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IN THE SUPREME COURT OF THE STATE OF WASHINGTON

In re the Detention of:

D.W., G.K., S.B., E.S., M.H., S.P., L.W., J.P., D.C. and M.P.,

Respondents,

v.

THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES and
PIERCE COUNTY,

Appellants

BRIEF of *AMICI CURIAE*
WASHINGTON STATE HOSPITAL ASSOCIATION,
ASSOCIATION OF WASHINGTON PUBLIC HOSPITAL
DISTRICTS, WASHINGTON STATE MEDICAL ASSOCIATION,
WASHINGTON CHAPTER OF THE AMERICAN COLLEGE OF
EMERGENCY PHYSICIANS, NORTHWEST ORGANIZATION
OF NURSE EXECUTIVES, WASHINGTON STATE NURSES
ASSOCIATION, SEIU HEALTHCARE 1199NW, and
WASHINGTON COUNCIL OF EMERGENCY NURSE
ASSOCIATION

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Washington State Supreme Court

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I. IDENTITY AND INTEREST OF AMICI CURIAE

The Washington State Hospital Association (“WSHA”) is a nonprofit membership organization representing Washington’s 98 community hospitals. WSHA works to improve the health of the people of the State by advocating on matters affecting the delivery, quality, accessibility, affordability, and continuity of health care. One of WSHA’s top advocacy priorities is supporting improvements to the mental health system—advocating for increased funding for mental health services, including capital and operating funds for new inpatient capacity at certified evaluation and treatment facilities.

The Association of Washington Public Hospital Districts (“AWPHD”) is an advocacy organization representing 57 public hospital districts, 42 of which operate hospitals. Most of the Districts serve rural communities, and their hospitals are the only significant provider of health care for the entire county. They are not only the hub, they are the link to all other health services—mental health, primary care, specialty care, and public health.

The Washington State Medical Association (“WSMA”) is a statewide professional association of medical and osteopathic physicians, surgeons, and physician assistants with over 9800 members. WSMA has been in existence for over 100 years and throughout its history, the WSMA and its members have participated in litigation, both as a party and as a friend of the court, because they offer historical and contemporary expertise about how health care is delivered.

The Washington Chapter of the American College of Emergency Physicians (“Washington ACEP”) is a nonprofit membership organization comprised of emergency physicians who practice in Washington hospitals.

Washington ACEP advocates with respect to emergency medical services, including appropriate use of emergency medical services.

The Northwest Organization of Nurse Executives (“NWONE”) was founded in 1996 and is a nonprofit membership association serving all levels of nursing leadership from the emerging nurse leader through nurses who are chief nursing executives, chief executive officers, academic deans, and owners of their own businesses. The mission of NWONE is to advance the leadership contribution of nurses in creating health care solutions to serve their communities.

The Washington State Nurses Association (“WSNA”) is the oldest and largest professional organization and labor union for nurses in Washington State, representing more than 16,000 Registered Nurses (“RNs”) at more than 40 hospitals and health care facilities. Since its founding more than a century ago, WSNA has strived to maintain and strengthen nursing’s role in client advocacy for consumer safety and quality health care as well as the development of quality nursing practice, education, and the professional development of RNs. Today, WSNA continues to be a leading voice in the advancement of the nursing profession and a strong advocate for access to quality health care including access to mental health services.

SEIU Healthcare 1199NW (“SEIU”) is 26,000 nurses, healthcare employees, and mental health workers in hospitals, agencies, and clinics across Washington State. SEIU is united to improve the quality of care by raising standards in the workplace, advocating for safer care, building workforce training funds, expanding funding for and access to mental healthcare, and standing up for social and economic justice. With healthcare workers in the state’s emergency rooms, state psychiatric

hospitals, and community mental health facilities, SEIU members confront the dangers of boarding and associated challenges every day.

The Washington State Council of the Emergency Nurse Association (“WA-ENA”) is a not-for-profit organization and the professional organization for emergency nurses dedicated to quality patient care, public safety, continuing education, nursing research and promotion of the nursing profession. WA-ENA is comprised of a membership of over 1,100 nurses working in emergency departments throughout Washington State who are frequently involved with initial assessment and stabilization of mental health patients.

