cure TB, however, continued therapy for six to twelve months may be required. Failure to complete the entire course of therapy risks a relapse and the development of MDR-TB.

> MDR-TB results when only some TB bacilli are destroyed and the surviving bacilli develop a resistance to standard drugs and thus become more difficult to destroy. This resistance may involve several drugs and directly results from a patient's failure to complete therapy.

(Emphasis in original; *see also* 24:11).

Although the contagious stage of tuberculosis is alleviated by a short course of drug therapy, that therapy will not remain effective unless the patient faithfully adheres to the full course of prescribed treatment. Failure to do so engenders likelihood of relapse, return to contagiousness, and development of multiple drug-resistant tuberculosis (*see also* 9; 22:5-7; 24:11-12, 14-16, 21, 26-27, 60-61, 67-68).

Once the contagious stage of tuberculosis has been alleviated, it may be successfully treated and cured through drug therapy (ingestion of anti-tuberculosis medication on a prescribed schedule), if the patient is cooperative and strictly follows the prescribed treatment regimen. Hospitalization, isolation, or secure confinement is not necessary for cooperative patients, once non-contagiousness has been achieved. Such measures are required only for uncooperative

patients who fail or refuse to adhere to their treatment regimen because of their behavior, not because of their disease.

Washington's treatment plan (9) dated September 26, 2005 specified the "length of treatment" as "at minimum, 39 weeks of intermittent twice weekly DOT" (directly observed therapy). The initial phase required periodic ingestion of a four-drug "cocktail" consisting of Isoniazid, Rifampin, Pyrazinimide, and Ethambutal, which must be ingested orally at least twice weekly, and sometimes more frequently (24:13-14; treatment plan; (9), category entitled "Medications"). Strict adherence to this regimen was essential; noncompliance would cause Washington's tuberculins to develop "acidics of resilience" (*i.e.*, drug resistance). Irmine Reitl, manager of the Department's Tuberculosis Control Clinic ("Clinic"), described the consequences of non-adherence (missed doses) as follows:

> The consequences are difficult for the patient. They can require more toxic drugs be used for a more protracted period of time. The drugs tend to cause more side affects [sic]. Depending on

> what would happen with resistance, it could cause [sic] the patient their life. The other problems are as the patient becomes resistant, they become again infectious and they're again able to transmit a resistant organism onto people that they spend time with.

(24:14; *see also* 24:21, 26-27).

Ms. Reitl characterized this as "a significantly more dangerous situation for the public" (24:15). Washington could, by coughing, laughing, singing, talking, sneezing, or even breathing in a room where another person is present, transmit to others the same type of active pulmonary tuberculosis that she had (24:12, 15, 16).

Successful treatment of tuberculosis also requires periodic laboratory and other testing to assess the course of the disease, the effectiveness of treatment, and the progress of recovery. Washington's treatment plan required that she periodically report to the Clinic for laboratory work, x-rays, and other medical assessment (9, category entitled "Follow Up at TB Control Clinic (TBCC)").

B. Washington's Hospitalization at Aurora Sinai Medical Center.

Washington did not have a fixed address (3:¶ 8). At the time of her diagnosis, she was living in a shelter, and was issued bus tickets by the Department to travel to the Clinic for administration of tuberculosis medication under direct observation (3:¶ 8). Washington failed to appear at two scheduled appointments and disappeared. The Department issued two orders on July 27, 2005, one directing that Washington take tuberculosis medication under direct observation (3:Ex. 2, "Directly Observed Therapy Order"), and one requiring her to remain at home or in a hospital and "to have absolutely no contact with the public" (3:Ex. 3, "Isolation Order"; see also 24:17). These orders could not be served upon Washington because she had disappeared. (3:¶ 9; 24:16, 28-29).

On August 22, 2005, the Department was informed that Washington was at Aurora Sinai Medical Center, giving birth (3:¶ 9; 24:29). The Department immediately served Washington with copies of their July 27, 2005 orders, which

she acknowledged receipt of and signed (3:¶9, Exs. 2, 3; 8). Washington threatened to leave Aurora Sinai Medical Center against medical advice, which concerned the Department given her diagnosis of active tuberculosis and the risk to the public were she to return to the streets and disappear again (3:¶ 10; *see also* 2:¶ 5). The petitioner-respondent, City of Milwaukee ("City"), filed a petition with affidavits for enforcement of its orders pursuant to Wis. Stat. § 252.07(9) (1; 4; 5; 6).

C. The Circuit Court Proceedings.

The initial hearing on the City's petition was conducted on August 26, 2005 before Judge Maxine A. White (21). The State Public Defender's Office was appointed to represent Washington pursuant to Wis. Stat. § 252.07(9)(d). Counsel for both parties stipulated that Washington would remain at Aurora Sinai Medical Center and receive treatment for tuberculosis until at least September 27, 2005, pending a review hearing on that date before Judge Clare L. Fiorenza. That hearing would address the progress of Washington's

recovery, conditions for her release from Aurora Sinai Medical Center, residential arrangements, the nature and extent of continuing treatment for her tuberculosis, and specification of measures to assure that she remained available on a continuous basis for treatment. The "Temporary Order for Enforcement of Isolation Order" issued by Judge White on August 29, 2005 (7) addressed these items. Washington remained confined at Aurora Sinai Medical Center, under guard, until September 27, 2005, receiving daily tuberculosis medication. Consequently, she became non-contagious, although contagiousness would return if she ceased taking medication (24:19-20, 31-32, 36, 59-60; App. pp. 123-124, 133, 150-153).

At the September 27, 2005 hearing, the parties, through counsel, reached a second stipulation that allowed Washington's release from Aurora Sinai Medical Center into the custody of her sister subject to adherence to strict terms and conditions, including that: (a) she fully comply with the terms of the July 27, 2005 "Directly Observed Therapy

Order" and "Isolation Order" (3:Exs. 2, 3); (b) she reside continuously with her sister and remain available there for contact and treatment until the Department judged that treatment was complete and she was cured of tuberculosis; and (c) she comply with any further measures prescribed by the Department to monitor the progress of her recovery and to assure the continuing effectiveness of treatment (10:¶¶ 1-3; 22:3-5, 16-20, 21-22).

Additionally, the parties stipulated to the following provision specifying the consequences of any noncompliance on Washington's part:

> That, in the event that respondent, Ruby Washington, fails to fully and completely comply with the provisions of this Order, she may be subject to imprisonment, to renewed isolation and inpatient confinement pursuant to Wis. Stat. §§ 252.07(8) and (9) and/or to such other and additional sanctions for contempt of court as this Court may determine.

(10:¶ 4).

Judge Fiorenza issued an order containing these provisions (10, hereafter the "Stipulated Order"). She and counsel for both parties repeatedly explained the terms of the

Stipulated Order to Washington (who appeared at the hearing by telephone). Washington affirmed that she understood those terms and the consequences of noncompliance (including the possibility of incarceration in a correctional facility), and agreed to abide by them (22:6-7, 15-16, 21-22).

During this hearing, it became apparent that Washington was a current, active cocaine user (22:7-14; *see also* 24:47-48). At no time does the record indicate that Washington sought or obtained treatment for cocaine use or that she ever began the process of recovery from her cocaine use.

D. Washington's Escape, Arrest, Confinement, Subsequent Release and Escape, and the October 5, 2005 Confinement Hearing.

Washington immediately violated the Stipulated Order. Upon release from Aurora Sinai Medical Center, she left her sister's residence and returned to the streets. This violated the condition that Washington continuously reside with her sister throughout the period of her treatment (10:¶ 3; 14:¶ 3).

The Department was informed of Washington's escape on September 29, 2005, when Washington's sister telephoned Ms. Reitl and stated that Washington had left her residence and had not returned. Ms. Reitl, accompanied by a City police officer, located Washington, and conducted a short conversation with her. A squad car arrived, and was presented with a copy of the Stipulated Order. Washington was taken into custody (14:¶4.g.; 24:22-23). She was transported to Aurora Sinai Medical Center for medical assessment and thereupon to the Milwaukee County Criminal Justice Facility (14:¶ 4.h.; 24:23). The City filed a Motion for Contempt, (11-14), which was scheduled for hearing before Judge Fiorenza on October 3, 2005 at 2:00 p.m.

Meanwhile, Washington was released from the Milwaukee County Criminal Justice Facility on October 1, 2005, and disappeared again. The City was not informed of her release until the start of the hearing before Judge Fiorenza on October 3, 2005 (23:3-5; 24:23-24). This necessitated adjournment of that hearing until Washington could be

located (23). She was eventually located on the morning of October 5, 2005 at a friend's home, and was detained by the police (24:25-26), transported to Aurora Sinai Medical Center for medical assessment (App. p. 153), and held at the Third District Station of the Milwaukee Police Department until Judge Fiorenza could convene a hearing that afternoon (24:26).

The October 5, 2005 hearing was a full adversarial proceeding. Ms. Reitl provided uncontested testimony concerning the nature of Washington's tuberculosis, and the necessary treatment for that disease, Washington's diagnosis, prognosis, consequences of failure to faithfully adhere to her treatment regimen, hospitalization, escapes, violations of the Stipulated Order, and unwillingness to follow any treatment regimen except under conditions of secure confinement and compulsion (24:10-32, 41-43, 45-48). She also testified that there was no indication that Washington was suffering from any form of mental illness (24:32).

Washington, who was represented by counsel, conceded that she had violated the Stipulated Order in the following respects: (a) failure to reside at her sister's house, choosing instead to stay at an unspecified friend's house (24:49-51); and (b) failure to take her prescribed medication, even on the day immediately prior to the hearing, claiming that "it had slipped my mind" (24:51-52, 61).

The City requested Washington's confinement at the Milwaukee County Criminal Justice Facility where tuberculosis treatment could be rendered in a secure environment from which she could not escape, noting that: (a) she could not be trusted to maintain adherence with treatment under any other conditions; and (b) there was no other suitable facility in the community within which she could be placed (24:54-56). Washington's counsel did not oppose the idea of secure confinement, contesting only the place of confinement. He suggested Aurora Sinai Medical Center and the Milwaukee County Behavioral Health Division as alternatives (24:56-57). The City opposed these suggestions

because: (a) this was not a civil-commitment proceeding; (b) a hospital would not assure the necessary degree of security that a correctional facility could provide; and (c) hospitalization was not medically necessary (App. pp. 150-153) and was very expensive, imposing a wasteful and unnecessary burden upon City taxpayers (24:57; App. p. 121).

Judge Fiorenza concluded that "There is a huge threat to our community if Miss Washington is walking around our community not taking her medicine for tuberculosis." (24:59; App. p. 123), and that "Washington cannot comply with court orders" (24:61; App. p. 125). She confirmed that Washington had violated the terms of the Stipulated Order (24:62-64; App. p. 126-128), that placement at the Milwaukee County Criminal Justice Facility was the only appropriate place for her in view of the "need to have a locked facility where she's going to stay put" (24:64; App. p. 128), and that months-long taxpayer-funded hospitalization and 24-hour guard service

was not appropriate (24:65; App. p. 129).[2] She ruled that Washington's confinement must extend throughout the course of her treatment until the Department could "certify that she's no longer a threat and that she's been cured" (*Id.*).

Judge Fiorenza issued an order at the conclusion of the hearing (R. 15, hereafter the "Confinement Order"), pursuant to Wis. Stat. § 252.07(9), the long-term confinement provisions of the Wisconsin tuberculosis-control statute confining Washington in the Milwaukee County Criminal Justice Facility for the duration of her treatment. She stated that that statute provided sufficient legal authority for issuance of the Confinement Order, and that an order of contempt was not needed (24:34-36, 63; App. pp. 127, 131-133).

Washington was subsequently transferred to the Milwaukee County House of Correction ("MHOC"), which provides a level of security comparable to the Milwaukee

[2] Judge Fiorenza stated that she would entertain suggestions from Washington's counsel for alternative locked, secure facilities within which she might be placed for the duration of her treatment (24:64-65; App. pp. 128-129). No suggestions were ever provided.

County Criminal Justice Facility. She received tuberculosis treatment at MHOC for almost eight months. She was released from custody on May 29, 2006 upon certification by the Department pursuant to Wis. Stat. § 252.07(9)(c) that her treatment was successfully completed and that she no longer represented a substantial threat to the public health.

E. The Court of Appeals Proceedings.

Washington appealed the Confinement Order on December 21, 2005 (19). On December 27, 2005, the Court of Appeals issued an order requesting the parties to file briefs as to whether, in addition to finding support in Wis. Stat. § 252.07(9), the Confinement Order could also be deemed a "functional" contempt order because it arose from Washington's failure to comply with the Stipulated Order. On January 9, 2006, the Court of Appeals issued a second order, which concluded that the Confinement Order amounted to a *de facto* order of contempt. (App. p. 108, ¶ 9).

The Court of Appeals issued its decision on March 28, 2006. Both the majority opinion by Judge Fine, and the

concurring/dissenting opinion by Judge Kessler, agreed on the ultimate issue—*i.e.*, that Washington could, as a consequence of her misconduct, lawfully be confined in the MHOC to assure the completion and effectiveness of her treatment for tuberculosis. Both rejected Washington's contention that Wis. Stat. § 252.07(9) imposes a "least restrictive alternative" standard upon the selection of a place of confinement for an uncooperative tuberculosis patient. (App. pp. 109-111, 116-117, ¶¶ 12, 22, 24). Both concluded that the Circuit Court properly exercised its discretion in determining that a secure correctional facility represented the most suitable place of confinement for Washington (App. pp. 107-108, 111-112, 117, ¶¶ 8, 14-15, 24).

The two opinions differed only as to rationale: Judge Fine relied on both Wis. Stat. § 252.07(9) (the tuberculosis-control statute) and Wis. Stat. § 785.04(1) (the remedial-sanction contempt statute), while Judge Kessler agreed as to Wis. Stat. § 252.07(9) and dissented only as to the applicability of the contempt statute.

SCOPE AND STANDARD OF REVIEW

This appeal presents review of both findings of fact and conclusions of law. A circuit court's findings of fact are entitled to deference and shall not be set aside unless "clearly erroneous." *State v. Martwick*, 2000 WI 5 ¶ 18 and n. 8, 231 Wis. 2d 801, 811, 604 N.W.2d 552, 557; *State v. Smith*, 207 Wis. 2d 258, 266, 558 N.W.2d 379, 382 (1995); Wis. Stat. § 805.17(2). Conclusions of law are reviewed on appeal without deference, although the Supreme Court benefits from the analyses of lower courts in their determinations of questions of law. *Steiher v. Wisconsin American Mut. Ins. Co.*, 2005 WI 72 ¶ 8, 281 Wis. 2d 395, 400-401, 697 N.W.2d 452, 455, *see also Scheunemann v. City of West Bend*, 179 Wis. 2d 469, 476, 507 N.W.2d 163, 165 (Ct. App. 1993) (noting that appellate courts "value a trial court's decision" on questions of law).

This proceeding is premised upon discretionary determinations of lower courts, which are entitled to a deferential standard of review by the Supreme Court. The

Court of Appeals' decision rests upon two sources of authority: (a) Wis. Stat. § 252.07(9), which was the basis for the Confinement Order (15); and (b) Wis. Stat. §§ 785.01(1)(b) and 785.04(1)(d), given the Court of Appeals' supplementary categorization of the Confinement Order as a "functional" *de facto* order of contempt. The same standard of review, *i.e.*, "abuse of discretion," or "erroneous exercise of discretion,"[3] applies to both sources.

That standard of review is deferential to the circuit court. An appellate court will uphold a discretionary decision if the circuit court reviewed the facts and applied the proper standard of law. *Imposition of Sanctions in Alt v. Cline*, 224 Wis. 2d 72, 83, 589 N.W.2d 21, 24-25 (1999); *Luciani v. Montemurro-Luciani*, 199 Wis. 2d 280, 294, 544 N.W.2d 561, 566 (1996). All presumptions favor affirmance of the circuit court's exercise of discretion; an appellate court must search the record for reasons to sustain a discretionary

[3] The terms "erroneous exercise of discretion" and "abuse of discretion" refer to the same standard of review. *City of Brookfield v. Milwaukee Metropolitan Sewerage District*, 171 Wis. 2d 400, 423, 491 N.W.2d 484, 493 (1992).

determination. *In re Commitment of Thiel*, 2004 WI App 225 ¶ 26, 277 Wis. 2d 698, 712-713, 691 N.W.2d 388, 395; *Lofthus v. Lofthus*, 2004 WI App 65 ¶ 21, 270 Wis. 2d 515, 528, 678 N.W.2d 393, 399, and will affirm it if there appears any reasonable basis for the circuit court's decision. *Littman v. Littman*, 57 Wis. 2d 238, 250, 203 N.W.2d 901, 907 (1973).

Wisconsin Stat. § 252.07(9) does not specify a standard of appellate review of tuberculosis-confinement orders. Nonetheless, its context indicates that such orders represent the exercise of discretion as to the appropriate course of action in light of particular facts and circumstances. This protects the public from the dangers of tuberculosis, and facilitates the recovery of the patient so that he or she no longer poses a danger to the public. Issues such as the nature, duration, and extent of treatment, the necessity of confinement, the place of confinement, and whether particular security measures are necessary in order to assure the patient's availability for treatment are intensely fact-based,

and rest with the discretion of the circuit court. Accordingly, every presumption must be exercised in favor of sustaining the Confinement Order, including the confinement of Washington in the MHOC for the duration of her treatment.

ARGUMENT

I. Introduction: The Causes of Washington's Incarceration.

Washington's argument is based upon the incorrect assumption that she was incarcerated because of her tuberculosis. Washington's incarceration was impelled by her repeated and willful refusal to submit to treatment for her tuberculosis. It was caused by her behavior and misconduct, not by her illness.

Washington was not a sick, unfortunate woman caught up in a City dragnet. She was a serious menace, who refused to do anything to address or alleviate the threat that she represented to the public, and acted in a manner that exacerbated that threat. The City made every effort to provide Washington with anti-tuberculosis medication, medical assessment, and other treatment at no cost to her.

She refused every effort. Instead, she repeatedly chose to escape, return to the streets, and disappear. She did so on three occasions during the few months pertinent to this proceeding: (a) for most of the summer of 2005 following her diagnosis; (b) on September 27, 2005, when she violated the Stipulated Order upon her release from Aurora Sinai Medical Center; and (c) on October 1, 2005 following her release from the Milwaukee County Criminal Justice Facility. She showed no desire to cooperate with the Department, and exhibited reckless disregard for her own health and that of the public.

Washington's conduct represented a series of intentional acts. The record indicates no history or pattern of mental illness; nor does it indicate any factor explaining Washington's behavior other than her own free will.

Washington submitted to medical assessment and treatment only under compulsion and within a secure environment from which she could not escape. Even she has not contested the need for secure confinement (P-Br, pp. 7, 20). Because her medical condition at the time of

confinement did not require hospitalization (App. pp. 150-153), a secure correctional facility was the most appropriate placement for her. Washington successfully received treatment for nearly eight months at MHOC, resulting in her release from custody on May 29, 2006. It provided the type of custodial setting that Washington required and that protection of the public demanded.

The Legislature has enacted a comprehensive tuberculosis-control scheme in Wis. Stat. § 252.07, which accords to local health authorities sufficient discretion and flexibility to address cases of active or suspected tuberculosis, including those involving uncooperative patients. That statute authorized the Department and the Circuit Court to do exactly what they did in this case.

II. The Circuit Court's Confinement Order Constituted an Appropriate Exercise of its Discretion Pursuant to Wis. Stat. § 252.07(9).

A. Wisconsin Stat. § 252.07(9) Permits a Circuit Court to Confine an Uncooperative Tuberculosis Patient in a Secure Correctional Facility.

The primary source of authority for the Confinement Order is Wis. Stat. § 252.07(9). This provision precisely applies to this situation. It was strictly followed by the City and the Circuit Court, and it alone provides sufficient authority for Washington's confinement in a secure correctional facility for the duration of her treatment.

Control of communicable disease constitutes a central mission of local health departments. This mission is particularly applicable to dangerous, communicable diseases such as tuberculosis, which the Wisconsin Department of Health and Family Services ("DHFS") classifies as "Category I" (a communicable disease of "urgent public health importance"), Wis. Adm. Code ch. HFS 145 Appendix A, entitled "Communicable Diseases." Both the Legislature and DHFS have deemed tuberculosis to constitute a danger of

sufficient magnitude to justify promulgation of detailed provisions concerning at its control and prevention. Wis. Stat. § 252.07; Wis. Adm. Code ch. HFS §§ HFS 145.08-145.13.

