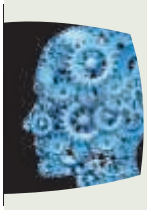

FALL VOLUME 33 ISSUE 2 2013

frontlines

WASHINGTON ASSOCIATION FOR DESIGNATED MENTAL HEALTH PROFESSIONALS

Letter from President, Luke Waggoner

It has been a busy summer in Walla Walla County! We are setting records that we never hoped to set by surpassing our total number of Single Bed Certifications (SBCs) for 2012 in the first 6 months of 2013 and, as I write this, we are setting a new record daily for longest SBC at 15 days and counting. Combine this with the normal scheduling challenges of summer vacations and it has been more exciting than any of us would prefer. How has 2013 been in your community? What kind of challenges are you facing as you do your job every day?

In case you aren't familiar with Walla Walla County we have a population just under 60,000 with just over 30,000 living in the city of Walla Walla and another 10,000 to 12,000 within 5 miles of the city limits. Downtown Walla Walla is just 6 miles from the Oregon state line and another 10,000 to 12,000 Oregon residents who come to Walla Walla for their outpatient and emergency medical services. Our county is also home to the Jonathan M Wainwright VA Medical Center with a catchment area reaching to Yakima, WA, Lewiston, ID, La Grande, OR and everything in between. Finally, we have three colleges and the Washington State Penitentiary that attract additional short term residents to our community. What does your community or county look like? Do you serve individuals from outside your county regularly because of the facilities or institutions in your community or because the nearest hospital is in your town?

Continued on page 4

WHAT'S IN THIS ISSUE?

Does someone have to die to get help?

By Gary Carter

I would bet that you have heard this desperate retort in your role as a DMHP? It comes when someone who is seeking a detention and who has just reviewed all the reasons care is indicated and instead hears from us, how "they don't meet criteria." Emergency Room Physicians (think SSB 5456, Section 1 of 2013), parents, RSN staff, clinicians of all kinds, have the same reaction to the news, "How can you say they don't meet criteria when any right-minded person on the street can see this person needs help!?"

Like many of you, I have struggled with this fact for years, trying to transform what feels like an attack on one's professionalism into a next-step of getting help for the person in question. Consequently, this is the third of three articles describing the inherent and unavoidable conflict every DMHP faces in the job of implementing RCW 71.05 and 71.34 and what can constructively be done about it.

It was transformative for me to realize that we appropriately don't respond to need or suffering in the same way care providers or family do. Instead, we are required to analyze and weigh facts according to the statue: do the facts of the case constitute a likelihood of serious physical harm that is a result of a mental disorder and no voluntary option is available, the three prongs of RCW 71.05.150(1)*. This difference of perspective on what justifies an intervention is central to the ongoing mistrust and at times hostility toward our work.

Saying it another way, we strive to be blind to individual suffering and situations in order to objectively weigh whether the facts of the case satisfy the evidence-based criteria of the three prongs. If they do, we, the DMHP, don't provide care; we instead make a single decision that may deprive the individual of her/his right to liberty and self-determination. In that way, we are actually at odds with our therapeutic counter-parts. Sound familiar?

So, they see need and suffering and are trained to respond by providing care and so turn to us. But in the role of a legal decision maker, the DMHP looks for whether there is enough risk of the right kind that necessitates the deprivation of the individual's of their constitutionally protected right to liberty and self-determination. They act (provide care); we withhold (liberty): Apples and oranges; the tusk and the tail; care versus confinement.

So then, is it enough to understand the differences then just carefully explain it to people? Ah, no. Most of us have experienced that fruitless exercise. It is in fact where this article began: "I don't care WHAT you just said, my client/friend needs help and you just said you aren't going to help! What, does someone have to die…"

I want to suggest what has turned out to be a time proven way to successfully move forward under these limitations. To get there, I think that one more construct would be helpful here, if understood. This has all to do with how to manage the obvious gap between where informal and outpatient care efforts have been exhausted and criteria for detention has not yet been met.

To the degree this gap exists as I have conceptualized it, doesn't it make sense that requests for help will tend to precede the high levels of criteria the law demands? Shouldn't we actually expect referrals to routinely not meet detention criteria? I think so. In fact, I think, on behalf of the client and the community, we might welcome them. Here is why.

