Frontlines

Washington Association of Designated Mental Health Professionals

Spring 2009 www.wadmhp.org Volume 29, Number 1

President's Letter

As this edition of Frontlines reaches your hands, we most likely know the outcome of the state budget and the cuts that health and human services will incur. This is a tense time for many in our state and beyond. As always, we first must take care of ourselves with our reactions and concerns before we can be effective change agents for those that we serve.

At least 11 bills have moved through the Washington State House and Senate this legislative session, and are either still ongoing, pending the governor's signature, or have already been signed into laws directly impacting the work of DMHPs. Some of these bills may not become law. For those that do, interpretations of the precise changes they will create in the work of DMHPs will undoubtedly be ongoing for some time. It would take too many pages to adequately summarize or address them here, but I have provided a list and title or main point for DMHPs. It is certain that some bills with direct impact on the practice of DMHPs have been inadvertently left off of this list.

Contents

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- **HB/ SHB 1071** authorizes ARNPs to, within their scope of practice, carry out all of the duties that physicians have in relation to people involuntarily committed.
- **SB 6022** addresses the allocation of court costs in ITA hearings to the county the person resides in.
- **HB/ SHB 1275** addresses consideration of a respondent's recent and past acts for ITA purposes.
- **SHB 1201** changes the name of the DMIO program.
- **SSB 5519** makes several changes to competency evaluation and the restoration process.
- **HB 1589** addresses venue relative to revocation of a conditional release or LRA.
- **HB 1486** specifically requires DMHPs and courts to include pertinent information submitted by a respondent's relatives for ITA process.
- **HB 1300** requires releasing information about a person that has been civilly committed to law enforcement, jail, the prosecutor's office, etc.
- **HB 1498** makes a person ineligible to own a firearm if they have been civilly committed for 14 days (this is a change from 90 and 180 days previously).
- **HB 1349** increases the ability to extend a person's 90/ 180 day LRA.
- **SB 5253** creates in Washington state a "Guilty but Mentally Ill" plea or verdict for respondents facing criminal charges. (**Continued on Page 5)**

Thoughts From the Editor: Behind Enemy Lines

By Kerry Schafer

"We ourselves feel that what we are doing is just a drop in the ocean. But the ocean would be less because of that missing drop." Mother Teresa

Contemplating the wreckage of the mental health care system here in Washington State, it is tempting to despair. We do not have enough beds, enough workers, enough services, enough of anything, to meet the needs of our most vulnerable clients. Many of the articles in this edition of Frontlines express frustration about the nearly intolerable situations in which we increasingly find ourselves and those we are trying to serve.

This has never been a job for sissies. As DMHPs, it is our responsibility to stand in the breach between vulnerable clients and the system. Sometimes that means protecting them from unnecessary hospitalization, sometimes it means protecting them from themselves through the process of detention. We defuse crises, create less restrictive alternatives, educate families and community providers and provide emergency counseling services.

At least, this is what we are meant to be doing. However, as resources dwindle, more and more hours are devoted to pursuing those elusive beds. Less restrictive alternatives get harder to find. Even the once simple task of referring a client to counseling or medication management is becoming increasingly complex and time consuming. Some of us are getting caught up in ethically complex situations where there is no good outcome, only a lesser of two evils.

I believe that the more it begins to feel like we are spinning our wheels in this job, the more important the job becomes. And I'm struck by the very appropriate name of our Newsletter: the Frontlines. That's were we are at – the battlefront, in the thick of the artillery fire. We are needed here.

Staying alive at the Frontlines means staying sharp, avoiding burnout, taking care of our physical, emotional, and spiritual health. As Mental Health Professionals, it's easy to brush aside this sort of advice, but I'm reminded of the old adage, "shoe maker's wives go barefoot, doctor's wives die young."

I've heard the term 'compassion fatigue' a lot recently. It's not a bad description of burnout, but I'm inclined to use the expression Battle Fatigue instead. I'm guessing every one of us has at least skirted the edges of this condition, and as we face the ever increasing challenges ahead of us, it will be an ever present danger.

1. Know yourself, and your own personal warning signs: apathy, irritability, depression are common.
2. Take vacation days and use them to rest and relax. Of course it's tempting to spend all of your time off getting caught up on chores, but refueling time is essential.
3. Make time for activities that inspire you, or give you pleasure. It's a reminder that there is a life beyond mental illness and system failures.
4. Seek out positivity wherever you can find it. Take a media holiday if the news is getting you down.
5. Laugh often.
6. Use your support people. If you don't have people – get some!
7. Channel your anger by advocating for change.
8. Attend the DMHP conferences. Nobody can understand your frustration better than your brothers and sisters in arms.

Frontlines is open for comment and feedback. Please feel free to contact me at kschafer@co.stevens.wa.us or (509) 685-0610.

