Psychiatric Boarding in Washington State and the Inadequacy of Mental Health Resources

Joseph D. Bloom, MD

Psychiatric boarding is a term derived from emergency medicine that describes the holding of patients deemed in need of hospitalization in emergency departments for extended periods because psychiatric beds are not available. Such boarding has occurred for many years in the shadows of mental health care as both inpatient beds and community services have decreased. This article focuses on a 2014 Washington State Supreme Court decision that examined the interpretation of certain sections of the Washington state civil commitment statute that had been used to justify the extended boarding of detained psychiatric patients in general hospital emergency departments. The impact of this decision on the state of Washington should be significant and could spark a national debate about the negative impacts of psychiatric boarding on patients and on the nation's general hospital emergency services.

J Am Acad Psychiatry Law 43:218–22, 2015

Psychiatric boarding is a term derived from the experiences of emergency medicine departments. Boarding occurs when a patient is held in the emergency department for an extended period after a decision is made regarding disposition of the case. The term applies specifically to the delay in transfer of psychiatric patients when there are no voluntary or involuntary psychiatric beds available in psychiatric facilities. It applies to both voluntary and involuntary psychiatric patients who are kept in emergency departments for long periods. There are no well-designed, comprehensive reviews of psychiatric boarding. However, it appears that psychiatric boarding is practiced in differing degrees across the country. It affects all age groups, but may be most acute in adolescent populations for whom services are less available than for adult psychiatric patients.[1] Psychiatric boarding in turn compromises the efficiency of emergency services and creates significant hardships for both psychiatric and nonpsychiatric patients.[2]

Dr. Bloom is Professor Emeritus, Department of Psychiatry, School of Medicine, Oregon Health and Science University, Portland, OR. Address correspondence to: Joseph D. Bloom, MD, Department of Psychiatry, School of Medicine, Oregon Health and Science University, 3181 SW Sam Jackson Park Rd., Portland, OR 97201. E-mail: bloomj@ohsu.edu.

Disclosures of financial or other potential conflicts of interest: None.

On August 7, 2014, the Washington State Supreme Court, *en banc*, decided the case of *In re the Detention of D.W. et al.*[3] In this decision, the court struck down the interpretation of a component of the civil commitment statute that had been used by Washington's Department of Social and Health Services (DSHS) to justify the psychiatric boarding of a large number of involuntary patients in general hospital emergency departments in the state. The basic problem was that the number of appropriate beds available fell short of the need. As is illustrated in this case, the shortage of appropriate beds for psychiatric patients either in general hospital psychiatric units or at state hospitals is the root cause of psychiatric boarding.[4–6] In this article, I discuss the Supreme Court's decision and the problem of psychiatric boarding in a larger context.

Washington's Involuntary Treatment Act

The Washington State Institute for Public Policy (WSIPP) was created in 1983 by the Washington Legislature to conduct nonpartisan research at the direction of the legislature or of WSIPP's Board of Directors.[7] The Board is composed of legislators, representatives of the governor's office and Washington's public universities. In 2011, WSIPP published a report assessing the impact on the Involuntary Treatment Act (ITA)[8] of legislative changes enacted

in 2010.[9] These changes expanded the scope of information and records available to investigators who are charged with making detention decisions under the ITA.[10] Because of these 2010 changes to the ITA, the WSIPP report predicted the need for additional psychiatric beds in the state.

Once patients are detained under the ITA for "evaluation and treatment," they are to be held in "certified evaluation and treatment facilities."[11] Based on the 2010 changes to the ITA, the WSIPP report (Ref. 9, p 1) estimated that the rate of civil commitment among all ITA investigations in the state would increase from 40 to 45 to 55 percent, and this increase would produce an estimated need for 23 to 54 new adult psychiatric beds at short-term evaluation and treatment facilities. In addition, the report predicted that there would be a need for an additional 19 to 114 psychiatric beds at state or community hospitals.

In 2014, before the Supreme Court decision, the *Seattle Times* published an article focused on psychiatric boarding and the background to the lawsuit.[12] Using statistics derived from several sources including WSIPP, the article demonstrated that the WSIPP predictions had been realized. The article stated that in 2009, 425 (18%) of 2,367 individuals detained under the ITA experienced psychiatric boarding. By 2012, 2,160 (64%) of the 3,401 detained persons experienced psychiatric boarding. During this same period the number of psychiatric beds in Washington certified to admit and treat ITA patients had decreased from 1,759 to 1,507, a loss of 252 beds. According to the article, the average length of boarding increased from 2.5 days in 2009 to 3.1 days in 2012. In 2009, the longest duration for boarding a patient was 23 days, compared with 100 days in 2012. On a regional basis within the state, there were different findings, depending on the resources available to a specific county.

