

**OUT OF COUNTY PLACEMENTS  
STATE PATIENTS' RIGHTS TRAINING 2003  
HOLIDAY INN, CAPITOL PLAZA, SACRAMENTO  
OCTOBER 17, 3:15 - 5:15 p.m.**

**Presenters: Janet Marshall Wilson, J.D., Program Director, Contra Costa County Patients' Rights**

Janet has worked in the area of Mental Health Patients' Rights since 1982, except for a brief time when she did refugee rights advocacy, among other things. Janet has been the Program Director for Contra Costa Patients' Rights for 8 years, and had the directorship of Solano County Patients' Rights for several years concurrently, as well. One county is largely a placing county, and the other largely a host county. Janet's siblings have had serious issues with out of county placement, as has Janet. Janet has presented two monitoring workshops at different state trainings, as well as the training for new advocates one year. Her staff reminds her of her introductory words: "I come from a long line of teachers."

**Pamela Wycoff, Acting Administrator, Crestwood Behavioral Health**

Pamela Wycoff has been a provider of mental health care for the past 21 years. She has 6 years experience working at Napa State Hospital in acute care receiving, and 17 years of supervisory experience. Pam has been an employee of Crestwood Behavioral Health [a corporation with many long-term facilities throughout California] for the past 9 years, where she has held positions of Charge Nurse, Program Director, and, currently, Acting Administrator. The Crestwoods present a host of out of county placement issues on the long-term level. Pam has

participated in presentations in Pleasant Hill, Ca in an educational forum on "The Faces Behind Mental Illness;" in Atlanta, Georgia to the International Association of Psychosocial Rehabilitation [and in New York City to the World Association of Psychiatric Rehabilitation] both on "Fighting Stigma: A Grassroots Community Approach."

**Michael Hansen, Program Director, Napa/Solano Patients' Rights/Advocate of the Year [2001]**

Michael has over 20 years experience working with people with developmental and psychiatric disabilities. In addition to his duties as Program Director for two counties [Napa/Solano], he is the current director of another nonprofit: Bayberry, Inc. , where he is responsible for respite/supportive living and early prevention programs for developmentally disabled clients. At Bayberry, he also oversees 3 mental health programs for SED children and their families. Michael is the former chair and vice-chair of the Napa County Mental Health Board and for several years has been the Patients' Rights liaison to the full Solano County Mental Health Board, where he is also a member of the Adult/Children Committee. He has been a founding member of the Napa County Elder Abuse Task Force and last year was recognized by the State Legislature for Outstanding Volunteer Service for Napa County Elder Abuse Task Force. Michael is IABA/ADHD certified. His Patients' Rights responsibilities include advocacy at three Crestwood facilities [long-term].

## I. Threshold Issues

A. **Client Issues:** moved far away from family and friends; visitors limited; money for telephone contact limited; poor to no medical care in long-term and residential facilities; not a welcome wagon when clients return home.

B. **Family Issues:** even when family/friends wish to visit, visits are difficult due to transportation expense, bridge fare, very lengthy drives without the funds to stay over in a motel. For many elderly family members, driving is limited if possible at all. There is no private place to visit unless the client can go out on pass. There is no communication with the facility to know what is acceptable to bring. There is lack of input into family member's care.

### C. County Issues:

1. **Host County:** takes on responsibilities of community and consumers. The host county takes on all responsibility and may have little authority. The host county facility does, though, have more control over areas such as choosing psychiatrists.

2. **Placing County:** Can't easily be involved in consumer care. It is extremely difficult to negotiate pharmacy, labs, medical care. When someone has private insurance, it is even more difficult to get HMO authorizations so people can get a full range of services. When consumers are out of county and need to be hospitalized [medically or psychiatrically], then legally, if conserved, can bring back to home county if a bed is available. If not, must rely on hospitals the county does not have relationships with. The further away, the more difficult it becomes. For any problem in a facility [real or perceived], it

takes time for an investigation to make consumers feel safe and comfortable. In the consumer's own county, there is a better likelihood of resolving administrative and clinical issues - a better ability to manage.

**D. Facility Issues:** Dealing with conservators/mental health division administrations/families in counties, some very far away. There is the need to make every effort to keep the family connected, including providing transportation. The facilities must deal with consumers' feelings of loss from separation from family and home. All the while, the facility is still under the jurisdiction of the county where facility is sited.

**E. Advocate Issues:** inconsistent training, telephone tag, unclear roles of host v. placement advocate, turf issues, priority of other issues including hearings/unavailability of time; county politics, host counties not having enough time to serve their own county's clients; EXHAUSTION.

THE FOLLOWING EXAMPLES WILL BE THE BASIS FOR A DISCUSSION ON CROSS-COUNTY ADVOCACY STRATEGIES.