All *amici* are familiar with the Involuntary Treatment Act (“ITA”), the inadequate funding for the mental health system in Washington, and the impact both have on their members and the patients and communities their members serve. *Amici* and their members have a strong interest in this Court addressing the merits of this case and upholding the Superior Court’s Declaratory Order.

II. STATEMENT OF THE CASE

Amici rely on Intervenor/Respondents Multicare Health System and Franciscan Health System Counterstatement of the Case.

III. ARGUMENT

A. Years of State Budget Cuts Have Resulted in an Inadequate Number of Beds at Certified Evaluation and Treatment Facilities and at Western and Eastern Hospitals.

Washington State’s community mental health system historically has been underfunded. Between 2000 and 2010, ITA-certified beds, also known as certified evaluation and treatment facilities, decreased by 36%,

from 790 to 593,¹ while Washington's population increased by 14.1%.² During the economic recession of 2009-2012, the Washington State Legislature severely cut the community mental health system's funding for consumers by a total of more than \$90 million. The 2009-2011 Washington State Budget reduced funding for community mental health services delivered through Regional Support Networks ("RSNs") by \$57.7 million or about 5%.³ Discontinuing funding for innovative approaches aimed at reducing the need for crisis inpatient mental health services resulted in an additional \$4 million reduction.⁴ Further reductions were made in the 2011-2013 Washington State Budget. Funding for community mental health services delivered through RSNs was reduced by a total of \$26.2 million, or about 3%.⁵ The 2012 Supplemental Budget also cut \$2.6 million in funding for other mental health services, such as supportive employment, clubhouse, and respite care, programs that allow consumers to receive services in their community and help keep people from needing crisis services in the future.⁶

¹ M. Burley. (2011). *Inpatient Psychiatric Capacity in Washington State: Assessing Future Needs and Impacts* (Document No. 11-10-3401) page 3. Olympia. Washington Institute for Public Policy. (Hereafter cited as "Burley 2011").

² United States Census. *Population Distribution and Change: 2000-2010*. Accessed May 20, 2014 at <http://www.census.gov/prod/cen2010/briefs/c2010br-01.pdf>

³ Washington State Legislative Evaluation & Accountability Program Committee, *Washington State Legislative Budget Notes (2009-11 Biennium and 2009 Supplemental)*, Part V-Omnibus Appropriations Act – Agency Detail, Department of Social & Health Services, p. 138. (Hereinafter "2009-11 Budget Notes.") Accessed May 13, 2014 at <http://leap.leg.wa.gov/leap/budget/lbns/2009dshs.pdf>

⁴ *Id.*

⁵ Washington State Legislative Evaluation & Accountability Program Committee, *Washington State Legislative Budget Notes (2011-13 Biennium and 2011 Supplemental)*, Part V-Omnibus Appropriations Act – Agency Detail, Department of Social & Health Services, p. 146. Accessed May 13, 2014 at <http://leap.leg.wa.gov/leap/budget/lbns/2011dshs.pdf>

⁶ Washington State Legislative Evaluation & Accountability Program Committee, *Washington State Legislative Budget Notes (2012 Supplemental with Revised 2011-2013 Biennium Numbers)*, Part V-Omnibus Appropriations Act – Agency Detail, Department of Social & Health Services, p. 113. Accessed May 13, 2014 at <http://leap.leg.wa.gov/leap/budget/lbns/2012dshs.pdf>

These cuts impacted Medicaid enrollees, as well as access to services for consumers detained under the ITA who would qualify for non-Medicaid funding. Non-Medicaid funding must be used for crisis response and commitment of those detained under the ITA who are not Medicaid eligible. Through the 2009-2013 biennial budgets, the Washington State Legislature reduced the funding levels for the delivery of mental health services, adjusting only for caseload growth associated with more people qualifying for Medicaid due to the recession. During these reductions in funding for mental health services, the number of single bed certifications across the state dramatically increased, from 1,221 in 2007 to 3,412 in 2013.⁷

