FRONTLINES

FALL 2017 VOLUME 37 ISSUE 1

WASHINGTON ASSOCIATION FOR
DESIGNATED MENTAL HEALTH PROFESSIONALS

Letter from the President

Dear Fellow DMHPs,

I hope this letter finds you well and enjoying some spring sunshine! It's been a busy few months for WADMHP. We held two DMHP Academies where we had the privilege of providing education to over 60 DMHPs. Each group was a pleasure to work with and we enjoyed talking through the concrete aspects of our work as well as working through the more ambiguous pieces. Overall, there was a ton of good discussion and learning had by all and we really enjoyed getting to know the participants. WADMHP would like to thank the Division of Behavioral Health and Recovery (DBHR) for allowing us to provide consistent education to new DMHPs across the state. Around the corner is our fall conference! This year's conference will be held October 12th at the Sun Mountain Lodge in Winthrop, WA. Deidre Berens, MS, ARNP will be presenting on Crisis Issues with Children and Adolescents and how it impacts DMHP work. We will also have Robbie Pellett presenting on Single Bed Cert updates as well as speaking about the continuing Designated Crisis Responder Training that is being provided throughout the year by DBHR.

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WHAT'S IN THIS ISSUE?

Spring 2017 DMHP Academy – Yakima, WA

The Spring 2017 DMHP Academy was held in Yakima, WA from March 6th to March 10th. Thirty-one individuals from six Behavioral Health Organizations, representing thirteen counties attended the Academy. There was an expansive history of combined experience with three participants being less than a month into their DMHP training and 3 having more than 5 years of experience. A majority of the participants had less than one year of experience on the job as DMHPs. The primary function of the DMHP Academy is to review the RCW/WAC requirements and DMHP Protocols

then allow for presentation and discussion of the principles and procedures common to the role of DMHP. At this Academy, aspects of Crisis Intervention (non-ITA Detention), Substance Use, Safety, Law Enforcement Collaboration, and Self-Care were additionally explored. On a whole, the Academy presentations were rated at an average of 94.3% relevant and applicable. Participants were surveyed and indicated a rate of 75% referral to coworkers to attend the Academy. WADMHP is working with DBHR for further development of future Academy events. Keep an eye on our Facebook page and website for announcements of DMHP Academy events!

PRESIDENT'S LETTER CONTINUED...

Along with providing these three trainings in the last six months, WADMHP was invited to attend a Senate work group on Outpatient Assisted Treatment and give input on HB 3095. It is always an honor to give our input on such important legislation. As representatives of DMHPs across the state, we would love to hear feedback or suggestions from you on bills each session.

The association has been pondering how to update our look in 2018 when DMHPs will become DCRs. When this change occurs, we will be changing our name and with that new name, we have also considered the need for a more updated look! We would love to give a fellow DMHP the opportunity to design our next logo. If you are interested in having your art work used please send your design to info to WADMHP@gmail.com If your artwork is chosen, we will feature you in a Frontlines article and your art will be the new face of WADMHP.
I hope that everyone had a wonderful summer and we hope to see you at our October conference!

Sincerely,
Tiffany Buchanan, LMHC, DMHP
WADMHP President

Taking it to the Streets: Potential Impact of Diversion Outreach Services on ITA Investigations and Detentions

A year ago, our *Needles in Haystacks* article looked at outcomes on the Single Bed Certification unit at Central Washington Hospital in Wenatchee. So when the Frontlines Editor put out a call for articles this year it seemed natural to tell the rest of the story. Activities on MU-1 happen *after* the patient is detained. Yet there is the story about what's happening *before* events in the emergency room. It may be of interest how those activities affect ITA investigations and ultimately detentions.

An incidental update….MU-1 received the Washington State Hospital Association's Silver Award for Community Leadership in 2016.

Local practice attempts to divert cases from ITA investigation or incarceration in the Chelan County Jail through early intervention by the Mobile Outreach and Diversion Teams. Chelan-Douglas Diversion services are modeled after Reno's *Mobile Outreach Safety Team* and Seattle's *Crisis Intervention Response Team.*

Diversion services are a subset of crisis outreach in our region. Beginning with one DMHP assigned to law enforcement collaboration in June of 2015, promising outcomes and community feedback led to the expansion of the program in 2016. A Diversion Case Manager was added in early 2016 and an additional DMHP came onboard in April of 2016. While Diversion staff back up DMHPs, their primary work is unrestricted to location or requesting agency so they are able to respond rapidly to community referrals. Law enforcement and MU-1 activities are top response priorities, in that order. If there is no business in either of these domains Diversion staff may back up crisis staff at traditional service locations.