The statutory tuberculosis-control scheme, Wis. Stat. § 252.07, relies heavily upon the expertise and discretion of local health officers concerning diagnosis, treatment, and confinement of tuberculosis patients. The Department's duty is to protect the public by enforcing tuberculosis-control measures with vigor and persistence.

Washington's diagnosis of tuberculosis is not in dispute. Nor was the necessity for her secure confinement on a 24-hour basis. Nor can it be doubted that, were it not for her secure confinement, Washington would have escaped, returned to the streets, and redeveloped contagious pulmonary tuberculosis in a more virulent, multi-drug-resistant form requiring even more intensive treatment, and posing even greater risks to the public (16; 17; 24:20-21, 27, 60-61; App. pp. 124-125).

Both the City and the Circuit Court faithfully followed the extensive due process requirements of Wis. Stat. § 252.07(9), including: (a) the filing of petitions and notices initiating those proceedings (Wis. Stat. §§ 252.07(9)(a) and (b); *see* 1-6); (b) appointment of adversary counsel to represent Washington (Wis. Stat. § 252.07(9)(d)); (c) the conduct of successive hearings, including a fully adversarial hearing on October 5, 2005 during which Washington's counsel presented evidence and cross-examined the City's witness (Wis. Stat. § 252.07(9)(d)); and (d) issuance of a Confinement Order fitting the requirements of Wis. Stat. § 252.07(9)(c), including that "confinement of Washington continue until the Department determines that treatment is complete or that the individual is no longer a substantial threat to himself or herself or to the public health," and provision for a hearing concerning Washington's confinement after six months.

This record presents a picture-perfect illustration of exactly how the "treatment ratchet, turned stop by stop" (P.-

Br. p. 19) is supposed to work—from the issuance of Department orders on July 27, 2005 through Washington's release from confinement on May 29, 2006. Washington's argument that Wis. Stat. § 252.07(9) "necessarily means that once the court authorizes confinement, the health bureaucracy has unfettered, unreviewable discretion to place the patient where it chooses" (P.-Br. p. 27) is incorrect. Her confinement in the MHOC was directed not by the "health bureaucracy" but by the Circuit Court, in accordance with Wis. Stat. § 252.07(9).

Washington's arguments related to Wis. Stat. § 252.07(9), are refuted by the statute itself. She contends that a "least restrictive alternative" standard applies to the place of her confinement. This contention is belied by the only provision that refers to such a standard, Wis. Stat. § 252.07(9)(a)3, which requires that a petition seeking confinement of a tuberculosis patient for longer than 72 hours include documentation that demonstrates the following:

> 3. That all other reasonable means of achieving voluntary compliance with treatment have been

> exhausted and no less restrictive alternative exists; or that no other medication to treat the resistant disease is available.

This provision plainly applies the "less restrictive alternative" standard in the context of voluntary versus involuntary treatment—*i.e.*, as to the **fact** of confinement, not the **place** of confinement. The distinction here is between cooperative and uncooperative patients. Both the Court of Appeals' majority and concurring/dissenting opinions agreed (App. pp. 109-111, 116-117, ¶¶ 11-12, 22-24).

The City disputes the proposition at P.-Br. p. 36 that a hospital would necessarily represent a "less restrictive alternative" to a correctional facility. Washington's invocation of a "less restrictive alternative" standard to the choice of hospital versus correctional facility placement is a misnomer because both environments would be at least equally "restrictive" of her liberty and mobility. Given that Washington's tuberculosis had been rendered non-contagious (although still active) prior to the time that she entered the MHOC (App. pp. 150-153), a hospital environment would

likely have been **more** "restrictive" than a secure correctional environment, because security considerations would have required confinement to her room, unless she was continuously accompanied by guards during any foray from that room. By contrast, she would be permitted freedom of movement throughout the grounds of a secure correctional facility, because it inherently provides the requisite level of security.

What Washington actually claims is an alleged right to be placed, as a result of her own uncooperative behavior, in the "most pleasant environment,"—a medical facility, under 24-hour police guard. In other words, she claims that she has a right to be hospitalized rather than incarcerated irrespective of necessity or cost. This right does not exist and is not recognized or supported by any provision of Wis. Stat. § 252.07(9) or, as explained subsequently in this Brief, by any other statutory or constitutional basis.

The only reference in Wis. Stat. § 252.07(9) to a place of confinement is a statement within subsec. (9)(a) that it be

"in a facility where proper care and treatment will be provided and spread of the disease will be prevented." This language cannot be fairly construed to require hospitalization, particularly when it is not required for any medical reason. The Legislature has deliberately chosen not to require placement of recalcitrant tuberculosis patients in a hospital or other "health care facility," as defined in Wis. Stat. §§ 150.84(2) and 155.01(6).

Nor does Wis. Stat. § 252.07(9) refer to a "specified" facility, utilizing only the phrase "a facility." A secure correctional facility certainly qualifies, particularly given the statute's emphasis on containment of tuberculosis. Washington conceded this point before the Court of Appeals:

> The commitment statute, § 252.07(9), permits confinement "in a facility where proper care and treatment will be provided"—there is simply no reason to doubt that a jail is a "facility" and thus comes within the statute. Washington thus does not dispute that confinement to jail may be ordered. *Contrast*, ***Souvannarath v. Hadden***, 95 Cal. App. 4th 1115 (2002) (jail placement improper where relevant California statute expressly excluded "correctional facilities" from tuberculosis control program).

(Brief of Respondent-Appellant, Ruby Washington to the Court of Appeals, District I in Appeal No. 2005-AP-003141 at p. 27).

Washington is judicially estopped from attempting to "withdraw" this concession (P.-Br. p. 20), which was consistent with both opinions of the Court of Appeals, and to now assert a directly inconsistent position before the Supreme Court. *Salveson v. Douglas County*, 2001 WI 100 ¶ 37, 245 Wis. 2d 497, 520-521, 630 N.W.2d 182, 193; *State v. Petty*, 201 Wis. 2d 337, 347-348, 548 N.W.2d 817, 820-821 (1996);

The Supreme Court should reject Washington's attempt to invent an ambiguity in the text of Wis. Stat. § 252.07(9), where none exists, in her effort to extend the "least restrictive alternative" standard to selection of a place of confinement (P.-Br. pp. 24-27). If the language of a statute is unambiguous, courts must not search for ambiguity or utilize extrinsic sources as an aid to interpretation, but must apply the statute as written, rendering Washington's discussion of statutory history (P.-Br. pp. 27-29) irrelevant. *State*

Department of Corrections v. Schwarz, 2005 WI 34 ¶ 13, 279 Wis. 2d 223, 232, 693 N.W.2d 703, 707; *Hamilton v. Hamilton*, 2003 WI 50 ¶ 38, 261 Wis. 2d 458, 477-478, 661 N.W.2d 832, 841. The Court of Appeals properly applied this rule, noting that the Legislature has chosen in many other contexts to apply a "least restrictive facility" mandate but has declined to do so in this context (App. pp. 109-111, ¶ 12).[4]

Washington's reliance on irrelevant statutes such as those contained in Wis. Stat. Chs. 51 (civil commitment) or 55 (protective services for developmentally disabled persons), is misplaced. Those statutes address different classes of individuals and serve distinct objectives as compared to Wis. Stat. § 252.07, which is specific to tuberculosis. This

[4] Washington's related argument that the application of the clear, unambiguous terms of Wis. Stat. § 252.07(9), to confine a recalcitrant tuberculosis patient in a correctional facility would necessarily lead to absurd results (P.-Br. pp. 23-24) is without merit. It rests upon speculation and the unwarranted assumption that Washington was confined due to her illness and not due to her misconduct and contumacy. The Legislature must be presumed to pass workable and practical statutes that do not lead to absurd results. *Weiberg v. Kellogg*, 188 Wis. 2d 97, 205 N.W.2d 896, 899 (1925); *see also State v. West*, 181 Wis. 2d 792, 796-797, 512 N.W.2d 207, 209 (Ct. App. 1993) (holding that "we must reject an unreasonable or absurd interpretation of a statute.").

proceeding was conducted by the Circuit Court under that statute from inception until completion. Judge Fiorenza cited that statute as the basis for the Confinement Order. Both opinions of the Court of Appeals properly upheld her application of that statute (App. pp. 109-112, 116-117 ¶¶ 11-15, 22-24).

Equally unconvincing is Washington's citation of Wis. Stat. § 252.06(6) and Wis. Adm. Code § HFS 145.06(5)(c) (P.-Br. pp. 19, 21, 25). These provisions arise from Wis. Stat. § 252.06, a statute specifying the unilateral authority of local health officers to direct isolation and quarantine of communicable-disease patients generally. This statute is quite old and pre-dates the modern era of due process; Wis. Stat. § 252.06(6) (formerly § 143.05(6)) was enacted in essentially its current form in 1923 (L. 1923 ch. 448 §§ 13a and 16). It was never invoked by the City or Circuit Court and played no role in these proceedings. It addresses only individuals who require isolation or quarantine for medical reasons and not those who do not, but who require custodial

security during treatment due to behavioral problems. It contains no due-process or judicial review provisions, let alone anything comparable to those of Wis. Stat. § 252.07(9), and does not specifically address tuberculosis.

DHFS has also issued regulations specifically applicable to confinement of tuberculosis patients. Wis. Adm. Code §§ HFS 145.10(6) and (7). These regulations are virtually identical to Wis. Stat. § 252.07(8) and (9), and include the exact language of Wis. Stat. § 252.07(9)(a)3. limiting application of the "least restrictive alternative" standard to the fact of confinement, as opposed to the place of confinement. Wis. Adm. Code § HFS 145.06(7)(a)3. Thus, the governing provisions for this proceeding would be in Wis. Stat. § 252.07 and Wis. Adm. Code § HFS 145.10, not Wis. Stat. § 252.06 and § HFS 145.06, because specific provisions control over general provisions. *Marder v. Board of Regents of the University of Wisconsin System*, 2004 WI App 177 ¶ 25, 276 Wis. 2d 186, 199, 687 N.W.2d 832, 838, *affirmed* 2005 WI 159 ¶ 23, 286 Wis. 2d 252, 267, 706 N.W.2d 110,

118; *State ex rel. Auchinleck v. Town of LaGrange*, 200 Wis. 2d 585, 596, 547 N.W.2d 587, 591 (1996).

Washington's attempt to read Wis. Stat. §§ 252.07(8) and (9) together in order to import a "least restrictive alternative" standard into the choice of facility placement where none exists (P.-Br. pp. 25-26) is without merit. Neither statute suggests the existence of any such standard or any restriction of the chosen facility to any "specified place." Wisconsin Stat. § 252.07(8), which allows local health authorities to confine tuberculosis patients on a short-term basis pending judicial review, contains language similar to that of Wis. Stat. § 252.07(9)(a) as to choice of facility, allowing placement in "a facility that the department or local health officer determines will meet the individual's need for medical evaluation, isolation and treatment." Wis. Stat. § 252.07(8)(b).

The Legislature has not only deliberately chosen not to ban the use of secure correctional facilities in order to house recalcitrant tuberculosis patients; it has also enacted a statute

that expressly endorses the use of such facilities for that purpose, refuting Washington's argument that no such authorization exists (P.-Br. pp. 20-21). *See*, Wis. Stat. § 302.31(9), which permits the use of county jails for "other detentions authorized by law" in addition to those enumerated in Wis. Stat. §§ 302.31(1) through (8m), a description that includes court-ordered confinement for tuberculosis treatment under Wis. Stat. § 252.07(9).

The Circuit Court found that the Milwaukee County Behavioral Health Division or a hospital such as Aurora Sinai Medical Center did not offer viable placement alternatives for Washington (24:64-66; App. pp. 128-130). These are crucial findings of fact, which are entitled to deference. This is not a civil-commitment proceeding under Wis. Stat. Ch. 51. The City was not required to initiate such proceedings in order to pursue Washington's secure confinement for treatment, particularly because there was no evidence that she suffered from mental illness. It was entitled to choose to proceed

under Wis. Stat. § 252.07(9). The Circuit Court agreed (24:63-64; App. pp. 127-128).

Similarly, the Circuit Court (24:65; App. p. 129) and the Court of Appeals (App. pp. 109-11, 112, 117 ¶¶ 12-13, 15, 24) properly found that hospital confinement did not represent a viable alternative. Washington did not require placement in a medical facility. The need for confinement was prompted by custodial, not medical concerns. Hospitalization would impose unnecessary and unreasonable burdens upon affected hospitals and upon the City for the cost of care, and of a round-the-clock police guard. Furthermore, a hospital cannot provide the same level of security as a correctional facility, whose very purpose is the provision of security and prevention of escape.

Washington's reliance upon *Benton v. Reid*, 231 F.2d 780 (D.C. Cir. 1956) ("*Benton*") and *State v. Snow*, 230 Ark. 746, 324 S.W.2d 532 (1959) ("*Snow*") is inappropriate. Both cases pre-date the modern era of due process, as exemplified by Wis. Stat. § 252.07(9). In *Benton*, the court ruled that the

District's Director of Public Health exceeded his authority by unilaterally confining a tuberculosis patient in the hospital section of the District of Columbia jail with no opportunity for judicial review. 231 F.2d at 781-782. This is not comparable to the situation here where Wis. Stat. § 252.07(9) provided Washington with extensive due-process rights, including full and repeated access to judicial oversight. *Benton* also rested upon a supposition that the then-effective D.C. Code did not contemplate the incarceration of a tuberculosis patient by administrative fiat, in contrast to Wis. Stat. §§ 252.07(9) and 302.31(9), which plainly allow for that outcome in appropriate circumstances by court order.

In *Snow*, the court upheld confinement of a recalcitrant tuberculosis patient in a sanitarium—a result that hardly assists Washington. Instead, she relies, out of context, on one sentence from *Snow* which stated that the pertinent Arkansas statute "is not a penal statute, yet it is to be strictly construed to protect the rights of the citizen." 230 Ark. At 748, 324 S.W.2d at 534. The City has never contended that Wis. Stat.

§ 252.07(9) is "penal" (it is a remedial police-power measure). Furthermore, Washington received the full measure of rights afforded to her under that statute.

While deprivation of liberty and confinement in a correctional facility is a remedy invoked only under drastic circumstances, such circumstances will arise from time to time. This is one of those times. Judge Fiorenza acted within her discretion under Wis. Stat. § 252.07(9) in issuing the Confinement Order, was properly upheld by the Court of Appeals and merits affirmance by the Supreme Court.

B. The Circuit Court and the Court of Appeals Correctly Ruled that Costs to City of Milwaukee Taxpayers May be Considered as a Factor in Determining that the Appropriate Place of Confinement for Washington Pursuant to Wis. Stat. § 252.07(9) Would be a Secure Correctional Facility and not a Hospital.

Washington argues that the place of her confinement under Wis. Stat. § 252.07(9) may not be influenced by the factor of cost to City of Milwaukee taxpayers. This contention is without merit. Nothing within Wis. Stat. § 252.07(9) suggests that this factor may not be considered,

particularly where the patient is both uncooperative and has no medical need for hospitalization. Both the Circuit Court and the Court of Appeals (App. pp. 111-112, 117 ¶¶ 14-15, 24) properly found that a correctional facility was the most appropriate and cost-effective location for Washington's confinement and treatment.

A mandate that Washington be hospitalized would impose costs upon City taxpayers that are both wasteful and exorbitant. Hospitalization would be wasteful because Washington had no need for it and no right to choose it rather than to be placed in the MHOC (App. p. 112 ¶ 15).

The cost of Washington's hospitalization would be huge, given the duration associated with successful treatment of tuberculosis (approximately nine months, longer for multi-drug-resistant tuberculosis) and the high daily cost of hospitalization of an uncooperative tuberculosis patient. These costs would have included: (a) daily hospital charges; and (b) costs associated with providing a police guard on a round-the-clock basis to assure that Washington did not

escape again. These resources would be better devoted to alleviation of other public health needs (App. pp. 111-112 ¶ 14).

Washington's reliance upon *D.E.R. v. LaCrosse County*, 155 Wis. 2d 240, 455 N.W.2d 239 (1990) ("*D.E.R.*") and *Dunn County v. Judy K.*, 2002 WI 87, 254 Wis. 2d 383, 647 N.W.2d 799 ("*Judy K.*") (P.-Br. pp. 33-36) is misplaced. Both cases concerned whether a county, charged with the responsibility for providing placement and services for developmentally disabled persons pursuant to Wis. Stat. § 55.06(9)(a) could decline to expend county funds in excess of some predetermined limit. (In *D.E.R.*, the limit was specified as funds that the county received from the state and federal governments, and the county's matching share associated with state funding; in *Judy K.*, the limit was a daily dollar amount representing a consolidation of state and federal funds and a *de minimus* amount of county funds).

This proceeding presents no comparable issue. Justice Abrahamson, the author of *D.E.R.*, expressly disclaimed any

intent to rule upon the issue of whether cost to taxpayers might be considered as a factor with respect to the extent of a county's obligation to expend funds for the placement of developmentally disabled persons:

> This case does not pose the question of whether the circuit court may ever consider the costs of the proposed placement. Counsel for D.E.R. and M.D.A. acknowledged at oral argument that there may be cases in which the costs of the proposed placement are so exorbitant and the benefits to the individual so minimal that it is not reasonable for a professional to recommend the placement or for a circuit court to order such a placement.

155 Wis. 2d at 253, 455 N.W.2d at 245.

This proceeding represents precisely one of those cases described by Justice Abrahamson. The costs of hospitalization of Washington would have been so exorbitant and the benefits to her so minimal that it would have been unreasonable to mandate that the City hospitalize her.

This proceeding is distinct from *D.E.R.* and *Judy K.* in other respects. *D.E.R.* and *Judy K.* concerned developmentally disabled persons, a class of individuals different from a contumacious tuberculosis patient. The

pertinent statutes, Wis. Stat. §§ 55.06(9)(a) and 252.07(9), are different, particularly as the former expressly mandates a "least restrictive alternative" standard for facility placement, while the latter does not.

Neither LaCrosse County (in *D.E.R.*) nor Dunn County (in *Judy K.*) objected to community-based placement for the affected individuals on the basis that its costs were exorbitant or unreasonable as compared to the benefit accruing to the affected individuals; *see e.g. D.E.R., supra*, 155 Wis. 2d at 245, 455 N.W.2d at 242. The City opposes any mandate that Washington be hospitalized, on precisely those grounds. Nor does this proceeding concern whether the City should be required to expend funds for the care and treatment of tuberculosis patients in excess of an arbitrary limit that would reduce the City's liability to virtually zero.[5] All the City asks

[5] Washington's contention (P.-Br. p. 36) that the City's ostensible intent was to shift the costs of confining her from its budget to the Milwaukee County budget (given that the MHOC is operated by Milwaukee County) is irrelevant and an accident of geography. There are very few municipal health departments in Wisconsin, confined to some of its largest cities. Throughout most of the state, public health functions are assumed by county health departments; accordingly, if this question arose in most parts of the State, all costs would be borne by county taxpayers.

is that it not be compelled to waste scarce funds in payment of unnecessary and huge costs.

Local governments throughout the State are continually faced with the necessity of meeting urgent public needs within stringent fiscal constraints. Local health officials must be accorded the requisite degree of flexibility to make decisions concerning the expenditure of limited resources available for protection of the public health. Preservation of that flexibility is vital, not simply in tuberculosis cases, but in future instances that may involve new or exotic diseases, pandemics or other serious public health emergencies.

C. Washington's Constitutional Arguments and Arguments Premised Upon the Americans With Disabilities Act are Without Merit.

Washington has belatedly raised contentions arising under the Due Process and Equal Protection Clauses of the Fourteenth Amendment and the Fourth Amendment to the United States Constitution and under the Americans With Disabilities Act ("ADA"), 42 U.S.C. §§ 12101, *et seq.* (P.-Br.

pp. 22-23, 29-33). None were raised or developed before the Circuit Court or the Court of Appeals (App. pp. 111 ¶ 13). The Supreme Court generally does not consider issues raised for the first time on appeal. *Smith v. Katz*, 218 Wis. 2d 442, 449, 578 N.W.2d 202, 205 (1998); *State v. Holland Plastics Co.*, 111 Wis. 2d 497, 504, 331 N.W.2d 320, 324 (1983). Additionally, there is no basis for constitutional or ADA-based attack upon the pertinent statutes or the manner in which they were applied to Washington.

1. Due Process.

Washington's due process argument relies upon civil-commitment proceedings under Wis. Stat. Ch. 51, which are inapplicable to confinement of tuberculosis patients under Wis. Stat. § 252.07. Because Wis. Stat. § 252.07 thoroughly covers the field of tuberculosis-control procedures, there is no occasion to invoke civil-commitment statutes by way of analogy.