Considering the high tolerance the law has for suffering and mental dysfunction, a call that immediately leads to detention points to either the individual that has had a sudden and acute deterioration in functioning or to someone who has been without supervision because his/her symptoms presumably developed gradually into an emergent situation. Either way, an individual meeting detention criteria on the first visit is in substantial risk of serious harm. Something all should be invested in avoiding. While it appears to be "a good referral" and most easily justifies our action, it also contains the highest potential for irreparable harm, a poor prognosis for recovery and high costs.

Better, by comparison, is the situation where an individual has not yet met criteria; the client is "in the gap" beyond the reach of voluntary care and short of involuntary rescue. Instead of simply declaring the client "not detainable," a plan is developed with the referring person or parties for what is to be done next. Strategic planning is around preventing the sudden, precipitous drop in functioning that has such potential for harm and slow recovery. The ideal would be that we receive two or three meaningful "data points" (referrals) from which we can make a dynamic decision about functioning so, best case scenario, detention happens just as criteria is reached, and no later.

Conversations of this type switches from a perceived "No, not my problem" to a partnership where instead of it being the DMHP who doesn't engage on a case, it is the referring party that must decide if this is in fact as important of a case as they initially thought it to be. And, we become part of the treatment community, consulting, planning and hopefully keeping as many cases as possible voluntary and in the outpatient venue.

Usually this takes the form of, "Yes, you are right in your concern about the client. While not yet detainable we need for you to continue to monitor Joe and report any (factual, not opinion based) changes in Joe's functioning." Again, two data points give much more information than a single referral. Three calls about factual changes in functioning during a relevant period of time can be all that is necessary to determine a significant and sustained deterioration in functioning that might not otherwise trigger the grave disability criteria of repeated and escalating loss of cognitive and volitional control. If no one is monitoring the client, maybe only one of those events is reported and the client continues to deteriorate to the point that an emergent detention is obviously necessary.

Finally, to briefly summarize all three articles in a few sentences. Our job is unique and impossible as we work between outpatient (voluntary) and inpatient (involuntary) systems with no actual authority or standing in either of the systems we rely on to accommodate our decision making.

Letter from President, continued...

SSB 5456

The 2013 legislative session was once again a busy one for legislation related to mental health and crisis services. If you made it to our spring conference in June you saw the half inch thick stack of bills that passed and in some way impact the job of the DMHP.

As I reviewed each piece of legislation that passed this session the one that stood out to me, as having the most potential impact on the day to day job of the DMHPs in our office, was Substitute Senate Bill 5456. This is the bill that started out as a bill that would allow two physicians, if they disagreed with a DMHPs decision not to detain, to petition the court to detain the person. The final product looks almost nothing like the original bill and Section 1 now requires a DMHP to consult with the treating ED physician and document the consult, including the physicians stated opinion on the individuals need for detention. Section 1 will require a few extra moments of documentation time but Section 2 appears to have the potential to increase detentions and subsequently increase boarding with very little hope for any meaningful increase in bed capacity (I'll talk more about that in a minute). It states that "A designated mental health professional who conducts an evaluation for imminent likelihood of serious harm or imminent danger because of being gravely disabled under RCW 71.05.153 must also evaluate the person under RCW 71.05.150 for likelihood of serious harm or grave disability that does not meet the imminent standard for emergency detention."

I have two primary areas of concern about this portion of the new law. First, full implementation of this requirement across the state seems very likely to increase detentions, further backup our system and increase boarding. Second, in many counties the court process is not available to facilitate non-emergent detentions currently. Does this new requirement of the law seem likely to increase detentions in your area? Are non-emergent detentions currently something you do or have the option to do in your area? If not, is your Superior Court willing to work to make this process available?