David Kludt

Greetings from Olympia

April 2009

As I prepared to write this article I thought to myself, is there anything positive to talk about? It seems that every day brings a new message of doom and gloom. Severe budget cuts looming, reductions in client benefits, the continued closing of community hospital behavioral health units, past legislative mandates to reduce state hospital capacity (no new reductions in current Senate or House budgets), increasing caseloads!

Despite this list of bad news, however, it is crisis and emergency services workers the community and our consumers are turning to for assistance. Ironically, as other resources are reduced or eliminated, it often leaves you and the crisis intervention skills that you possess as the only resource still available. In addition, as you know, the people we see in crisis are more acute, more desperate, and at times more dangerous.

This is not a call to arms – it is a call for unity, a call for thoroughness in your work, a call for your continued care and passion. It is also a call for each and every one of you to continue to let our elected officials know that Washington State's ranking as last in the country for psychiatric in-patient beds is not acceptable. According to an American Hospital Association survey, Washington ranks last in the nation for the number of psychiatric beds available — 8 per 100,000 residents. The report said 50 per 100,000 are considered adequate. In-patient hospitalization is our most restrictive treatment option, and in working with consumers we do what we can to avoid hospitalizations. However, the availability of inpatient psychiatric care close to a person's home is essential to our mental health care system.

On to a related subject – The Mental Health Division and Washington Institute for Mental Health Research and Training (WIMHRT) recently completed three 2-day safety trainings. Approximately 130 individuals representing 65 provider agencies attended the training. In addition to training related to the requirements of the legislation (SHB 1456), and how to utilize the training materials, participants received extensive training from Seattle Police Department Officer Joe Fountain on personal safety and safe outreaches, and from Ellis Amdur of Edgeworks on verbal de-escalation. Follow-up training and long-term sustainability will now be our focus. Agencies that did not participate in one of the trainings will be provided with the training materials as a resource for them.

The 2008 edition of the DMHP Protocols have been completed and are available on the DMHP website and on the MHD Internet: (http://wadmhp.org/) or (http://www.dshs.wa.gov/pdf/hrsa/mh/dmhpprotocolsfinal.pdf)

They can also be received by requesting a copy from either Louie Thadei (ThadeLA@dshs.wa.gov) or Dave Kludt (kludtdj@dshs.wa.gov). I would like to sincerely thank the DMHP Association and the other members of the protocol work group for their participation in producing the 2008 protocols.

Congratulations to Spokane County, Spokane RSN, and Spokane Mental Health! Their new 16-bed evaluation and treatment facility (Foothills E&T) is scheduled to open in early May.

Take care, and as always stay safe!

David Kludt
MHD/Program Manager

ITA and Boarding: A Creeping Compromise

Jo-Ellen Watson, LICSW, Ph.D

King County Crisis and Commitment Services (CCS) attempts to place involuntarily detained individuals in certified Evaluation and Treatment (E&T) beds in King County. However, over the past few years a variety of factors have resulted in a severe shortage of inpatient beds for voluntary and involuntary patients. When there are no E&T beds available in King County, DMHPs have had no other choice but to send an individual detained in the community to the nearest emergency room. If the person is already in a hospital setting, (i.e. ER or medical unit) the DMHP detains and leaves him/her in the referring facility. A one bed certification form is filled out, faxed to WSH, signed and returned to our office. When these circumstances arise, the detained individual is referred to as a "boarded patient."

The boarding facility is authorized to provide psychiatric care as needed. Physical restraints and seclusion may be used according to the facility's own policies, to ensure safety of the person and others (WAC 388-865-0845). The facility is expected to provide necessary medical care, although detained people are assumed to be competent and have the right to refuse medical treatment for non life threatening conditions. The detained individual must be seen daily and charted on by a mental health professional as defined in RCW 71.05.020(25). If the facility does not have one on staff, Crisis and Commitment staff will provide this service. The detained individual's public defender is notified where the person is boarded and the facility must allow the attorney the right to visit the person and to review and copy the medical chart.

Psychiatric medication can be given to an individual against their will by the boarding facility, though an attempt must be made to obtain the person's consent. (RCW 71.05.215). If informed consent cannot be obtained, we recommend that the facility document in the patient record and then give antipsychotic medications under the following circumstances:

- If the physician determines an emergency exists in which the person presents an imminent likelihood of serious harm to self or others and there are no other medically acceptable or available alternatives.
- The physician must get a second opinion within 24 hours to justify the use of antipsychotic medication.
- Antipsychotic medication is designed for short term treatment if a failure to treat may result in a likelihood of serious harm or substantial deterioration or prolong the length of the hospitalization and there is no less intrusive treatment option.
- The detained person has the right to refuse all psychiatric medications in the 24 hour period prior to the probable cause hearing unless the criteria for involuntary antipsychotic administration are met (See below). (RCW71.05.210).
- The 24 hour Treatment Notice needs to be completed 24 hours prior to court, documenting that the detained person was informed of his/her right to refuse and whether or not that right was exercised. If the person indicates a refusal to accept medication and later agrees to take medication, there must be documentation in the person's medical record as to what was given and the time noted when the individual accepted the medication.