Diversion services consist of crisis outreach and crisis follow up components. Crisis outreach is initiated by a request from law enforcement. Diversion staff attempt to respond to calls in Wenatchee-East Wenatchee within 7-10 minutes of the call with goals of mental health crisis resolution and return of police to patrol duties. Responses to outlying rural and mountainous areas of Chelan and Douglas Counties obviously take longer. Diversion staff share "look up" duties or contact crisis staff in the DMHP office to conduct records review (on hands-free technology) en-route to the scene.

Most service contacts are crisis follow up referrals received from law enforcement during passdown meetings. All four law regional law enforcement agencies participate. Law enforcement passdown meetings occur daily or weekly, depending on the schedule that works for the particular agency involved. Law enforcement agencies make note of "high volume contacts" with suspected mental disorders engaged in misdemeanor crimes such as criminal trespass. Diversion staff look cases up in the BHO Database following referral and process under the general structure of RCW 10.31.110.

As stated above, Diversion activities generally occur *before* referral for ITA investigation or admission to jail or Emergency Department. So the focus of this article asks *to what extent have Diversion Services actually diverted individuals from the jail or the Emergency Department and prevented needless hospitalization?*
There is no way to know the number of arrests and incarcerations avoided. We can't assume that each law enforcement referral would've resulted in an arrest. We don't have access to jail admission records and mental health screening records for analysis.

On the other hand, we **can** look at the number of diversion outreach contacts and compare them to the number of ITA investigations and detentions. Do the data support the working hypothesis that diversion outreaches reduce investigations and detentions?

The answer is qualified by the fact that other things have been happening during the period in which the Diversion team developed. For example, changes to MHP/DMHP coding practices and increased efficiency of hospital staff processing referrals may have impacted the frequency of reported ITA investigations and detentions. That said, the overall number of ITA investigations and detentions have shown a significant decrease following implementation of the Diversion team.

Using the first six months of 2015 as baseline (i.e., the period immediately prior to the Diversion team), 188 community outreaches occurred. During the same period there were 331 ITA Investigations resulting in 113 detentions/revocations.

As the first Diversion DMHP initiated services in the second half of 2015, community outreach contacts increased from 188 to 220. ITA Investigations fell from 331 to 272 and detentions decreased slightly from 113 to 106 . During this period the primary engagement was with Wenatchee Police Department and the Chelan County Jail. Chelan and Douglas County Sheriff's offices and the East Wenatchee Police Department were not fully engaged in referral and passdown at that time.

"Taking it to the Streets" Continued from page 5

A Diversion Case manager came on- line and East Wenatchee and Chelan County were engaged in the first half of 2016. Community outreach contacts increased from 220 to 279. ITA investigations rose slightly to 314 (still lower than the 331 at baseline) while detentions dropped from 106 to 78, significantly below the baseline total of 113 a year earlier.

A second Diversion DMHP became active in the second half of 2016 allowing the team to fully engage Douglas County Sheriff in Diversion outreach and weekly passdown of high-volume contacts. During this period outreach contacts skyrocketed from 279 to 738. ITA Investigations fell again from 314 to 271, while detentions remained essentially unchanged rising from 78 to 81. This was still well below the baseline total of 113 a year and a half earlier.

We have not completed the first 6 months of 2017 yet the current data suggest an even more striking pattern. If the trend for 2017 holds we project approximately 700 outreach contacts resulting in a decrease from 271 to approximately 200 ITA Investigations and a drop from 81 to 50 detentions.

Analysis

Applying Pearson r product-moment correlation to the actual 2015-2106 data shows a correlation of -0.58 between community outreaches and ITA Investigations, a moderate to strong inverse relationship. Applying Person r to community outreaches and detentions results in -0.63, again a moderate to strong inverse relationship. In simpler terms, detentions decreased by 28 percent during the period in which the Diversion team developed.