Budget

After failing to come to a budget agreement during the regular session our state legislature came back for a special session with the hope of coming to some agreement over the next biennium budget. As the month of June started to wind down and no budget agreement had been reached the state began to prepare for the possible shutdown of many state agencies and services. Finally in the last couple days of the month an agreement was reached. Earlier in the session I heard that the governor's budget proposed as much as $21,000,000 to increase inpatient psychiatric bed capacity and community based less restrictive treatment options. As the budget was clipped and cut throughout the regular and special session we ended up with a whopping $5,000,000 to increase bed capacity (see Sec. 1071 on page 32 and 33 of the state budget document). *Continued on next page...*

These dollars will be issued as grants through the Department of Commerce to "hospitals or other entities to establish new community hospital inpatient psychiatric beds, free-standing evaluation and treatment facilities, enhanced services facilities, triage facilities, or crisis stabilization facilities with sixteen or fewer beds…" Priority will be given to new capacity over renovations of current facilities, programs that can serve individuals with medical and psychiatric co-morbidity and that will meet geographical gaps in access. Although I am happier with some money than I would have been with no money, this small amount seems woefully inadequate in light of the current capacity crisis in our state. It seems optimistic to me to expect one newly constructed 16 bed evaluation and treatment facility or two facilities established by remodeling a current building. Let's hope that this small amount is just the beginning! I'd love to hear your thoughts on new legislation, the state budget and your day to day challenges so that I can learn more about the needs of DMHPs around the state. Just drop me an e-mail at president@wadmhp.org and tell me your story. You can also contact us via our Facebook page. Just search for Washington Association of Designated Mental Health Professionals.

Be safe and may you always find a bed,
Luke Waggoner
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VOICE OF THE DMHPs

"What's the one thing you wish other people knew about the job you do and why?"

"I wish people knew the criteria for detention. Law enforcement, family, medical providers, everyone. I wish they knew that so they wouldn't look to us as miracle workers who can fix anything simply by detaining." *Tony Talacko, DMHP 2 years, Thurston County*

"I have been a Designated Mental Health Professional since June of 2012. During this time I discovered the importance of building relationships with community partners and providing education on what my job entails; one of my goals is to ensure this community service is used effectively. As DMHPs we help individuals in crisis. In certain sense, my position is stepping stone for many of the client with whom I serve. When working with individuals I encourage them to take responsibility for self-care by providing therapeutic guidance and attempting to instill a sense of empowerment. The best results come from combination of natural and professional supports." *Tera Stickley, DMHP 1 year, Lewis County*

"I think the highest compliment I've received as a DMHP from a client is 'you are the first person to listen to me.' I have to wonder how it is, in our society, that a person has to reach the level of an ITA evaluation to finally be heard." *Lorraine Brilliant, DMHP 3 years, Thurston County*

"Often times, the most stressful part is trying to decide whether or not to hospitalize someone involuntarily, especially when it's the middle of the night. Where it's often most difficult is when there's maybe a glimmer that it's not needed, and the person really wants to just go home. But you know that if you don't detain them, there's a significant chance that a person could further harm themselves, to the point of death. The weight of responsibility is really huge." *Ed Fitzpatrick, DMHP 3 years, Clallam County*

"Actually, I wish fewer people knew what we can do. I see a lot of other agencies calling us that actually could meet the persons needs better through less restrictive." *Michael Shoemaker, DMHP 9 years, Thurston County*

****Look for this section in future issues. Questions will be posted on Facebook on the Washington Association for DMHPs page.*

DMHP Word Search Ed. 1

Mental Health Law Vocabulary

INVOLUNTARY
SUICIDE
LAW
DMHP
PETITION
IMMINENT
CRISIS
EVALUATION
WITNESS
PROTOCOLS
ITA
LRA
ATTORNEY
RIGHTS
HOSPITAL
HEARING
LIABILITY
RESPONDENT

*answers on page 9

"ROCK AND A HARD PLACE"

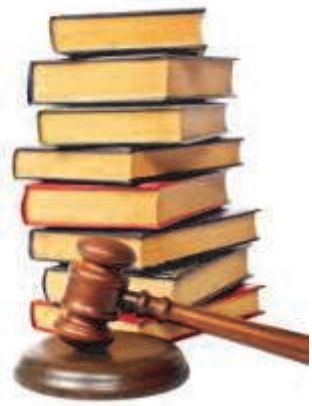
by Anonymous

"Availability of a resource shall not be a criteria for refusing to initiate an ITA investigation"
(DMHP Protocols Update December 2011, p. 11).