In addition to the reductions in funding for community mental health services delivered through certified evaluation and treatment facilities (“E&T Facilities”) and programs designed to prevent the need for crisis interventions, there have been significant reductions in beds available for long term (90-day) commitments in state psychiatric hospitals. Based on a community treatment strategy initiated in 2006, the number of civil commitment beds at Eastern and Western State Hospitals was reduced by 120 or 13% during the year ending 2009.⁸ A ward closure at Western State Hospital in 2011 resulted in additional bed reductions.⁹ While beds at Eastern and Western State Hospitals are not available for

⁷ *DSHS: Mental Health Updates*. Andy Toulon, Office of Program Research, presentation to Washington House Appropriations Subcommittee on Health and Human Services, October 16, 2013. Accessed May 13, 2014 at <https://app.leg.wa.gov/CMD/Handler.ashx?MethodName=getdocumentcontent&documentId=svE8ROxR73E&att=false>

⁸ *2009-11 Budget Notes* at 138.

⁹ Washington State Legislative Evaluation & Accountability Program Committee, *Washington State Legislative Budget Notes (2011-13 Biennium and 2011 Supplemental)*, Part V-Omnibus Appropriations Act – Agency Detail, Department of Social & Health Services, p. 146. Accessed May 13, 2014 at <http://leap.leg.wa.gov/leap/budget/lbns/2011dshs.pdf>

individuals detained under the ITA for 72-hour or 14-day commitments, the reduction in their numbers impacts the availability of beds at certified E&T Facilities. If a patient in a certified E&T Facility is committed on a 90-day order for placement at Western or Eastern State Hospital, but no bed is available either Western or Eastern State Hospital, the patient remains at a certified E&T Facility, occupying a bed that should be freed up for another patient in need. This means fewer available beds and fewer patients in need of mental health services receiving them at E&T Facilities for 72-hour and 14-day commitments. The result is increased “psychiatric boarding” in hospitals, to the detriment of the patients detained, the hospital emergency departments required to detain them, other emergency department patients, and emergency physicians and nurses.

B. Hospitals Are Often the Entry Point to the Mental Health System By Virtue of Federal and State Law, Even If They Do Not Provide Psychiatric Services

Washington hospitals provide a range of services to patients, but no hospital provides all types of health care services. The mission of the hospital, as set by its governing board, as well as the hospital’s size, its financial strength, available resources, including physicians and nurses, and the needs of the community it serves, are all considerations in defining the services the hospital will offer. The governing board and leadership of each hospital determine the scope of services it will offer based on its own unique circumstances.

Recognizing the need for local decision-making in determining what services are offered, Washington law does not require that hospitals offer specific types of services in order to be licensed. For example, in order to be licensed hospitals are not required to offer surgical services (WAC 246-320-236), anesthesia services (WAC 246-320-241), obstetrical

services (WAC 246-320-251), neo-natal or pediatric services (WAC 246-320-256), critical or intensive care services (WAC 246-320-261) or even emergency services (WAC 246-320-281).¹⁰

Hospitals are not required to provide psychiatric services, but a number of them do. WAC 246-320-271. Of the 98 WSHA member hospitals in Washington, about one quarter have inpatient psychiatric units and of those hospitals with psychiatric units, about half are certified to accept involuntary patients.¹¹ Yet, Washington hospitals participating in Medicare and critical access hospitals which offer emergency services are obligated under the Emergency Medical Treatment and Active Labor Act (“EMTALA”) to provide screening and stabilizing care to all patients who come to their emergency rooms. 42 U.S.C. § 1395dd. This includes patients who come for psychiatric care. Under the ITA, an individual may be brought to a hospital emergency department and, if the patient presents “an imminent likelihood of serious harm” as a result of mental disorder, or “an imminent danger because of grave disability,” he or she may be detained for sufficient time to notify a designated mental health professional. RCW 71.05.050. To fulfill their obligations under EMTALA and the ITA, hospitals often become the entryway to the mental health system; an entryway in which patients ordered detained under a single bed certification become stuck without access to the specialized psychiatric care and therapeutic treatment they require.