Washington's attempt to misconstrue the due process clause of the Fourteenth Amendment and Wis. Stat. Ch. 51 to

"backdoor" a "least restrictive alternative" standard into the choice of treatment facility, when the Legislature has declined to do so should be rejected. Wisconsin Stat. Ch. 51 repeatedly invokes this standard (App. pp. 109-110 ¶ 12). Wisconsin Stat. § 252.07(9) pointedly omits it. Both the short-term and long-term confinement provisions of the tuberculosis-control statute, Wis. Stat. §§ 252.07(8) and (9) are of recent vintage (*see* 1999 Wis. Act 9 §§ 2400rn and 2400ro). The Legislature has accorded thorough and recent attention to this topic, including delineation of those due process rights to be afforded to tuberculosis patients whose confinement is sought. The imposition of a "least restrictive alternative" requirement upon the choice of treatment facility is not included among those rights.

Washington's reliance upon *City of Newark v. J.S., supra.* ("*J.S.*") (P.-Br. pp. 29-31) is unavailing. The court in *J.S.* had to analogize between tuberculosis control and civil commitment because New Jersey did not have a tuberculosis-control scheme comparable to Wis. Stat. §§ 252.07(8) and

(9); thus, the *J.S.* court utilized it as a means of deriving a standard for decision. *J.S., supra*, 279 N.J. Super. at 184, 189-190 and fn. 3, 4, 652 A.2d at 268, 270. There is no need to do so in Wisconsin because Wis. Stat. §§ 252.07(8) and (9) provide a sufficient standard for decision.

Furthermore, *J.S.* did not address the issue involved in this case. The *J.S.* court simply concluded (without elaboration) that hospital confinement, the alternative presented by the City of Newark, was the "least restrictive mode of isolation" proposed at that time. 279 N.J. Super. at 204, 652 A.2d at 278. By contrast: (a) the City proposed incarceration and not hospitalization as the most viable confinement option for Washington; (b) the "least restrictive alternative" standard for selection of a place of confinement for uncooperative tuberculosis patients does not apply in Wisconsin; and (c) hospitalization likely represented a more, not less, "restrictive" environment for Washington's confinement.

The requirement of due process is satisfied if statutory procedures provide an opportunity to be heard in court at a meaningful time and in a meaningful manner. *Matthews v. Eldridge*, 424 U.S. 319, 333, 96 S.Ct. 893, 902, 47 L.Ed. 2d 18 (1976); *State ex rel. Strykowski v. Wilkie*, 81 Wis. 2d 491, 512, 261 N.W.2d 434, 444 (1978). Wisconsin Stat. § 252.07(9) satisfies this requirement. It sets forth a detailed procedure for determination of controversies concerning long-term confinement of tuberculosis patients, including initial and review circuit court hearings, appointment of counsel for the patient, delineation of the circumstances under which patients may be involuntarily confined, and availability of appellate review. These procedures safeguard both the interests of the patient and those of the public, which is entitled to protection from the ravages of communicable disease. They were strictly followed at each step of these proceedings. Washington was afforded every opportunity to present her contentions concerning the location of her

confinement. Those contentions were properly rejected by every reviewing court.

2. Equal Protection.

Washington's equal protection claims (P.-Br. pp. 31-33) are baseless. This claim attacks the constitutionality of Wis. Stat. § 252.07(9) on equal protection grounds. Washington is barred from first presenting this contention at this late stage, as she failed to provide the Attorney General with requisite notice as mandated by Wis. Stat. § 806.04(11).

Uncooperative tuberculosis patients whose refusal to submit to treatment present a clear and continuing danger to the public do not constitute a "suspect class" for equal protection purposes. *Cf. Thielman v. Leean*, 140 F.Supp. 2d 982, 997 (W.D. Wis. 2001) *affirmed*, 282 F.3d 478 (7th Cir. 2002) (involuntarily committed sexually violent persons do not constitute a suspect class for equal protection purposes).

Thus, in order to prevail on an equal protection claim, Washington must demonstrate that the Legislature, in enacting Wis. Stat. § 252.07(9), created an irrational or

arbitrary classification lacking any rational relationship to any legitimate governmental interest. *Kohn v. Darlington Community Schools*, 2005 WI 99 ¶¶ 46-47, 283 Wis. 2d 1, 30-31, 698 N.W.2d 794, 808; *State v. Jorgensen*, 2003 WI 105 ¶ 32, 264 Wis. 2d 157, 179, 667 N.W.2d 318, 328.

Stated alternatively, she must prove unconstitutionally different treatment among members of similarly situated classes, which cannot exist "where there exist reasonable and practical grounds for the classifications created by the legislature." *In re Commitment of Burgess*, 2003 WI 71 ¶ 32, 262 Wis. 2d 354, 377, 665 N.W.2d 124, 135; *In re Commitment of Curiel*, 227 Wis. 2d 389, 413, 597 N.W.2d 697, 708 (1999).

Washington has proven nothing of the sort. There is certainly a rational basis for providing secure confinement of recalcitrant tuberculosis patients who refuse to comply with a treatment regimen, who escape to the streets at every opportunity, and who present a continuing danger to the public if allowed to roam at large. There is an equally

rational basis for utilizing correctional facilities to confine patients who require custodial security, not hospitalization, because such facilities provide the requisite security in a cost-effective manner. Wisconsin Stat. §§ 252.07(9) and 302.31(9) confirm the Legislature's endorsement of this conclusion.

Washington's comparison of herself with violent mental health patients subject to civil commitment under Wis. Stat. Ch. 51 is unwarranted. Such individuals require secure confinement because of severe mental illness that renders their behavior uncontrollable, and who require long-term, perhaps lifetime, treatment. By contrast, Washington was not mentally ill, required treatment for months, not years, and required custodial security only because of her contumacy, a factor within her ability to control and unrelated to illness.

Washington fails to indicate why the Legislature's deliberate choice to include "less restrictive alternative" standards throughout Wis. Stat. Ch. 51 and many other statutes, but not in Wis. Stat. § 252.07(9) lacks a rational

basis or how any of the statutes applied in this proceeding otherwise violate equal protection guarantees.

3. Fourth Amendment.

Washington's Fourth Amendment claims (P.-Br. pp. 22-23) are unwarranted. These claims, which amount to a constitutional attack on the 72-hour provisions of Wis. Stat. §§ 252.07(8)(c) and (9)(a), are barred under Wis. Stat. § 806.04(11) for the same reason as that applicable to Washington's equal-protection claims. They are also irrelevant because Washington's confinement hearing of October 5, 2005 was held within a few hours of her pickup by Milwaukee police and before she was confined pursuant to the Confinement Order.

The cases cited by Washington concern a requirement that persons arrested for criminal offenses without a warrant receive a judicial determination of probable cause within 48 hours of their arrest. The inapplicability of this analysis to Wis. Stat. § 252.07(9) is obvious.

Washington is not a criminal defendant and was not arrested for commission of a criminal offense.[6] She was placed in secure confinement because her refusal to treat her tuberculosis voluntarily presented a clear and continuing danger to the public. Secure confinement of dangerous persons under conditions of "enforced quarantine" has long been recognized as constitutional by American courts. (App. p. 111 ¶ 13 citing *Compagnie Francaise de Navigation a Vapeur v. Board of Health of the State of Louisiana*, 186 U.S. 380, 22 S.Ct. 811, 46 L.Ed. 1209 (1902)); *see also Kansas v. Hendricks*, 521 U.S. 346, 365-366, 117 S.Ct. 2072, 2084, 138 L.Ed. 2d 501 (1997) (holding that ". . . under the appropriate circumstances and when accompanied by proper procedures, incapacitation may be a legitimate end of the civil law.").

[6] Washington's contention that she was transformed into a "quasi-criminal defendant by public dissemination of her "mug-shot" (P.-Br. pp. 7 and n. 4, 22) is baseless. This did not transform her into a criminal defendant. Additionally, the City had nothing to do with the taking of the "mug shot" or its dissemination; that was done by independent actors—Milwaukee County and the Milwaukee Journal Sentinel.

4. ADA Claims.

Washington's claims that her incarceration violated the ADA, 42 U.S.C. § 12101, *et seq.* (P.-Br. p. 33) are spurious. Washington is not entitled to ADA protection, and even if she were, the City violated none of its provisions in dealing with her situation.

The only potentially applicable portion of the ADA is Title II, which prohibits discrimination in the provision of government services or participation in government programs, 42 U.S.C. §§ 12131-12134. The operative prohibition is 42 U.S.C. § 12132:

> **§ 13132. Discrimination**
>
> Subject to the provisions of this title, no qualified individual with a disability shall by reason of such disability, be excluded from participation in or be denied the benefits of the services, program or activities of a public entity, or be subjected to discrimination by any such entity.

Even assuming that tuberculosis is an ADA-recognized form of "disability," Washington's ADA claim fails on several counts.

First, Washington was not a "qualified individual with a disability" under 42 U.S.C. § 12132, due to her current, active and admitted cocaine use (22:7-14). A current and active user of illegal drugs, who is not participating in or who has not successfully completed a supervised drug-rehabilitation program does not fall within the classification of a "qualified individual with a disability" and is not entitled to ADA protection. *Thompson v. Davis*, 295 F.3d 890, 896 (9th Cir. 2002) (Title II, ADA); *Collings v. Longview Fibre Company*, 63 F.3d 828, 831-832 (9th Cir. 1995) (Title I, ADA); 42 U.S.C. §§ 12114(a) and (b); 42 U.S.C. §§ 12210(a) and (b). Judge Fiorenza perceptively recognized the link between cocaine use and the misconduct which impelled Washington's incarceration (22:9-10, 12-13).

Second, Washington was not incarcerated "by reason of [her] disability," as required by 42 U.S.C. § 12132. The cause of her incarceration was not her tuberculosis, but rather her misconduct and propensity to escape. A cooperative tuberculosis patient would not be confined, so long as he or

she adhered to the prescribed treatment regimen and did not require isolation or confinement in a medical setting for medical reasons. This alone defeats Washington's reliance on *J.S., supra* (P.-Br. p. 33), in which the court specifically ruled that the patient's confinement in that case was attributable to his illness. 652 A.2d at 273-274.

Third, Washington has failed to demonstrate the existence of any form of "discrimination" suffered at the hands of the City. She conceded that she required secure, continuous confinement throughout the duration of her treatment. This was provided by the MHOC. She has not disputed that she received free medical assessment and treatment for her tuberculosis. She does not dispute that this treatment proved successful, and allowed for her release from custody on May 29, 2006. Washington forfeited any right to influence the choice of her treatment environment as a consequence of her contumacy (App. p. 112 ¶ 15).

Nothing within the ADA indicates that Washington is entitled to a "reasonable accommodation" that would mandate

that she not be confined in a correctional facility. Even if she would have proven such an entitlement, a hospital setting would fail the tests of "reasonableness" and "necessity" that must be met by any form of "accommodation." 28 C.F.R. § 35.130(b)(7). This determination requires a balancing of costs and benefits. In *Oconomowoc Residential Programs v. City of Milwaukee*, 300 F.3d 775 (7th Cir. 2002), the court defined the requisites of "reasonableness" and "necessity" as follows:

> Whether a requested accommodation is reasonable or not is a highly fact-specific inquiry and requires balancing the needs of the parties. . . . An accommodation is reasonable if it is both efficacious and proportional to the costs to implement it. . . . An accommodation is unreasonable if it imposes undue financial or administrative burdens or requires a fundamental alteration in the nature of the program. . . . In assessing costs, the court may look at both financial and administrative costs and burdens. . . .
>
> Whether the requested accommodation is necessary requires a "showing that the desired accommodation will affirmatively enhance a disabled plaintiff's quality of life by ameliorating the effects of the disability."

(Citation omitted). 300 F.3d at 784; *see also, Dadian v. Village of Wilmette*, 269 F.3d 831, 838 (7th Cir. 2001). Any mandate to hospitalize Washington under the guise of a "reasonable accommodation" fails these requirements. Nor would such an "accommodation" ameliorate Washington's tuberculosis. As proven by experience, her treatment and recovery from her disease proceeded just as rapidly and efficiently at the MHOC as it would have were she hospitalized. There is also no evidence in this record that she would have been less prone to escape from a hospital environment as opposed to a correctional environment; indeed, a comparable experiment (placement at her sister's house) was tried and failed.

Finally, no ADA "accommodation" is required if such would "fundamentally alter the nature of the service, program or activity" in question. 28 C.F.R. § 35.130(b)(7); *Oconomowoc Residential Programs v. City of Milwaukee, supra*, 300 F.3d at 784; *Dadian v. Village of Wilmette, supra*, 269 F.3d at 838; *Washington v. Indiana High School Athletic*

Association, Inc., 181 F.3d 840, 850 (7th Cir. 1999). The "program" here concerns placement in secure confinement by local governments of recalcitrant tuberculosis patients who endanger the public health. A mandate that all such persons be hospitalized at public expense for the duration of their treatment would certainly work "a fundamental alteration" to that program by imposing an unreasonable price tag upon its exercise. This effect would be greatest upon smaller units of government, facing the most severe financial constraints. The resultant detrimental effects upon the public health are obvious.

III. The Court of Appeals Properly Ruled that Washington Committed a "Functional," *De Facto* Contempt of Court.

Judge Fine's majority opinion concluded that the Confinement Order constituted a "functional" order of contempt, and that her incarceration under the Confinement Order was within the range of remedial sanctions for contempt available to the Circuit Court under Wis. Stat. §§ 785.04(1)(a) and (e) (App. pp. 112-114 ¶¶ 16-19). Judge

Kessler's opinion dissented on this point (App. pp. 118-120 ¶¶ 25-32). This was the sole disagreement between the two opinions. This is not an outcome-determinative disagreement because both opinions concluded that Wis. Stat. § 252.07(9) provided sufficient authority for Washington's incarceration.

The issue of "contempt" arose as a consequence of the Court of Appeals' procedural orders of December 27, 2005 and January 9, 2006, whereby it concluded that the Confinement Order represented a "functional" *de facto* order of contempt of court arising from Washington's willful violation of the Stipulated Order. This constitutes an alternative basis for the Confinement Order, in addition to its primary basis, Wis. Stat. § 252.07(9).

There is no basis for invoking judicial estoppel against this conclusion because the City never asserted an inconsistent position on this issue. Thus, the first essential element of judicial estoppel is absent. *Salveson v. Douglas County, supra; State v. Petty, supra.* The City never acknowledged that no contempt occurred or that the remedial

contempt sanctions provided in Wis. Stat. § 785.04(1) were not available as an alternative to those remedies available under Wis. Stat. § 252.07(9). All it did was to elect to proceed before Judge Fiorenza under Wis. Stat. § 252.07(9), which is tailor-made for this situation, in preference to the contempt statute (24:35-36; App. pp. 131-132).

Similarly, Judge Fiorenza never ruled that contempt did not occur; she simply concluded that she did not need to make a finding of contempt to confine Washington in a correctional facility because Wis. Stat. § 252.07(9) provided sufficient authority for that purpose (24:34-39, 63; App. pp. 127, 131-136). Certainly, the Court of Appeals was free to conclude *sua sponte* that a *de facto* "functional" contempt occurred as well, and the City is free to support that conclusion now.

Furthermore, Judge Fine was correct in concluding that the Confinement Order was a "functional" contempt order. It fits within Wis. Stat. § 785.01(1)(b), which includes within the definition of "contempt of court": "disobedience,

resistance or obstruction of the authority, process or order of a court." Consequently, the Circuit Court was authorized to impose "one or more" of the remedial sanctions available under Wis. Stat. § 785.04, including "an order designed to assure compliance with a prior order of the court." That is what Judge Fiorenza did (even though she declined to call it contempt) and what the Court of Appeals upheld (App. pp. 113-114 ¶¶ 18-19).

The fact that this might include confinement in a correctional facility for a period longer than the six months referenced in Wis. Stat. § 785.04(1)(b), because completion of Washington's treatment required more than six months is of no consequence. Wisconsin Stat. §§ 785.04(1) (introductory paragraph) and (1)(d), specifically authorized the Circuit Court to impose such a sanction.[7] Nor does Washington's attempt to slip in the "least restrictive

[7] It cannot be disputed that imprisonment is an available "remedial" sanction for civil contempt of court. *Upper Great Lakes Shipping, Ltd. v. Seafarers' International Union of Canada*, 22 Wis. 2d 7, 13-14, 125 N.W.2d 324, 328 (1963); *State ex rel. N.A. v. G.S.*, 156 Wis. 2d 338, 341, 456 N.W.2d 867, 869 (Ct. App. 1990).

alternative" standard through the backdoor of contempt (P.-Br. p. 41) have any merit, as it relies on a case (*Interest of D.L.D.*, 110 Wis. 2d 168, 327 N.W.2d 682 (1983)) that simply applied pertinent statutory standards (in that case, provisions of Wis. Stat. Ch. 48) to associated contempt proceedings. Because Wis. Stat. § 252.07(9) eschews any "least restrictive alternative" standard to the choice of treatment facility, this does not assist Washington.

Equally unavailing is Washington's contention that such a sanction is unlawful because it cannot be immediately purged by the contemnor. The Court of Appeals properly disposed of this contention (App. p. 114 ¶ 19). There is no authority for the proposition that a contempt of court must be instantaneously purgeable by the contemnor. Here, the contempt consisted of Washington's refusal to comply with her treatment regimen, the necessary purging act therefore being completion of that regimen to the point of cure. Of necessity, that act must be accomplished over a period of

months. Washington caused that predicament, as it arose as a consequence of her own misconduct.

IV. Mootness.

This proceeding is moot as to Washington herself due to her release from MHOC confinement on May 29, 2006. Since resolution of the issues raised at this stage of these proceedings has no effect upon any existing legal controversy, the City will accede to the discretion of the Supreme Court as to whether this proceeding should be deemed moot, in whole or in part.

CONCLUSION

For the foregoing reasons, the Petitioner-Respondent, City of Milwaukee, respectfully submits that the confinement of Ms. Ruby Washington in the Milwaukee County House of Correction, a secure correctional facility, for the duration of her treatment for tuberculosis, was in all respects lawful, proper and within the scope of its authority. Accordingly, it requests that the Supreme Court affirm: (a) the Confinement Order issued by the Circuit Court for Milwaukee County in

Case No. 05-CV-007563 dated October 5, 2005; and (b) the decision of the Court of Appeals dated March 28, 2006 in 2006 WI App 99, affirming the issuance by the Circuit Court of that Confinement Order. It further requests that the Supreme Court dismiss Washington's appeal in its entirety, on its merits, and with prejudice.

Dated and signed at Milwaukee, Wisconsin this 3rd day of August, 2006.

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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), Wis. Stats., for a Brief produced with a proportional serif font. The length of this brief is 10,922 words.

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STATE OF WISCONSIN
IN SUPREME COURT

In Interest of RUBY WASHINGTON:

CITY OF MILWAUKEE,

Petitioner-Respondent,

v.

Case No. 05AP003141

RUBY WASHINGTON,

Respondent-Appellant-Petitioner.

WIS. STAT. § (RULE) 809.62 REVIEW OF DECISION OF COURT OF APPEALS, AFFIRMING CONFINEMENT ORDER FOR TUBERCULOSIS TREATMENT, ENTERED IN MILWAUKEE COUNTY CIRCUIT COURT (HON. CLARE L. FIORENZA)

REPLY BRIEF OF RESPONDENT-APPELLANT-PETITIONER

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STATE OF WISCONSIN
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ARGUMENT

I. JAIL IS NOT AN AUTHORIZED PLACEMENT OPTION UNDER THE TUBERCULOSIS-CONTROL REGIME.

A. Ms. Washington's acknowledged waiver of this issue below does not impede review.

The City asserts that Ms. Washington is judicially estopped from making the threshold argument that jail is not a statutorily authorized placement option. Resp. Br., p. 34. Judicial estoppel is inapt (among other things, Ms.

Washington's concession below did not prevent the court of appeals from deciding this issue, 2006 WI App 99, ¶12; and, plainly, the concession—which was to her disadvantage—was a mere blunder as opposed to cold manipulation, see, generally, ***State v. Petty***, 210 Wis. 2d 337, 354, 548 N.W.2d 817 (1996)). There are ample reasons for this court to overlook the waiver. The issue is purely one of law: either the statutes allow for jail confinement or they don't. And, the issue is organically related to the question of whether the trial court properly ordered confinement to jail. Moreover, reaching the merits will resolve a recurrent issue and thus inhibit further litigation.[1]

B. *Confinement to jail is not only* not *expressly authorized, but various provisions are explicitly incompatible with such a notion.*

True, the statutory scheme authorizes placement in "a facility," Wis. Stat. § 252.07(9), and equally true, a jail is a facility; indeed, just about anything can be regarded as a "facility." At the same time, the statutes do not expressly authorize confinement to jail, and as a result questions remain. In various respects, a number of different sections are incompatible with the idea that jail is a suitable placement for compulsory treatment. Those provisions were identified and discussed in Ms. Washington's Br.-in-Ch., pp. 21-22, and will not be repeated here—not least because the City fails to address them at all.

