

Spring 2023



Newsletter

NEUROLOGY: RESEARCHERS MAKE PROGRESS IN EARLY DETECTION OF PARKINSON'S DISEASE

Researchers have been searching for a way to diagnose Parkinson's before its clinical presentation

Because Parkinson's disease is known as a progressive neurological disease, most treatments have been aimed at slowing its progression. Therapies ranging from increased exercise to deep brain stimulation have ameliorated symptoms. Other treatments include medications, cannabis-based therapies, diet, speech therapy, and dopamine agonists, including L-DOPA.¹ The commonality between these interventions is that they all begin after diagnosis. At this point, the major regulatory system indicated in Parkinson's is irreversibly damaged. For years, researchers have been searching for a way to diagnose Parkinson's before its clinical presentation, giving practitioners the opportunity to postpone its development rather than slow it. Now, they may have.

What if these dopaminergic neurons showed impairment before their breakdown and death? A group of researchers from IDIBELL and the University of Barcelona led by Antonella Consiglio, PhD, group leader at IDIBELL, ICREA Academy researcher, and a professor at the University of Barcelona's Faculty of Medicine and Health Sciences and Institute of Biomedicine, have identified early functional deficiencies, before neuron death, in patients with genetic Parkinson's disease.

To conduct the study, the team used induced pluripotent stem cell (iPSC) technology, which enables the creation of patient-specific, disease-relevant, cell-based experimental models of human diseases. iPSC models can produce some of the earliest signs of a disease, even at presymptomatic stages. By separating pluripotent stem cells of healthy individuals from those with genetic Parkinson's disease, the researchers were able to observe differences at a preclinical level. The dopaminergic neurons of people with Parkinson's disease were more spontaneously active and presented more explosive episodes than those of people without the disease. These explosive episodes could contribute to the pathogenesis of Parkinson's.

The results of this study could initiate steps forward in the diagnosis of preclinical Parkinson's. Consiglio explains that this research could allow the identification of key molecular events involved at the early stages of Parkinson's disease, which could be exploited for therapeutic intervention. Moreover, the study, which was limited to patients with genetic Parkinson's disease (about 5% of known cases), suggests the role of iPSC in the presymptomatic evaluation of neurodegenerative disorders. "Although it is unknown the cause of the disease in

Gene Mapping and Bio Markers

It's necessary to understand the hurdles to discuss different methods of early detection. In Parkinson's disease, neurons break down and die — particularly neurons in regions of the brain called the nigrostriatal and the substantia nigra, which are responsible for dopamine production. The clinical stage of Parkinson's disease is marked by symptoms of dopamine deficiency, including tremors, slowed movement (bradykinesia), rigid muscles, impaired posture and balance, loss of automatic movements, changes in speech, and changes in writing. Even when diagnosed early, most people with Parkinson's disease have already lost 60% to 80% of their dopaminergic neurons. Because there are no diagnostic criteria for preclinical Parkinson's disease, by the time a patient is diagnosed, this dopaminergic regulatory system is severely damaged, and symptoms can't be reversed, only relieved.¹

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Guidance for Licensees: How to Choose and Document Continuing Education

The Bureau of Professional Licensure does not pre-approve continuing education providers, sponsors or individual programs. It is the licensees' responsibility to determine if the continuing education programs they attend meet the requirements of their professional licensure board.

A percent of licensees are randomly audited following each license renewal cycle. If selected, the licensee must submit to the board office an individual certificate of completion issued to the licensee or evidence of successful completion of the course from the course sponsor. These documents must contain the course title, date(s), contact hours, sponsor and licensee's name. In some instances, licensees will be requested to provide to the board additional information, including program content, objectives, presenters, location and schedule. Many times an inclusive brochure meets this requirement.

When selecting continuing education programs, licensees need to make sure they are compliant with administrative rule requirements. Some professions require specific conditions to exist such as presentation method (home study, ICN, etc.), specific hours on ethics and Iowa law and rules, certification status by national associations or boards, clinical content, and hours required in a specific practice discipline, as well as other items. To ensure compliance, each licensee must understand the continuing education administrative rules for their profession prior to choosing and attending a particular program. No matter what a program brochure indicates, it is the responsibility of the licensee to ensure compliance with licensing requirements.