Right now, single bed certifications are illegal in Pierce County, although that decision is on hold until December 2013. This case is on its way to the appellate court, where a ruling would affect not just detention procedures in Pierce County, but the entire state. The court testimony, editorial opinion, community discussion, and ensuing drama are readily available public knowledge for anyone with internet access. Notably absent from this public debate is the viewpoint of the individuals at the heart of the controversy – the person getting detained, and, standing next to them, the DMHP.

Politics, budgets, and public opinion aside, what do we do with the person in front of us when their safety is our responsibility and we know we have an array of options (from ideal to less than ideal) to choose from to keep them safe? Anyone even peripherally involved in community mental health can tell you that there are not enough resources, that there are never enough resources. There will never be enough inpatient psychiatric beds – or adult family homes, next-day appointments, crisis beds, case managers, or readily available housing for everyone who needs them. As DMHPs, our job is to assess the situation, figure out what the person in front of us needs to be safe, and make it happen. We take a deep breath, find a corner to work in, pick up the phone, and start making phone calls. We don't walk away until that person is safe and the immediate crisis is resolved.

A single bed certification in an emergency room or on a medical floor of a community hospital is closer to the 'less ideal' end of the spectrum. It can be noisy, crowded, overstimulating, and uncomfortable in the emergency room, and isolating on the medical floor. The nursing staff aren't trained to provide psychiatric care and they're often afraid of, or irritated by the presence of the person who's detained. Hospital staff may hold boundaries too hard and leave the person in restraints for hours or not hold boundaries enough and send in an inexperienced nursing assistant to sit with the person. There likely isn't a psychiatrist, or a psychiatric ARNP, or even a physician able to prescribe psychotropic medications readily available.



It goes without saying that there isn't any counseling, or groups, or therapeutic milieu on a single bed certification.

But all of this is still better than the person being dead. All of it. As unpleasant, and unhelpful, and downright dangerous as a single bed certification can be, it's still a vast improvement over sending the person back out into the community to hurt themselves or someone else. This is our rock and our hard place. We know better than almost anyone else that changes are needed, more resources are needed, different resources are needed. DMHPs have a unique perspective of the system as a whole, but in the moment, we just have to figure out what the person in front of us needs to be safe. This is what I remind myself of when my client is throwing their food tray, their family is upset with me, and the doctor is angry at me. I've started employing the same technique when I read something in the newspaper that makes my blood pressure go up.

We can want change, and support change, and focus on the needs of the person in front of us, one client at a time. Just like we always have.~

Results from word search on page 7

Our service is limited to the investigation, the decision and, at times, the custody authorization. All else is our begging and finessing those systems to act on behalf of our clients whether we detain or not.

While we have the training and speak the language and are often employed by mental health agencies, we do not participate in the ongoing care of the client. Our role instead is limited to rescue when such care has failed. When detaining, we suspend care, in a sense, to administer an external fix (involuntarily and coercively) so the individual can eventually return to the outpatient care paradigm.

Our single tool is the proverbial hammer that makes all issues a nail. All nuance and individual choice is suspended. All problems get fixed in the same way, for all people. That isn't treatment. That is rightfully the last option. It is rescue. And folks don't understand that even when it is explained.

So, to avoid protection of civil rights to appear like abandonment of the client and our community, we need to actively engage others in monitoring clients who fall short of the statue's high threshold for action. That way, people don't need to die or be harmed, in order to get emergency help. ~

* The Three Prongs of RCW 71.05.150(1) and Imminence.
Risk: DTO, DTS, DTP and/or both GD or GDCV which establishes the standard of " a likelihood of serious physical harm" except in the case of GDCV [see RCW 71.05.020(14)]
Mental Disorder: demonstrated to be causing "substantial impairment" in functioning and is currently causing the risk.
No Lesser Restrictive Alternative to hospitalization. That is, we can "prove" there were no viable or available voluntary alternatives to hospitalization that mitigates the risk.
Imminence is not a prong. Technically this does not have to be proved because the statute allows for non-emergent detentions (See the other new provisions of SB 5456 in Section 2) which identifies the obligation to consider the Summons process when there are grounds but no imminence. Unfortunately, the summons isn't available in many counties for a host of reasons involving county and local resources. Consequently, the importance of imminence varies by the court that hears the case and can take on the importance of a prong as framed it above.