Under EMTALA, a hospital must “provide for an appropriate medical screening examination within the capability of the hospital’s

¹⁰ Critical access hospitals are required by federal law to offer emergency care 24-hours, 7 days a week. 42 C.F.R. §485.618; Medicare Conditions of Participation require hospitals to “meet the emergency needs of patients in accordance with acceptable standards of practice.” 42 C.F.R. §485.55.

¹¹ See Burley, 2011, p. 8.

emergency department” to any patient who comes to the emergency department. 42 U.S.C. § 1395dd(a). The purpose of the medical screening examination is to determine “whether or not an emergency medical condition . . . exists.” *Id.* If an emergency medical condition is determined to exist, the hospital is required to: (i) provide any necessary medical examination and treatment within the capabilities of the staff and facilities available at the hospital, as required to stabilize the medical condition; or (ii) arrange for an appropriate transfer of the individual to another medical facility provided certain additional conditions are met. 42 U.S.C. § 1395dd(b).

Under the EMTALA regulations, a hospital’s obligation to provide a medical screening examination to determine whether a patient who has come to the emergency department has an emergency medical condition includes the obligation to identify and evaluate psychiatric conditions. “Emergency medical condition” is defined as:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, **psychiatric disturbances** and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily function; or (iii) serious dysfunction of any bodily organ or part

42 C.F.R. § 489.24(b). (Emphasis added.) The EMTALA *Interpretive Guidelines*¹² explain:

In the case of psychiatric emergencies, if an individual expressing suicidal or homicidal thoughts or gestures or if determined dangerous to self or others would be considered to have an [Emergency Medical Condition].

¹² Found in Appendix V of CMS State Operations Manual available at http://www.cms.gov/manuals/Downloads/som107ap_v_emerg.pdf

A hospital's obligation to screen for emergency psychiatric conditions is based on the staff and facilities available at the hospital. 42 U.S.C. § 1395dd(b)(1)(A). A hospital must provide an appropriate medical screening examination "within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department." 42 C.F.R. 489.24(a)(ii). The "capability" of each hospital's emergency department to screen for and treat emergency psychiatric conditions depends on whether the hospital provides specialized services such as psychiatry. If a hospital does not offer psychiatric treatment and has no psychiatrists, psychologists or mental health professionals on staff, it has no duty to provide a mental health screening examination. *Baker v. Adventist Health Inc.*, 260 F.3d 987 (9th Cir. 2001). Under those circumstances, a hospital may seek an evaluation by a designated mental health professional to screen a patient for a psychiatric emergency medical condition. *Id.*¹³

The screening obligation under EMTALA is generally consistent with the requirements of the ITA. Under the ITA, a person who may be suffering from a mental illness can be taken to a hospital for observation and treatment and, if necessary, referred to a designated mental health professional "to authorize such person being further held in custody or transported to an evaluation treatment center." RCW 71.05.050; *In re Detention of C.W.*, 147 Wn.2d 259, 271 (2002).

Under the ITA, hospital professional staff determine whether an

¹³ The Washington statutory scheme now contemplates two-way communication between the emergency room physician and the designated mental health professional. Under RCW 71.05.154, a designated mental health professional must consult with any examining emergency room physician and take serious consideration of the emergency room physician's observations and opinions in determining whether detention is appropriate.

evaluation by a mental health professional is required. RCW 71.05.150. To comply with EMTALA, such a determination is ideally part of a medical screening examination to determine whether an emergency medical condition exists. Regardless of whether a hospital uses its own personnel or a designated mental health professional, once a determination is made that a patient has an emergency medical condition, the hospital must provide treatment to stabilize the patient's emergency medical condition within its capability and capacity. 45 C.F.R. 489.24(a)(ii). A hospital may transfer the patient to another hospital or treatment facility only if the patient is stabilized or if the hospital does not have the capability or capacity to provide the treatment necessary to stabilize the emergency medical condition (or the capability or capacity to admit the individual). 42 C.F.R. 489.24(d). An appropriate transfer under EMTALA requires, among other things, that the receiving facility must have available space and qualified personnel for the treatment of the individual and have agreed to accept the transfer of the individual and provide appropriate medical treatment. 42 C.F.R. 489.24(e).¹⁴ When there is no bed available in a certified E&T Facility for an individual with a psychiatric emergency medical condition, a hospital that does not have the capacity or the capability to treat the psychiatric condition may be prevented from arranging an appropriate transfer, leading to the situation in which a patient is "boarded" in the hospital emergency department until

