May 2010

Out Of The Fog

The monthly newsletter of NAMI San Francisco
www.namisf.org

April Meeting Notes
Speaker: Barnett Levin, PhD
by Roberta Kaye

Dr. Levin is a psychologist in private practice. His specialization is in crisis intervention consultation as well as individual and family therapy for those diagnosed with a severe mental illness. Dr. Levin is also a founding member of the Mobile Crisis Team in San Francisco's Department of Mental Health. He spoke on ways to set limits without withdrawing love from one experiencing a mental health crisis, and he reviewed the criteria for satisfying the requirements of a "5150" hospitalization.

Mobile crisis intervention in San Francisco is open 7 days a week from 8:30am to 11:00pm M - F, and noon to 8:00pm on weekends and holidays. NAMI has repeatedly asked for mobile crisis hours to be expanded to 24/7 as part of the Mental Health Services Act. A crisis team responds to the need for emergency mental health evaluations performed by persons trained in psychiatry, psychology, nursing and social work, who determine whether the prospective patient's behavior satisfies the criteria for involuntary or voluntary hospitalization. Can he/she be treated on the scene and sent home with out-patient referrals? What can be done before and after the psychiatric emergency? It is the latter question that was explored in the NAMI meeting by Dr. Levin's response to vignettes presented by several family members in attendance.

Our speaker's involvement with mobile crisis started in November 1995...over 14 years ago. In his experience the San Francisco Mobile Crisis Treatment Team typically gets a call from a family, a friend, a clinic, or a residential hotel manager requesting an evaluation of someone who may be in need of hospitalization and who is ultimately a danger to self (suicidal), a danger to others (hostile or threatening), or who is "gravely disabled" (unable to provide for basic needs such as food, shelter or clothing).

Can family members set limits for one who is in a mental health crisis while, at the same time, providing love and support? The number one stumbling block for families is dealing with someone for whom they want to secure treatment, but who has refused to accept the family's recommendations. The family finds itself "at an impasse, a stalemate and it is very difficult for something to change." Mobile Crisis goes out and evaluates, but if the person is not a danger to self or others, if he/she has a place to stay or can state three sentences about how they have access to food and shelter, then they don't meet the criteria for involuntary hospitalization. Even if they do meet the criteria, their stay at SFGH Psychiatric Emergency Service (PES) or other inpatient unit may be very brief. It is often very difficult to surmount the limited availability of places providing psychiatric inpatient or residential treatment. Services have been cut to the bone.

Given the impediments to care, what can one do? Dr. Levin recommends that families to **find the leverage to** make some kind of change. As an example, a manic family member (a mother, for example) is in the hospital

and refuses to allow her family to consult with the doctors providing her treatment. The mother wants the family to come and visit. This provides an opportunity for the family to require the mother to sign a release of information form in exchange for the family coming to visit. Also, at the end of a 72 hour "hold" when the patient is stabilized, he/she may be more amenable to acceptance of longer term therapeutic needs in a private practice setting.

Dr. Levin emphasized the need to immediately get consents or releases of information signed by the patient for all the treatment providers immediately because six weeks or six months later patients may not be conforming to their medical needs and, without the signed consent, there is nothing to allow families to confer with therapists. The release must name the person(s) the provider is allowed to talk to, a specified length of time, and recognize the legal right to withdraw that consent at any moment.

Medication compliance is another issue. If the family member is living in the family home or financially dependant, that person must agree to take their medications as prescribed and allow someone to watch them take it. It is helpful to know that certain medications can be ordered as liquids or quick-dissolve tablets. The monitor is then supporting the person and can verify to the Rx'ing MD that the meds were taken consistently and as prescribed. This facilitates the patient working with his/her doctor to find a way to adjust the doses so that they are effective and not overwhelming.

A mentally ill person must have assurance of his/her family's love while, at the same time, the family no longer supports or colludes with unhealthy behavior. Dr. Levin helps families strategize, problem-solve and fine tune their specific situation depending on the individual's and family's particular needs. For example, money and what it provides can be used as leverage when there is a strong desire or need for it. Sometimes, a person may refuse to take medications and be willing to give up what money provides thus becoming homeless if the family were to withdraw financial support. Many families are unwilling to force their loved one into homelessness. There is no one right or wrong answer. Finally, a family must act cautiously to retain trust. Requiring conditions can be a "slippery slope." It is important to explore what each family member's thoughts and feelings are about an issue. The goal should allow the ability to think a situation through, consider all sides and come up with a decision and a plan of action.

Additional clinical/legal considerations:

People experiencing auditory hallucinations may also require treatment in an inpatient psychiatric facility. Often accompanied by paranoid delusions, their decision making process is no longer grounded in reality and they may become agitated, hostile and/or threatening. Dr. Levin pointed out that command hallucinations are auditory hallucinations that "command" the person to do something and are among the most dangerous conditions. They are very hard for the person to resist. The "voices" may be telling the person to hurt or kill themselves or someone else. The person feels compelled to comply. Psychiatric hospitalization is helpful in maintaining safety and provides a range of treatment options.

Just because someone is hearing voices doesn't mean s/he needs to be in the hospital. Part of the Mobile Crisis Team's assessment focuses on how the person responds to authority. If the patient can "pull it together" and is not threatening to hurt themselves or others then they can go, for example, during the day, to Westside Crisis Clinic or to the outpatient mental health clinic where they already receive services. Over the years, mental health services in San Francisco have been decimated and the current

budget deficit will certainly lead to even more cuts.

Dr. Levin is available to address any group interested in learning more about the Mobile Crisis Team in San Francisco, the "5150" criteria for involuntary hospitalization and the work he does in private practice including crisis intervention consultation as well as individual and family therapy for those diagnosed with a severe mental illness such as bi-polar disorder, schizophrenia, major depression, etc.

He can be reached at:
Barnett Levin, PhD
2964 Fillmore Street, Suite 5
San Francisco, CA 94123
Office phone: 415-440-5505
Crisis line: 888-744-2747
drlevin@barnettlevin.com / www.barnettlevin.com