If the individual's condition improves prior to the 72 hour hearing, and the hospital staff believes that the person no longer presents a substantial risk, or is not gravely disabled, the boarding facility may discharge the person (RCW 71.05.210). If the facility has a voluntary unit, the person can also be admitted voluntarily for continued treatment.

Unfortunately, there are times when a placement is not available for the entire 72 hour hold. Within twenty four hours prior to the end of the 72 hour, a court evaluator or DMHP acting as a court evaluator, will see the individual in preparation for the Probable Cause court hearing. If a petition for further treatment is written by a court evaluator, the statute requires a physician's signature on the petition. This means that one of the boarding facility's physicians will be asked to meet with the patient, review and co-sign the petition. The court evaluator/DMHP will act as the witness in court. In most cases, the boarding facility's staff do not testify. The boarding facility has

access to advice or counsel from the ITA Prosecuting Attorney, who acts as the hospital representative at court. At the probable cause hearing, if the person is committed for up to an additional 14 days of inpatient treatment, the individual will go back to the boarding facility if there is not an appropriate E&T bed available. Crisis and Commitment continues to make every effort to get the individual transferred as quickly as possible.

In King County, we have been boarding people since 2004 with a steady increase in the frequency and longevity. In 2008, Crisis and Commitment boarded 801 people in hospital medical units or ERs throughout King County. We boarded every age group from 14 years through 90 plus. Many people stayed in boarding facilities for their entire 72 hour detention period and a significant number remained up to 14 days. Our office works closely with the boarding facility until the person is placed in a certified inpatient unit or is discharged. We monitor the detained person's situation several times per day. Crisis and Commitment has one staff person dedicated to managing the transfer of boarded people. A CCS involuntary commitment supervisor works closely with the boarding DMHP to ensure continuity and problem-solve the inevitable questions and concerns that arise from boarding detained individuals. In the first few months of 2009 we saw a drop in boarding for the first time in nine months. This was due in large part to Western State Hospital accepting all people on 90 day more restrictive orders who had been waiting in local beds. Unfortunately, in the last month, we have seen our boarding numbers climb again (36 boarded at this writing in mid- March) Boarding takes a terrible toll on detained individuals, families, boarding facilities (especially emergency departments), and DMHPs who spend hours trying to find appropriate placement as well as providing hours of support to hospitals and families of those detained. My worst fear is that boarding has become "institutionalized" in the way that food banks are now a way of life. What was, at one time, a solution to a temporary problem, is now standard practice and one that we have developed processes and procedures to support.

This is a tragedy. Clients and families deserve better care than this.

(**President's Letter, Continued from Page 1**)

As always, the WADMHP will provide training and information at workshops and conferences about changes in the laws that directly impact the work we do. We will also attempt to offer some articles with specific summaries in future editions of the Frontlines and on our website.

Recently we signed a contract with WIMHRT to provide the DMHP boot camps again this year. The DMHP association is excited to again be able to provide this training for DMHPs across the state and wish to extend our appreciation to the State Mental Health Division for its continued vision in sponsoring these statewide trainings. In addition, we are providing a one-day workshop at the state Behavioral Healthcare Conference on June 17 in Vancouver, WA. Our annual Fall conference is set for October at Sun Mountain Lodge in Winthrop.

The association has been involved in a variety of activities over the past several months and continues to advocate for responsible system changes or restraints as the opportunities arise. I want to take a moment to specifically recognize Robby Pellett, 2nd Vice President, Pierce County DMHP. Robby has been working tirelessly for several years now, with the assistance of some representatives (primary sponsor Representative T. Green), to address the issue of venue in LRA and conditional release orders. This bill specifically allows a DMHP to file a petition for revocations of an LRA in either the county the order was originally issued or in the county the respondent is in when they interact with a DMHP. Robby: thank for your dedication and work on behalf of DMHPs and the people we serve. As a quick side note, if this does not work, for once we all have someone specific to blame (it works both ways Robby ☺).

The WADMHP has also been involved in a project with the State MHD to provide trainings to DMHPs and other crisis responders on intervention strategies and resources for Military Veterans in Crisis. These trainings will be free of charge as the Mental Health Division is using federal block grant money for this important and timely topic. Training announcements will come out to all of the DMHP offices in the near future from the state MHD. This project included representatives from the Division of Alcohol and Substance Abuse, the State Office of Veteran Affairs and the DMHP association. The association would like to extend its thanks to all involved for putting together what promises to be a great training.

One Day Spring Conference in Vancouver

This spring, the WADMHP is offering a one day workshop as part of the Washington State Behavioral Healthcare Conference, located at the Hilton Hotel, in Vancouver, WA. We are pleased to offer you '*Crisis and the Geriatric Population'* and *'Psychiatric Emergency Care and Forensic Issues,'* as well as a *Legislative Update*.