¹⁴ There are four requirements for an appropriate transfer: (1) the transferring hospital must provide medical treatment within its capacity and capabilities that minimize the risk to the individual's health; (2) the receiving facility must have available space and qualified personnel for the treatment of the individual and have agreed to accept the transfer of the individual and provide appropriate medical treatment; (3) the transferring hospital sends the receiving facility all the medical records related to the emergency medical condition at the time of transfer; and (4) the transfer is effected through qualified personnel and transportation equipment as required including the use of necessary and medically appropriate life support measures during the transfer.

an appropriate transfer can be arranged.

As described below, typically a patient in this circumstance receives care to keep them safe and to prevent them from harming themselves or others. However, this is not individualized treatment for the mental illness and typically involves sedation, restraint and guarding. Notwithstanding EMTALA's requirements regarding the circumstances in which a patient with an emergency medical condition may be transferred to another facility, there is nothing in EMTALA that either requires or permits a hospital to detain a patient involuntarily. Those issues are generally left to state law.

C. **“Psychiatric Boarding” Harms the Detained Patients, Other Patients, Physicians, Nurses and Hospitals**

1. **Psychiatric Patients Involuntarily Detained in Emergency Rooms Generally Receive Limited Care in a Nontherapeutic Environment**

Many emergency departments are poorly equipped to deal with mental health needs of psychiatric patients. They do not have the resources to provide psychiatric services to patients. Leslie S. Zun, *Pitfalls in the Care of Psychiatric Patients in the Emergency Department*, J. Emerg. Med. 2012 43(5)(29-835) (hereinafter cited as “*Pitfalls in the Care of Psychiatric Patients*”). Unless operating a certified E&T Facility, most acute care hospitals, and particularly their emergency departments, are not equipped to properly manage the full range of care and services which would ordinarily be afforded mental health patients in a certified E&T Facility. Among other things, a certified E&T Facility must be able to provide a psychosocial evaluation by a mental health professional (WAC 388-865-0541), a plan of care/treatment, including daily contact by a mental health professional (WAC 388-865-0547), and clinical

supervisors who are mental health professionals or specialists (WAC 388-865-0551). Hospitals that do not have a psychiatric unit—and even those that do, but the units are full—simply are not able to provide patients with direct access to mental health professionals that a certified E&T Facility can and must provide. Although 90 of the 98 WSHA member hospitals have emergency departments, half of Washington’s hospitals are small, rural hospitals with very limited staffing—39 of Washington’s hospitals are critical access hospitals with fewer than 25 beds. While it is possible in larger hospitals to have someone on staff with some expertise in psychiatric care, it is very unlikely with the limited staff in these small rural hospitals, most of whom are generalists, to find someone with psychiatric expertise.

Even if hospitals have psychiatrists, psychiatric advanced registered nurse practitioners or other mental health professionals on staff, the other members of the emergency department team are not necessarily prepared to deal with mental health patients. They are educated to deal with patients in crisis, not provide ongoing therapeutic care. Emergency physicians and nurses are often not trained in psychiatry and their mental health training and skills are focused on initial diagnosis, care for related medical issues, and emergent intervention such as sedation or restraint. B.A. Nicks and D.M. Manthey, *The Impact of Psychiatric Patient Boarding in Emergency Departments*, 2012 *Emergency Medicine International* (Article ID 360308) p. 2 (hereinafter cited as “*Impact of Psychiatric Patient Boarding*”). The fact emergency physicians take psychiatry courses during medical school and have been exposed to psychiatric patients as emergency room physicians does not give them any material expertise in psychiatry. See, *Baker v. Adventist*, 260 F.3d 987,