## II. Acute

A. Adoptive parents [County X] of special needs child with mental and developmental disabilities [from County Y] admitted to inpatient unit in County Z 9 times in one year. He is a Regional Center client. Medi-Cal continues to be from County Y. Problems in reimbursement for inpatient hospital due to billing.

Discharged to adoptive parents, who arranged Therapeutic Behavioral Services when County Y refused to provide them. Hospital in County Z threatened to sue County Y for abandonment of child, but did not. With County Z advocate's efforts, child was represented in State Fair Hearing by PAI attorney. Results of State Fair Hearing: adoptive parents reimbursed for necessary TBS at home; brokered case management not required by hearing but County Y did provide this. PAI helped work out with all agencies who among the multiple agencies needed to do what.

B. What needs to be done to make an effective referral [1] to attorney or [2] to Protection and Advocacy, Inc?

C. With the closing of most acute psychiatric hospitals north of Sonoma County, most clients who receive inpatient psychiatric hospitalization are transferred far away. This includes John Doe, an adult from County 1 with a psychiatric disability, who has managed to maintain out of the hospital for the last 8 years. He is now involuntarily hospitalized 300 miles from home in County 2. It is very hard for him to telephone his case manager and his family/friends, and he has no visitors. He loses his Gallinot hearing because the advocate in County 2 found that family and friends were not willing to offer Third Party Assistance without seeing him first-hand at a visit. The Advocate in County 2 found that discharge planning was very difficult for the hospital for

some of these same reasons, especially telephone tag. John Doe was placed on Temporary Conservatorship and placed in a locked facility in County 3, losing his apartment where he had lived for 10 years. His dog was taken to the animal shelter. The Temporary Conservator was presented with two ambulance bills totaling \$2500.

D. Client was transferred from long-term placement in County A to acute psychiatric inpatient in county of residence [County B], due to deteriorating medical condition. At the acute care hospital no medical care was provided until much advocacy, after which client was transferred to long-term placement in third county [County C], where client still has not received recommended diagnostic tests.

### **III. Residential**

A. County 1 has inadequate number of licensed board and care placements, so on a county level it pays a large monetary "patch" for beds in adjoining County 2. This displaces the residents in County 2. Also, mental health services from the clinics in County 1 are supposed to follow these out of county placements, but the County 1 advocate receives complaints that there are little to no services. County 2 advocate receives complaints that County 1 residents lack services. County 2 mental health administrator calls County 1 advocate threatening lawsuit against County 1 for abandonment, because a County 1 client is continually accessing mental health crisis services in County 2.

B. Also, what can the advocate in County B do if client placed in a licensed residential care facility his county tells him she wants change of residence and Medi-Cal to County B? And what will

client have to do in your county, if Medi-Cal is changed, to then receive county mental health services?

#### **IV. Long-Term**

A. Client conserved in County A is placed in an IMD several counties away, in County B. Advocate's office in County B receives telephone call from frantic mother of client, who says that under the conservatorship papers her daughter retains the right to make medical decisions; that she is in a medical hospital facing surgery within 2 hours because she has consented to surgery on her infected arm. County B's advocate's office made referral to advocate assigned to the IMD as well as to the Director of the Patients' Rights office in County A. Advocate in County B was able to stop the knife, by speaking to client, who agreed with mother on wanting a second opinion and surgery [if it is to happen] in home county. Advocacy Director in County A was not available, but his secretary left a series of questions on voicemail, at about the deadline when the surgery would have occurred.

The next week, client's mother called again, saying that the father of her daughter convinced her to consent to the surgery. Mother wants close monitoring of daughter so that medical care and supervision are provided, so that her daughter does not lose her arm. She questions the ability of the IMD to take care of her daughter.

A telephone conversation between mother and Patients' Rights office in County B is interrupted by Director of Advocacy office in County A, who insists he will handle the matter. He has been non-responsive to communications re the "mutual client" since.

How is responsibility for out-of-county clients shared between the county of residence and the county of placement? Is the model of: placing county dealing with conservatorship issues and host county dealing with facility issues workable? What might be a better way of communication and working together for County A and County B advocates than what occurred in this case?

B. County B, with a long-term facility and a large licensed board and care facility, is a placement county for clients in many other counties. When the out-of-county clients at the long-term facility in County B request writs to terminate their conservatorships, what is the advocate in County B to do? What if the public defenders in the placing counties refuse to file the writs of habeas corpus for which the clients are eligible?

C. The placement committee in County H has decided to send client Jane Doe to a MHRC in a faraway county, and has told Ms. Doe that the facility is "like a large group home." Ms. Doe has just turned 18 and is quite sexually vulnerable and active. There have been recent allegations of sexual assault at this MHRC. Ms. Doe's mother contacts the Patients' Rights Office in home county [County H] questioning the placement; advocate in County H contacts advocate in host county. Advocate in host county responds with concerns about the facility, which home county advocate takes to county. A different placement is arranged.

EXAMPLES/STRATEGIES FROM THE GROUP.