Ed Samuelson, MA, MHP, GMHS, is not only a Geriatric Mental Health Specialist, he is also a bona fide geriatric. In 1974, mandated by this state's new ITA legislation, he developed the first Crisis Response Teams in King County. He remembers, "It was the wild West where reality therapy prevailed!" As the Associate Director of Seattle mental health Institute, he went on to develop one of the largest geriatric mental health programs in the State. Later, as the Director of Special Services at Kitsap Mental Health, he directed their Adult Services Programs. Both of these programs had vigorous outreach components and reduced hospitalizations dramatically. Until recently, Ed was a member of the Human Services faculty at Western Washington University as well as teaching Dementia and Mental Health Specialty training to ESL providers. He will be speaking on '*Crisis and the Geriatric Population.'*

Thomas Rosko, MD, is currently the Director, Psychosomatic Medicine Department of Psychiatry and Behavioral Neurosciences at Cedars-Sinai Medical Center in Los Angeles. He previously was the Chief Psychiatrist and Associate Health manager as well as a former Staff Psychiatrist and Senior Psychiatric Supervisor for the California Department of Corrections. He completed his Psychiatric Residency in 1999, serving as Chief Resident on Consultation-Liaison and Emergency Psychiatric Services at UCLA Medical Center. He is Board Certified in both Anesthesiology and Psychiatry. He is an expert medico-legal witness in criminal and civil cases, and he has extensive experience in the training and education of health care professionals.

For further conference information, contact Jami Larson at (360-754-1338). For registration questions, please contact Kincaid Davidson at (360) 676-5162. For updated information, check the WADMHP website: www.wadmhp.org

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REGISTRATION FORM

Washington Association of Designated Mental Health Professionals

2009 Spring Conference

June 17, 2009
The Hilton, Vancouver, Washington
Reservations: 1-360-993-4500

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work phone: (_____) _____

Employer: _____ County: _____

Position Title: _____

☐ WADMHP member ☐ Non member
Registration fee: $70
☐ A check payable to WADMHP is enclosed for: _____
Please note: Check or cash only

Signature: _____ WADMHP Identification Number: 91-1997711

Mail registration form to:

WADMHP PO Box 5371, Bellingham, WA 98227

WADMHP

2009 Spring Conference

The Hilton
Vancouver, Washington
June 17th

Morning Session

Crisis and the Geriatric Population
Presenter: Ed Samuelson

7:45 am – Registration and Breakfast
8:30 – 8:45 am – Legislative Updates
8:45 am – 10:15 am – Presentation – Ed Samuelson
10:15 – 10:30 am – Break
10:30 am – 12:00 Presentation continued
12:00 pm – 1 pm Lunch

Psychiatric Emergency Are and Forensic Issues

Presenter: Dr. Thomas Rosko

1:00 pm – 2:30 pm – Dr. Thomas Rosko
2:30 pm – 2:45 pm – Break
2:45 pm – 4:15 pm – Legislative Update

CEUs will be given.

Initial Detentions (72 hour) and Revocations for Calendar Year 2007

Source: Ad Hoc Query Tool from MHD CIS (Note: missing data for some counties at time of printing)

DMHP Investigation County	Detention to MH Facility (72 hours)	Detention to Secure Detox Facility (72 hours)	Returned to Inpatient Facility/Filed Revocation	Grand Total (All DMHP Investigation Outcomes)	Estimated Population for 2008 Source: Office of Financial
Adams	9	--	5	25	17,600
Asotin	16	--	1	73	21,300
Benton	174	--	32	1,313	162,900
Chelan	78	--	19	461	71,200
Clallam	59	--	13	122	68,500
Clark	274	--	5	651	415,000
Columbia	8	--	1	36	4,100
Cowlitz	148	--	12	287	97,800
Douglas	--	--	--	--	36,300
Ferry	--	--	--	--	7,550
Franklin	57	--	9	435	67,400
Garfield	1	--	--	5	2,350
Grant	1	--	--	4	82,500
Grays Harbor	45	--	1	50	70,800
Island	91	11	9	328	78,400
Jefferson	49	--	1	50	78,400
King	1,482	--	229	4,543	1,861,300
Kitsap	333	--	55	1,139	244,800
Kittitas	39	--	--	107	38,300
Klickitat	25	--	2	133	19,900
Lewis	20	--	2	359	74,100
Lincoln	--	--	--	--	10,300
Mason	22	--	2	94	54,600
Okanogan	16	--	5	24	39,800
Pacific	16	--	--	99	21,600
Pend Oreille	--	--	--	--	12,600
Pierce	731	537	91	2,727	790,500
San Juan	17	1	--	43	15,900
Skagit	428	101	34	1,152	115,300
Skamania	--	--	--	47	10,700
Snohomish	737	142	92	1,944	686,300
Spokane	651	--	173	1,035	451,200
Stevens	--	--	--	--	43,000
Thurston	201	--	21	684	238,000
Wahkiakum	--	--	--	2	4,000
Walla Walla	64	--	2	723	58,300
Whatcom	537	114	72	1,234	188,300
Whitman	8	--	--	33	42,700
Yakima	305	--	51	2,572	234,200
Grand Total	6,642	906	939	22,534	6,537,800