Applying the Pearson product-moment correlation to the projected 2017 data sets produces stronger results of -0.73 for community outreach and ITA investigations, while the relationship between community outreach and detention/ revocation would be -0.76. Recall that no correlation is 0, and a perfect correlation negative correlation is -1.0. Negative 0.70 is considered to be a strong inverse, or downhill relationship between variables. But here we are perhaps counting our chickens before they are hatched.

Discussion

As above, other factors could complicate or confound the relationship between outreach and investigations/detentions. The current report is merely archival data presented here as a description of the potential for Diversion Services to reduce ITA Investigations and Detentions.

In terms of actual effects, it seems obvious that an active outreach program would resolve some crises in the field at a point where multiple options remain open. It is well known that as a crisis develops options dwindle until there may be nothing left but involuntary hospitalization. Early identification and referral of individuals in crisis along with active crisis resolution diverts some percentage from higher levels of care. Our data appear to support that conclusion.

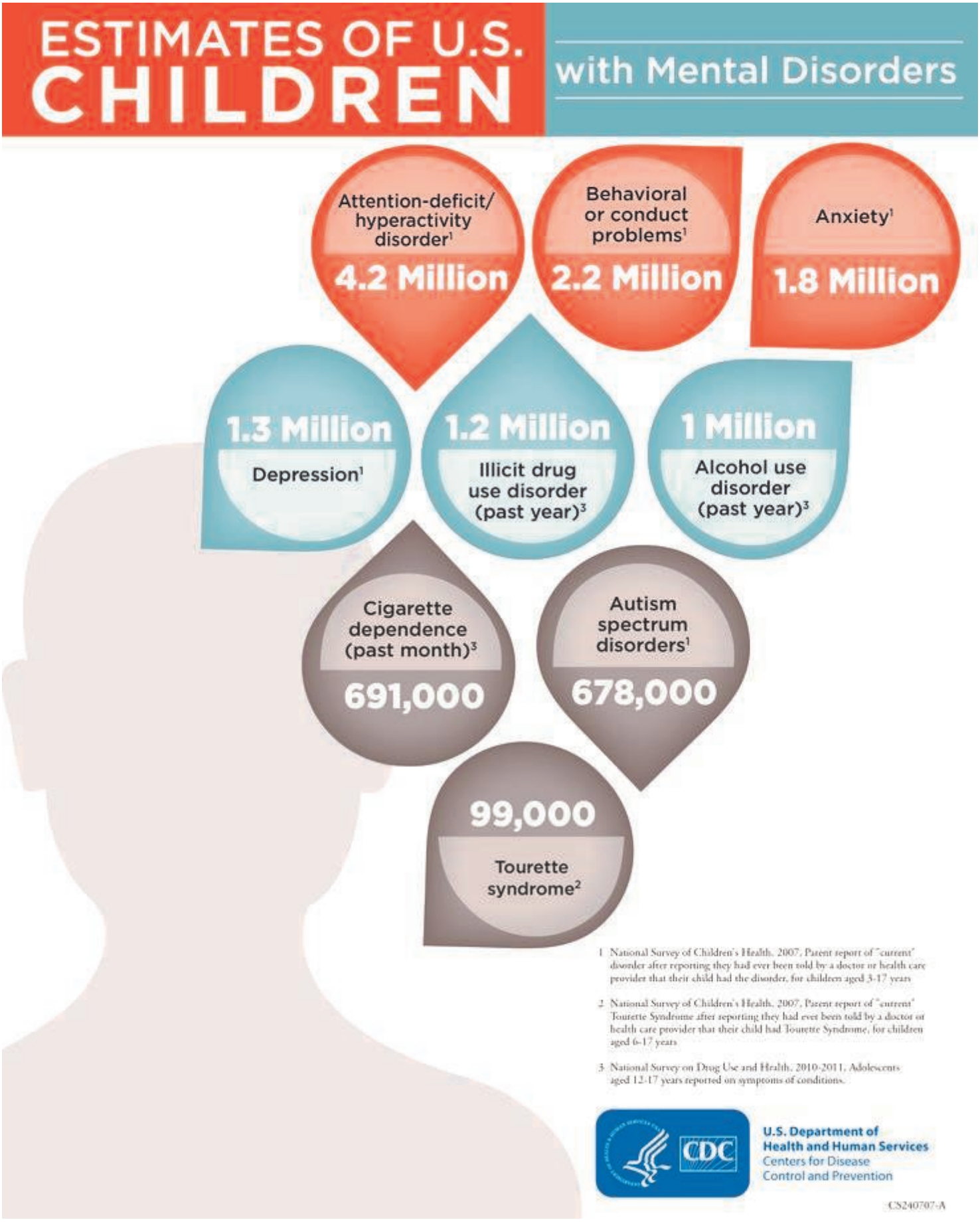
Law enforcement agencies report that their calls are briefer when Diversion Staff are involved, allowing them to return to patrol duties sooner. Moreover, some cases are resolved without the need to contact ambulance or arrange for other transport options. Law enforcement also report a sense of support in the daunting task of community policing during the Diversion Team hours of operation.