In summary all licensees should:

- Be familiar with the continuing education requirements of their professional boards
- Obtain inclusive written materials about continuing education programs from program sponsors for post-renewal auditing purposes
- Maintain certificates of completion that includes the program or course title, date(s), contact hours, sponsor and licensee's name for four years.

Iowa Department of Public Health

https://hhs.iowa.gov/sites/default/files/portals/1/files/licensure/coned_license_e_guidelines.pdf

~ Submitted by Ceci Johnson



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idiopathic patients, a relevant proportion of them have LRRK2 polymorphisms, and LRRK2 function appears dysregulated even in the absence of LRRK2 mutations/polymorphisms,” Consiglio explains. “Also, disease progression in LRRK2–G2019S carriers is clinically indistinguishable from idiopathic cases, suggesting common disease mechanisms.”

Many researchers have focused on people with a family history of Parkinson’s disease, and mutations in the LRRK2 gene are the most commonly known genetic cause. These studies implicate lysosomal and mitochondrial dysfunction and inflammation in disease pathogenesis.²

Intraneuronal accumulation of α -synuclein is the major pathological hallmark of Parkinson’s disease, but it’s not clear when these problems begin.

Other research suggests that nonmotor symptoms, such as anxiety, depression, and idiopathic anosmia, may predate motor symptoms, but these symptoms are found in many disorders and are often overlooked. Parkinson’s is known to begin long before it’s diagnosed, but the isolation of early symptoms continues to evade the medical sciences—even if the neurons themselves provide clues.

How can science untangle preclinical symptoms from those that occur after a significant loss of dopaminergic function? Researchers in Russia have been examining exactly that. The goal is to identify biomarkers in body fluids that could signal the development of the disease. Discovering those biomarkers is a multistep process.

“The most important takeaway is that neurodegenerative diseases like Parkinson’s and Alzheimer’s begin 20 to 30 years before we see symptoms; at this point, the regulatory systems are already almost completely destroyed. The only conclusion is that it’s absolutely necessary to develop preclinical diagnostic criteria so we can apply neuroprotective therapies in the early stages of the disease,” says Michael V. Ugrumov, MD, PhD, head of the Laboratory of Neural and Neuroendocrine Regulations Koltzov at the Institute of Developmental Biology RAS. Ugrumov explains the importance of Parkinson’s being a systematic disease; it means other clinical signs—premotor symptoms and biomarkers in body fluids—precede the death of dopaminergic neurons, and it’s why previous research has focused on uncovering such biomarkers.

To differentiate clinical indicators from preclinical indicators, Ugrumov and colleagues compared biomarkers of clinical Parkinson’s disease in human models to biomarkers of preclinical Parkinson’s in mice models.³ “The idea is to research Parkinson’s in humans in tandem with animal models. We focus on select markers from the clinical stage of Parkinson’s in humans that we also observed in the preclinical stage of animal models,” Ugrumov says. The researchers discovered that 25% of all markers found in patients with clinical Parkinson’s were also found in the preclinical animal models. “It is believed that only these markers can be used to diagnose Parkinson’s at the preclinical stage,” he adds.

The researchers understood the importance of producing the same metabolic pathogenesis of Parkinson’s that’s been identified in humans in the mice model. To achieve this, the researchers reproduced Parkinson’s in mice by administering a toxin of dopaminergic neurons. The hypothetical preclinical biomarkers of Parkinson’s disease were represented by a reduced concentration of L-DOPA and DOPAC in plasma and a change in the gene expression of a dopamine receptor (D3) in lymphocytes.

The comparison of clinical Parkinson’s in humans with preclinical Parkinson’s in animals was just the first step—the results aren’t conclusive enough to design diagnostic protocol. The next step was to find these clinical markers in people at risk for Parkinson’s—selected by premotor symptoms, PET scans, and known biomarkers.