994 (2001). This lack of educational preparation causes emergency physicians and nurses to commonly perceive themselves as lacking in knowledge, skills and expertise to provide appropriate care and treatment to the detained long-term psychiatric patients beyond initial stabilization. Anne Manton, *Care of the Psychiatric Patient in the Emergency Department*, Emergency Nurses Association (2013) p. 2 (hereinafter cited as “*Care of the Psychiatric Patient*”).¹⁵

When staff does not have the necessary psychiatric education and expertise, psychiatric patients often do not receive definitive psychiatric intervention, and the only medications they receive are for treatment of agitation. *Pitfalls in the Care of Psychiatric Patients*. The use of seclusion, restraint, or forced medication intended to calm the agitated patient has the potential for harmful side-effects, both physical and psychological. *Care of the Psychiatric Patient*, p. 7. Rather than provide ongoing treatment, the primary goal in many emergency departments is to keep psychiatric patients safe—to ensure they do not harm themselves or anyone else—until they can be moved to an appropriate facility to receive the definitive mental health treatment they require. *See Impact of Psychiatric Patient Boarding*, p. 2. This means the patients are not receiving the “adequate care and individualized treatment” to which they are entitled under the ITA. RCW 71.05.360(2).

In addition to the absence of the full range of mental health services that would be available in a certified E&T Facility, hospitals in general, and emergency departments in particular, and are not designed to safely house and care for mental health patients. Hospital emergency

¹⁵ Accessed May 21 at <http://www.ena.org/practice-research/research/Documents/WhitePaperCareofPsych.pdf>

departments are designed to perform emergency triage and medical screening exams twenty-four hours a day. *See* WAC 246-320-281. They provide initial treatment for emergency medical conditions—screening and stabilization—then either discharge the patient, or admit the patient to the hospital to be cared for by a team of specialists, or transfer the patient to a facility that is designed to provide the specific type of treatment the patient requires. This is the pattern of care for all kinds of medical emergencies—heart attacks, pneumonia, gunshot wounds, and psychiatric care, for example. Given the breadth of services delivered in emergency departments, there are often medical instruments or other objects in treatment rooms that are unsafe for psychiatric patients, in contrast to an E&T Facility that removes such dangers, including items as simple as a telephone cord which could be used by patients to hang themselves.

Emergency departments generally do not provide care to patients for days or long periods of time. While emergency department physicians and nurses do their best to care for detained psychiatric patients, emergency departments are not structured or designed to provide ongoing services. They have neither the physical layout nor the staff to provide the services of a certified E&T facility and therefore are destined to fail to fully meet the therapeutic needs of detained patients.

By its very nature, the emergency department environment hinders the ability to provide quality care to psychiatric patients in crisis. *See, Care of the Psychiatric Patient* at 9. “Emergency rooms are generally loud, hectic environments that are poorly suited to deescalating a mental health crisis.” V. Alakeson, N. Pande, and M. Ludwig, “*A Plan to Reduce Emergency Room ‘Boarding’ of Psychiatric Patients*” *Health Affairs* 29, No. 9 (2010); 1637-1642 (hereinafter cited as “*Reducing ‘Boarding’ of*

Psychiatric Patients”). The noise and stimuli from a busy emergency department can increase patient anxiety and agitation, which is potentially harmful for both patients and staff. *Impact of Psychiatric Patient Boarding*. Patients requiring psychiatric care are optimally assessed and treated in safe, quiet, calm areas, not the “hurried, chaotic environment that is characteristic of most emergency departments.” *Id.* In contrast to a hospital emergency department, a certified E&T Facility provides an environment in which patients can receive the “prompt evaluation and timely and appropriate treatment” to which they are entitled. RCW 71.05.010.

The conclusion in the Superior Court’s Declaratory Order that “[t]he facilities to which the respondents were initially detained on single bed certifications in these matters were more restrictive environments which did not provide them counseling or therapeutic support” is consistent with the findings of the numerous studies regarding psychiatric patients detained in emergency departments. Such patients detained in the general wards of hospitals and particularly in hospital emergency departments, generally are not provided with “care and treatment adequate to meet their mental health care needs.”