Another potential impact is that Diversion staff learn from police and police learn from diversion staff. With close contact law enforcement officers become more adept at understanding ITA criteria and what constitutes a legitimate ITA referral. It is possible that decreased ITA investigation and detentions may be partly a result of a higher community bar for transport to the emergency room and subsequent ITA investigations. Diversion staff maintain personal relationships with members of the PACT, Crisis, and Intensive Treatment Services teams as well as the homeless shelters, hospital, and so on. They are able to negotiate and resolve crises with resources not easily accessed by law enforcement officers.

Yet another impact may be the deterrent effect of law enforcement referring cases to persistent "friendly visitors" who, like bulldogs, follow up on high-volume contact referrals until they are either connected to services, incarcerated, or perhaps move on to other areas.

Overall, our data seems to suggest that engaging local law enforcement in proactive Diversion Outreach has a significant potential to reduce hospital utilization.

- Eric Skansgaard, DMHP


ESTIMATES OF U.S. CHILDREN
with Mental Disorders
Attention-deficit/ hyperactivity disorder[1]
4.2 Million
Behavioral or conduct problems[1]
2.2 Million
Anxiety[1]
1.8 Million
1.3 Million
Depression[1]
1.2 Million
Illicit drug use disorder (past year)[3]
1 Million
Alcohol use disorder (past year)[3]
Cigarette dependence (past month)[3]
691,000
Autism spectrum disorders[1]
678,000
99,000
Tourette syndrome[2]
1 National Survey of Children's Health, 2007. Parent report of "current" disorder after reporting they had ever been told by a doctor or health care provider that their child had the disorder, for children aged 3-17 years
2 National Survey of Children's Health, 2007. Parent report of "current" Tourette Syndrome after reporting they had ever been told by a doctor or health care provider that their child had Tourette Syndrome, for children aged 6-17 years
3 National Survey on Drug Use and Health, 2010-2011. Adolescents aged 12-17 years reported on symptoms of conditions.
CDC
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
CS240707-A

February 17, 2017

RE: Senate Bill 5441

To Senator Kuderer and Senate Committee:

The Washing Association of Designated Mental Health Professionals (WADMHP) have a neutral position on SB 5441 but would like to respectfully suggest some changes to the bill in its current form as it presents significant logistical challenges.

We would strongly suggest that the discharging facilities be responsible for notifying individuals detained under RCW 71.05.150 or 71.05.153 but are not subsequently detained for involuntary treatment under RCW 71.05; both verbally and in writing regarding their inability to possess firearms for the suggested six month time period.

When a DMHP detains someone under RCW 71.05, the detained individual is frequently sent to facilities outside of the county they were detained in. This causes several obstacles for DMHPs notifying the individual of their loss of gun rights for the six month period. These obstacles include:

Detaining DMHPs not having access to discharge information regarding the individuals detained and therefore not being able to notify the individual.

Questions regarding whether it be the detaining DMHP office that is responsible for notification or the office of the county where the individual is hospitalized being responsible for notification.

Most importantly, just because a DMHP detains someone, they don't have access to know what the treatment outcome is and/or when the individual will be discharged, due to HIPAA regulations.

To further complicate the notification process, DMHP offices are operated differently in different counties. Many are separate from the mental health agency who oversees the care of individuals coming out of the hospital. These offices have no way of knowing where someone is in the treatment process once they locate a psychiatric bed.