Initial Detentions (72 hour) and Revocations for Calendar Year 2008

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DMHP Investigation County	Detention to MH Facility (72 hours)	Detention to Secure Detox Facility (72 hours)	Returned to Inpatient Facility/Filed Revocation	Grand Total (All DMHP Investigation Outcomes)	Estimated Population for 2008 Source: Office of Financial
Adams	--	--	--	--	17,800
Asotin	13	--	--	58	21,400
Benton	245	--	44	1,952	165,500
Chelan	90	--	16	509	72,100
Clallam	45	--	37	120	69,200
Clark	208	--	7	934	424,200
Columbia	9	--	1	47	4,100
Cowlitz	156	--	26	313	99,000
Douglas	--	--	--	--	37,000
Ferry	--	--	--	3	7,700
Franklin	46	--	11	417	70,200
Garfield	--	--	--	9	2,300
Grant	--	--	--	--	84,600
Grays Harbor	21	--	1	26	70,900
Island	65	15	6	178	79,300
Jefferson	30	--	--	30	28,800
King	1,939	--	305	6,110	1,884,200
Kitsap	379	--	44	1,100	246,800
Kittitas	51	--	1	52	39,400
Klickitat	18	--	3	21	20,100
Lewis	52	--	3	528	74,700
Lincoln	--	--	--	--	10,400
Mason	24	--	4	124	56,300
Okanogan	--	--	--	--	40,100
Pacific	22	--	2	107	21,800
Pend Oreille	--	--	--	--	12,800
Pierce	581	417	61	1,362	805,400
San Juan	16	2	1	37	16,100
Skagit	407	150	42	947	117,500
Skamania	3	--	--	64	10,700
Snohomish	705	134	89	1,480	696,600
Spokane	675	--	197	1,103	459,000
Stevens	--	--	--	--	43,700
Thurston	175	--	11	841	245,300
Wahkiakum	--	--	--	2	4,100
Walla Walla	52	--	7	401	58,600
Whatcom	562	141	83	1,021	191,000
Whitman	6	--	--	20	43,000
Yakima	355	--	55	489	235,900
Grand Total	6,950	859	1,057	20,405	6,587,600

Meeting the Needs of the Psychiatrically Compromised Geriatric Individual

By Scott Kuhle

As our population ages, a number of societal issues arise due to the differences between elderly and younger populations. For example, older people generally tend to be less mobile, and their social and recreational interests are different than those who are younger. Just as the etiology of the medical conditions is often different, emotional and cognitive symptoms may have different etiologies, indicating different treatment needs for these age groups.

Society is slowly learning how to meet the vastly different needs of the elderly. There are residential homes or gated communities where they can live near friends with similar interests and receive a degree of assistance in order to continue independent living. Many communities have senior centers where older persons can gather for meals and social activities. The medical community has developed new medical procedures such as hip replacements. New medications are continuously being developed.

But other than the development of medications to slow down Alzheimers deterioration, little is being done to address the mental health needs of our increasing geriatric population. Prior to the enactment of the Involuntary Treatment Act in 1973, hospitalization was the common way of dealing with people who exhibited serious mental health issues. Lobotomies, archaic methods of ETC, and warehousing persons in *insane asylums* are now considered treatment from the Dark Ages.

Fortunately, society realized that warehousing people in psychiatric wards often equaled cruel and unusual punishment, and developed more effective methods of treating persons who exhibited symptoms of mental illness with the object of providing care that enabled them to remain in the community.

Unfortunately, the clock seems to be turning backwards for our geriatric population: the community often thinks that the first line of treatment for elderly persons is inpatient treatment. "Do anything, just get them out of our hair."

Over the years a number of programs were developed to address the needs of elderly people who present with mental health problems. Two excellent programs were designed and implemented in the state: the Short Stay Program at Eastern State Hospital, and the Gatekeeper Program in Spokane.

The Short Stay Program

In the 1990s, Mark Krielkamp, a social worker at Eastern State Hospital, designed the Short Stay program. This novel and extremely effective program provided for a person who was becoming agitated in the nursing home setting to be evaluated for two weeks in the nursing home and then admitted to ESH if the person met pre-determined criteria. During the two week evaluation time, the behavior of the resident was monitored daily and recorded by nursing home staff.

At the end of two weeks, a mental health professional would perform an evaluation of the person, and, if the resident met the requirements, arrange for admission to ESH for further observation and treatment. The program was named Short Stay because it was designed for the resident's stay at ESH to be limited to approximately two weeks. Prior to admission to ESH, agreement was established among the nursing home, the community mental health agency, and ESH that the nursing home would accept the patient back as soon as inpatient treatment was completed.