2013 FALL CONFERENCE at SUN MOUNTAIN LODGE

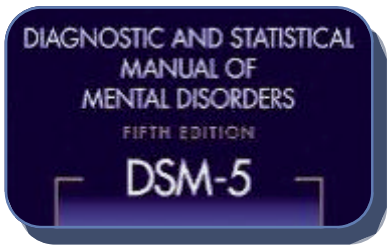
DSM:V
What You Need to Know
with Dr. Matt Layton

Thursday, October 17
07:30 am Registration and Breakfast
08:30 am Opening Remarks
08:45 am DSM-V
10:30 am Break
10:45 am DSM-V
12:00 pm Lunch & Business Meeting
1:30 pm DSM-V
2:30 pm Break
2:45 pm DSM-V
4:30 pm Adjournment

Friday, October 18
07:30 am Breakfast & Registration
08:30 am Opening Remarks
08:45 am Legislative Update with David Kludt
10:30 am Break
11:00 am Roundtable: Future Protocols
12:00 pm Conference Adjourns

CEU/CME: 6 hours on Thursday, 3.5 hours on Friday

Dr. Matt Layton serves as Program Director for the UW Psychiatry Residency Training Program – Spokane Track and Medical Director for the Program of Excellence in Addictions at WSU. He is Clinical Associate Professor in the UW Department of Psychiatry & Behavioral Sciences and the WSU Medical Sciences Program. He earned his M.D. and Ph.D. in Pharmacology from Kansas University Medical Center before completing psychiatry residency training at UW in Seattle. He is certified by the American Board of Psychiatry and Neurology. Dr. Layton is listed as one of "America's Top Psychiatrists".



Carolyn Williamson Scholarship

The Washington Association of Designated Mental Health Professionals is very proud to be able to offer this Scholarship.

Carolyn was passionate about seeking justice for the mentally ill. From 1995 until she retired in 2007 she served as the Pierce County Deputy Prosecuting Attorney in charge of handling civil commitment hearings. She also represented the petitions of DMHP's from across the state for patients sent to Western State Hospital on a 72 hour hold for many years. She was involved in a number of cases which were eventually brought to the State Supreme Court and that became a part of case law for involuntary commitment.

The Williamson family in honor of Carolyn's long time dedication to and support for DMHPs solicited funds to create this fund. The Scholarship Fund will offer a $160 gift to one DMHP to attend the Fall Conference each year.

To be considered for this gift a Supervisor needs to submit the name of a DMHP who will be attending the Fall Conference for the first time, by September 15 to the WADMHP president Luke Waggoner by email at president@wadmhp.org. The WADMHP board will pick the winning DMHP and will inform the DMHP's supervisor by September 23. At the Fall conference the winning DMHP will be acknowledged at the lunch meeting on Thursday October 17.

REGISTRATION FORM
FALL CONFERENCE 2013
Washington Association of Designated Mental Health Professionals

October 17 & 18, 2013
Sun Mountain Lodge

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone: (_____)_____ Work phone: (_____)_____

Employer:_____

Position Title:_____ County: _____

Email Address: _____

☐ Yes! Please email me future Newsletter and Conference information.
☐ No, please never contact me through email.

WADMHP member_____ Non member_____

Registration fee: One Day Only $95. Both Days $160

Make check payable to WADMHP
Please note: Check or cash only- through mail
Credit card only- online

WADMHP Tax Identification Number:
91-1997711

Mail registration form to:

WADMHP, PO Box 5371, Bellingham, WA 98227

Or contact Kincaid Davidson at (360) 676-5162

Or Register Online at WADMHP.ORG!!

CALENDAR

JUNE 18, 2014
wadmhp spring conference

yakima, wa

OCTOBER 16-17, 2014
wadmhp fall conference

winthrop, wa

** Dates may change

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