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[1] Ms. Washington's concession below was premised on California legislation, described in ***Souvannarath v. Hadden***, 95 Cal. App. 4th 1115, 116 Cal. Rptr. 2d 7 (2002), which expressly bars use of "correctional facilities," see 95 Cal. App 4th at 1123. However, California's situation is not comparable to Wisconsin's and neither, therefore, is that state's legislation a guide. Among other things, California caselaw had allowed a jail to be used under a quarantine order, ***In re Martin***, 83 Cal. App. 2d 164, 188 P.2d 287 (1948), such that an express legislative prohibition might have been required to obtain the desired result; the same cannot be said here.

Nor, for that matter, does the City address Ms. Washington's absurd-results argument, Br.-in-Ch., pp. 23-24 (the legislature could not possibly have intended to jail, let alone indefinitely, someone just because her tuberculosis is not amenable to treatment; nor intended to jail someone with a sexually transmitted disease). The City lards its brief with references to Ms. Washington's blameworthiness (e.g., Resp. Br., p. 24: "repeated and willful refusal to submit to treatment"), plainly suggesting that she richly deserved incarceration. But similar moral blame simply cannot be assigned someone who merely finds herself with a disease that resists treatment, or someone who has merely acquired a sexually transmitted disease. It is not remotely fathomable that the legislature intended such patients to be incarcerated on account of their medical conditions, and the City does not claim otherwise. Yet that would be the inescapable conclusion if Ms. Washington's incarceration is upheld.

The City does, by contrast, address Ms. Washington's fourth amendment claim, compare Br.-in-Ch., pp. 22-23, with Resp. Br., pp. 55-56. Ms. Washington's point is that if the scheme is interpreted to allow a patient to be incarcerated under order of a public health official for more than 48 hours before seeing a judge then the statutory scheme will be subject to fourth amendment attack. The scheme should be construed so as to avoid such a constitutional problem. More to the present point: had the legislature intended to give health officials the power to jail the sick, then it would have been more assiduous in providing swift judicial oversight.

The City further says that the fourth amendment does not apply, because Ms. Washington "was not a criminal defendant and was not arrested for" committing a crime, Resp. Br., p. 56, yet there can be no doubt that she was treated as if she were a common criminal. Not, as the City would have it, Resp. Br., p. 56 n. 6, simply because her mug shot was disseminated to the public; but, rather, because her circumstance was altogether indistinguishable from any criminal's. She was arrested by the police; put in jail; put not merely in jail, but among the general population; and had her

mug shot and medical condition disseminated to the public. (For that matter, she found herself worse off, in that she was ineligible for any release privileges.) Indeed, the City itself describes her circumstance as one of "incarceration," Resp. Br., pp. 24, 32, 62, the overall theme of the City's brief being that she deserved incarceration. In any event, it is fair to say that if the legislature had intended to place a tuberculosis patient *in jail,* it would have provided for swifter judicial oversight than the 72 hours written into the legislation.

II. IF JAIL IS AN OPTION, THEN THE CONFINEMENT COURT MUST CONSIDER WHETHER THERE ARE ANY LESS RESTRICTIVE ALTERNATIVES TO JAIL.

A. Read contextually, the legislative scheme requires that the circuit court must determine that there are no less restrictive alternatives to the specified *place of confinement.*

Even if jail is authorized for placement under § 252.07 the question remains as to whether such an order must be premised on a least-restrictive calculus.

The City first argues that under the plain wording of Wis. Stat. § 252.07(9)(a)3, the "(least) restrictive alternative" (LRA) phraseology relates "to the *fact* of confinement not the *place* of confinement," Resp. Br., p. 31, emphasis in original. LRA is not, in other words, a placement variable. As noted in Ms. Washington's opening brief (pp. 24-27), this provision must be read contextually, something the City fails to do.

Briefly put, a health officer orders temporary "confinement," continuation of which beyond 72 hours requires judicial review and approval. It is in that context that a judge must determine whether "all other reasonable means of achieving voluntary compliance with treatment have been exhausted and no less restrictive alternative exists," Wis. Stat. § 252.07(9)(a)3. Alternative to what? The patient has been confined to a particular place and the health officer is seeking

continuation of that *particular* confinement. Therefore, the LRA calculus very much implicates place as well as fact of confinement.

The City's opposition is based on an assumption that the legislation refers only to confinement in a "facility" rather than a "specified" facility. Resp. Br., pp. 33, et seq. There is no need to address the particulars of the City's argument on this point, because it is definitively refuted by Admin Code § HFS 145.08(2) ("'Confinement means the restriction of a person with tuberculosis to a specified place ....")

Ms. Washington's opening brief both reproduced the full text of this provision (p. 13) and also explicitly relied on it (p. 25), but the City fails to address it all. In any event, there can be no doubt from the plain text of this provision that confinement of a tuberculosis patient is to "a specified place"; the question thus devolves to the significance of that definition. Ms. Washington covered this point in her opening brief, pp. 25-27, and will therefore not repeat the remarks made there, except in summary form: the purpose of judicial review is to see whether the specified place of confinement should be continued, and it is in that context that the circuit court determines whether any less restrictive alternative exists.

It is also worth repeating that the City's blinkered reading of subdivision (9)(a)3 would eliminate judicial oversight with respect to whether the patient was receiving proper care. That is, Wis. Stat. § 252.07(9)(a) plainly requires that confinement be "in a facility where proper care and treatment will be provided and spread of the disease will be prevented"; yet, according to the City, the statute allows for judicial scrutiny merely of fact not place of confinement—thus, under the City's view the confinement judge would be unable to determine even something as basic as whether the patient would receive proper care and treatment.

The City's rendering would give the health bureaucracy virtually untrammeled placement authority. The

City's only answer is that Ms. Washington's confinement to jail "was directed not by the 'health bureaucracy' but by the Circuit Court," Resp. Br., p. 30. But this is not really an answer, because regardless of what was done in this instance the clear implication of the City's argument is that the health bureaucracy would be ceded unreviewable authority as to place of confinement. Nor is the City's assertion entirely accurate: Ms. Washington was indeed jailed on the health officer's say-so; the trial court continued that placement, which brings us full circle to whether that determination was proper.

B. Due process requires that the place of confinement be the least restrictive alternative.

Ms. Washington argued that due process imposes a least-restrictive calculus on the placement decision, citing in the process various authorities to the effect that mental health commitment law was the closest analogy to tuberculosis commitment, Br.-in-Ch., pp. 29-31. The City resists both the analogy and the analysis, Resp. Br., pp. 49-50, arguing that due process requires only "an opportunity to be heard in court at a meaningful time and in a meaningful manner," something satisfied by Wisconsin's scheme without regard to least-restrictive placement, *id.*, p. 51. However, as the Supreme Court recently held, "due process requires that the conditions and duration of confinement under the Act bear some reasonable relation to the purpose for which persons are committed," ***Seling v. Young***, 531 U.S. 250, 265 (2001). The City might rejoin that the conditions of Ms. Washington's incarceration *were* reasonably related to the purpose of her commitment, but that is beside the point: the fact is that due process demands (among other things) scrutiny of those conditions, so that clearly something more than the purely procedural matter of opportunity to be heard enjoys protection. (Indeed, under the City's stilted view of the legislative scheme discussed above, a judge cannot even review those conditions despite their due process protection,

because only the *fact* and not the *place* of confinement is at issue.)

The City purports unconvincingly to distinguish ***Newark v. J.S.***, 279 N.J. Super. 178, 652 A.2d 265 (1993) on the ground that "New Jersey did not have a tuberculosis-control scheme comparable to" Wisconsin's, Resp. Br. p. 49. However, that circumstance is irrelevant to whether due process demands consideration of an LRA with regard to placement. And, contrary to the City, ***J.S.*** did derive such a holding: "The terms of confinement must minimize the infringements on liberty and enhance autonomy. ... Lesser forms of restraint must be used when they would suffice to fulfill the government interests." *Id.*, at 272.

Nor does the City address a larger point: "least restrictive alternative" phraseology had a settled meaning when § 252.07(9) was promulgated in present form, such that it shows legislative intent to impose an LRA requirement on placement (see Br.-in-Ch., p. 31).[2]

C. Equal protection would require consideration of less restrictive alternative placement options.

If construed to omit least-restrictive placement the tuberculosis-control scheme would be open to equal protection attack. Ms. Washington agrees that the rational basis test would apply. Resp. Br., pp. 52-53. The principal comparison is to mental health commitment procedure, which explicitly imposes an LRA requirement for placement; the question is thus whether there is a rational basis for affording such a right to that class of patients but denying it to tuberculosis patients.

The City asserts in conclusory fashion that comparison between the two classes "is unwarranted," Resp. Br., p. 54, citing no authority for the proposition. But as noted above a

[2] See also ***Lynch v. Baxley***, 744 F.2d 1452, 1459 (11th Cir. 1984) (due process precludes use of jail for emergency mental health detention where less restrictive alternative exists).

number of different authorities agree that mental health commitment is the "closest legal analogy" to involuntary tuberculosis treatment. Ms. Washington cited these authorities, Br.-in-Ch., p. 30, but the City discusses none of them on this particular point. Given this widespread agreement that mental health commitments serve a purpose very close to that served by tuberculosis commitments; (sufficiently close that the law guiding the former has been imported into the latter), it stands to reason that the two classes should therefore be taken as comparable for equal protection purposes. And, given that the two classes are regarded as quite similar, it necessarily follows that there is no rational basis to grant a right of least-restrictive placement to one but deny it to the other.

The City makes two substantive points, the first irrelevant and the second self-defeating. First, it is assertedly rational to provide "secure confinement" for uncooperative tuberculosis patients, Resp. Br., p. 53. But that is not precisely the question. Rather, the question is whether it is rational to jail such a patient without regard for less drastic placement options, when such a right is given to violent, uncooperative mental health patients who also present an on-going threat to the public.

Second, the City argues that mental patients may "require long-term, perhaps lifetime treatment" in distinction to tuberculosis patients such as Ms. Washington, who "required treatment for months, not years," *id.*, p. 54. Why a violent individual's *non*-amenability to treatment should lead to *greater* protections than someone who can be cured is something the City does not explain. That a mental health patient may require a lifetime of confinement as the only alternative to safeguarding the public quite simply means that that person is if anything more of a danger than a patient who is responsive to medication. The City, though, might add that the critically distinguishing feature is that (unlike the mental health patient) the tuberculosis patient is confined "only because of her contumacy, a factor within her ability to control and unrelated to illness," *id.* But this is not *necessarily*

so: a tuberculosis patient may be confined if "the disease is resistant to the medication prescribed to the individual" and "no other medication to treat the resistant disease is available," Wis. Stat. § 252.07(9)(a)2., 4. "Contumacy," then, has nothing to do with it.[3] In any event, the City's observation suggests if nothing else that the aim is punishment.

Nor is mental health commitment the only comparable class; juvenile delinquency is another, see Br.-in-Ch., pp. 32-33. Tellingly, the City does not address this comparison, and Ms. Washington therefore sees no need for further discussion.

III. COSTS, AT LEAST ON THIS RECORD, ARE NOT AN AUTHORIZED LEAST-RESTRICTIVE ALTERNATIVE CONSIDERATION.

The statutes do not provide for consideration of costs in fashioning an LRA; thus, the rule of ***D.E.R. v. LaCrosse County***, 155 Wis. 2d 240, 248, 455 N.W.2d 239 (1990) is triggered (absence of express legislative linkage of LRA to available funds means that costs are off-limits). The City does not really claim otherwise, but instead tries to establish two points of distinction.

The City first asserts that the costs of hospitalization (the asserted alternative to jail) would be "huge," and that therefore this case comes within the possible "exorbitant-costs" exception noted in ***D.E.R.***, 155 Wis. 2d at 253, Resp. Br., pp. 42-47. However, there is nothing in this record to indicate *what* the costs would be, let alone that they would be "huge." Nor, for that matter, is there anything to indicate what the costs of Ms. Washington's incarceration were so that a point of comparison might be made. At a minimum, a hearing would be necessary to establish a record on the point.

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[3] To be sure, Ms. Washington was *not* drug-resistant, but that is beside the point. The question is how to construe the statute, and drug-resistant patients are subject to the same strictures and procedures as "contumacious" patients.

Next, the City argues that ***D.E.R.*** involved a statutory scheme that explicitly provided for LRA placement, while § 252.07(9) does not, Resp. Br., pp. 45-46. But this purported distinction is meaningless: either LRA placement applies here or it doesn't; if the latter, then Ms. Washington's argument fails altogether; if the former, then the rule of ***D.E.R.*** applies.

IV. THE CONFINEMENT ORDER IS NOT SUSTAINABLE AS A MATTER OF CONTEMPT

The City's claim that the confinement was a "functional" contempt order, Resp. Br., p. 62, ignores the established principle that contempt must follow legislatively prescribed procedure, see Br.-in-Ch., p. 40. There is no such thing as a "functional" contempt.

On the merits, the City's arguments were anticipated in Ms. Washington's opening brief, and she therefore has little to say now. She would, however, focus the court's attention on the City's recognition that "the necessary purging act [was] completion of [the treatment] regimen to the point of cure," Resp. Br., p. 66. That characterization has the virtue of factual accuracy. (The court of appeals instead pinned duration of confinement on "the medically required time," which is more vague, see Br.-in-Ch., p. 42.) However, the City still fails to resolve the fatal conundrum: just how is it within someone's power to effectuate a cure? To cooperate with treatment, surely; but that was not what the confinement order said.[4]

[4] Ms. Washington reiterates that the City's argument should be barred under judicial estoppel. The City told the trial court that it was *not* seeking a contempt remedy, in that the *only* remedy being pursued was under § 252.07 (Br.-in-Ch., pp. 37-38). As a result, the trial court made no attempt to fashion a purgeable condition of the confinement order.

CONCLUSION

Ms. Washington renews her request for relief, Br.-in-Ch., p. 45.

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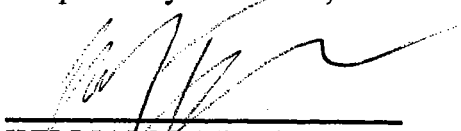
CERTIFICATION

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 300 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. The text is 13 point type and the length of the brief is 2947 words.

Respectfully submitted,



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WISCONSIN SUPREME COURT

In the Interest of Ruby Washington

CITY OF MILWAUKEE

Petitioner-Respondent,

v.

Appeal No. 2005AP3141
Circuit Court Case No. 2005CV7563

RUBY WASHINGTON,

Respondent-Appellant-Petitioner

THE AMERICAN CIVIL LIBERTIES UNION OF WISCONSIN FOUNDATION, INC.'S AMICUS BRIEF

On Appeal from a Milwaukee County Circuit Order of Confinement Dated October 5, 2005, Judge Clare L. Fiorenza Presiding, and from a District I Court of Appeals Decision Dated March 28, 2006

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STATEMENT OF INTEREST

This case concerns the City of Milwaukee's demand that Ruby Washington be confined to the Milwaukee County Criminal Justice Facility for treatment of pulmonary tuberculosis. Washington requested confinement in a hospital. The court of appeals appears to have issued the nation's first published appellate decision ordering a noncompliant TB patient to jail for medical treatment. *City of Milwaukee v. Washington*, 2006 WI App 99, __Wis. 2d__, 716 N.W.2d 176. One issue for review is "whether the 'no less restrictive alternative' requirement of Wis. Stat. § 252.07(9)(a)3 applies to the place and not merely the fact of confinement; and if the former, whether the court may take into account costs in determining which placement is appropriate." (Pet. Brief at 1-2).

The ACLU-WIF is a charitable, nonprofit organization whose purpose is to maintain and advance civil liberties, including the freedoms of association, press, religion, and speech, and the rights to franchise, to due process of law, and to equal protection under the laws for all people throughout the state of Wisconsin. The ACLU-WIF is affiliated with the American Civil Liberties Union of Wisconsin, which has over 9,000 members statewide, and the American Civil Liberties Union, which has a national membership of over 500,000 individuals. To further its mission, the ACLU and its affiliates have participated, either as counsel or as *amici*, in numerous cases supporting the due process rights of individuals facing civil confinement.

ARGUMENT

The City paints an ugly picture of the homeless Ruby Washington. "Washington was not a sick, unfortunate woman caught up in a City dragnet," the City claims without record support. "She was a serious menace, who refused to do anything to address or alleviate the threat that she presented to the public, and acted in a manner that exacerbated that threat." (City's Br. at 24.) Whatever Ruby Washington's faults may be, this case is no longer about her. She has served her 8 month jail detention for tuberculosis treatment. Thus, this case is about future individuals who will fail to comply with a TB treatment regimen. It presents questions of statutory construction, constitutional law, and ultimately, a policy choice for the supreme court: where are non-compliant TB patients to be detained for compulsory treatment? The answers require some understanding of the people most vulnerable to TB, why they are non-compliant, the evolution of constitutional protections for individuals subject to civil commitments, where tuberculosis breeds, and how it is controlled most effectively.

I. Understanding the Problem: Why Some People Fail to Complete TB Treatment.

TB was close to eradication in the 1980s, but the disease returned with a vengeance in the 1990s. Health departments cut budgets for TB control programs at that same time that poverty rose, forcing greater reliance on homeless shelters where the disease spread rapidly. Barron H. Lerner, *Tough Love Lessons from a Deadly Epidemic*, NYT June 27, 2006. The AIDS epidemic also contributed to the problem. Of persons infected with the TB

organism, those with HIV are 40 times more likely to develop active TB. Rosemary G. Reilly, *Combating the Tuberculosis Epidemic: The Legality of Coercive Treatment Measures*, 27 Columbia J. L. & Soc. Probs., 27:101, 104 (1993-94). An infusion of resources at the national, state and local levels and the development of effective interventions arrested that resurgence so that the incidence of TB in the United States has again declined—44% between 1993 and 2003—and in fact reached a historic low in 2003. CDC, *Controlling Tuberculosis in the United States*, MMWR, Nov. 4, 2005, Vol. 54, No. RR-12 at 2.[1]

Despite these successes, certain populations remain at high risk for developing TB. They include: (1) homeless persons, especially if they have spent time in overnight shelters; (2) prisoners in jails and correctional facilities; (3) foreign-born persons who lack access to medical services due to cultural, linguistic, financial and legal barriers; and (4) people with compromised immune systems as a result of infection with the HIV virus. *Id.* at 3, 11-12.

Not surprisingly, these populations also have the most difficulty complying with TB treatment regimens. For initial infections standard treatment includes multi-drug therapy for at least six months. But a person with reactivated or multi-drug resistant strain of TB could require six different drugs each day for 18 to 24 months. "Needless to say, this places a severe burden on the patient, particularly after the first few months, at which time the patient has few symptoms and feels cured." Reilly, *Combating the Tuberculosis*

[1] All CDC articles cited in this brief are available at www.cdc.gov/search.do?action=search&subset=MMWR&querytext=Tuberculosis&Submit.x=15&Submit.y=8.

Epidemic at 108. Some patients are unwilling to continue treatment because the medication causes side effects, or they have difficulty obtaining additional medication, or they believe the medication is no longer necessary. CDC, *Tuberculosis Control Laws—United States, 1993 Recommendations of the Advisory Council for the Elimination of Tuberculosis*, MMWR, Nov. 12, 1993, Vol. 42, No. RR-15 at 6.

For homeless people like Ruby Washington, adherence to a TB treatment regimen is especially challenging. It is their day-to-day struggle to live—not a defiant attitude or indifference to health risks, as the City suggests—which prevents them from adhering to the long-term treatment regimen.

> Homeless, by definition, means lack of permanent shelter. Whether a person lives on the streets, wanders from one SRO to another, or moves in and out of a congregate facility, medical care is rarely his or her first priority. The daily search for food and shelter belie the possibility of an organized schedule, appointment keeping or routine medical ingestion as is necessary with TB treatment. Alcoholism, drug dependence and psychiatric disturbances affect anywhere from 50 to 90 percent of the homeless, and the notion that persons so affected can remember and comply with clinic appointments and medication regimens is laughable.

K. Brudney, *Homelessness and TB: A Study in Failure*, 21 J. Law Med. Ethics, 360-7 (1993)(quoted in Ronald Bayer and Laurence Dupuis, *Tuberculosis, Public Health, and Civil Liberties*, 16 Annu. Rev. Public Health, 307, 314 (1995)).

II. The Evolution of TB Control Laws: Application of the Due Process Requirement that Only the "Least Restrictive" Coercive Public Health Measures Are Justified.