Provocative Tests — Applying Internal Medicine to Neurological Diagnostic

A provocative test predicts a person’s risk for developing a disease by deliberately provoking characteristic aspects of the disease. For example, an oral glucose tolerance test is widely used to detect the abnormal regulation of glucose metabolism in diabetics. Provocative tests are common in internal medicine but, according to Ugrumov, haven’t been applied to testing chronic brain diseases at the preclinical stage. “The provocative allows us to make a specific test for a chronic disease,” he says. The researchers based their study on the knowledge that in Parkinson’s motor symptoms appear at the threshold of degradation of the nigrostriatal dopaminergic system, with a loss of 70% dopamine in the striatum and 50% to 60% dopaminergic neurons in the substantia nigra. They used α -methyl-p-tyrosine (α MpT) as a provocative agent, which has a dose-dependent reversible short-term inhibitory effect on tyrosine hydroxylase, inhibiting dopamine synthesis.



Ugrumov and colleagues first found the dose that would surpass the threshold for dopamine loss and cause motor symptoms in the mice without preclinical Parkinson’s symptoms—170 mg/kg. Next, they confirmed that a lower dose of 125 mg/kg did

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not cross that threshold or initiate motor symptoms in mice exhibiting biomarkers of preclinical Parkinson's. Then, the team administered a 125 mg/kg dose to mice that exhibited the preclinical signs of Parkinson's disease as predicted from their previous study. Having received this 125 mg/kg dose, the mice displayed symptoms of clinical Parkinson's disease. The results confirmed these preclinical signs as potential biomarkers for early diagnosis.

"For the development of any technology, we must first prove it's not toxic by testing it in animal models. Next, we move to clinical trials in humans," Ugrumov says. Proving safety was the main goal of the study. "Because we used an inhibitor that is reversible and cannot be metabolized by the body, it provokes the loss of dopamine for only a short time; it is then eliminated from the body." In the mice models, the dopamine content in the striatum returned to a normal level, followed by normalization of motor behavior within 24 hours of administering the inhibitor. There were also no structural or functional changes in the nigrostriatal dopaminergic system one week later. However, the researchers did note that intranasal administration of the inhibitor (αMPT) is important to avoid decreased content of catecholamines in the brain and peripheral nervous system, which is an effect of systematic administration.

Early Diagnosis to Early Treatment

Without early treatments, patients are unlikely to benefit greatly from early diagnosis. "I always say, show me the situation in which we developed a treatment before a diagnosis," Ugrumov says. "Also, we already know various neuroprotectors, so if we can diagnose early, we'd be able to select neuroprotectors that are most precise—we could also potentially combine therapies," he says. Indeed, many studies are testing the potential of neuroprotective agents—none have shown great success, but there have been some promising results. Among the agents being studied are anti-diabetics, such as exenatide. Anticancer drugs such as nilotinib are also being studied, along with glutamate receptor agonists. Another future treatment option could be neurotrophic factors.

The accumulation of α-syn is an example of a targeted biomarker. As researchers learn more about early biomarkers, research can continue to become more specific and targeted.

The Beginning of Novel Treatments in Neurodegenerative Disease?

Parkinson's is the second most common neurodegenerative disease in the United States; Alzheimer's is the first. Both are systemic diseases. Many researchers, including Ugrumov, believe that developing a method for early diagnosis of one neurological disease could be universally applied to others. Because neurodegenerative diseases are systemic, the key is finding the earliest pathologies—sort of like finding the first knot in your tangled headphones. For example, tau proteins are indicated in the pathologies of both Alzheimer's and Parkinson's, but tau is one of many pathologies. By the time patients are in the clinical stage of disease progression, multiple biomarkers are already present. This is evident when we hear researchers debate whether tau proteins or amyloid proteins are the initiating factor in Alzheimer's. Knowing what comes first could mean a breakthrough in treatment, but once a certain amount of damage is done, neurodegenerative diseases cascade, and providers are left to treat the symptoms. The recent progress in the early diagnosis of Parkinson's is no small feat—it could be the model for early diagnosis of neurodegenerative disease.

— Jennifer Lutz is a freelance journalist who covers health, politics, and travel. She's written for both consumer and professional medical magazines as well as popular newspapers. Her writing can be found in **Practical Pain Management**, **Endocrine Web**, **Psychom Pro**, **The Guardian**, **New York Daily News**, **Thrive Global**, **BuzzFeed**, and **The Local Spain**. In addition to journalism, Lutz works as a strategies and communication consultant for nonprofits focused on improving community health.