Unfortunately, the program was defunded.

The Gatekeeper Program

The Gatekeeper Program, a Geriatric program designed by Ray Rasko at Spokane Mental Health, was an innovative program to find elderly individuals in the community who might have an untreated mental disorder, or be in need of other community based services. Mail men and service delivery people, who noticed that one of their customers was not picking up his or her mail or news papers, were encouraged to notify the police who would then do a wellness check. If the police had concerns about the individual's mental status, they would make a referral to the mental health agency. When the concerns warranted it, a team of geriatric/mental health specialists would make an outreach contact.

Nursing Home Guide Lines

In 1990, recognizing the need for some standard guidelines that DMHPs could use for assessing persons in nursing facilities, a group of DMHPs at a WADMHP conference suggested developing guidelines. Kin Davidson, a DMHP from Bellingham, started writing the Nursing Home

Guidelines. On September 7, 1996 the WADMHP Executive Board recommended adoption of the Guidelines by the association membership and they were adopted by the members at the 1996 Fall Conference.

The guidelines, based on Federal and State laws, provided criteria for: 1) determining when an evaluation is necessary; 2) what should be done by the nursing facility prior to an evaluation; 3) and how the evaluation should proceed once it was determined to be necessary.

These guide lines became the basis for the Protocols in the section on evaluations for detention in residential care facilities.

DMHP Protocols

The DMHP Protocols address referrals from residential care facilities, which include: nursing homes; boarding homes (assisted living facilities); and adult family homes.

Protocol 120 states: *unlike the general community, licensed residential care facilities are required to provide individualized services and supports and may be considered a less restrictive alternative to involuntary detention….*

The facility may be considered a potential less restrictive alternative if the needs of the resident can be met and the safety of other residents can be protected through reasonable changes in the facility's practices or the provision of additional services. However, if the facility cannot protect the resident and safety of all residents, the facility may not be an appropriate less restrictive alternative.

Author's opinion: Unless there is clear indication that the resident will benefit clinically from inpatient treatment, the DMHP is simply transferring the problem from one entity to another. It is my contention that the DMHP must be reasonably sure that the psychiatric facility can offer something different than the nursing facility.

The protocols continue:
Whenever possible, the DMHP evaluates the person at the licensed residential care facility rather than an emergency room so that situational, staffing, and other factors can be observed.

Author's opinion: On the surface this protocol would appear to make good clinical sense. However, it addresses actions that are more appropriately carried out by a geriatric specialist over a period of time than by a DMHP doing an evaluation for detention. It is a broad assumption to think that a person in a nursing home has been checked out for all possible medical complications that may cause cognitive and/or emotional problems. A urinary tract infection (UTI) may be successfully treated within a few days with antibiotics, but the cognitive/mood impairment may take a week or more to improve because brain organicity lags in reconstituting.

The Protocols continue: *The DMHP confers with and obtains information from the facility on the reason for the referral, the level of safety threat to residents, and alternatives that may have been considered to maintain the individual at the facility. Alternatives could include changes in care approaches, consultation with mental health professionals/specialists and/or clinical specialists, reduction of environmental or situational stressors, and medical evaluation of treatable conditions that could cause aggression or significant decline in functioning.*

- *When appropriate, available, and consistent with confidentiality provisions, the DMHP obtains information from a variety of sources such as the resident, family members of the resident, guardians, facility staff, attending physician, the resident's file, the resident's caseworker or mental health provider, and/or the ombudsperson. All collateral contacts are documented, including the name, phone number, and substance of information obtained.*
- *If the investigation does not result in detention but the resident has remaining mental health care needs, the DMHP may also provide further recommendations and resources to the facility staff and others, including recommendations for possible follow-up services.*
- *If the resident is being evaluated in an emergency department and the investigation does not result in detention, the resident may have re-admission rights to the long-term care facility. If the DMHP has concerns about facility refusal to re-admit the resident, the DMHP notifies the Residential Care Services Complaint Resolution Unit.*

Author's opinion: These three protocols point to work that is best performed by a geriatric team that includes: 1) a mental health geriatric specialist; and 2) a prescriber familiar with geriatric medicine.

According to those specializing in geriatric mental health care, a rule out to determine what is driving psychiatric symptoms takes days; it *cannot* be done in a few hours or even one day.

The Geriatric Specialist

Probably the most important and practical ingredient in reducing the need for involuntary detentions is the Geriatric Specialist within the mental health agency. This is a person who is familiar with: 1) geriatric medical conditions that may cause psychiatric symptoms; 2) geriatric medications; 3) the community physicians who are prescribing for the compromised resident; 4) the nursing home social workers; 5) and, finally, the local resources that are available for handling a psychiatrically fragile individual.