In *Jacobson v. Massachusetts*, 197 U.S. 11, 24 (1905) the United States Supreme Court held that states may use their police power to enact quarantine and health laws. Thereafter numerous cases affirmed the government's almost unlimited right to quarantine patients with communicable diseases which threatened the community. Reilly, *Combating the Tuberculosis Epidemic* at 116. But between the 1950s and 1980s the Supreme Court began to impose substantive and procedural due process restrictions on government action, particularly in the area of involuntary civil detention for the mentally ill. *Id.* at 117-18. Among those restrictions is the principle that when civil liberties are at stake the state must use the least restrictive means possible to achieve its goals. *Shelton v. Tucker*, 364 U.S. 479, 488 (1960); *Covington v. Harris*, 419 F.2d 617, 627-29 (D.C. Cir. 1969); *Lessard v. Schmidt*, 349 F. Supp. 1078, 1103 (E.D. Wis. 1972).

For involuntary civil commitment cases, the "least restrictive alternative" due process principle clearly demands that a person be confined to the least restrictive ***place*** in which public health goals can be achieved. *Covington*, 419 F.2d at 623-24 ("The principle of the least restrictive alternative is equally applicable to alternate dispositions within a mental hospital . . . The range of possible dispositions . . . within a hospital, from maximum security to outpatient status is almost as wide as that of dispositions without"); *Lynch v. Baxley*, 744 F.2d 1452, 1459 (11th Cir. 1984)(emergency

detention in jail cannot be the least restrictive means for holding people pending civil commitment proceedings).

Decisions like *Addington v. Texas*, 441 U. S. 418, 425 (1979), which recognized that "civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection," allowed TB patients to assert that they too are entitled to the Constitution's due process protections. Bayer and Dupuis, *Tuberculosis, Public Health* at 319-20. Courts thus began to apply the law governing the civil commitment of the mentally ill to protect the due process rights of TB patients. *City of Newark v. J.S.*, 279 N.J. Super. 178, 652 A.2d 265 (1993); *Green v. Edwards*, 164 W. Va. 326, 263 S.E.2d 661, 663 (1980). Consequently, "[l]egal commentators frequently draw an analogy between involuntary confinement for communicable diseases and involuntary confinement for mental illness." Lisa A. Vincler and Deborah L. Gordon, *Legislative Reform of Washington's Tuberculosis Law: The Tension Between Due Process and Protecting Public Health*, 71 Wash. L. Rev. 989, 1012 (1996).

As for legislation, New York led the way on revision of TB laws to protect civil liberties. Barron H. Lerner, *Catching Patients: Tuberculosis and Detention in the 1990s*, 115 Chest 236, 237 (1999). In 1993, the New York City Department of Health promulgated new tuberculosis regulations articulating the compulsory measures available to control tuberculosis and to ensure that the Department complied with sound principles of due process. Reilly, *Combating the Tuberculosis Epidemic* at 133. That same year, the Centers for Disease Control issued a report on United

States tuberculosis control laws, which made the following recommendations:

- The isolation, detention or commitment of a person for TB treatment must meet state and federal constitutional due process and equal protection requirements. CDC, *Control Laws* at 9.

- "Appropriate residence facilities should be designated for the care of homeless persons infected with active TB." *Id.* at 8.

- "State laws should permit the involuntary isolation and detention of non-infectious patients who, after being offered less restrictive alternatives, refuse to adhere to a treatment regimen or to complete treatment." *Id.*

- "Commitment laws should specify a) where patients will be treated, b) the duration of commitment . . . and c) the reimbursement mechanism for the treatment. *Id.* at 9.

- Cities and counties should establish a variety of facilities for treating people with TB including homeless shelters, half-way houses, and long-term care facilities like hospitals. *Id.* at 10.

In short, commentators on TB detention law urged that, like the mentally ill, TB patients should receive due process protections such as the provision of counsel, the right to present evidence, and judicial review. They encouraged public health authorities to eliminate the barriers that prevent TB patients from completing treatment. And they argued that given the obstacles hindering high-risk TB patients from completing treatment, they should not be punished by confinement to criminal facilities. Instead, they should be confined in hospital wards where they can receive the necessary medical and social assistance. Lerner, *Catching Patients* at 237-38.

III. The Court of Appeals' Solution—Ordering the Confinement of the Non-Adherent TB Patient in Jail—Is Wrong.

A. Wisconsin's TB Control Law Is Designed to Protect Both Public Health and the Individual's Constitutional Rights.

In 1999, the Wisconsin legislature adopted a tuberculosis control law that, consistent with CDC recommendations, balances the public's need for protection from infectious tuberculosis with the patient's right to due process of law. Specifically, the legislature permitted the Wisconsin Department of Health and Family Services (the "Department") or local health officer to petition a court for a hearing to determine "whether an individual with infectious or suspect tuberculosis should be confined in a facility where proper care and treatment will be provided and the spread of disease will be prevented." Wis. Stat. § 252.07(9)(a). Among other things, the petition must demonstrate that: (1) the individual has either infectious tuberculosis, noninfectious tuberculosis and a high risk for developing infectious tuberculosis, or suspect tuberculosis; (2) the individual has failed to comply with a prescribed treatment regiment; (3) "all other reasonable means of achieving voluntary compliance with treatment have been exhausted and no less restrictive alternative exists;" and (4) the individual poses an imminent and substantial threat to himself or to the public. Wis. Stat. § 252.07(9)(a)(1)-(4). Safeguarding due process rights, the legislature also provided that individuals subject to such petitions have the right to appear at the hearing, the right to present evidence and cross-

examine witnesses, the right to counsel, and the right to an appeal. Wis. Stat. § 252.07(9)(d)-(e).

The legislature could have been clearer about what it meant by "a facility where proper care and treatment will be provided and the spread of disease will be prevented" and "no less restrictive alternative." However, as a simple matter of statutory construction, it seems unlikely that the legislature envisioned that patients who cannot comply with a treatment regimen would be detained at a local county jail rather than a hospital or a guarded ward. Allowing detention in a jail (or possibly a Supermax prison, under the court of appeals' interpretation) is inconsistent with the legislature's 1999 overhaul of Wisconsin's tuberculosis law, which significantly increased due process protections for non-compliant tuberculosis patients. *State v. White*, 2004 WI App 237, ¶ 10, 277 Wis. 2d 580, 690 N.W.2d 880 (statute should be construed to support its overall purpose).

B. As a Matter of Public Policy, the Court of Appeals' Decision Is Short-Sighted and Self-Defeating.

The problem in this case is that Wis. Stat. § 252.07 does not define the term "facility" or explain what the legislature meant by the phrase "no less restrictive alternative exists." Consequently, the court of appeals essentially made a public policy choice about where the Department or local health authorities may confine non-adherent TB patients for treatment. The court explained:

> [G]overnment spending is a zero-sum endeavor—money spent on giving Washington the type of confinement she prefers would, per force, have to be diverted from other more worthwhile endeavors, such

> as both helping persons who want but cannot afford medical treatment, and who will ***cooperate*** with that treatment.

Washington, 2006 WI App at ¶ 14. (Emphasis in original). Mocking Washington's alleged request for a guard-enforcement confinement in a hospital,[2] the court of appeals observed that a "guard at the Pfister Hotel or some other luxury facility would be 'less restrictive' than either a hospital or the justice facility." *Id.* at ¶ 15.

The court of appeals made a poor public policy decision. First, if cost is to be the deciding factor, then jail is possibly the worst place to confine non-adherent TB patients for treatment. Unlike Ruby Washington, the next TB patient who fails to complete therapy may be infectious. TB control is especially difficult in correctional facilities where persons from diverse backgrounds are housed in close proximity for varying times. CDC, *Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from the CDC*, MMWR, Jul. 7, 2006, Vol. 55, No. RR-9 at 1. "Correctional facilities are common sites of TB transmission and propagation. Incidence of TB and LTB1 are substantially higher in prisons and jails than in the general population. TB is believed to be the leading cause of death for prisoners world wide." CDC, *Controlling Tuberculosis in the United States* at 30. Released inmates having TB return home and

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[2] Washington requested confinement at a hospital. She did not request a guard. Nor did she require a guard when she was confined for 30 days at a hospital in order to be rendered non-infectious. The City raised the specter of a guard, and the court of appeals appears to have attributed the City's comment to Washington. Pet. Br. 5; Pet. App. 121-22; *Washington v. City of Milwaukee*, 2006 WI App 99, ¶ 15, __Wis. 2d__, 716 N.W.2d 176.

infect their loved ones and communities. CDC, *Prevention and Control of Tuberculosis in Correctional and Detention Facilities* at 12; Editorial Desk, *Where Tuberculosis Breeds*, N.Y. Times, May 11, 1993. Any decision approving the confinement of a TB patient to jail thus potentially foists upon taxpayers: (1) the cost of treating prisoners, prison-workers, and others who contract the disease from the non-compliant patient; (2) the cost associated with isolating and treating TB patients in jail—which includes negative pressure rooms, environmental controls, and personal respirators;[3] and (3) the lawsuits filed by people who contract TB while in jail or from inmates released from jail. The court of appeals simply made a snap decision about the presumed immediate cost of jail versus a guarded hospital ward without considering the long-term costs of its decision.

Second, if protecting public health is of paramount concern, then the court of appeals' decision is self-defeating. Early detection and diagnosis of TB improves the success of treatment and reduces transmission of the disease and death. CDC, *Controlling Tuberculosis* at 32. The first step to improving detection is to remove the stigmas associated with the disease. *Id.* People at high risk for TB—for example, foreign-born persons—tend to deny or hide symptoms for fear of being reported to immigration authorities. *Id.* For people who are sick but have committed no crime, the possibility of and stigma associated with being committed to jail for treatment will deter them from seeking access to medical care and

[3] For the special environmental controls required to treat TB in jail see CDC, *Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from the CDC*, MMWR, Jul. 7, 2006, Vol. 55, No. RR-9 at 11-15.

thereby impair efforts to control the spread of tuberculosis in the general population.

Third, the court of appeals' simplistic solution—put persistently non-adherent TB patients in jail—ignores the reasons these patients failed to complete treatment in the first place. "Non-adherence is 'socially rooted' in homelessness, untreated drug and alcohol addiction, and psychiatric disorders." Lerner, *Catching Patients* at 238. The social circumstances of those at highest risk for TB make adherence to a long-term treatment regimen difficult or impossible. Thus, commentators on this issue have "strongly encouraged the use of locked hospital wards—rather than criminal facilities—as the sites of isolation. Such units . . . should not be 'punitive or custodial but therapeutic.' Those confined to locked wards 'are not convicted criminals undergoing punishment but non-compliant patients who require medical and social assistance.'" *Id.* at 237 (quoted source omitted).

CONCLUSION

For the reasons stated above, the ACLU-WIF respectfully requests that the Wisconsin Supreme Court reverse the court of appeals' decision.

Dated this 7th day of September, 2006.

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WISCONSIN SUPREME COURT

In the Interest of Ruby Washington

CITY OF MILWAUKEE

Petitioner-Respondent,

v.

Appeal No. 2005AP3141
Circuit Court Case No. 2005CV7563

RUBY WASHINGTON,

Respondent-Appellant-Petitioner

FORM AND LENGTH CERTIFICATION

I hereby certify that this non-party brief conforms to the rules contained in § 809.19(7) and § 809.19(8)(c)(2) of the Wisconsin Statutes for a brief produced with a proportional serif font. The length of this brief is 2, 998 words.

Dated this 7th day of September, 2006

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WISCONSIN SUPREME COURT

In the Interest of Ruby Washington

CITY OF MILWAUKEE

Petitioner-Respondent,

v.

Appeal No. 2005AP3141
Circuit Court Case No. 2005CV7563

RUBY WASHINGTON,

Respondent-Appellant-Petitioner

CERTIFICATE OF MAILING AND SERVICE

Pursuant to Wis. Stat. § 809.80(3)(b) and (4)(a), I hereby certify that on September 7, 2006, I filed 22 copies of the ACLU-WIF's Amicus Brief by depositing them in the U.S. mail for delivery by first-class mail to:

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I further hereby certify that I served 3 copies of the ACLU-WIF's amicus brief, by first class mail, upon counsel for the parties and amicus parties at the following addresses:

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IN SUPREME COURT

Case No. 2005AP003141

In the Interest of Ruby Washington

CITY OF MILWAUKEE,

Petitioner-Respondent,

v.

RUBY WASHINGTON,

Petitioner-Appellant-Petitioner.

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STATEMENT OF INTEREST

The Wisconsin Association of County Corporation Counsels ("Association") is an unincorporated association of county corporation counsels. Its membership consists of 65 attorneys from 37 counties and it is governed by officers selected by its member attorneys.

Under Wis. Stat. § 59.42, a county corporation counsel is responsible for providing necessary civil legal services to a county government and the county's various boards, commissions, committees, and departments. Thus, a county corporation counsel is responsible for prosecuting actions that are referred by a county health department pursuant to Wis. Stat. § 252.07 in the same way that the Milwaukee city attorney was responsible for representing the city health department in this case.

The issue in this case is of interest to the Association because, as the City notes, public health functions are assumed by county health departments throughout most of the state.[1] And the issue is of interest to the Association because, as Ms. Washington's counsel notes, the cost of jail confinement would be borne at the county level.[2]

The Association believes that the Court of Appeals was correct in affirming the lower court's order that a noncompliant tuberculosis patient should be confined in a correctional facility to assure that she completed the prescribed course of treatment for the disease. The Association believes that jail confinement under these circumstances is a proper exercise of public health powers under Wis. Stat. § 252.07 and of remedial contempt powers under Wis. Stat. Ch. 785.

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[1]BRIEF OF THE PETITIONER-RESPONDENT CITY OF MILWAUKEE (CITY BRIEF) at p. 46 n.5.

[2]BRIEF-IN-CHIEF AND APPENDIX OF RESPONDENT-APPELLANT-PETITIONER (WASHINGTON BRIEF) at p. 36.

ARGUMENT

I. CONFINEMENT OF A NONCOMPLIANT TUBERCULOSIS PATIENT TO A CORRECTIONAL FACILITY IS A PROPER EXERCISE OF PUBLIC HEALTH POWERS.

A. The Tuberculosis Statute Provides Appropriate Due Process Protection.

A local health officer may order that an individual who has tuberculosis be confined to a facility if certain conditions are met.[3] However, the local health officer must petition a court for a hearing to determine whether the individual should be confined for longer than 72 hours in a facility where proper care and treatment will be provided and spread of the disease will be prevented.[4] The health officer must demonstrate all of the following:

> 1. That the individual named in the petition has infectious tuberculosis; that the individual has noninfectious tuberculosis but is at high risk of developing infectious tuberculosis; or that the individual has suspect tuberculosis.
>
> 2. That the individual has failed to comply with the prescribed treatment regimen or with any rules promulgated by the department under sub. (11); or that the disease is resistant to the medication prescribed to the individual.
>
> 3. That all other reasonable means of achieving voluntary compliance with treatment have been exhausted and no less restrictive alternative exists; or that no other medication to treat the resistant disease is available.
>
> 4. That the individual poses an imminent and substantial threat to himself or herself or to the public health.[5]

The individual must be given written notice of the hearing, the grounds and facts upon which confinement is sought, an explanation of the individual's rights, and the actions proposed to be taken and the reason for those actions.[6] Additionally, the individual has a right to appeal at the hearing, the right to present evidence, the right to cross-examine witnesses, and the right to be

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[3]Wis. Stat. § 252.07(8).

[4]Wis. Stat. § 252.07(9)(a).

[5]Wis. Stat. § 252.07(9)(a)1-4.

[6]Wis. Stat. § 252.07(9)(b).

represented by adversary counsel.[7] If the individual is ordered to be confined for more than six months, the court must review the confinement every six months.[8] And any order of the court may be appealed as a matter of right.[9]

Finally, the statute provides that the Department of Health and Family Services may promulgate any rules necessary for the administration and enforcement of the statute.[10] To that end, the Department has enacted Wis. Admin. Code Ch. HFS 145 pertaining to the control of communicable diseases and Wis. Admin. Code Ch. 145, Subch. II pertaining to tuberculosis. These rules authorize a local health officer to take the following actions:

> (a) order a medical evaluation of a person.
>
> (b) require a person to receive directly observed therapy.
>
> (c) require a person to be isolated under ss. 252.06 and 252.07(5).
>
> (d) Order the confinement of a person if the local health officer decides that confinement is necessary and certain conditions are met.[11]

Confinement must be to a location that will meet the person's needs for medical evaluation, isolation, and treatment.[12] Under the Department's rules, no person may be confined for more than 72 hours, excluding Saturdays, Sundays, or legal holidays, without a court hearing.[13]

Clearly, both the statute and the administrative code provide substantial due process protection to an individual who has tuberculosis.

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[7]Wis. Stat. § 252.07(9)(d).

[8]Wis. Stat. § 252.07(9)(c).

[9]Wis. Stat. § 252.07(9)(e).

[10]Wis. Stat. § 252.07(11).

[11]*See* Wis. Admin. Code § HFS 145.10(6).

[12]Wis. Admin. Code § HFS 145.10(6)(e).

[13]Wis. Admin. Code § HFS 145.10(6)(f).

B. Ms. Washington's "Plain Text" Argument Attempts To Rewrite The Tuberculosis Statute.

Despite the clear and substantial due process protections provided by the tuberculosis control statute and the administrative code, Ms. Washington argues that she has been denied due process. Her argument, she claims, is supported by the "plain text" of the statute. She asserts that an individual cannot be confined to jail when a less restrictive alternative is available, that the place of confinement must be the "(least) restrictive alternative available," and that a hospital is the least restrictive environment.[14]

Confinement of an individual with tuberculosis for more than 72 hours requires that a local health officer demonstrate to a court, among other things, that "all other reasonable means of achieving voluntary compliance with treatment have been exhausted and no less restrictive alternative exists."[15] Ms. Washington correctly asks, "Alternative to what?"[16]

The City states that the phrase "less restrictive alternative" means that there is no less restrictive alternative to the **fact** of confinement, not the **place** of confinement.[17] The Court of Appeals concurred and noted that "the section does not reference the *nature* of the place of confinement."[18]

Ms. Washington disagrees and asserts that the phrase "naturally, necessarily and grammatically refers to the overarching issue of confinement in a specified, and therefore, *identified* 'facility.'"[19] Washington also claims that the phrase "least restrictive alternative" had a settled meaning when sec. 252.07(9) was adopted and claims that this showed a legislative intent to impose a "least restrictive alternative" requirement on placement.[20]

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[14]WASHINGTON BRIEF at 24, 25 (citing Wis. Admin. Code § HFS 146.06(5), and 36.

[15]Wis. Stat. § 252.07(9)(a)3.

[16]WASHINGTON REPLY BRIEF at 4.

[17]CITY BRIEF at 31 (emphasis in original).

[18]*In re Washington*, 2006 WI APP 99 ¶ 12 (emphasis in original).

[19]WASHINGTON BRIEF at 26.

[20]WASHINGTON REPLY BRIEF at 7.

The principal problem[21] with Washington's argument is that the phrase "least restrictive alternative" doesn't appear in Chapter 252 at all. And, as the Court of Appeals observed:

> Certainly if the legislature intended to engraft a "least restrictive facility" dictate, it could have easily done so in § 252.07(9)(a)3 as it has elsewhere.[22]

The Court of Appeals correctly noted that "We apply statutes as they are written."[23] And this statue states that an individual may be confined only if a public health officer demonstrates that there is "no less restrictive alternative."

In this case, Ms. Washington was provided with a less restrictive alternative than confinement when she was allowed to reside with her sister and participate in directly observed therapy on an outpatient basis. But she refused to follow the prescribed treatment and confinement became the only way to assure that she was available to participate in directly observed therapy. But because the legislature did not include "least restrictive alternative" language in the statute, the Court of Appeals correctly concluded that Ms. Washington "is not entitled to choose the place of her confinement."[24]

C. Cost Is A Legitimate Consideration When Determining The Place Of Confinement.

Ms. Washington asserts that cost is not a proper consideration when making the determination about where an individual with tuberculosis should

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[21] A secondary problem is the way in which the language in her argument shifts about. The argument is initially presented as a "plain text" argument concerning the statutory phrase "no less restrictive alternative." But Ms. Washington promptly rewrites the phrase as "(least) restrictive alternative." WASHINGTON BRIEF at 24 ¶ D. She then substitutes her "(least) restrictive alternative" language for the City's use of the phrase "less restrictive alternative" when she summarizes the City's argument. *Cf.* WASHINGTON REPLY BRIEF at 4 and CITY BRIEF at 31. Then she drops the parentheses denoting her revision of the text and uses the phrase "least restrictive alternative" as if that's what the statute actually said. WASHINGTON REPLY BRIEF at 6. Finally, she simply shifts to the acronym "LRA" and uses that acronym fairly indiscriminately in her reply brief.