Personally, I have the unique experience of managing both DMHPs and a 15 bed inpatient psychiatric unit. The additional work that would go into tracking and notifying hospitalized individuals who fall into the category that SB 5441 would cover, would cause extreme hardship to DMHP offices across the state up to and including the need to hire additional staff to take on this responsibility. Inpatient units already have discharge planners who would be able to absorb this work easily as part of their routine discharge practice.

Thank you for your thoughtful consideration of our suggestions to this bill.

Sincerely,

Tiffany Buchanan, LMHC, DMHP
President
Washington Association of Designated Mental Health Professionals

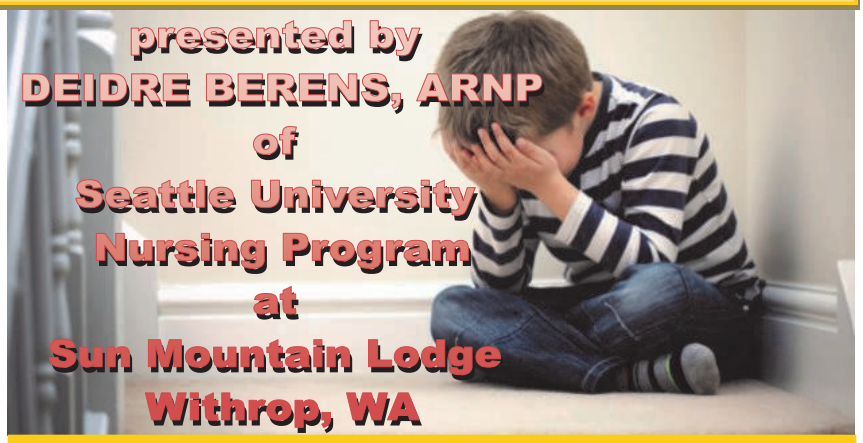
2017 FALL CONFERENCE "CRISIS ISSUES FOR CHILDREN AND ADOLESCENTS FOR DMHPS"

Wednesday, October 11, 2017
6:30—9:00 pm Hospitality Reception

Thursday, October 12, 2017
08:00 am Registration and Breakfast
08:30 am Opening Remarks
08:45 am Crisis issues of Children & Adolescents
10:30 am Break
10:45 am Crisis issues of Children & Adolescents
12:00 pm Lunch & Business Meeting
1:00 pm Crisis issues of Children & Adolescents
2:30 pm Break
2:45 pm Crisis issues of Children & Adolescents
4:30 pm Adjournment

Friday, October 13, 2017
08:00 am Breakfast & Registration
08:30 am Opening Remarks
08:45 am SBC updates with Robbie Pellett
10:30 am Break
11:00 am **Roundtable: TBA**
12:00 pm Conference Adjourns

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



LUNCH BUSINESS MEETING:

We will be holding elections for-

2nd Vice President & Treasurer

If you are interested in being on the board, please email board at wadmhp@gmail.com with the position you are interested so you can be added to meeting election.

ABOUT OUR PRESENTER: **Deidre Berens, MS, ARNP** is a Psychiatric Nurse Practitioner who went to school at OHSU in Portland, OR. She has a social interest in psychopharmacology and neuroanatomy. She currently is a professor at Seattle University School of Nursing in Seattle Washington who has nursing school is located at Swedish Cherry Hill Hospital. She works at Navos providing psychiatric assessment and treatment to children and adolescents. She has been serving children and families as Psychiatric Nurse Practitioner since 2007, and has worked in a number of settings including inpatient, day treatment, outpatient, in both rural and urban areas, and both in community and private practice.

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 25th to the WADMHP board by email at wadmhp@gmail.com. The WADMHP board will pick the winning DMHP and will inform the DMHP's supervisor by October 1st. At the Fall conference the winning DMHP will be acknowledged at the lunch meeting on Thursday October 12.

REGISTRATION FORM
SPRING CONFERENCE 2017

Washington Association of Designated Mental Health Professionals

October 12-13, 2017
Sun Mountain Lodge WINTHROP, WA

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.**

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

REGISTER ONLINE

www.wadmhp.org

Registration Contact: WADMHP@gmail.com

If you have any questions, you can call Lisa Westland at 503-805-0989

CALENDAR

JUNE 2018/ TBA
wadmhp spring conference

OCTOBER 13-14 2018
wadmhp fall conference
winthrop, wa

** Dates may change

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