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From: Today's Geriatric Medicine

Vol. 15 No. 5 P. 28

<https://www.todaysgeriaticmedicine.com/archive/SO22p28.shtml>

~ Submitted by Lorene Austin-Bennett

Spring Conference In Review

The LTCSWI Spring Conference was held at the Gateway Conference Center March 30-31. There was a total of 76 people in attendance (66 Thursday & 69 Friday). Nine exhibitors shared their products and services.

Chris Sparks, LISW, Iowa Veterans Home, presented *Complicated and Prolonged Grief: When Things Get Really Complicated*.

Sarah Greazel, LISW, VA Central Iowa, helped us learn about *Veterans Affairs: Caregiver Support Program and In-Home Services*

Our next topic covered *A Psychosocial Approach to Reducing Use of Unnecessary Medications for People Living with Dementia*, by a team from Oaknoll Retirement in Iowa City: Kaleigh Gilmore, LMSW, Lindsey Reed, CTRS, and Sarah Neary, LMSW.

Deanne Carman, RN, CHPN, and

Leigh Ann Gibb, RN, from Mary Greeley Hospice, presented on *Hospice Care: Having Conversations, Dispelling Myths, and Understanding Treatments*.

We ended the day with *Hey! Mr. Funeral Director*, led by Blair Overton, BA, AS, Iowa Funeral Planning.

Friday morning's presentation was given by Ben Woodworth, MSW, CBIST, Hartworth Consulting, and Holli Petersen Striegel, LMSW, St. Luke's Hospital....*Social Work in Long Term Care: Yesterday, Today, and Tomorrow*.

Sonya Ackerson, Founder/CEO, The Sonya Group, covered *Medicaid: How Does it Really Work*.

Our day concluded with a presentation on *Fighting Back Against Parkinson's*, by Jon Jordan, Director of Community Well-Being at Heritage House in Atlantic.

I loved the Grief Presentation; I'm a hospice SW and this was especially helpful

Great exhibitors and opportunity to network and learn.

Such an amazing program to learn about! (Parkinson's)

Great food!

Love the funeral director - great information I can apply to my job

! liked having the vendors and door prizes. Absolutely wonderful conference!

Good job selecting a variety of topics of interest; practical and useful info.

~ Comments from Attendees

Conference Resources

Chris Sparks—*Prolonged Grief*

Book Recommendation: *Grief Counseling and Grief Therapy*, by J. William Worden

Book Recommendation: *Finding Meaning: The Sixth Stage of Grief*, by David Kessler

Sarah Greazel - *VA Affairs*

Program of General Caregiver Supportive Services (PGCSS)

Sarah Greazel, LISW, Caregiver Support Coordinator, 515-661-2864; Sarah.Greazel@va.gov

Blair Overton - *Hey! Mr. Funeral Director*

Website: Social Workers Resources Page: IowaFuneralPlanning.com/SW

Form: *Declaration of Designee for Final Disposition*

https://www.iowafuneralplanning.com/_files/ugd/92875b_8ab4a23d7113496b931af15f88861cbe.pdf

Jon Jordan - *Fighting Back Against Parkinson's*

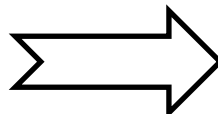
Rock Steady Boxing...Find a class near you!

<https://rocksteadyboxing.org/find-a-class/>

Ben Woodworth & Holli Petersen Striegel

Social Workers in LTC

Resilience



Remember you are good enough

Everyone is different

Stop comparing yourself

Individuality rocks 🧸

Learn something new daily

Involve yourself in what you love doing

Enjoy things that make you happy

Not everyone can be 1st, 2nd, or 3rd

Care about yourself and others

Expect that some days won't be great

Nursing Home Social Work Network Listserv

The University of Iowa School of Social Work listserv provides an opportunity for nursing home social workers and social service staff to network and discuss issues related to nursing home social work. This listserv is under the supervision of Associate Professor Mercedes Bern-Klug, with assistance from social work students, and **typically generates 3-4 daily emails** among nursing home social workers in our network.

To join the Nursing Home Social Work Network listserv, send an e-mail to nh-sw-network@uiowa.edu, including your first and last name.



Social Work

We're not in it for the income;

We're in it for the outcome.