Psychotic symptoms in an elderly person are often driven by a medical condition such as a urinary tract infection (UTI), a bowel blockage, or dietary deficiency. It is essential that all medical problems be ruled out prior to determining that an elderly person needs to be detained for psychiatric treatment.

Elderly persons generally metabolize medications differently than younger persons. Therefore, it is necessary to have a prescriber who is knowledgeable about the possible different effects of psychotropic medications on their elderly patients. Ativan is frequently used to quiet an agitated nursing home resident, but in some elderly persons, it has a paradoxical effect, thus increasing agitation rather than calming the person. When a resident starts striking out toward other residents, the Geriatric Specialist, who is knowledgeable about these possible medication responses, can be available to consult with nursing staff (often by phone), and then provide helpful information to the prescriber, who may be in the nursing home only once a month.

Community physicians who attend to residents in nursing homes are often not familiar with either the evaluation or treatment of their geriatric patients who suddenly present with acting out behavior. They usually welcome the assistance of the Geriatric Specialist/mental health professional who is familiar with mental disorders and can offer help about treatment needs.

Social workers working in nursing homes and other community agencies are the ones who are on the front lines with elderly persons who are exhibiting concerning behavior of grave disability and/or dangerousness to others. Since the behavior is often new behavior for the client and looks similar to symptoms of a mental disorder, it is easy to assume that the behavior is caused by a mental disorder. Therefore, it is necessary to have a mental health professional, who is familiar with geriatric issues, available for consultation and hands on help in assisting with assessment and resource utilization.

Two Departments Not Communicating

In Washington, there is a serious problem of two departments, both under the umbrella of DSHS – the Department of Mental Health and the Department of Licensing (Nursing Home Care) frequently being at odds with one another. Because they can't seem to agree on adequate psychiatric care for persons who are exhibiting symptoms of mental illness, they too often work against the welfare of elderly residents in nursing homes and residential care facilities under their licensure. The inability of those responsible for the oversight of nursing homes to recognize the psychiatric needs, and the least invasive treatment for residents with mental illness, is a disservice to the population they purport to serve.

Conclusion

Geriatric individuals, both those living independently in the community and those in nursing homes and residential facilities, are better served in the community. When good geriatric mental health resources are developed, symptoms and behavior can be managed with community resources, and inpatient treatment is *rarely* required.

Generally, the person living in the community who develops mental health problems that compromise continued independent living due to grave disability needs community based resources.

The person who surfaces in the residential setting with mental health symptomology is usually agitated and exhibiting behavior that may be of harm to other residents. This person usually needs medical attention and some type of behavioral management.

While each of these cases has different solutions, the solutions are community based. Inpatient psychiatric treatment is usually contraindicated since there is little, if any, treatment or rehabilitation for the geriatric patient in a psychiatric hospital beyond medication management. The hospital stay becomes a matter of providing expensive custodial care, and utilizing beds that are needed for persons who would be benefiting from inpatient treatment. (**Cont. on p. 15**)

A National Pickle

By Gary Carter

The state's shortage of social services for the chronically mentally ill is not a new notion for mental health professionals. But with the national recession worsening, and more of the general population discovering that they themselves are without the services they need, people outside the field seem increasingly less concerned about this situation.

"Nation-wise, we're in a pickle."

We are in a pickle, a national pickle, at that.

In the last edition of Frontlines I wrote about the looming catastrophe awaiting B-Boomers who are now beginning to be admitted to inpatient psychiatric care. Driven by the systematic closure of state hospital beds, Washington State Hospital's refusal to treat people suffering from Alzheimer's disorder, and the ever-expanding ripple effect of those policy decisions, our specialized care system in Washington has been ripped apart.
It isn't anything to wait for. It is here now and it is worsening.

Some of you may have attended the DSHS presentation a few months ago that was given to provider agencies and the public by the then Mental Health Division Director, Richard Kellogg. For those who haven't had the opportunity to gape, here is what, in part, was presented:

90% Decrease in Public MH Inpatient Beds Proportional to the US Population Since 1970

UNITED STATES	1970	2002	CHANGE
State & County MH Beds	413,066	57,263	-86%
Beds per 100,000 Population	207.4	19.9	-90%

Expert Panel of Psychiatrics Unanimously Agreed that Public Beds per 100,000 Population is a Minimum Standard

RATING	BEDS PER 100,000	# STATES
Critical Bed Shortage	Less than 12	11
Severe Bed Shortage	12 to 19	21 including Washington
Serious Bed Shortage	20 to 34	16
Marginal Bed Shortage	35 to 49	1
Meets Minimal Standard	50 or More	1

Washington lags behind other States in the number of Community hospital psychiatric inpatient beds per 100,000

- Washington Ranked 51st of all the states and the District of Columbia
- Washington's per capita average was 66% below the national average

US STATES	POPULATION – JULY 2006	COMMUNITY BEDS – 2006	COMMUNITY BEDS / 100,000	RANK
US Average	5,870,558	1,478	25.2	----------
Washington	6,395,798	522	8.2	51st

Closer to home, we have just learned that in two more weeks Kitsap County will lose its only voluntary inpatient unit. It is the only community hospital psychiatric unit available for our three-county RSN. With its loss, our community also loses the skilled labor pool who worked there. Emergency Departments, already the front door for almost all emergency psychiatric care, will now be the only treatment provider for local voluntary care. They are already shouldering the burden of the boarded psychiatric client.

