SPRING VOLUME 34 ISSUE 1 2014

frontlines

WASHINGTON ASSOCIATION FOR DESIGNATED MENTAL HEALTH PROFESSIONALS

Letter from President, Luke Waggoner

On July 5th, 2013 Joel Reuter was shot and killed by members of the Seattle Police Department SWAT team after an 8 hour standoff that ended when Joel fired a shot from a 9mm handgun. Joel's family and friends had watched for months as the symptoms of his Bi-polar illness increased and he withdrew further and further from them. Joel was placed involuntarily in inpatient psychiatric treatment on several occasions but released each time prior to the 90-day commitment. Following Joel's death his parents made a commitment to lobby for change in our state's commitment laws, changes they believe would have saved their son's life.

Here in Walla Walla I remained unaware of this tragic incident until I started looking at the bills related to the ITA law that were being introduced at the 2014 legislative session. Although I was unable to go to Olympia to testify on particular bills I was attempting to stay as up to date as possible on each bill as it progressed, or didn't progress, through various committees. I first heard about Joel when I watched his parent's testimony at the public hearing in the House Committee on Judiciary on February 3rd. As I heard them tell their story and witnessed their grief I had tears in my eyes. As a parent, imagining what it would be like to have my son shot and killed is unbearable to me. I cannot think about it without feeling strong emotions well up within me. I am a human that happens to be a DMHP and the suffering I witness or hear about daily touches my heart.

As a DMHP, my initial reaction upon reading HB 2725[1], the bill Joel's parents and friends were testifying for, was first something akin to an eye roll. What I was reading seemed to be just another bill pointing the finger at DMHPs and blaming us for the problems in our states involuntary mental health treatment systems. But as I listened to testimony where DMHPs were called bureaucrats and bed monitors who lack the appropriate training and will only respond if the individual has their finger on the trigger of a loaded gun I became angry. Every DMHP I know is a skilled clinician who considers all the available information and then works hard to find the best solution for that individual while following the requirements of the law. We do all this within a system that is woefully inadequate to meet the demand and where we face daily doses of anger and hostility from citizens and professionals alike.

When the legislative session ended this bill had not been brought to a vote in

Continued on page 5

WHAT'S IN THIS ISSUE?

GREETINGS FROM OLYMPIA –David Kludt

March 2014

It has been a busy and as always very interesting legislative session. As of this writing (3/11) there are still a number of bills alive related to community mental health and crisis services. Among the bills still alive SHB 2725 and 2SSB 6312 are of particular importance. SHB 2725 proposes that a family member would be allowed to petition the Superior Court when a decision is made by a Designated Mental Health Professional (DMHP) to not detain an individual. In this circumstance the Superior Court Judge would then be able to order an initial detention if they determine probable cause exists. A current amendment to the original bill would delay the implementation until July 1, 2017 and require DSHS to contract with the Washington State Institute for Public Policy to conduct a comprehensive assessment of the utilization and capacity needs of crisis mental health services, including, the potential impact of this legislation. 2SSB 6312 is a comprehensive bill related to state purchasing of mental health and chemical dependency treatment services. Both of these bills if passed will have a major impact on our system.

ESSB 5480 (2013 Session) which accelerates the implementation of 2SHB (2010 Session) goes into effect on **July 1, 2014**. As a reminder, this legislation expands the criteria for involuntary civil commitment.

It provides, in part, that civil commitment would be permissible when a DMHP determines that the person under investigation who has refused voluntary treatment exhibits symptoms or behaviors which standing alone would not justify civil commitment, but:

- Such symptoms or behavior are closely associated with symptoms or behavior which preceded and led to a past incident of involuntary hospitalization, severe deterioration, or one or more violent acts;
- These symptoms or behaviors represented a marked and concerning change in the baseline behavior of the person, and
- Without treatment, the continued deterioration of the person is probable.

Amazing how quickly time goes by! It really does seem like just yesterday when we last conducted our legislatively mandated (every 3 years) review and updating of the Statewide DMHP Protocols. The 2014 protocol workgroup has been established and began their work on March 6, 2014. The workgroup is comprised of many DMHP's and DMHP Managers as well as representatives from; Regional Support Networks, Developmental Disability Administration, Home & Community Services, National Advocates for the Mentally Ill, Public Defender's Association, Prosecuting Attorney's Association, Washington State Tribes, Department of Corrections, and the Division of Behavioral Health and Recovery (Children's, Consumer Partnership, Chemical Dependency, Licensing and Certification). In June the workgroup will submit our draft protocol report to the Behavioral Health Services Administration (Jane Beyer), the Director of the Division of Behavioral Health and Recovery (Chris Imhoff) and the State Attorney General Office. After approval of these entities the protocols will be sent on to the legislature for approval. It is my hope that by the end of July the 2014 DMHP Protocols will be approved and distributed.