Eye on Ethics:

Understanding Behavioral Health Advance Directives

By Frederic G. Reamer, PhD—Social Work Today, Vol. 22 No. 4 P. 30

Several years ago, I consulted on an ethics case involving a social worker's client who struggled with schizophrenia. The client once had a thriving career as a supervisor in the construction industry. Over a period of years, the client had been hospitalized in a psychiatric facility on three occasions and received outpatient counseling services in a community mental health center and in a clinical social worker's independent practice.

Following his most recent hospitalization, the client told his social worker: "I'm not sure how much longer I can take this. Going in and out of the hospital and taking all the meds is getting to me. Some days I wish I could just end it all. The next time someone tells me I need to go to the hospital, I think I'll refuse and just live or die with the consequences."

Of course, upon hearing those words, the social worker conducted a thorough suicide risk assessment and explored in depth the client's feelings of despair. The social worker then reflected on the daunting question about the extent to which her vulnerable client has a right to refuse treatment.

The Right to Refuse

The concept of "right to refuse treatment" has a long and storied history, including several key court decisions. The 1977 Massachusetts case of *Superintendent of Belchertown State School v. Saikewicz* was pivotal. Joseph Saikewicz was a 67-year-old who had been diagnosed with profound intellectual disability (then known as mental retardation) and acute myeloblastic leukemia. His guardian ad litem sought to protect Saikewicz from the pain and discomfort associated with his treatment that could only postpone his death.

The Supreme Judicial Court of Massachusetts concluded that all people, both competent and incompetent, have a right to refuse medical treatment in appropriate circumstances. The court outlined a process whereby decisions should be made in accordance with what an incompetent person would want if he or she were competent. The court ultimately ruled that Saikewicz, if competent, would have refused treatment and could still do so despite his incompetence.

The 1981 case of *Guardianship of Roe* introduced what has become known as the concept of "substituted judgment." Richard Roe III's father (Roe's guardian) consented to the administration of antipsychotic medications over Roe's objection. The Supreme Judicial Court of Massachusetts called for a determination of substituted judgment that would consider the patient's stated preferences, religious beliefs, impact on his family, probability of adverse side effects, likely results of refusing treatment, and prognosis with treatment.

Soon after this key judicial decision, the 1983 case of *Rennie v. Klein* addressed the issue of an involuntarily committed patient's right to refuse treatment with antipsychotic medication. John Rennie, who had been hospitalized many times, filed a class action suit asserting his right to refuse antipsychotic medication. The US Court of Appeals for the Third Circuit ruled that involuntarily committed mentally ill patients have a constitutional right to refuse the administration of antipsychotic drugs and that this right can be overridden only after qualified professionals conclude there is evidence of dangerousness to the patient or others.

Two subsequent Supreme Court decisions also addressed key right-to-refuse issues. In *Washington v. Harper*, the court concluded that a state government may forcibly treat a prison inmate with a serious mental illness, provided that he or she is dangerous and that the treatment is in the individual's medical interest. In *Sell v. United States*, a judge ordered a criminal court defendant's hospitalization to determine whether he would attain the capacity to allow his trial to proceed. The judge also authorized forced administration of antipsychotic medication so that the defendant could stand trial. In a 6-3 opinion, the court held that the Constitution allows the federal government to administer antipsychotic drugs against a defendant's wishes in limited circumstances. The court concluded that these conditions include whether the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the trial's fairness, and, considering less-intrusive alternatives, is necessary to further governmental trial-related interests.

These and other appellate court decisions have sought to clarify whether and when people who struggle with psychiatric illness have a right to refuse treatment. Given the frequency with which social workers encounter vulnerable people who refuse services, the implications of these decisions are significant.