The Washington State Supreme Court Decision

The case of *In re the Detention of D.W. et al.*[3] was initially brought by 10 patients involuntarily boarded under the ITA in Pierce County, Washington. The trial court in Pierce County found that the prolonged detention of these patients was unlawful, and the case was appealed to the Washington Supreme Court.

The heart of the August 7, 2014, Supreme Court decision focused directly on certain provisions of the ITA. The state's DSHS had been faced with an increasing number of involuntary patients and an inadequate number of beds in certified evaluation and treatment facilities. DSHS found a solution to this problem in a section of the ITA which provides for the transfer of detained individuals to a chemical dependency facility or to a hospital if the physical condition of the patient requires immediate medical care.[13] This section of the law, as interpreted in state administrative rules, allowed for the creation of a single-bed certification[14] that would permit transfer of the patient to a specific facility and for specific reasons. This administrative rule requires that, to be eligible for single-bed certification, the person must be in need of services not provided by a certified treatment facility or that the person's transfer would facilitate "continuity of care, consistent with the consumer's individual treatment needs" (Ref. 14, p 1).

A unique interpretation of statute and of this administrative rule provided DSHS with a means to issue single-bed certifications based on a specific request detailing that the person meets one of the two criteria. The use of these single-bed certifications formed the basis of how the State of Washington managed the problem of too many detainees and too few certified beds. Testimony reviewed by the Supreme Court in its decision reported that, when no certified evaluation and treatment beds were available, Pierce County would request a single-bed certification to detain the individual in a community hospital and fax this request to Western State Hospital. Testimony stated further that Western State Hospital "never asked why Pierce County was seeking the single-bed certification" and would "invariably approve" the request (Ref. 3, p 2). Similar procedures were followed in other areas of the state, including in King County, the site of the state's largest city, Seattle. Approval of these single-bed certifications led directly to the creation of significant psychiatric boarding in the state.

The analysis section of the decision began with review of the general principles of civil commitment law. Paragraph 8 of the decision cites various State of Washington, Ninth Circuit, and U.S. Supreme Court decisions, to provide a short, cogent statement of the purpose and limitations of civil commitment statutes. Citing the Ninth Circuit Court of Appeals case of *Oregon Advocacy Center v. Mink,*[15] the deci-

sion declared that a lack of funds, staff, or facilities do not justify the lack of treatment needed for rehabilitation. The Washington decision stated: "Patients may not be warehoused without treatment because of lack of funds" (Ref. 3, p 2). The court declared that there is a state interest in the treatment of persons with mental illness and in the protection of society. However, once detained, individuals have a right to treatment that will provide them an opportunity to improve.

The court concluded that the Washington ITA embraces all of the principles embodied in the purposes and limitations of civil commitment law nationally and that the ITA "also repeatedly provides that those involuntarily detained for evaluation, stabilization, and treatment are to be held in certified evaluation and treatment facilities" (Ref. 3, pp 2–3).

The court then focused on what was ultimately the central issue in the case: the use of single-bed certification as a means of detaining individuals while they are awaiting a bed in a certified evaluation and treatment facility. The court found that DSHS's interpretation of single-bed certification did not fall within the definitions provided in the ITA or in the administrative rule. Based on this finding, the Washington Supreme Court found no justification for the use of single-bed certification as it was used in Pierce County and, by extension, in other counties in Washington. The court ordered this particular use of single-bed certification to end on August 27, 2014, some 20 days after the decision was rendered.

Following the decision, concerns were raised about the August 27 deadline by DSHS and by the state's general hospitals and emergency department physicians. The state government was faced with the challenge of developing an adequate number of certified evaluation and treatment beds in 20 days. The community hospitals, their emergency departments,[16] and the physicians were very concerned about conflicts generated by their legal and professional duties to patients with mental illness. They especially did not want to release unstable patients into the community without treatment.

On August 22, 2014, the State of Washington, the intervener/respondents (the two affected health systems) and the *amici* filed a joint motion[17] that asked the Washington State Supreme Court to delay the issuance of the mandate to implement the decision for 120 days until December 26, 2014. The motion argued that more time was needed to increase the number of available beds and that, without it, patients in need of the protection of the ITA would have to be released without the necessary treatment. This situation in turn would force the hospitals into a direct conflict between the requirements of the ITA and the requirements of the Emergency Medical Treatment and Active Labor Act.[18] On September 4, 2014, the Supreme Court granted the state's request for a 3-month stay.[19] On December 26, psychiatric boarding based on single-bed certification ended.