A belated shout out of appreciation and well wishes to Amnon Shoenfield. Amnon recently retired after 34 years with King County. His career in King County began as a Designated Mental Health Professional and DMHP Supervisor before moving on to, Coordinator of Crisis and Commitment Services and for the past 11 years as the Director of Mental Health Chemical Addiction and Dependency Services Division. Amnon was responsible for the adoption of the one tenth of 1% sales tax funding for new mental health programs in King County. Amnon was a tireless advocate for people with mental illness and was very instrumental in local and state efforts to improve the mental health crisis system. Hope you have a terrific retirement Amnon!

Take care, and as always stay safe!

~David Kludt, Division of Behavioral Health and Recovery/Program Administrator

BOOT CAMP SUPPORT LETTER

February 9, 2014

Dear Ms. Jane Beyer,
Assistant Secretary for Behavioral Health
and Service Integration

The Washington Association of Designated Mental Health Professionals would like to bring to your attention the need for funding for the DMHP Boot Camp, which is the only training program specifically tailored to the educational and skill development needs of Designated Mental Health Professionals across the state.

DSHS funded the DMHP Boot Camps from 2001 to 2012. From 2006 to 2012 the Washington Association of Designated Mental Health Professionals was contracted by DSHS to provide the DMHP Boot Camps. Over the years the Association evolved the training though feedback from the DMHP Managers and DMHPs who participated in the programs. The Boot Camp is a 40 hour, weeklong, in person training which is provided in venues on both sides of the state. The DMHP Boot Camps provide the specific education and skills DMHPs need to do the important job of involuntary commitment investigations and to understand changes in the law.

In 2013 the DMHP Boot Camps were not funded. Many DMHP managers expressed strong disappointment at the loss of the Boot Camps. DMHP managers from across the state continue to expressed the need for the DMHP Boot Camps which many counties have counted on to supplement their own training programs as well as for updating staff on the important changes made to the Involuntary Treatment Act.

We would like to request your consideration when making funding decisions this year, for the DMHP Boot Camps as provided by the Washington Association of Designated Mental Health Professionals. Thank you for your time and attention.

Sincerely,

Luke Waggoner
President
WADMHP

Detention: Why Not Never a "No," only a "Not Now?

By Gary Carter

The call for help comes in to the office. The allegations are reviewed with the caller, a bit of research may be done, it is a first time call regarding the individual and let's say a decision to investigate results.

Next, records are reviewed, collaterals are interviewed and finally the client is questioned. There are plenty of facts to weigh: there are symptoms of a mental disorder and some resulting impairment is noted. Even so, criteria for a likelihood of serious harm due to substantial impairment of functioning didn't exist.

So, what is next? Stop here; this is important. What is the next thing to be done? What is the next thing YOU usually do...?

We, of course are to refer the person for services when the decision is not to detain (Paragraph 235; 2011 DMHP Protocols). Those steps include referring the individual to appropriate outpatient care centers and consider if it is necessary to re-contact the individual to see if they failed to follow through on the referral; Advise the service provider to contact the DMHP if the individual refuses to participate in treatment, if the decision not to detain was based on the individual's accepting less restrictive treatment; and/or plan to reestablish contact with the individual if a second referral is requested.

Asking again, what is it that is usually done when we decide not to detain? My observation is there is a great likelihood to limit our response to providing referrals and then to leave. Consider that when we make the decision to deny access to treatment, even when completely justified and defensible, we move into the domain of greater responsibility. I feel that our responsibility grows when we identify a need and then don't act in a way that contains it.

When we deny access, something that we are required to do in our role, I am of the mind that we have a legal/ethical responsibility to explain our decision with the same detail as we do in a petition following detention. This means we don't limit ourselves to just that the facts that didn't allow for detention, but what we believe is now necessary to provide for the protection of our client and the community.

So, here is my pitch to our profession: when we do not detain we routinely recruit and educate the individual(s) who are referring to continue to monitor the individual's behavior and provide referrals of facts in the coming days to assist us in building a case. We actively and effectively coach them that while we are completely aware and sympathetic about the need they are reporting we are limited by the absence of facts that establish grounds to detain. Everyone understands that one gets arrested only after they are adequate facts (radar clocks a driver going above the posted speed limit) to impose the law on someone. In the same way, being concerned about someone - observing there is a need or suffering - isn't enough to detain. Facts drive this bus.