[22] *In re Washington*, 2006 WI APP 99 ¶ 12 (discussing the other statutes where the legislature actually used the "least restrictive alternative" language and distinguishing Wisconsin's statutes from those in other jurisdictions).

[23] *Id.* at ¶ 12 (citations omitted).

[24] *Id.* at ¶ 15.

be confined.[25] And she claims that the sole basis for rejecting her placement in a hospital was that it would cost too much, rather than because it was not suitable to her treatment needs. She attempts to bolster this claim by pointing out that she was compliant while she was at the hospital.[26]

Her argument overlooks a critical fact — she was originally confined to the hospital because her tuberculosis was infectious and medical quarantine was required. But when her disease became noninfectious, the local health officer was required to discharge her from the hospital. That is because a local health officer may direct that a person with a contagious disease "[b]e placed in an appropriate institutional treatment facility *until the person has become noninfectious*."[27]

At the time of the confinement order, Ms. Washington's treatment needs were limited. She only needed to be confined so her compliance with the directly observed therapy order could be monitored. But she had no medical need that required her to be hospitalized and a hospital was not suitable to her treatment needs. On the other hand, the jail where she was confined was perfectly able to provide the proper care and treatment that she required. In short, she was confined to the jail because it was the appropriate place to assure her confinement and provide for her limited treatment needs.

Ms. Washington cites *D.E.R. v. La Crosse County*[28] for the proposition that taxpayer cost is an impermissible placement consideration. But despite this assertion, cost is a legitimate consideration in deciding where a person should be confined. As the Court of Appeals noted, subsequent changes to the statutes reflect a legislative concern that was similar to those expressed by the trial court and that were shared by the Court of Appeals.[29]

And, as the City points out, even under *D.E.R.*, the cost to hospitalize Washington would have been so great and the benefit so small, that it would have been unreasonable for the court to mandate that the City hospitalize her.[30] Washington's response is that "[t]here is nothing in the record to indicate what

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[25]WASHINGTON BRIEF at 33.

[26]WASHINGTON BRIEF at 36.

[27]Wis. Admin. Code § HFS 145.06(4)(g) (emphasis added).

[28]*D.E.R. v. La Crosse County*, 155 Wis. 2d 240, 248, 455 N.W. 2d 239, 243 (1990).

[29]*In re Washington*, 2006 WI APP 99 ¶ 14.

[30]CITY BRIEF at 44-45.

the costs would be, let alone that they would be 'huge.'" Instead, she suggests that "a hearing would be necessary to establish a record on the point."[31]

But the record does indicate enough about the additional costs that would be required to confine Ms. Washington in a hospital. Specifically, taxpayers would have to pay the additional cost of providing a guard at the hospital 24 hours a day, 7 days a week, for a period of approximately 9 months.[32] Even at minimum wage, this would easily cost the taxpayers more than $37,000.[33] And that does not even take into account the difference between the per capita daily rate at a jail and at a hospital.[34]

Moreover, Ms. Washington's own arguments show that cost factors are legitimate considerations in deciding where tuberculosis patients are to be placed. She specifically notes that there has been a substantial reduction in the number of tuberculosis cases. She states that the number is "well below the number needed to justify the expense of sanitariums dedicated to that purpose."[35] Moreover, she has acknowledged that "[a] graduated scheme of coercive intervention seems to be *the most cost-effective mechanism* for delivering treatment" and that "Wisconsin's TB control regime follows this model."[36]

Despite Washington's predilection for pointing out what she claims to be "absurd results," she overlooks the most obvious — requiring that the public pay a substantial amount to place her in a hospital bed that she doesn't need when all that is really warranted is confinement to assure compliance with her

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[31] REPLY BRIEF OF RESPONDENT-APPELLANT-PETITIONER (WASHINGTON REPLY BRIEF) at 9.

[32] APPENDIX TO WASHINGTON BRIEF at 57:13-24.

[33] The cost of providing a guard at the State minimum wage of $5.70 per hour, 24 hours per day, 30 days per month, for 9 months would be $36,936. There are probably not many City police officers who are paid only at the minimum wage, and this doesn't include the cost of social security taxes or any fringe benefits.

[34] Experience at the county level suggests that the per capita daily rate for a jail would be around $50 – $55 per day, while the per capita daily rate for a hospital would be on the order of $900 – $1,000 per day.

[35] WASHINGTON BRIEF at 29.

[36] *Id.* (emphasis added).

treatment regimen.[37]

Taken as a whole, there is sufficient evidence in the record to support the application of cost as a factor in determining the place of confinement.

II. COURT-ORDERED CONFINEMENT OF A NONCOMPLIANT TUBERCULOSIS PATIENT IN A CORRECTIONAL FACILITY IS A PROPER EXERCISE OF REMEDIAL CONTEMPT POWERS.

A. Judicial Estoppel Should Not Bar Review Of The Remedial Contempt Issue.

Ruby Washington argues that the City is estopped from arguing that jail confinement is an appropriate remedial contempt sanction in her case. She notes that the City initially brought a contempt motion before the trial court, but elected to proceed under the tuberculosis control statute.[38] Moreover, she claims that the City's inconsistent positions "induce[d] the court of appeals to hold that the confinement order was...a contempt order."[39]

The problem with Ms. Washington's claim is that it misrepresents the evolution of the remedial contempt issue on appeal. As the Court of Appeals noted:

> This appeal comes to us in two interconnected postures. First, an appeal from the trial court's order in which the trial court specifically did not invoke its contempt power. Second, by virtue of an order issued by this district's motions judge on January 9, 2006, that nevertheless characterized the trial court's order as "at base, an appeal from a contempt order."[40]

It is true that the City pursued a remedy under the tuberculosis control statute, rather than under the remedial contempt statute, at the trial court level. But the motions judge for the Court of Appeals reintroduced the remedial

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[37]Washington suggests that the City is merely trying to shift the cost to the county. WASHINGTON BRIEF at 36. But the fact is that 100% of the cost of her confinement and treatment will be borne by taxpayers.

[38]WASHINGTON BRIEF at 37-38

[39]WASHINGTON BRIEF at 37.

[40]*In re Washington*, 2006 WI APP 99 ¶ 9.

contempt issue to the proceedings in the January 2006 order. And contrary to Ms. Washington's claims, the City has not taken an inconsistent position on appeal. It's position now is precisely the same as its initial position at the trial level. Under these circumstances, the City should not be estopped because of the way in which the Court of Appeals elected to characterize the issue when it accepted the case on appeal.

Additionally, Ms. Washington's own reasoning favors consideration of the remedial contempt issue. She argues that her case falls within settled exceptions to the mootness doctrine.[41] She points to *State v. Michael S.*, which states:

> A court may decide a moot issue when the issue is of great public importance; occurs frequently and a definitive decision is necessary to guide the circuit courts; is likely to arise again and a decision of the court will alleviate uncertainty; or will likely be repeated, but evades appellate review because the appellate review process cannot be completed or even undertaken in time to have a practical effect on the parties.[42]

The same reasons that Ms. Washington relies on to argue that her case is not moot also warrant this Court's consideration of the remedial contempt issue.

This case raises an issue of great public importance. And while noncompliant tuberculosis patients are fortunately not a frequent occurrence, guidance is necessary because the situation may arise again. A decision by this Court will resolve questions about the appropriateness of remedial contempt sanctions in such cases that will be of benefit to other courts. And, as the history of this case demonstrates, the appellate review process cannot be completed in time to benefit the parties when the issue arises again.

Under these circumstances, this Court should consider the remedial contempt issue in order to provide prospective guidance.

B. The Confinement Order Contained A Proper Purge Condition.

Ruby Washington argues that the confinement order was not a proper remedial contempt sanction because it set "*a clean bill of health*" as the purge

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[41] WASHINGTON BRIEF at 43-45.

[42] WASHINGTON BRIEF at 44 citing *State v. Michael S.*, 2005 WI 82 ¶ 6.

condition and that this was "*quite outside her capabilities.*"[43] The problem with this argument is that it misstates what the court actually ordered.

The trial court ordered that Ms. Washington be confined in the Milwaukee County Justice facility until further order of the court and set a date to review the matter for April 7, 2006. Additionally, the trial court ordered that Ms. Washington was to comply with the Milwaukee Health Department's order for Directly Observed Therapy (DOT) while she was confined.[44]

The purge condition was not, as Ms. Washington claims, that she have "a clean bill of health." The purge condition stated in the order was that she complete the prescribed course of treatment for her disease.

The requirement that Ms. Washington comply with the DOT order is, itself, wholly unremarkable. Ms. Washington had been confined to a hospital in August 2005 because her tuberculosis was contagious. At that time she entered into a stipulation with the City that she would continue a course of supervised treatment for approximately nine months after she was discharged from the hospital to ensure that she was cured.[45] The reason that confinement became necessary was solely because of Ms. Washington's repeated noncompliance with the terms of this stipulation.

Compliance with the prescribed course of treatment while confined to jail was clearly within Ms. Washington's ability. As Ms. Washington points out, a person confined to a jail may refuse treatment.[46] Thus, she had a choice about whether to comply with the treatment regimen and ultimately held the key to her own release.

This Court has previously found that setting treatment for a medical condition as a purge condition was within a circuit court's authority and did not violate an individual's due process rights.[47]

Gaylon Larsen suffered from Post Traumatic Stress Disorder (PTSD).

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[43]WASHINGTON BRIEF at 41 (emphasis in original).

[44]APPENDIX TO WASHINGTON BRIEF at pp. 138-39.

[45]*In re Washington*, 2006 WI APP 99 ¶ 4.

[46]WASHINGTON BRIEF at 22.

[47]*In Re Marriage of Larsen: State ex rel. Larsen v. Larsen*, 165 Wis. 2d 676, 681, 478 N.W.2d 18, 19 (1992).

During a child support proceeding, the circuit court found that PTSD was a factor in his inability to maintain employment and pay child support. Mr. Larsen stipulated to continuing a PTSD counseling program and the court entered an order for him to do so. Larsen failed to comply with the order and the circuit court subsequently found him in contempt. At the same time, the court provided that the contempt would be purged if Larsen agreed to receive treatment for PTSD and seek work. Larsen appealed the PTSD treatment condition.[48]

This Court found that the purge condition did not violate Mr. Larsen's due process rights. It noted that "Larsen had been ordered to jail, not to a treatment program. The treatment was only a purge condition, exercisable at Larsen's will."[49] Citing *Lessard* ,[50] this Court acknowledged that the circuit court could not have ordered inpatient treatment without a Chapter 51 hearing. But this Court has distinguished *Larsen* from *Lessard* and has concluded that "allowing Larsen to seek treatment for PTSD as an opportunity to purge his contempt, without a ch. 51 hearing, did not violate his right to due process."[51]

In the present case, as in *Larsen*, the purge condition was designed to compel Ms. Washington to do what she had already agreed to do. Thus, it did not violate her due process rights.

The purge condition set by the trial court was proper and the Court of Appeals' decision should be affirmed.

C. The Confinement Order Complied With Statutory Requirements For Remedial Contempt Orders.

Ruby Washington complains that she was deprived of her due process rights because the order confined her to jail for more than six months.[52] Ms. Washington predicates her argument on Wis. Stat. § 785.04(1)(b), which provides that imprisonment for contempt "may extend only so long as the person is committing the contempt of court or 6 months, whichever is the

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[48]*Id.* at 681-82.

[49]*Id.* at 684.

[50]*Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972).

[51]*In re Larsen*, 165 Wis. 2d at 684-85.

[52]WASHINGTON BRIEF at 42.

shorter period."

Ms. Washington ignores Wis. Stat. § 785.04(1)(e), which expressly provides that a court may also impose "[a] sanction other than the sanctions specified in pars. (a) to (d) if it expressly finds that those sanctions would be ineffectual to terminate a continuing contempt of court." And, as the Court of Appeals found:

> Here, the trial court fully explained why confinement for more than six months was necessary to ensure Washington's compliance with her treatment regimen; namely, that the six-month limitation would be "ineffectual to terminate" Washington's continuing failure to comply with its September 27, 2005, order, which directed, upon the parties' stipulation, Washington to voluntarily complete her course of treatment.[53]

Nonetheless, Ms. Washington asserts that the order violated her due process rights and her counsel invokes images of a "health bureaucracy" with "unreviewable authority" that would "eliminate judicial oversight with respect to whether the patient was receiving proper care."[54]

Hyperbole aside, this claim is simply wrong on the facts. The trial court order expressly set a date on which the matter was to be reviewed by the court.[55]

CONCLUSION

The Wisconsin legislature has created a comprehensive program to protect the public against the spread of tuberculosis. This program includes a progressive system of measures designed to assure that a tuberculosis patient is compliant with the medically necessary treatment regimen. When a patient is noncompliant and threatens both the patient's and the public's health, a court may order the patient confined to a facility where proper care and treatment can be provided.

Ruby Washington repeatedly failed to comply with the required treatment regimen and the court ordered that she be confined to a correctional facility. Ms. Washington complained that she would rather be confined to a medical facility and asserted that she could not be jailed for more than six

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[53] *In re Washington*, 2006 WI APP 99 ¶ 19.

[54] WASHINGTON REPLY BRIEF at 5 and 6.

[55] APPENDIX TO WASHINGTON BRIEF at 139 ¶ 4.

months under the court's remedial contempt powers.

The fact is that Ms. Washington had no medical need that required hospitalization, and the correctional facility was able to provide her with proper care and treatment. Ms. Washington's repeated escapes meant that confinement to a facility was necessary to assure her compliance, and a correctional facility is a "facility" within the meaning of the statutes. Under these circumstances, the trial court properly concluded that a jail — not a hospital — was the appropriate facility where Ms. Washington should be confined.

Finally, the Court of Appeals noted that although the remedial contempt statute generally limits confinement to not more than six months, it also expressly permits a trial court to customize an order when the general provisions are inadequate. And the Court of Appeals found that "the trial court fully explained why confinement of more than six months was necessary."[56]

The order of confinement to a correctional facility in this case was both a proper application of public health law and an appropriate exercise of remedial contempt powers. Accordingly, the Court of Appeals' decision should be upheld.

Dated this 8th day of September 2006.

Respectfully submitted,

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[56] *In re Washington*, 2006 WI APP 99 ¶ 19.

CERTIFICATION OF FORM AND 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 font. The length of this brief is 4,935 words.

Steven J. Rollins

CERTIFICATE OF FILING

I certify that I filed the original and twenty-two copies of the foregoing BRIEF OF AMICUS CURIAE WISCONSIN ASSOCIATION OF COUNTY CORPORATION COUNSELS on this date by causing the original and copies to be sent by FedEx, a third-party commercial carrier, to:

Clerk of the Supreme Court
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Dated: September 8, 2006

Steven J. Rollins

CERTIFICATION OF SERVICE

I certify that I served three copies of the foregoing BRIEF OF AMICUS CURIAE WISCONSIN ASSOCIATION OF COUNTY CORPORATION COUNSELS on this date by causing the copies to be sent to the following persons by first class mail, postage prepaid:

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STATE OF WISCONSIN
SUPREME COURT

In the interest of Ruby Washington:

City of Milwaukee,

Petitioner-Respondent, 2005AP003141

v.

Ruby Washington,

Respondent-Appellant-Petitioner.

AMICUS CURIAE WISCONSIN ASSOCIATION OF COUNTY CORPORATION COUNSELS' AMENDED CERTIFICATION OF LENGTH AND FORM

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 font. The length of this brief is 4,207 words.

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STATE OF WISCONSIN
IN SUPREME COURT

In Interest of RUBY WASHINGTON:

CITY OF MILWAUKEE,

Petitioner-Respondent,

v.

Case No. 05AP003141

RUBY WASHINGTON,

Respondent-Appellant-Petitioner.

WIS. STAT. § (RULE) 809.62 REVIEW OF DECISION OF COURT OF APPEALS, AFFIRMING CONFINEMENT ORDER FOR TUBERCULOSIS TREATMENT, ENTERED IN MILWAUKEE COUNTY CIRCUIT COURT (HON. CLARE L. FIORENZA)

REPLY BRIEF AND SUPPLEMENTAL APPENDIX OF RESPONDENT-APPELLANT-PETITIONER TO BRIEF OF AMICUS CURIAE WISCONSIN ASSOCIATION OF COUNTY CORPORATION COUNSELS

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STATE OF WISCONSIN
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REPLY BRIEF AND SUPPLEMENTAL APPENDIX OF RESPONDENT-APPELLANT-PETITIONER TO BRIEF OF AMICUS CURIAE WISCONSIN ASSOCIATION OF COUNTY CORPORATION COUNSELS

ARGUMENT

I. CONFINEMENT OF TUBERCULOSIS PATIENT RUBY WASHINGTON TO JAIL WAS NOT A PROPER EXERCISE OF DISCRETION: JAIL IS NOT AN AUTHORIZED PLACEMENT OPTION; EVEN IF IT WERE, IT WAS NOT THE LEAST RESTRICTIVE ALTERNATIVE PLACEMENT.

A. Because jail is not an authorized placement option, the trial court's order was necessarily an erroneous exercise of discretion.

The Association argues that a patient's confinement to a "correctional facility" was a proper exercise of public health powers (Association Amicus Brief, p. 2, Argument heading). However, this argument does not meet the threshold issue that jail is simply not an authorized option. If Ms. Washington is correct in her analysis that jail is not a placement option at all, then it necessarily follows that the trial court erroneously exercised discretion in ordering such placement.

1. The legislative history shows that § 252.07 was meant to expand the due process rights of TB-commitment patients, bringing that procedure into line with mental health commitments; incarceration would be antithetical to that overarching purpose.[1]

Ms. Washington sees no need to burden this court with a full rehearsal of reasons the scheme does not support jail placement, but elaboration of previously unmentioned legislative history may be beneficial. This history is contained in the drafting file, 1999 LRB-0183; relevant documents are reproduced in the Supplemental Appendix to this brief.

The very purpose of the 1999 TB-control scheme update was to ensure that involuntary TB patients receive due process protections similar to the mentally ill. The Department of Health and Family Services requested changes to the TB commitment procedure in Wis. Stat. ch. 252 because these statutes had become "outdated," in part because of advances in TB treatment and elimination of sanitariums. DHFS Memo, pp. 1-2, Drafting File, 6/29/98 (Supp.-App. 102-03). But the statutes had also become outdated in light of

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[1] Ms. Washington assumes, without conceding, sufficient ambiguity to justify inspection of legislative archives. That said, this court is certainly empowered to undertake this exercise to bolster its interpretation of statutory language, ***Megal Development Corporation v. Shadof***, 2005 WI 151, ¶22, 286 Wis. 2d 105, 705 N.W.2d 645.

advances on the constitutional front, a point explicitly made by the Department of Administration, which oversaw the drafting process:

> First, a clarification of what lies behind the proposals for statutes on confinement and hearings. The old communicable disease statutes arose eons ago when there was little concern about due process. That used to be the case also with regard to involuntary treatment of the mentally ill. However, numerous court rulings in Wisconsin and elsewhere with regard to mental illness have made it clear that the mentally ill have constitutional rights to due process, and statutes concerning mental illness were therefore created to spell out a process that addressed those concerns. In recent years, some courts in other states have issued rulings declaring that TB patients have analogous rights. Thus far, there has been no such court decision in Wisconsin. However, if the Wisconsin TB statutes are going to be modernized anyway, it makes sense to develop a statutory process that would address due process concerns.

Department of Administration Memo to Legislative Reference Bureau, p. 2, Drafting File, 1/20/99 (Supp.-App. 114).

The latter Memo goes on to describe the process for committing the mentally ill, and allows that the "system for dealing with TB does not have to be as elaborate as that for mental illness, because the existence of mental illness and the level of dangerousness involved is a very subjective situation as opposed to the relative certainty of a TB diagnosis" (*id.*). The "relative certainty of TB diagnosis" permits, as the Memo clearly indicates, a less "elaborate" process, but that singular distinction has nothing whatsoever to do with putting someone in jail. It simply means that more attention to process is required before you can be sure of the need to hospitalize the mentally ill as compared with the tubercular.

The palpable concern animating the changes, then, was to *expand* due process rights (more accurately, perhaps, to introduce them into an ossified process). To accomplish this aim the drafters drew an explicit parallel to mental commitments, though the relative certainty of TB as

compared to mental health diagnosis allowed some divergence in procedure. It would thus be *extremely* odd to say that the expressly intended *protection* of due process should be translated into *incarceration* on a bureaucrat's authorization with court review lagging behind that afforded street criminals. And odder still that legislation expressly based on the model for mental health commitments, which of course can not result in incarceration, would allow jailing.