In June 2014, the Washington State Legislature, obviously aware of the matter before the Supreme Court, directed the WSIPP to study the state's crisis mental health and involuntary treatment services. In January of 2015 WSIPP issued a report entitled Inpatient Psychiatric Capacity and Utilization in Washington State.[20] In addition to reiterating the findings of the 2011 WSIPP study,[9] the report noted that there were 819 total adult psychiatric beds in the state in 2014, compared with 660 in 2013, a gain of 159 beds in 2014. These new beds were divided among three different types of psychiatric facility: 22 in facilities accepting voluntary psychiatric admissions, 89 in facilities certified to manage ITA admissions, and 48 in freestanding evaluation and treatment facilities (Ref. 20, p 15). The WSIPP agenda for future work includes an examination of the impact of these changes on the state as a whole and on various regions of the state (Ref. 20, pp 15–16).

Discussion

The importance of *In re the Detention of D.W. et al.*[3] may lie less in the details of the case and more in the fact that the Washington Supreme Court delivered a significant decision on a topic that has existed for many years in the shadows of mental health care. Psychiatric boarding has been a commonplace occurrence for years, and the impact has been felt by the general hospitals and by the patients seeking access to care through the nation's emergency departments.[4]

Although narrowly based, the Washington State Supreme Court's decision should have important implications for the care of mentally ill individuals in the state, but it also may be influential on the national stage. There were two *amicus* briefs in the case that supported the patients who had experienced prolonged boarding in Pierce County. The first was submitted by the Washington State Hospital Association. It included as cosigners the Washington State Medical Association, the local chapter of the Ameri-

can College of Emergency Physicians, the Association of Washington Public Hospital Districts, the Washington State Nurses Association, several other nursing organizations, and the powerful Service Employees International Union (SEIU).[21] A second *amicus* brief[22] was submitted by Disability Rights Washington, the Washington Chapter of the National Alliance on Mental Illness, and the American Civil Liberties Union (ACLU). These are local chapters of influential national organizations representing hospital and physician perspectives and organizations dedicated to patient rights, and their national reach is significant. The Washington Supreme Court decision could have ramifications in other states.[23]

Several of the involved organizations heralded the decision as the end of psychiatric boarding in the state of Washington. However, it is probably premature to make this claim. The court's decision did not end psychiatric boarding. We do not know if other categories of patients are subject to psychiatric boarding in Washington, but it is very possible that they are. In Oregon, for example, in addition to problems with the implementation of the civil commitment statute,[24] there is an unspecified number of voluntary patients who wait in emergency departments for hours to days for an open bed to become available in any general hospital psychiatric unit anywhere in the state.[25,26] These patients are also experiencing a cruel version of psychiatric boarding. We do know that sending patients to an open bed anywhere in a state violates many of the principles of community mental health care that psychiatrists have subscribed to for decades.[27]

In addition to the potential for continued psychiatric boarding in the State of Washington, there is another possible negative consequence of the Washington Supreme Court decision. We do not know if the expanded number of beds and other services now available in Washington are sufficient to meet the needs of seriously ill patients who come to or are brought to emergency departments for evaluation and treatment under the ITA. If the resources provided by the DSHS in response to this Washington Supreme Court decision are not sufficient to meet the needs of this patient population, we can hypothesize a situation in which the bar for continued hospitalization will be raised and premature discharge of patients becomes a new norm of this beleaguered system.[24]

Psychiatrists and emergency medicine physicians approach the problems of insufficient mental health services from very different perspectives. Each specialty is concerned primarily with its own traditional sphere of activity. Psychiatrists concentrate on the adequacy of hospital and community care. Although it is true that emergency department psychiatry is a growing part of psychiatric practice, most psychiatrists do not work in this setting and are not familiar with the everyday problems of emergency departments. Emergency medicine physicians work at the interface of the emergency room and the community, and they are the gatekeepers for a significant portion of both inpatient medical and psychiatric care. They work almost exclusively in a very specific setting, and from that viewpoint, they want their emergency room beds available so that they can practice medicine in a safe, secure, and nonchaotic environment. They do not shrink from taking care of psychiatric patients, but they are badly in need of relief from the larger crisis in mental health care so that they can return to the orderly practice of their medical specialty.[2]

In the end, both medical specialties agree that shortages of inpatient beds and community mental health resources result in psychiatric boarding. The recent decision by the State of Washington Supreme Court is one step taken in one state to move the state's involuntary care system in the right direction. How the decision will be implemented in the state and how it affects other states is to be observed and studied further.