Recruiting them to continue to monitor the client and call us any and every time new facts relevant to this case are found keeps them involved and it builds a case for us over a short time. If the case fails to generate new facts, it disappears and presumably so does the risk to the client and community. Alternatively, when the case complicates and the calls can document a recent or imminent deterioration, then we have a case where we can intervene at the right time and before the client drops, unobserved into hell and/or harm. That is, "no, a person doesn't have to die to get help!" We make it clear at every point that our "no" is only a "not now."

This helps the community because they have a useful service available and assurances that help is still available and even poised to act with their continued involvement. It works for us because we get the facts we need to make an informed and timely decision. If we have set it up correctly the calls that come in are more likely to inform instead of demand or plead for an outreach when little has changed or when the client unfortunately is discovered to have come to harm of some sort.

"Detention" Continued….

It is my idea that efforts like these will demonstrate to our community a commitment to help and be responsive to their needs in the face of our statue-based limitations. Fostering a means for our community to engage with us will promote trust in our judgment and will foster respect for the law and it's limits.

Then, when partnered with those who rely on our work we will not need or will we continue to see legislation that requires us to "consider" the opinion of an ED MD or that provides a means for families to act when they don't agree with the decision of a DMHP. It just would not be necessary.

Letter from the President Continued…

… the Senate and so it died, for this session at least. As touched as I was by the Reuter family's story I don't believe this bill was the answer they were hoping it would be. We have yet to see what the full implementation of 3076[2] will mean for detentions in our state and many, if not most, counties in our state still do not have the option to utilize the non-emergent detention available under RCW 71.05.150. It seems foolish to me to pass more legislation until we fix a couple significant issues. First, we need the capacity to serve all those detained under the current law and the changes effective on 7/1/14. Second, we need to see the full ITA law available to DMHPs in every county, including non-emergent detentions.

After many hours spent thinking about Joel, his family and friends, fatherhood, and what it is like to be a DMHP I can't blame the Reuters for pushing for this change. If I was in their shoes I think I might be doing the same thing. I can't even fault them for blaming DMHPs. What I hope is that the Reuters can find solace in their grief and that our legislature can carefully and thoughtfully work to pass legislation that moves us forward in a way that protects the rights of the individual, the safety of the community and provides adequate access to appropriate mental health treatment to all who need it.

-Luke Waggoner

[1] See http://apps.leg.wa.gov/billinfo/summary.aspx?year=2014&bill=2725 for bill information.
[2] See http://apps.leg.wa.gov/billinfo/summary.aspx?bill=3076&year=2009 for bill information.

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VOICE OF THE DMHPs

What do you think about family members being able to petition the court if the DMHP decides not to detain?

"I can understand the pain and the emotions a family may go through when their loved one is struggling with mental issues and maybe even substance issues. Rapport between the DMHP and the family must be established and if done well, the family will learn to trust the system and the legalities behind whether to detain someone or not. I feel it would be highly detrimental to the mental health system as well as to the mentally ill individual if an untrained family member had the right to force their loved one into inpatient psychiatric care. I would not support a bill that would allow families to override a DMHP's skill set to detain an individual."

-Jon London, MS, CMHS, DMHP in Cowlitz County

"Family members are always involved in the ITA evaluation process and their testimony taken seriously, as with any credible witness. Those instances where families have been failed by the system must certainly be rare, given the numbers of ITA investigations performed state-wide every single day. That said, it may very well be that the frustration of family members stems from the fact that those individuals who have serious and persistent mental illnesses are not well served by the "revolving door" nature inherent in our current system. Families should instead get active in NAMI or form other supports to lobby for legislation and funding essential to stabilize and treat those with severe, chronic, and treatment-resistant mental illness. "Watering down" and complicating RCW 71.05 and/or 71.34 is not the answer, it's a half-measure at best."

-Sandarah A. Amun, MA, LMHC, DMHP in Whatcom County

"There are times when families, who are dealing with mentally challenged family members, come face to face with the narrow window of the involuntary treatment process. Generally they have provided much needed support to the consumer living with a mental illness—sheltering the consumer, helping with medications, ensuring that the consumer makes and keeps appointments with prescriptive authorities and treatment providers are but a few of the ways they contribute to the continuing well-being of the consumer. Their investment can be substantial—financial and emotional commitment of resources can and often does affect the entire family system. Little wonder, then, that a family comprised of caring individuals who sacrifice time, money, emotions in an effort to help another family member stay socially functional experience frustration and disappointment (at the least) when that family member is essentially denied the treatment they feel is needed to keep them at that level of functioning. Little wonder that families advocate for a voice.