Drafting intent to throw patients in jail for treatment purposes would surely have been manifest in some way. Instead, the express concern runs, if anything, in the other direction—toward the mental illness commitment model.

> 2. *Any concern the drafters expressed with use of penal facilities was* limited *to treatment of* already-*incarcerated inmates.*

To be sure, DOA did bring up the subject of defining "facility":

> 1. "Facility". Starting on page 8, line 17 and throughout the remaining provisions dealing with confinement and hearings, the language talks about confining the patient in a "facility". The Department would like to have a definition of "facility" which could include something other than a health care facility. For example, if the person is incarcerated the facility would be a jail, which would be treating the person for TB.

DOA Memo, *id.*, p. 1. The response was as follows:

> In addition, please note that I did not include a definition of "facility" because I was unsure how the department wanted it defined (other than to make sure it included a penal facility). I do not believe it's a problem to leave it undefined. It would just take on a rather broad dictionary definition. Also, leaving it undefined permits the department to create a definition by rule. If these results are unsatisfactory, please let me know what facilities should be included in the definition.

Drafter's Note from LRB, p. 1, 1/25/99 (Supp.-App., 116).

The term was thus left undefined on purpose, so as to give it a broad coloration. But that is something that Ms. Washington has never doubted (e.g., Reply Br., p. 2), and is obvious from the plain text; that idea adds nothing to resolution of the issue. Nonetheless, the quoted reference to making sure that the term "included a penal facility," may at first blush provide the Association (and the City of Milwaukee) with some ammunition. And yet, on closer examination this exchange if anything supports Ms. Washington's position. Note that the drafters assuredly did *not* express any desire that *a patient be placed in jail solely for treatment purposes*—which is the precise issue. To the contrary, the only concern was exquisitely narrow: that an *already-incarcerated patient remain in jail* for treatment. Had there been any intent to place someone in jail for treatment as an original matter the drafters surely would have expressed it.

This exchange, then, does not really provide much insight into drafting intent, at least with respect to placing a patient in jail; what little it does provide supports Ms. Washington. The term "facility" is broad and undefined by statute: that much was already known. The drafters were concerned lest the new statute require an inmate's removal from jail in order to receive treatment: that concern may not have been readily inferable from the plain text, but it most certainly does not demonstrate an intent to allow a health officer to throw someone in jail.[2]

Even though DHFS never defined "facility" in the rules it is empowered to promulgate, Wis. Stat. § 252.07(11), it did define "confinement," Administrative Code § HFS

[2] On the one hand, this concern may well have been overstated, given the jail-keeper's duty to provide medical care, see generally, Wis. Stat. § 302.38. On the other hand, the concern may have been that a jail-keeper might be tempted to exercise his or her authority to transfer a prisoner to a hospital, Wis. Stat. § 302.38(1), in some instance where the local health bureaucracy prefers the prisoner to remain in jail; a confinement order from a court would surely trump the jail-keeper's attempted exercise of authority. If so (and that certainly seems to be a plausible assumption), then the legislation may have accomplished the aim. But that is a far cry from the issue at hand.

145.08, as follows: "the restriction of a person with tuberculosis to a specified place." Not "detention," but "restriction." This specific definition binds the court's construction. ***Wisconsin Citizens Concerned for Cranes and Doves v. Wisconsin Department of Natural Resources***, 2004 WI 40, ¶21, 270 Wis. 2d 318, 677 N.W.2d 612 ("the definition the legislature has provided for a term controls the plain meaning of that term in the statute"); ***State ex rel. Smith v. Litscher***, 2004 WI 36, ¶19, 270 Wis. 2d 235, 677 N.W.2d 259 ("When interpreting an administrative regulation, we generally use the same rule of interpretation as applicable to statutes"). It follows that, because a health official's authority goes no further than a patient's "restriction"; and also because there must first be a "detention" before the jail can receive an inmate, a health official is not empowered to place a patient in jail.

Use of the jail is limited to the matters enumerated in Wis. Stat. § 302.31; the most pertinent is subs. (9) ("Other detentions authorized by law"), because none of the other possibilities conceivably fit TB confinement. Had DHFS intended to broaden placement possibilities to include jail *in the first instance*, it would have at a minimum used the term "detention" rather than "restriction." At most, an inmate, *already* detained in jail, may be "restricted" to jail for treatment purposes.

This construction strikes the appropriate balance: it reserves to health officials the power to determine where best to treat prisoners presenting public health hazards, while protecting citizens from abusive governmental coercion. Generally, "(w)hen the local health officer deems it necessary that a person be quarantined or otherwise restricted in a separate place, the officer shall remove the person, if it can be done without danger to the person's health, to this place," Wis. Stat. § 252.06(6)(a). That authority extends to treatment of jail (and prison) inmates, whom the health officer is empowered to remove "to a hospital or other place of safety," Wis. Stat. § 252.06(6)(b). As noted, the grant of this authority concentrates placement power where it properly belongs, with

the health bureaucracy rather than jail. And, with a broad definition of "facility," the health officer has placement flexibility in terms of whether to monitor treatment in rather than out of jail, for *already*-incarcerated inmates.

Finally, the court should consider that the legislature also used "restrictions" (and "restricted") in § 252.06, with reference to isolation and quarantine. The term is *not* used there to mean incarceration, further bolstering the idea that neither does "confinement."

3. Jail placement is incompatible with other provisions.

As Ms. Washington previously argued (Brief-in-Chief, pp. 20-24), jail placement is incongruous with other provisions. That argument need not be repeated here. She would, however, mention that jail clearly *is* an option for violating health orders, *after successful prosecution for that offense*: for willful violation of a health order, a patient can be jailed for up to 30 days, Wis. Stat. § 252.25. This is more than enough coercive power. The City could have proceeded under this provision and upon conviction Ms. Washington could have been jailed for 30 days, during which time she would have received TB treatment in the jail. Upon her release, she would have remained under the § 252.07 treatment order and had she not learned her lesson the first time, prosecuted and incarcerated again. More to the point: a means of prosecuting nonadherent patients is readily available; it is inconceivable that the legislature would have intended that a newly enacted scheme undeniably meant to expand and modernize due process protections actually *circumvents* that option and replaces it with one that provides not merely fewer protections but a vastly greater length of incarceration.

Similarly, this prosecution option shows that when the legislature wants to add the threat of incarceration to the public health official's armamentarium it does so forthrightly, not by stealth. Also in this regard see Wis. Stat. § 252.05(4)(b), creating a misdemeanor punishable by 9 months for violation of isolation/quarantine orders during a time of a

declared public health emergency. Had the legislature intended a TB patient to be placed in jail for treatment purposes it would have explicitly so provided.

In this regard, Wisconsin statutes have never authorized jailing TB patients solely for treatment (so far as Ms. Washington can ascertain). For example, Wis. Stat. § 143.06(4) (1971-72) authorized commitment "to a county tuberculosis hospital or other place or institution where proper care will be provided." Violation of the TB section could be prosecuted *as a crime* under § 143.06(8) (1971-72), incorporating the penalties under § 143.05(11) (1971-72).[3] Eventually, this penalty provision was moved, without impact on its effect, see Wis. Stat. § 143.11 (1981-82) (establishing criminal penalties for any willful violation of the chapter); that section was essentially the forerunner to current § 252.25, the principal distinction being length of punishment. At the same time, placement under a TB commitment was changed, from sanitariums (which were no longer in use) to "a place that will provide proper care and prevent spread of the disease," Wis. Stat. § 143.06(4) (1981-82); Wis. Stat. § 252.07(4) (1993-94) (same).

The long and short of it is that our statutes have never authorized placement in jail for TB treatment. Instead, jail was an option upon prosecution and conviction. Nothing in the legislative history of the current enactment suggests any intent to change that approach.

B. Assuming that jail is a proper placement option, it must be the least restrictive alternative.

The Association argues (Amicus Brief, pp. 2-4) that the TB-control scheme implements "substantial due process protection." No doubt. But that simply begs the fundamental question, whether the legislature intended *to exclude* least-

[3] As has always been true, conduct punishable by fine and/or imprisonment as opposed to mere forfeiture was by definition a "crime" § 939.12 (1971-72). Conduct violating TB rules exposed the actor to both fine and imprisonment, the latter a mandatory 5 to 90 days, see § 143.05(11) (1971-72).

restrictive placement from those protections. Before addressing the Association's misplaced criticism of Ms. Washington's analysis (Amicus Brief, pp. 4-5), Ms. Washington focuses on what the Association omits: any discussion of the statutory and regulatory text.

Given that a patient's confinement is a *restriction* to a specified place (HFS § 145.08(2)), the requirement that "no less restrictive alternative exists" (§ 252.07(9)(a)3) naturally and necessarily refers to the place of confinement. And although the parties not to say amici have spilled much ink on the subject, in the end it may not be necessary to go beyond HFS § 145.06:

> **(1)** APPLICABILITY. The general powers under this section apply to all communicable diseases listed in Appendix A of this chapter and any other infectious disease which the chief medical officer deems poses a threat to the citizens of the state.
>
> ...
>
> **(4)** AUTHORITY TO CONTROL COMMUNICABLE DISEASES. When it comes to the attention of an official empowered under s. 250.02 (1), 250.04 (1) or 252.02 (4) and (6), Stats., or under s. 252.03 (1) and (2), Stats., that a person is known to have or is suspected of having a contagious medical condition which poses a threat to others, the official may direct that person to comply with any of the following, singly or in combination, as appropriate:
>
> ...
>
> (b) Participate in a defined program of treatment for the known or suspected condition.
>
> ...
>
> **(5)** FAILURE TO COMPLY WITH DIRECTIVE. When a person fails to comply with a directive under sub. (4), the official who issued the directive may petition a court of record to order the person to comply. In petitioning a court under this subsection, the petitioner shall ensure all of the following:

...

> (c) *That the remedy proposed is the least restrictive on the respondent which would serve to correct the situation and to protect the public's health.*

(Emphasis supplied.)

The remedy proposed in this instance was Ms. Washington's confinement. Under *express* regulatory terms *that* remedy must have been the "least restrictive." There can be simply no doubt that this provision applies to Ms. Washington—the regulation applies generally to all communicable diseases listed in Appendix A to HFS ch. 146, and tuberculosis is assuredly one. Indeed, the Association relies on HFS § 145.06(4)(g), for the inapt point that Ms. Washington was ineligible for hospital confinement because she had become non-infectious (Amicus Brief, p. 6 n. 27, and accompanying text). (Inapt, because for one thing, the very point of her confinement was that the health department could not be sure she was non-infectious; for another, and relatedly, she had failed to comply with her treatment program.) This court need not go beyond the plain text of the control-regime to impose a least-restrictive placement requirement.

The Association complains (Amicus Brief, pp. 4-5) that Ms. Washington's interpretation attempts a rewrite of the statutory language, in particular "that the phrase 'least restrictive alternative' doesn't appear in Chapter 252 at all."

It is true that the statutory wording is, "no less restrictive alternative exists"; and equally true that Ms. Washington rendered that phrasing as, the chosen alternative must be the "least restrictive." But if there is *any* distinction between "no less" and "least" is it highly elusive. Certainly the Association does not condescend to explain the distinction. Indeed, "no less" and "least" are identical in meaning, hence Ms. Washington has used them interchangeably.

To say that something is the "least" is to say that it is the "(s)mallest in magnitude or degree." *American Heritage Dictionary* (Second College Edition 1982), p. 781. *Least* is an

absolute—there must be nothing less than whatever is being measured—and conveys precisely the same idea that there must be *no less* than whatever is being measured.

To put it in concrete terms: the statute requires that there be "*no* less restrictive alternative"; hospital confinement existed as *a* less restrictive alternative than jail confinement; therefore, placement should have been in hospital rather than jail. The Association implies (Amicus Brief, p. 5) that offering Ms. Washington the opportunity to reside with her sister satisfied the "no less restrictive alternative" requirement. But the fact that one less restrictive alternative (than jail) could be discounted is irrelevant to the fact that *another* less restrictive alternative *also* existed. In any event, the option of living with her sister no longer "existed" at the time of the confinement hearing. However, the option of hospital placement did, and *that* option was therefore the least restrictive alternative.

C. *This record does not support consideration of costs in determination of the least restrictive alternative.*

The Association adds little to the issue of costs in the placement calculus. The control-regime says nothing at all about costs entering into the placement decision, and introducing costs into the process would amount to a judicial act of legislation. The rebuttal is, in effect, that Ms. Washington's hospitalization would amount to an extravagant tax in comparison to incarceration. Thus, the Association posits that hospital guards would run $37,000 or more; and to that must be added the per capita daily rate of hospitalization ($900–1,000), as compared with that for a jail ($50-55).

Ms. Washington repeats that this record is not the one that this court will need to resolve the question of whether and how much extravagance is necessary to trigger a duty to consider costs. The Association's figures are unsourced and therefore cannot be accepted at face value. Moreover, they are not necessarily applicable to Ms. Washington's circumstance. Jails are required to maintain "suitable wards or buildings or cells ... for the separation of criminals from noncriminals. All

prisoners shall be segregated accordingly." Wisconsin Statute § 302.36(1). Even if the Association's estimate of a daily per capita rate is roughly accurate with respect to the Milwaukee House of Correction, it simply is not known whether that figure is also comparable to the costs of a segregated noncriminal. (*Whether* Ms. Washington was segregated is yet another question; it does not, on this record, appear that she was.) Nor should the Association's reckoning of hospital costs be taken as definitive. There is only the barest indication in this record that she had been "under guard" during her hospital stay (24:32) and whether that was around-the-clock simply is not known. Nor can it be said with certainty that she would have required that level of monitoring throughout a nine-month confinement. How likely would she have been to flee given that her shoes and clothes would be taken from her upon admission? Could she have been subject to electronic monitoring?

One thing *is* certain on this record: dispensing with the need for a least restrictive placement alternative will simply mark a path of least resistance to incarceration. Difficult patients undeniably tax the system. But as long as the health bureaucracy can deal with nonadherents by throwing them in jail, then it will lack incentive to try other approaches. Whether that means contracting with facilities on a permanent or ad hoc basis, or even hiring guards, Wis. Stat. § 252.06(5), the solution that will be derived is the one that requires no creativity: incarceration.

II. THE TRIAL COURT, WHICH WAS INDUCED BY THE CITY NOT TO DISPOSE OF THE MATTER AS A CONTEMPT, MADE NO EFFORT TO, AND DID NOT IN FACT, IMPOSE A PURGEABLE CONDITION; AS A RESULT, THE CONFINEMENT MAY NOT BE UPHELD AS AN EXERCISE OF CONTEMPT POWER.

Although it is not clear what expertise or experience the Association brings to bear on either judicial estoppel (Amicus Brief, pp. 8-9) or the larger question of whether the

confinement order may be upheld as a contempt sanction, a brief rejoinder may be helpful.

The Association would avert an estoppel bar under mootness-like analysis (Amicus Brief, p. 9). The analogy is grossly misplaced. The doctrine of judicial estoppel is aimed at preventing manipulation of the judiciary. That the manipulation concerns an issue of "great public importance" is all the more reason to enforce, not overlook, an estoppel bar lest manipulation be encouraged where it is least wanted.

On the merits, (Amicus Brief, pp. 9-11), the Association premises its argument on an inaccurate recitation of the trial court's confinement order. As has now been asserted at some length, the confinement order required that "(t)he health department has to certify that she's no longer a threat and that she's been cured" (24:65). The Association makes no attempt to justify that condition as purgeable. No wonder: it clearly isn't. Instead, the Association manufactures a different treatment condition, "that she complete the prescribed course of treatment for her disease" (Amicus Brief, p. 10). But even if that were in fact what the trial court ordered, it would still remain true that "the prescribed course of treatment" was however long it took *the health department* to determine that she had completed the prescribed course.

The Association is actually undermined by the authority on which it relies, ***State ex rel. Larsen v. Larsen***, 165 Wis. 2d 676, 681, 478 N.W.2d 18 (1992). Larsen was committed to jail as a matter of contempt, subject to stay through a purge condition of seeking PTSD treatment. This court upheld that condition. Had Ms. Washington been committed to jail subject to stay if she *sought* treatment, then the commitment would be purgeable under ***Larsen***. Or, had ***Larsen*** said that jail may be ordered until *completion* of PTSD treatment (or, for that matter, until a therapist certified a cure), then Ms. Washington's commitment could be said to contain a purgeable condition. But neither is true, and ***Larsen*** therefore provides no benefit to the Association's argument.

The trial court, it is worth repeating, made no attempt to fashion a purgeable condition. But that is because the City assured the court it was proceeding under the TB commitment regime *rather than* contempt. And that, in turn, is why a judicial estoppel bar ought to be invoked against the City's appellate volte-face.

CONCLUSION

Ms. Washington renews her request for relief, Br.-in-Ch., p. 45.

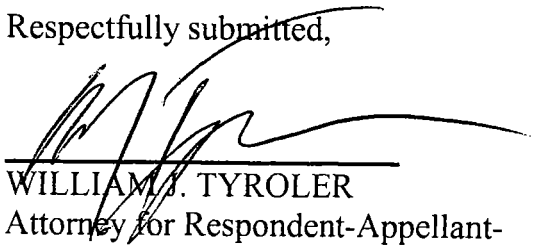
Respectfully submitted,

WILLIAM J. TYROLER, SB No. 1016229
Assistant State Public Defender
735 North Water Street, Suite 912
Milwaukee, WI 53202
Telephone (414) 227-4134
Attorney for Respondent-Appellant-Petitioner

CERTIFICATION

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 300 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. The text is 13 point type and the length of the brief is 4036 words.

Respectfully submitted,



WILLIAM J. TYROLER
Attorney for Respondent-Appellant-Petitioner
SB No. 1016229

SUPPLEMENTAL APPENDIX

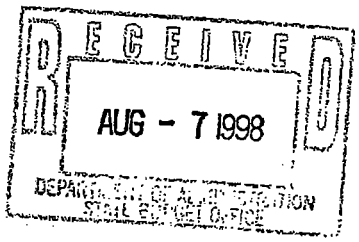
(Materials in this Supplemental Appendix relate to the legislative history to Wis. Stat. ch. 252 (2003-04), whose LRB number is 99-0183. The drafting file, from which the Supplemental Appendix items are culled, is posted on the Internet, as part of the 1999 budget [http://libcd.law.wisc.edu/%7Edraftingrecords/1999/budget/], ab-133, part i. Navigation from there is required to access the particular records for 99-0183, which are spread throughout 3 files; or, the page listing these 3 links may be directly accessed via the following address: http://libcd.law.wisc.edu/%7Edraftingrecords/1999/budget/(%23002)%20ab-133%20(part%20i)/99-2079df%20...%202)%20DOA%20compile%20drafts/. Legislative materials such as these, relating to statutory history, are subject to judicial notice. ***State ex rel. Strykowski v. Wilkie***, 81 Wis.2d 491, 504, 261 N.W.2d 434 (1978).)

INDEX

OSF

Department of Health and Family Services
Office of Strategic Finance
PO Box 7850
Madison WI 53707-7850
Phone (608) 266-3816
Fax (608) 267-0358

Date: August 6, 1998



To: Tilli de Boor, Chief
Human Resources Budget Team
Department of Administration

From: Fredi Bove, Chief
Budget Section

Subject: 1999-2001 Statutory Language Budget Requests

Attached is the second set of DHFS statutory language requests for the 1999-2001 biennial budget. My understanding is that you will transmit this package to the Legislative Reference Bureau with a request that LRB prepare drafts for these items. I will be submitting to you additional packages of statutory language requests between now and September 15 as they are ready.

Thank you for your assistance in handling these statutory language requests.

cc: OSF Budget Staff
John Kiesow
Kevin Lewis

DHFS

Department of Health and Family Services
Annual Budget Statutory Language Request
June 29, 1998

TB/Communicable Disease Statutory Changes

Current Language

Chapter 252 of the state statutes includes sections devoted to tuberculosis. Many of these sections were drafted when treatment for TB was not as advanced as it is now and are consequently outdated.

Proposed Change

1. Require the laboratories that perform primary culture for mycobacteria also perform organism identification for *M. tuberculosis* complex and that laboratories that identify *M. tuberculosis* assure that antimicrobial drug susceptibility tests are performed.

2. Permit local health officer to issue an emergency detention order.

3. Expand s.252.973 (commitment) to describe under what circumstances a local health officer or the department may petition the court to order the commitment of a person, under what circumstances the commitment may be terminated and what the rights of the committed person, including right to appeal, are.