As I know it is the case in Pierce County crisis services, it is true here: the Crisis Response Team at Kitsap Mental Health cannot fill our need for skilled clinicians. Positions can go unfilled for years. While we have recently filled all our permanent positions, we have been able to retain only a single on-call DMHP at a time. The last one to quit could only cover shifts that were at least one week long because she lived in Vancouver, WA. That is a 165 mile, three hour one-way commute! Our current single on-call staff works as a fulltime DMHP three counties away. He is only available for a shift or two a month and often isn't able to cover the entire 10-hour shift because of the distance he must travel. This situation, in some form, is familiar to most of the DMHP readers, I am sure.

Some months ago I received this resignation letter from an on-call DMHP, bringing our numbers back to one. She had been an excellent full-time DMHP for years here. After being away for about five years she returned to work a single shift a month as on-call because of her private practice and active personal life. I was happy to have her because even with her limited availability she was an excellent clinician and could handle conflict well, she also was able to adapt to the constant changes faced every time she returned to the job. It was impressive. Well, until she quit last September.

> September 25, 2008
> Re: Letter of Resignation
> Dear Gary:
> I am writing to formally resign my position as on-call DMHP at Kitsap Mental Health Services. Recent shifts this summer became more and more frustrating as the focus was always on where to detain a client and the difficulties inherent in that process. Also, with my work schedule, the possibility of having to appear in person to testify at hospitals outside of Kitsap County would be a great detriment to my own private clients as I'm sure you can imagine. I had continued my on-call position in the hopes of "keeping up my clinical skills" but found that increasingly, what was demanded was more creative thinking in obtaining beds and keeping abreast of every changing certification regulations…
> Recently you wrote a long e-mail about adjusting to a system that is largely broken and I so agree with you. I think you and the team do a fabulous job and I will miss all my colleagues, but the strain of the shifts and all I have mentioned is becoming counter-productive in my own calling as a mental health professional…
> Sincerely,
> JP

The difficulty determining "where to detain a client" refers to the boarding process that is becoming routine in Kitsap County. Having to appear in out of county hearings is a fact of inpatient bed reductions, we place people detained in Kitsap in Yakima. That is a three and a half hour one-way trip in an ambulance; we are not able to

schedule transports during the evenings and night as the ambulance company has to make special arrangements. Meanwhile, the clock is ticking on the court clock and in the ED.

The "certification regulations" refers to Medicaid funding changes that began August 1, 2008 which added additional complexity to our work. The reference to our team doing something "fabulous," while true, is nothing more than what most all emergency units are doing as they make a renewed effort to adjust the needs of our clients to the increasingly impersonal and unresponsive state healthcare system.

DMHPs have a unique opportunity each shift they work to provide an exclusive service to the most vulnerable clients in our state. This has always been true. It still is, now for additional reasons. It seems to me that the more difficult it is for us to identify and organize the existing services for our clients, the more these folks are increasingly compromised and reliant on us to be successful in this work. No one is excluded, we are all struggling. There is no room to feel as the victim. We all play a part in this, both how it affects us individually and how we get through this.

So, that was the extent of my meager encouragement to all of you doing this difficult work. 'taint much, huh? We truly have a special and essential role doing something no other professional group is empowered to do. You can be proud of that. If there is one phrase I often repeat to myself and those I work with, it is this: this is work worth doing and no one else can do it if we do not.
I'll end again with an abbreviated list of the suggestions I left last edition:

- Do what is right for your client, every time.
- Over-communicate what you are doing with everyone who relies on you.
- Develop and nurture collaborative relationships with everyone. You cannot afford to be isolated or feel as the victim.
- Stay fresh and stay in supervision.
- Document the facts of the case, the dilemmas and your decision. You must pass the "reasonable person" test.
- Participate in local and state government by voting, calling and writing letters.

(Continued from p. 12) Unlike firefighters, DMHPs do not need to slide down a fire pole in order to put out a raging fire.

Granted, although the people requesting the evaluation may consider the situation an emergency, it rarely is. DMHPs, not being first responders, have the opportunity to slow down the process, and in doing so, let more thoughtful and clinically beneficial solutions percolate and prevail.

RCW 71.05 was not enacted to solve the problems of society or residential care facilities. DMHPs are wise in resisting the pressure to be the de facto/default solution for the elderly by detaining them.

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Contact Ian Harrel (360-415-5824) or Gary Carter (360-415-5865)
for registration form or additional information

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