It's important to stay grounded—will this process avert all adverse outcomes? No. Will this address the expressed needs of the family to realize treatment for their loved one? Sometimes. Will we still have to deal with issues regarding the final decision sometimes? Yes. Will this mitigate family concerns? We hope. Will families realize that the need for treatment alone is not sufficient for ITA? No. Fine points of the law may never be appreciated by the public at large but these fine points ensure that the rights of the consumer are recognized and respected. We work in a field that is filled with areas of gray deliberation—often there is a fine line between less restrictive and involuntary treatment and our decision process can benefit from conversations with those most intimate to the consumer.

Legislation was initiated because the child of a parent died. To that parent it matters little that their child is an adult in our eyes. Our decisions can have far ranging effects and the extension of our care must extend to families of those we serve. If we do not succeed in representing the family's point of view regarding the care of their loved one, they will, and they will be in the right to do so.

-Jace Knievel, LMHC, DMHP in Thurston/ Mason Counties

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

DMHP Word Search Ed. 2

M U K A I K H A W U T E H
T I G A K S D X D P A F G
V F E R R Y N E P L T G N
S E S S U P A C A G I H I
N A W A K N L R C A K S K
E D A K L B S E I R C I N
V A Y I I G I I F F I M L
E M J Y B T U P I I L O O
T S E K A M S O C E K H C
S R F M W K U A D L P O N
B E N T O N I L P D H N I
M C L A L L A M O D S S L
W H A T C O M G A C F G J

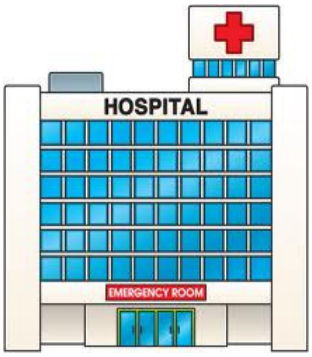
WA State Counties Part 1

ADAMS
BENTON
CLALLAM
COLUMBIA
FERRY
GARFIELD
DOUGLAS
ISLAND
KITSAP
KLICKITAT
LINCOLN
KING
PACIFIC
PIERCE
SKAGIT
SNOHOMISH
STEVENS
WAHKIAKUM
WHATCOM
YAKIMA

*answers on page 10

Single Bed Certifications by Hospital County State Fiscal year

Hospital County	*Certifications*	*Patients*
Missing	2	2
Asotin	1	1
Benton	94	83
Chelan	15	13
Clallam	31	30
Clark	87	72
Cowlitz	7	7
Franklin	26	25
Grays Harbor	38	31
Island	25	23
Jefferson	9	7
King	1450	1158
Kitsap	102	93
Kittitas	3	3
Lewis	22	17
Mason	7	7
Pacific	20	14
Pierce	707	491
Skagit	50	46
Snohomish	298	235
Spokane	187	112
Thurston	108	96
Walla Walla	27	23
Whatcom	17	17
Yakima	5	5
STATEWIDE	***3338***	***2549***



Source: Single Bed Certification requests to Eastern State Hospital and Western State Hospital.

Notes:

The difference between the sum of unduplicated patients in each county and the statewide total for unduplicated patients is due to individuals receiving Single Bed Certifications in more than one county during SFY2013.

Single Bed Certifications not requested through the State Hospitals are not reflected in this report.

Whose Patients are they? By Anonymous
(Part 2 to "Rock and a Hard Place " Fall 21013)

We've all heard it. "Your patient", "one of your people is in here again", "we've got somebody who belongs to you". When you walk into a hospital and the client you are there to assess already has a "Property of the DMHP" sticker firmly attached to them, you might have any of a range of responses, depending on where you are from. Anything from rueful acceptance, to irritation, to polishing up your best "mental health disorders are just as legitimate as medical disorders" speech.