References

1. Bender D, Pande N, Ludwig: A literature review: psychiatric boarding. Olympia, WA: Office of the Assistant Secretary for Planning and Evaluation. Available at http://aspe.hhs.gov/daltcp/reports/2008/PsyBdLR.pdf. Accessed October 18, 2014
2. Hirshon JM: Testimony on behalf of the American College of Emergency Physicians (ACEP). Hearings on "Where have all the patients gone? Examining the psychiatric bed shortage." Washington DC: U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, March 26, 2014. Available at https://www.acep.org/uploadedFiles/ACEP/Advocacy/federal_issues/Dr.%20Hirshon%20Written%20Testimony.pdf. Accessed May 3, 2015
3. Detention of D.W. v. Department of Social and Health Services, 332 P.3d 423 (Wash. 2014)
4. Stone A, Rogers D, Kruckenberg S, *et al*: Impact of the mental healthcare delivery system on California emerging departments. West J Emerg Med 13:51–6, 2012
5. Bloom JD, Krishnan B, Lockey C: The majority of inpatient psychiatric beds should not be appropriated by the forensic system. J Am Acad Psychiatry Law 36:438-42, 2008

6. Torrey EF, Fuller DA, Geller J, *et al*: No room at the inn, trends and consequences of closing public psychiatric hospitals, 2005–2010. Arlington, VA: Treatment Advocacy Center, July 19, 2012. Available at http://tacreports.org/storage/documents/no_room_at_the_inn-2012.pdf. Accessed October 29, 2014
7. General Information. Olympia, WA: Washington State Institute for Public Policy. Available at http://www.wsipp.wa.gov/about. Accessed January 30, 2015
8. Wash. Rev. Code § 71.05 (2014). Available at http://apps.leg.wa.gov/rcw/default.aspx?cite=71.05. Accessed October 19, 2014
9. Burley M: How will 2010 changes to Washington's Involuntary Treatment Act impact inpatient treatment capacity? Document No. 11-07-3401. Olympia, WA: Washington State Institute for Public Policy, 2011. Accessed January 29, 2015
10. Wash. Rev. Code § 71.05.212 (2015) and § 71.05.245 (2015)
11. Wash. Rev. Code § 71.05.150(4) (2014)
12. Rosenthal BM: "Boarding" mentally ill becoming epidemic in state. Seattle Times. October 4, 2013. Updated June 13, 2014. Available at http://seattletimes.com/html/localnews/2021968893_psychiatricboardingxml.html. Accessed February 18, 2015
13. Wash. Rev. Code § 71.05.210 (2014)
14. Wash. Admin. Code § 388-865-0526 (2014)
15. Oregon Advocacy Center v. Mink, 322 F.3d 1101 (9th Cir. 2003)
16. Kutscher B: Hospitals in Washington state can't board psych patients in EDs, but where will they go? Modern Healthcare. Available at http://www.modernhealthcare.com/article/20140818/NEWS/308189940. Accessed May 3, 2015
17. Joint Motion to Stay Issuance of Mandate, In re the Detention of D.W. v. Department of Social and Health Services, No. 90110-4 (Wash. August 7, 2014)
18. Emergency Medicine Treatment and Labor Act, 1986. Baltimore, MD: Centers for Medicare and Medicaid Services, 2012. Available at https://www.cms.gov/regulations-and-guidance/legislation/EMTALA/index.html?redirect=/emtala/. Accessed February 20, 2015
19. In re Det. of D.W., 2014 Wash. LEXIS 751 (Wash. Sept. 4, 2014)
20. Burley M, Scott A: Inpatient psychiatric capacity and utilization in Washington State. Document No. 15-0104102. Olympia, WA: Washington State Institute for Public Policy, Revised February 20, 2015
21. Brief of Amici Curiae Washington State Hospital Association et al. In re Det. of D.W. Supreme Court No. 90110–4, filed May 23, 2014. Available at http://www.wsha.org/files/Brief%20of%20Amici%20Curiae%20Washington%20State%20Hospital%20Association%20et%20al%20.pdf. Accessed May 3, 2015
22. Press release: WA Supreme Court rules "psychiatric boarding" is illegal. August 7, 2014. Seattle: Disability Rights Washington. Available at www.disabilityrightswa.org/wa-supreme-court-rules-psychiatric-boarding-illegal. Accessed October 24, 2014
23. Kardish C: Mental health ruling in Washington State could reverberate through the country. New York: The Council of State Governments Justice Center, October 2, 2014. Available at http:governing.com/topics/health-human-services/gov-washington-boarding-ruling.html. Accessed October 14, 2014
24. Bloom JD: Civil commitment is disappearing in Oregon. J Am Acad Psychiatry Law 34:534–7, 2006
25. Meieran S: 'Boarding' psychiatric patients in emergency departments is barbaric: Guest opinion, The Oregonian, February 22, 2014. Available at http://www.oregonlive.com/opinion/index.ssf/2014/02/boarding_psychatric_patients_i.html. Accessed May 3, 2015
26. Jaquiss N: All stacked up and nowhere to go: psychiatric patients are being warehoused in Portland's emergency rooms in growing numbers. Willamette Week. July 16, 2014. Available at http://www.wweek.com/portland/article-22806-all_stacked_up_and_no_place_to_go.html. Accessed August 26, 2014
27. Caplan G: Principles of Preventive Psychiatry. Basic Books, Inc: New York, 1964