2. The Presence of Involuntarily Detained Patients in Emergency Rooms Diverts Staff and Resources, Negatively Impacting Other Patients, Nurses and Physicians

Not only do patients involuntarily detained in emergency departments not get the individualized, therapeutic care they are required to receive under the ITA, but the presence of involuntarily detained patients in hospital emergency departments diverts staff and resources, reducing the care available for other emergency patients.

A place must be found to keep detained patients, often within the

emergency department. The location must assure the safety of the patient, staff and other patients while still maintaining necessary flows of staff and patients. Detained patients are often restricted to their beds or placed in a locked section of the hospital. *See, In re. Det. C.W.*, 147 Wn.2d 259, 273 (2002). Staff must be assigned to monitor detained patients, typically requiring one-to-one, around the clock care. This is generally not the care model in a hospital and takes providers away from other patients. Monitoring may include safety attendants or security officers as a safety measure to protect staff and patients.

Forty-two of Washington's hospitals operate as public hospital districts, a form of local government. The intensive staff requirements for taking care of a boarded psychiatric patient are essentially a drain on the resources of a local government. Small rural hospitals, with very limited staff, are particularly challenged to meet the intensive staff requirements for taking care of boarded psychiatric patients. They also are less likely to have a safe space to put a patient who needs psychiatric care and for whom a normal hospital room can be hazardous.

The beds or rooms used by detained patients reduce emergency department capacity, leading to longer wait times and patient frustration. *Impact of Psychiatric Patient Boarding*. Emergency department crowding, lack of available emergency beds, and patients leaving without being seen, all which may be caused or increased by involuntarily detained patients, have been associated with poor clinical outcomes for other emergency department patients including increased risk of morbidity or mortality, an increased door-to-needle time delay for treatment of patients with suspected acute myocardial infarction and poorer performance on pneumonia quality of care measures. *Id.* at p. 3. An overwhelming 84%

of emergency physicians report that psychiatric patients are being “boarded” in their emergency department, with nine in ten (91%) saying this practice has led to harm (violent behavior, staff distractions, and tied-up beds) to other patients or emergency staff.¹⁶

Due to already high patient volumes and crowding in emergency departments, emergency nurses particularly feel the strain of involuntarily detained patients. Psychiatric patients intensify high stress situations for nursing staff, which may be exacerbated by negative attitudes and safety concerns. *See Care of the Psychiatric Patient*, p 3. These safety concerns are very real given that a detained patient, by definition, has been found to present either an “imminent likelihood of serious harm” or an “imminent danger.” RCW 71.05.050. Violence against emergency nurses is highly prevalent. Jessica Gacki-Smith, et al., *Violence Against Nurses Working US Emergency Departments*, 39 *Journal of Nursing Administration* (August 2009). Among the most important factors identified as being related to frequent physical violence experiences were care of psychiatric patients, crowding, and boarding patients. *Id.* Emergency nurses, along with nurses in other parts of the hospital, are not necessarily educationally or experientially prepared to deal with aggressive or violent detained patients, which can undermine their confidence and their ability to provide effective, empathic care to detained patients. *Care of the Psychiatric Patient* p. 9.

3. Single Bed Certifications are Inherently Inconsistent With Hospital Licensing Requirements

Under WAC 388-865-0526 an adult on a 72- hour detention or 14-

¹⁶ 2014 ACEP Polling Survey Results, prepared for the American College of Emergency Physicians. April 2014. Available at: <http://newsroom.acep.org/ACEP-Emergency-Visits-Up-Since-Implementation-of-ACA> accessed on May 21, 2014.

day commitment may be treated in a facility that is not otherwise certified under WAC 388-865-0500, if that facility receives a single bed certification. In addition to the how the unilateral imposition of single bed certifications affects hospitals, as described by Intervenors/Respondents Multicare Health System and Franciscan Health System, Brief of Intervenors/Respondents Multicare Health System and Franciscan Health System at p. 22, single-bed certifications pose a potential licensing concern for hospitals.¹⁷

Hospitals providing psychiatric services are required to meet the specific licensing requirements for those services. WAC 246-320-271. “Psychiatric Service” means “the treatment of patients pertinent to a psychiatric diagnosis.” WAC 246-320-010(54). A single bed certification, is “to allow treatment to an adult on a seventy-two hour detention or fourteen-day commitment” (WAC 388-865-0526), which by definition is “treatment of patients pertinent to a psychiatric diagnosis.” The issue is whether a hospital providing care under one or more single-bed certification(s) is doing so in accordance with hospital licensing.