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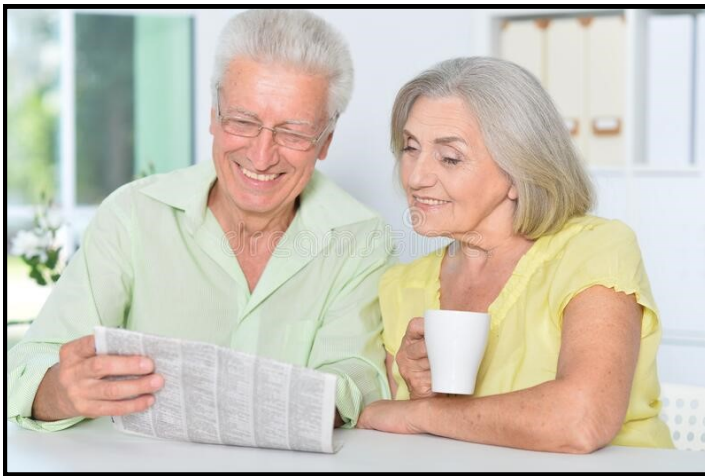
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Behavioral Health Advance Directives

More recently, behavioral health professionals have used advance directives specifically tailored to mental health. A psychiatric or behavioral health advance directive (commonly referred to as a PAD) is a legal tool that allows people with mental illness to state their preferences for treatment in advance of a crisis. PADs, which emerged in the 1990s as a parallel to medical advance directives for end-of-life planning, are designed to help protect a person's autonomy and ability to direct the care they receive.

Laws on PADs vary from state to state. In general, a PAD has two parts: an advance instruction and a health care power of attorney. The advance instruction can include treatment preferences and give advanced consent for hospital admission. Also, a PAD can identify preferred medications and treatment options.

The health care power of attorney can be used for psychiatric emergencies. It allows the person to appoint a trusted individual to serve as a health care agent with decision-making authority during times when a person is incapacitated. In principle, PADs can enhance the therapeutic relationship by helping people feel more connected to and aligned with behavioral health professionals. Furthermore, a PAD



can provide a mechanism to involve family or significant others in the individual's treatment without having to go through a consent process during a crisis.

PADs differ from medical advance directives, which first emerged in the 1960s, in important ways. Living wills or medical advance directives require thinking forward to a future state or set of circumstances that a person has never experienced. In contrast, a PAD is often based on an individual's past treatment experiences. Although a PAD generally binds the individual to decisions made in advance, it can be overridden by involuntary treatment orders or other compelling emergencies. Even in these situations, the PAD can still be consulted to learn about the person's treatment preferences.

The Relevance of Social Work Values

Social workers who serve vulnerable people who wish to use a PAD should always consider key social work values. The NASW *Code of Ethics* provides a valuable guide. Social workers who assist clients who wish to prepare a PAD should honor the code's commitment to the "dignity and worth of the person," as set forth in the principles section of the *Code of Ethics*. Furthermore, social workers' efforts should "respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals" and "provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent."

If social workers encounter clients who are unable to make sound decisions about their care, they "should protect clients' interests by seeking permission from an appropriate third party, informing clients consistent with the clients' level of understanding. In such instances, social workers should seek to ensure that the third party acts in a manner consistent with clients' wishes and interests. Social workers should take reasonable steps to enhance such clients' ability to give informed consent."

Social workers are accustomed to challenging circumstances that require balancing clients' self-determination rights with the moral duty to protect clients and others from harm. As the NASW *Code of Ethics* says, "Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others."

Threading this needle is not easy. Invariably it requires skilled consultation, sound judgment, and a deep commitment to social work's core values.

— Frederic G. Reamer, PhD, is a professor in the graduate program of the School of Social Work at Rhode Island College. He is the author of many books and articles, and his research has addressed mental health, health care, criminal justice, and professional ethics.

~ Submitted by Lori Miller, LBSW

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The Long Term Care Social Workers of Iowa is a statewide organization, promoting the professional status of social work in long term care facilities. Our purpose is to facilitate your professional growth in long term care, offer continuing education opportunities for you, and provide the means with which you can enrich the lives of long term care residents and their families. Anyone who works in long term care is welcome to join!

Member Benefits

- ◆ Conference Discounts
- ◆ Quarterly Newsletter
- ◆ Membership Directory
- ◆ Discussion Forum

Mark Your Calendars

LTCWSI FALL CONFERENCE

Friday, October 27, 2023

Gateway Conference Center ~ Ames

Topics Scheduled To Date...

- ◆ **State Inspections**—Christopher Dunn, LTC Bureau Chief
- ◆ **Huntington's Disease**—Amy Lemke, LISW, Clinical Social Worker and Coordinator of University of Iowa Huntington's Disease Center
- ◆ **Care Planning**—Trisha Easton, LISW, Care Initiatives Hospice