4. Insert the phrase "by court order" after the word "isolated" in s.252.08(3).

5. Delete obsolete language related to TB sanitariums and TB acute treatment centers.

6. Delete certain language related to reimbursable services for public health dispensaries and include that language in the administrative rule. Add language allowing any local health department to request public health dispensary certification.

See attached statutory language draft.

Effect of the Change

1. The language on *M. tuberculosis* is intended to decrease both the amount of time laboratories take to identify TB and the likelihood that drug-resistant disease will develop due to inappropriate treatment.

2. The sections on emergency detention and commitment clarify these procedures.

3. The addition of "by court order" before "isolated" in s.252.08 (3) will make it clear that the Department is required to pay for inpatient treatment patients who are isolated by court order only.

4. The deletion of obsolete language concerning sanitoriums and acute treatment centers will assure that statutes reflect current practice.

5. Currently dispensary certification is limited to counties with populations of more than 25,000. This language will allow local public health departments in counties of any size to establish dispensaries.

Rationale for the Change

The present statutes governing the tuberculosis program do not reflect current practice. TB sanitariums no longer operate. TB infections are handled by local public health departments and by acute treatment centers in hospitals. The provision concerning the payment of costs for isolated patients is clarified to reflect what the Department believes was legislative intent; which was that the Department pay for the costs of patients who are isolated by court order, not those isolated voluntarily.

Certification of TB acute treatment centers is unnecessary because the Department assures that hospitals meet infection control standards established by OSHA. Current practice and public health needs dictate a change to statutes that reflect current treatment and will allow for effective public health measures to be taken to prevent and control the transmission of TB in Wisconsin.

Recommendation

Make the changes requested so that the TB statutes can be updated to reflect current practice and the best possible use of resources to prevent the spread of tuberculosis.

Desired Effective Date:	Upon passage of bill
Agency:	DHFS
Agency Contact:	Ellen Hadidian, OPB
Phone:	266-8155

01slth

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–0183/P1dn
TAY:jlg:lp

September 21, 1998

1. This draft is basically identical to and replaces 1997 LRB–5303/P1. Please refer to 1999 LRB–0183 when requesting changes to this draft.

2. The drafting instructions contain several definitions for words or phrases that do not appear anywhere but in the definition section. I have not included in this draft definitions of words or phrases that do not appear elsewhere in s. 252.07 (either currently or in this draft), but I recognize that you may have a nondefinitional reason for including some of the words or phrases. If you provide me with the nondefinitional context in which you'd envisioned the words and phrases to appear, I can incorporate that into the substantive portion of this draft. For example, how did you envision "detention" or "isolation" to be incorporated into these provisions? Who would detain or isolate whom and under what circumstances? Please be sure to differentiate between the circumstances under which someone would be detained and those under which someone would be isolated. Also, did you want to set forth the standards for finding a person noninfectious? If so, please indicate who would make the finding. Finally, please note that defining a term for one section of the statutes does not define the term for other sections of the statutes. Make sure that the terms are defined for the sections in which you want to use the terms.

3. The drafting instructions (item 3) refer to s. "252.973 (commitment)" and indicate that the provision is to be expanded. Section 252.973 does not exist and I am uncertain to what section you intended to refer. I cannot, without more direction, describe under what circumstances a local health officer or the department may petition the court to order the commitment of a person, etc.

4. The effect of striking through an entire statutory unit is to repeal that unit. The proposed language strikes through all of s. 252.08. Item 4 of the drafting instructions, however, request that an amendment be made to s. 252.08 (3). In this draft, I have repealed s. 252.08 and therefore made no amendment to any of its subsections. Is this your intent?

Finally, please review the notes that are embedded in the draft.

If you have any questions about this draft, or if any part of it does not effect your intent, please let me know. I would be happy to meet with you to discuss the draft.

Tina A. Yacker
Legislative Attorney
261–6927

OSF

Department of Health and Family Services
Office of Strategic Finance
PO Box 7850
Madison WI 53707-7850
Phone (608) 266-3816
Fax (608) 267-0358

Date: October 26, 1998

To: Tina A.Yacker
Legislative Reference Bureau

From: Ellen Hadidian EH
Budget Section

Subject: LRB 0183 – Tuberculosis Statutes

Public Health and Office of Legal Counsel staff have reviewed this draft. Our answers to questions raised in the draft and other comments are given below.

1. Definitions of isolation and detention. Department staff assumed that s. 252.06, which describes isolation and quarantine in general for communicable diseases, would apply to TB patients as well. References to "detention" and "isolation" are made with this assumption in mind. We have made no changes to isolation and quarantine statutes, only to commitment and detention statutes. (See note below on 252.073). None of our requested language for 252.072 (emergency detention) or 252.073 (commitment) were included in this draft. Please add them to the next draft. I have attached another copy of our request, highlighting the missing sections. If, after drafting these sections, you still have questions about the way in which the revised statutes treat isolation and detention, we can discuss this further.

Since "isolation" is not defined in statute, a definition could be added if it was thought necessary. However, isolation is not specific to TB so any definition would have to be broader than one for just the TB program. OLC staff would like to see a cross-reference to 252.06 in s.252.07 (1m) to make it clear we are using the existing isolation and quarantine statutes.

2. s.252.973 (commitment). This was a typo in the cover memo; the reference to "252.973 (commitment)" was meant to be a reference to "252.073. (commitment)." Our drafting instructions included a revised "252.073 Order for Commitment." This revised section does not appear in this draft but it provides the details we are requesting for commitment orders. Please incorporate this section in the next draft. I am attaching another copy.

3. s.252.08 (3). In our statutory language draft, section 253.08 (3) was repealed and recreated as 252.074 (2). This revision does not appear in the LRB draft. Our cover memo was misleading because it referred to a change requested for s.253.08(3) and it should have referred to a change requested to the new 252.074(2). Please add this language to the draft and amend as follows:

(2) Inpatient care for ~~isolated~~ pulmonary tuberculosis patients isolated by court order. . .

4. Page 2. Yes, please remove references to tuberculosis hospital in 46.18 (1) and 46.20 (1).

5. Page 5. Please repeal s.58.06 and all cross-references to this section. (See attached for cross references in this draft.)

6. Page 6. Yes, please delete s.102.26(2m).

7. Page 6. Please change s.102.42(6) by adding "or medical" in place of the deleted "or sanatorium."

8. Page 7. Please change s.252.07 (1g) (b) to read: "Isolate means a population of Mycobacterium tuberculosis bacteria that has been obtained in pure culture medium. "

9. Page 8. In section 252.07 (1p), you asked by whom the rapid testing procedure must be approved. Could you add the phrase, "as determined by rule"? We will be following Center for Disease Control guidelines here and these may change frequently, so it is preferable to have the authority to amend the rule rather than try to revise the statutes every time CDC guidelines change.

10. Page 9. In section 252.07(5), the person who does not voluntarily comply is the person who is reported in the first sentence. The person does not voluntarily comply with "the provisions of the order." Also, does "Department of Health and Family Services" have to be written out each time? Can just "Department" be substituted as is usually done in other sections of the statutes?

11. Page 10. Yes, local health departments should be offered the right to a hearing prior to revocation.

12. The Department would like to add language that makes it clear that local health departments may obtain department certification to be a dispensary and that local health departments may contract for dispensary services. The language should specify that local health departments with dispensary certification that contract for dispensary services will ultimately be responsible for upholding standards of certification.

Thank you for your work on this draft. I am enclosing a summary of the changes the Department is requesting which may be helpful. If you have any questions about this request or wish to discuss any of the issues you have raised further, please call me at 6-8155.

cc: Sue Jablonsky
Mike Bormett
Jerry Young
Tanya Beyers

Cross references to s.58.06, to be deleted

p. 1, line 5
p. 3, line 16
p. 4, line 12
p. 4, line 22
p. 7, line 2
p. 7, line 10
p. 12, lines 18 and 25

Changes Requested in the Communicable Disease Statute (s.252)
Related to Tuberculosis
August 26, 1997.

A section on definitions has been added to clarify the meaning of terms used in the statute revision.

New language has been added requiring that laboratories that perform primary culture for mycobacteria also perform organism identification for *M. tuberculosis* complex and that laboratories that identify *M. tuberculosis* assure that antimicrobial drug susceptibility tests are performed [s. 252.071 (2) and (3)]. This language is intended to decrease both the amount of time laboratories take to identify tuberculosis and the likelihood that drug-resistant disease will develop due to inappropriate treatment.

A new section has been added permitting the local health officer to issue an emergency detention order (s.252.072). This section describes how and where that person will be detained, how long the detention will last, and the rights of the detained person.

The section on commitment (s. 252.073) has been expanded. The new language describes how and under what circumstances a local health officer or the department may petition the court to order the commitment of a person, under what circumstances the commitment may be terminated and the rights of the committed person including the right to appeal.

Language allowing department reimbursement of hospital costs after 30 days, for patients with TB, has been retained in this proposed statute language (252.074(2)). This applies to hospitalized patients with TB who have no other means of payment. The Joint Finance Committee modified this language during their deliberation on the 97-99 budget bill (see attached budget bill language). We are seeking clarification on the effect of this modification.

Obsolete language related to tuberculosis sanitoriums and tuberculosis acute treatment centers has been eliminated (s. 252.073, 252.076, 252.08 and 252.09). All tuberculosis sanitoriums have been closed and are not expected to reopen. Certification of treatment centers is unnecessary because the Bureau of Quality Compliance assures that hospitals meet infection control standards established by OSHA.

The section on public health dispensaries (s. 252.10) has been shortened. Specific details regarding reimbursable services and the amount of reimbursement that originally appeared in statute have been moved to proposed rule HSS 145. In addition, new language has been added permitting any local health department, regardless of jurisdictional size, to request public health dispensary certification. Dispensary

certification is currently limited to counties with populations of more than 25,000. At this time, the City of Milwaukee Health Department is the only certified tuberculosis public health dispensary in Wisconsin.

The fiscal impact of these changes is estimated at $297,510 (GPR = $264,785 and federal = $32,725) to pay for services provided through public health dispensaries. These services are listed in the attached fiscal impact statement and are included in the proposed rule, HSF145.

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

99–0183/P2dn
TAY:jlg:hmh

Friday, December 11, 1998

Sue Jablonsky:

I have attempted to make the changes that the department has requested. However, as I have stressed many times, it is more difficult to draft a request that the department "drafts" for me than it is to draft a request that clearly and concisely states the issues or problems that the department wants to address and the concepts that would address them. We have very particular and technical rules for drafting that I do not by any means expect DHFS staff to know or follow. However, the department's drafting style (for example, the improper use of striking and scoring) makes it very difficult for me to follow what the department is trying to accomplish. In the future, I urge the department to state its intent outright rather than attempt to draft the legislation. I will have a much easier time inferring the department's intent that way and will more successfully effect its intent in the bill.

The provisions regarding confinement and hearings are in s. 252.07 (9) and (10) in this draft. Please review the provisions carefully to ensure that I captured the department's intent. Note that the department's request appears to treat a hearing after temporary confinement differently from a hearing for confinement. I did not understand why the two provisions in the department's request differed (for example, one provision required not less than 24 hours notice, the other not less than 48 hours notice; one provision specified appeal rights and documentation required to be given to the subject of the petition, the other did not). I drafted one provision on hearings, rather than two. You might also note that I specified the tuberculosis patient's rights with respect to the hearing, rather than referring to them obliquely in the notice requirement.

In addition, please review the dispensary provision (s. 252.10 (1)). The department asked why I could not simply refer to DHFS as "the department" as is otherwise done. The answer is that the provision refers to a local health department and, although "department" is defined as "the department of health and family services," use of the word is confusing. It could be difficult to determine whether the word refers to the local health department or the department of health and family services. Therefore, I left the references to the department of health and family services in that provision.

Finally, I was uncertain about the department's intent in the provision that states, "A case of infectious or suspect tuberculosis in an uninsured person shall constitute a medical emergency for the purpose of determining eligibility for general relief under

s. 49.015 (3)." Section 49.015 (3) allows a relief agency to waive the residency requirement for a person receiving health care services from a trauma center. Would a TB patient receive services in a trauma center? Why is that provision included?

Tina A. Yacker
Legislative Attorney
261–6927

Yacker, Tina

From: Jablonsky, Sue [sue.jablonsky@doa.state.wi.us]
Sent: Wednesday, January 20, 1999 5:14 PM
To: Yacker, Tina
Subject: FW: LRB 0183

Memo to LRB - TB language.doc

> -----Original Message-----
> From: Hadidan, Ellen
> Sent: Tuesday, January 19, 1999 2:03 PM
> To: Jablonsky, Sue
> Subject: LRB 0183
>
> Attached are comments from the Department's program staff and OLC
> concerning
> this draft, which relates to tuberculosis treatment. We appreciate the
> effort
> which the drafter has made to incorporate all our suggested revisions.
> Could
> you forward the attached comments to the drafter so that she can finish
> working
> on this piece of legislation? Thanks.
> <<Memo to LRB - TB language.doc>>

Comments on LRB 0183

Thank you for your careful reading of the Department's draft and the subsequent LRB draft of the proposed revised TB statutes. This draft has been reviewed by both program people and the Office of Legal Counsel, and their comments are given below.

1. In referring to s. 49.015(3) we apparently intended to reference an obsolete provision. Our intention is to waive residency requirements for an uninsured person with infectious or suspect tuberculosis for the purpose of determining eligibility for general relief. In other words, we want to make sure a person with TB that may pose a public health threat will receive services, with insurance, Medicaid, general relief being the first source of payment.

2. page 5, line 17--in the text of statute 102.42(6) there is a reference to "sanatorium" that needs to be deleted, in keeping with the deletions of "sanatorium" elsewhere in the draft.

3. Page 10--line 10 252.07 (9) 4. (b) change to the following language: "notice of a hearing at least 48 hours before the scheduled hearing is to be held."

4. Page 10--line 18 252.07 (9) 4. (c) change to the word "remained" to "remain"

5. Page 10--line 23 252.07 (9) 4. (d) we want to add language that specifies "a person has the right to appear at the hearing", but this appearance must be in a manner that does not transmit disease. We want to make sure the person is not infecting the judge and attorneys, after all.

7. Page 11--lines 10-19 252.07 (10) This section is the renumbering of former section 252.08(3) and should reflect the current language (changed during the 1995-96 legislative session) which is as follows:

"Inpatient care for isolated pulmonary tuberculosis patients, and inpatient care exceeding 30 days for other pulmonary tuberculosis patients, who are not eligible for federal Medicare benefits, for medical assistance under subch. V of ch. 49 or for health care services funded by a relief block grant under subch. II of ch. 49 may be reimbursed if provided by a facility contracted by the department. If the patient has private health insurance, the state shall pay the difference between the health insurance payments and total charges."

8. pages 12 and 13--in the text of statute 252.10(1), we continue to recommend that the lengthy references to "department of health and family services" be replaced with a reference to "department". It does not seem that a simple reference to "department", if used, would generate confusion. This is not a situation where the language refers to more than one state agency, so there is no need to distinguish DHFS from some other state "department". It is clear from the substance of the language that the local health

D-Note

department is requesting certification from some entity that is not the local health department, and "department" is already defined elsewhere to be the DHFS. If a reader were to assume "department" means the local health department, it would require the reader to interpret the statute as calling for the local health department to request itself to certify itself, and to then subsequently suspend or revoke the certification it issued to itself. That would be illogical. The only logical interpretation of "department" would be that it refers to the Department of Health and Family Services, just as is defined in statute, and just as we want it to be interpreted. In contrast, if the longer title of DHFS is used, it creates highly cumbersome language, and such language would be inconsistent with the drafting style of existing health statutes. See ss. 251.04(1) and (3), 251.05(3)(d), and 254.152 for some examples of existing statutes that refer to DHFS as the "department" in the same provisions that also refer to the local health department.

9. Page 15--line 1 and 2 Section 252.10 (9)
Change the last sentence to :
"Records may be audited by the department of health and family services."

Comments about confinement/hearing provisions

First, a clarification of what lies behind the proposals for statutes on confinement and hearings. The old communicable disease statutes arose eons ago when there was little concern about due process. That used to be the case also with regard to involuntary treatment of the mentally ill. However, numerous court rulings in Wisconsin and elsewhere with regard to mental illness have made it clear that the mentally ill have constitutional rights to due process, and statutes concerning mental illness commitments were therefore created to spell out a process that addressed those concerns. In recent years, some courts in other states have issued rulings declaring that TB patients have analogous constitutional rights. Thus far, there has been no such court decision in Wisconsin. However, if the Wisconsin TB statutes are going to be modernized anyway, it makes sense to develop a statutory process that would address due process concerns.

The statutory system in Wisconsin for involuntary mental illness commitments is in s. 51.20. That statute describes the authority to detain a person on an emergency basis, and then follows that up with a 2-stage hearing process. First there is a hurried-up hearing to establish the existence of probable cause to continue holding the person, and then there is a more final hearing held on a more leisurely basis. From the court rulings we have seen on TB, however, there is nothing magic in the number of hearings--it is the rights granted in the hearing process that matter. Accordingly, we don't object to the notion of one hearing rather than two if the deadlines involved are something that are medically feasible. A system for dealing with TB does not have to be as elaborate as that for mental illness, because the existence of mental illness and the level of dangerousness involved is a very subjective situation as opposed to the relative medical certainty of a TB diagnosis. However, some more clarification of terms

and issues would be helpful.

1. "Facility". Starting on page 8, line 17 and throughout the remaining provisions dealing with confinement and hearings, the language talks about confining the patient in a "facility". The Department would like to have a definition of "facility" which could include something other than a health care facility. For example, if the person is incarcerated the facility would be a jail, which would be treating the person for TB.

2. Notice to court. The system described starting on page 8, line 19, requires that the process begin with notice to a court that a person has been confined. This appears to apply to confinements of individuals for less than 72 hours. What is the purpose of that notice to the court if the individual is going to be released in, say, 48 hours? What does the court do in response? The Department must petition the court to hold someone for longer than 72 hours, but is a court notification necessary here where no action is required of the court?

3. "Authorized person". Page 9, line 9 refers to transport by an authorized person. This should be changed to indicate that the local public health officer has the authority to authorize this person (to answer the question, "authorized by whom?").

4. Any need for periodic review of longterm confinement? If a person is confined pursuant to a court order, and the doctors believe the person continues to fall within the criteria eligible for continued confinement, is there any time limit to the confinement, or should there be a periodic court review? The Department's thought is that these confinements should receive regular reviews, perhaps every six months.

5. Location of hearing Could we build into the hearing process a possibility of holding the hearing at the treatment location, to address the concerns raised by program staff about the need to protect from spread of the infection.

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

99–0183/1dn
TAY:jlg:ijs

January 25, 1999

Sue Jablonsky:

I appreciate the department's efforts in response to my previous drafter's note to provide me with clear redrafting instructions. I have made most of the changes requested. Please review the changes to ensure that I've captured the department's intent. In particular, please note the following:

1. I renumbered s. 252.08 (3) to 252.07 (10) rather than repealing it in one place and creating it in another. This facilitates legislative history research and accomplishes the same result. I also amended the provision to correct an incorrect cross–reference.

2. To address the concern that an infected person not appear in person to a hearing I have included language found in s. 967.08 (1) that permits the hearing to be conducted by telephone or live audiovisual means, unless good cause is shown as to why that would not be permissible.

3. I have required the court to conduct a review every six months of confinements that are over six months. OK?

4. Although I agreed with the department that for the most part the use of the phrase "the department" would not cause confusion in s. 252.10 (1), there are a couple of instances in which confusion could result (in particular with respect to rules promulgated by "the department"). Nonetheless, I made the changes requested by the department because it seemed a silly battle to fight.

In addition, please note that I did not include a definition of "facility" because I was unsure how the department wanted it defined (other than to make sure it included a penal facility). I do not believe it's a problem to leave it undefined. It would just take on a rather broad dictionary definition. Also, leaving it undefined permits the department to create a definition by rule. If these results are unsatisfactory, please let me know what facilities should be included in the definition.

Finally, I kept the provisions requiring notice to the court whenever there is a confinement order for two reasons:

1. Whenever a person must be unwillingly detained, it is a pretty good idea in terms of due process to have the court involved right away, even if the court ultimately will do nothing with the information.

2. The court should be informed of the confinement immediately because of the likelihood that only 48 hours later a hearing will be necessary to detain the person for longer.

If these reasons do not satisfy the department, I can certainly remove the provision, but I recommend against it.

Tina A. Yacker
Legislative Attorney
261–6927

Certification of Supplemental Appendix

I hereby certify that I have previously filed (with the Brief-in-Chief) an Appendix complying with Rule 809.19(2)(a) and containing required materials. This Supplemental Appendix is limited to materials relating to legislative history which are susceptible to judicial notice by the court.

Respectfully submitted,

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