If a hospital provides psychiatric services, it must comply with the requirements of WAC 246-320-271. These include that services be provided according to WAC 246-322-170¹⁸ which, among other things, requires the availability of a psychiatrist for consults daily and a full time psychiatric nurse supervising nursing services twenty-four hours per day. As described above, many hospitals do not have such services available, and almost none have such services available in their emergency

¹⁷ *Amici* fully agree with the argument beginning at page 31 of the brief of Intervenors/Respondents that WAC 388-865-0526 was never intended to address overcrowding of certified evaluation and treatment facilities.

¹⁸ Chapter 246-322 WAC sets forth the regulations applicable to private psychiatric and alcoholism hospitals.

departments. Other requirements under WAC 246-320-271 are equally challenging for hospitals to meet. For example, hospital emergency departments are not designed to assure privacy during “social activities,” or to provide or have access to at least one seclusion room. There is no mechanism to reconcile the imposition of a single bed certification on a hospital and the potential citation by the Department of Health for failure to comply with hospital licensing requirements when offering psychiatric services.

In short, detaining psychiatric patients in emergency departments pursuant to single bed certifications creates a lose-lose situation. The detained patients do not receive the care to which they are entitled and are kept in an environment which is the antithesis of beneficial. Their presence contributes to overcrowding in the emergency department which leads to less timely care and may negatively impact the outcomes for other emergency department patients. It also increases the workload and safety concerns of emergency nurses, contributing to overall stress and tension for staff and other patients. And it raises concerns for both emergency room physicians and hospitals.

The circumstances in which a psychiatric patient is permitted to be involuntarily detained in a hospital should be limited to the initial detention for up to six hours as provided in RCW 71.05.050, or if a patient admitted to a certified E&T Facility is determined to have a physical condition requiring care from an inpatient hospital, in which case the E&T Facility may transfer the patient to a hospital to receive medical treatment for the physical condition as provided in RCW 71.05.210.

IV. CONCLUSION

Hospital emergency departments are not designed to provide the

services of certified E&T Facilities. Years of state budget cuts do not justify the serious deprivation of personal liberty of patients who are involuntarily detained and boarded in hospitals or emergency departments and do not receive the individualized evaluation and treatment to which they are entitled. Nor does inadequate state funding provide a reasonable rationale for the adverse impact on other emergency department patients, emergency physicians, nurses and other emergency department and hospital staff that result from court ordered detention of individuals in hospital emergency departments. The Superior Court's Declaratory Order was correct and should be upheld.

RESPECTFULLY SUBMITTED this 23rd day of May, 2014.

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CERTIFICATE OF SERVICE

I hereby certify that on this 23rd day of May, 2014, I caused the foregoing pleading to be filed via email with the Clerk of the Supreme Court, a true and correct copy of the same to be delivered via email and via US First Class Mail, to the following counsel of record:

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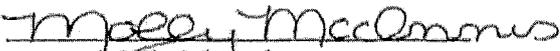
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Counsel,

Attached please find the following:

- 1) Motion for Leave to File Brief of *Amici Curiae* Washington State Hospital Association, Assn of Washington Public Hospital Districts, Washington State Medical Assn, Washington Chapter of the American College of Emergency Physicians, Northwest Organization of Nurse Executives, Washington State Nurses Assn, SEIU Healthcare 1199NW and Washington Council of Emergency Nurse Assn; and
- 2) Brief of *Amici Curiae* Washington State Hospital Association, Assn of Washington Public Hospital Districts, Washington State Medical Assn, Washington Chapter of the American College of Emergency Physicians, Northwest Organization of Nurse Executives, Washington State Nurses Assn, SEIU Healthcare 1199NW and Washington Council of Emergency Nurse Assn.

Hard copies will follow via U.S. Mail.

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