I think we used to be able to blame this attitude on lack of awareness and minimal experience with mental health disorders and treatment. Not anymore. With the increase in boarding and single bed certification statewide, and the ongoing media coverage, mental health patients in the emergency room (and the rest of the hospital) are a more common sight. As resources decrease, beds evaporate, and caseloads get bigger, everyone gets more protective of their own corner. Hospital staff are no exception to this. Where you work, what your relationship is like with local hospitals, and how many crisis beds, follow up appointments, and discharge plans you have, will all affect your response to the above statements. Substance abuse, developmental disabilities, and dementia throw a wrench in the situation too. Are they still "your patient" if they have mental health symptoms but not an actual disorder? What if they're not medically cleared? Or they're voluntary? Or they're mostly a gigantic placement issue? I can't think of a DMHP who will argue that the floridly psychotic guy with chronic schizophrenia who is flailing on the gurney, or the manic woman with Bipolar Disorder whom you have seen three times before is not one of "your people". When I'm told they belong to me I'm probably going to roll my eyes (when no one can see me) but I'm also going to roll up my sleeves and willingly do what needs to be done.

But the complicated cases, they require more work. More than a detention. More than a hand off. Even if they are "my person", they need more than I can give them. They're going to need medical treatment, a psychiatric assessment, some (or a lot of) discharge planning, or some persistent calls to their nursing home. If a person is in the hospital, they belong to the hospital. They are a patient and they require care – for diabetes, or schizophrenia, or a heart attack. I am a professional, like the doctor and the nurse and the psychiatrist, and I will do my part. But we all have a role to play in caring for people in our community.

Single bed certification and the increase in boarding mental health patients accelerates this debate. More and more, when the DMHP shows up, we don't whisk "our patient" away to an appropriate mental health facility because we simply can't. Detention doesn't solve the issue of providing ongoing care to vulnerable people, some of whom may be violent, or uncooperative, or need a lot of social work to find an appropriate place for them. Even after they're detained, hospital staff still need to provide care, giving us more time to have the "your patient" conversation. The way that we negotiate this conversation affects the care our clients receive. These individuals belong to all of us.

2014 SPRING CONFERENCE
DRUG INTERACTIONS in MENTAL HEALTH
at YAKIMA CONVENTION CENTER

WEDNESDAY, JUNE 18th

07:30 am Registration and Breakfast
08:30 am Opening Remarks
08:45 am Legislative Updates
Presenters: David Kludt
10:30 am Break
10:45 am Legislative Updates
12:00 pm Lunch & Business Meeting
1:30 pm Drug Interactions
2:30 pm Break
2:45 pm Drug Interactions
4:30 pm Adjournment
CEU/CME: 8 hours

***Deidre Berens, MS, ARNP**, is a Psychiatric Nurse Practioner who went to school at OHSU in Portland, OR. She has a social interest in psychopharmacology and neuro-anatomy. She currently is working in Community Mental Health in Astoria, OR as a psychiatric medication prescriber. She has experience working in corrections, medical clinics, hospitals, and outpatient mental health clinics. She frequently works with crisis teams when it's unclear if a patient's condition would benefit from certain types of treatment - inpatient versus IOP, versus medical floor. She collaborates with local pharmacists to improve the packaging on meds in order to improve patient compliance, and works very closely with case managers to ensure that people's medical and psychiatric needs are adequately addressed to prevent a crisis or hospitalization.*

Like us on Facebook

Like our WADMHP Facebook page before May 15th and you will have a chance to win *ONE FREE* entry to the Spring WADMHP Conference in Yakima on June 18th!!!

Results from word search on page 7

REGISTRATION FORM
SPRING CONFERENCE 2014
Washington Association of Designated Mental Health Professionals

JUNE 18, 2014
Yakima Conference Center

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 $ 70

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:

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Or contact Kincaid Davidson at (360) 676-5162

Or Register Online at WADMHP.ORG!!

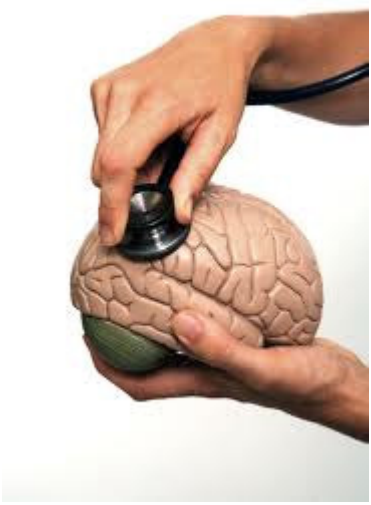
CALENDAR

OCTOBER 16-17, 2014
wadmhp fall conference

winthrop, wa

JUNE 17, 2015
wadmhp spring conference

** Dates may change



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