SPRING VOLUME 35 ISSUE 1 2015

frontlines

WASHINGTON ASSOCIATION FOR
DESIGNATED MENTAL HEALTH PROFESSIONALS

WHAT'S IN THIS ISSUE?

Letter from President, Tiffany Buchanan

Fellow DMHPs,

I want to introduce myself and thank each one of you for your support of Washington Association of Designated Mental Health Professionals. My name is Tiffany Buchanan and I am honored to serve, along with my fellow committee members, as the voice of DMHPs across the state. What a start to the year and the beginning of my role as WADMHP President this has been! The legislative session is in full swing and there are more bills in the House and Senate that will impact DMHP work than ever before. WADMHP has been actively involved in this year's legislative session, participating in work groups, meeting with legislature, and providing feedback on bills. As bills such as SHB 1448 and SSB 5269 continue to be amended, it is crucial that we hear your concerns and creative solutions so that we can provide feedback directly to legislature.

Not only are we as DMHPs anticipating change with new bills on the horizon, but we are still reeling from the change that occurred December 26, 2014 with WAC 388-865-0526. For the first time since the Involuntary Treatment Act was enacted, DMHPs do not have the authority to detain when a psychiatric bed is not available and a hospital is unable to accept a single bed certification, even if the DMHP believes the person meets criteria for detention. DMHPs in many counties must continue to do their work knowing that they may have to walk away from a client who is a danger to themselves or others and will not receive the treatment they desperately need.

There are many reasons why DMHPs do the work they do. We want to be able to make an impact in someone's life when they are at their lowest, save someone's life, help someone who is unable to make the decisions or take steps to care for themselves, and protect peoples' civil liberties. Many of us have been doing this job for years and the idea that someone we believe needs inpatient intervention might not receive it because there is no bed available, leaves us feeling helpless and puts our most vulnerable clients and the community in danger.

Continued on page 5

GREETINGS FROM OLYMPIA

-David Kludt

March 2015

Greetings from Olympia,

It certainly has been a busy and interesting 2015 legislative session. Thank you once again for all of your assistance in providing information and your thoughts on these proposed bills! Currently the following bills continue to move forward.

House Bills:

-Engrossed HB 1258 – An act relating to court review of detention decisions under the involuntary treatment act. (Family petition when DMHP does not detain)

-Substitute HB 1348 – An act relating to requiring crisis intervention training for peace officers.

-Engrossed Substitute HB 1448 – An act relating to procedures for responding to reports of threatened or attempted suicide.

-Engrossed 2nd Substitute HB 1450 – An act relating to involuntary outpatient mental health treatment.

-Substitute HB 1536 – An act relating to the timing of emergency detentions and assessments under the involuntary treatment act. (Establishes definition for medical clearance)

-Engrossed Substitute HB 1713 – An act relating to integrating the treatment systems for mental health and chemical dependency. (ITA systems)

Senate Bills:

-Engrossed 2nd Substitute SB 5269 (companion bill to EHB 1258) – An act relating to court review of detention decisions under the involuntary treatment act.

-2nd Substitute SB 5311 (companion bill to SHB 1348) – An act relating to requiring crisis intervention training for peace officers.

-Substitute SB 5645 – An act relating to data reporting concerning the collection of data when a psychiatric patient meets detention criteria and no evaluation and treatment bed is available.

-Engrossed 2nd Substitute SB 5269 – An act relating to the involuntary treatment act. This bill includes provisions for; assisted outpatient mental health treatment, puts into statute the use of single bed certification, reporting by a DMHP when no bed is available and DSHS publishing reports re: SBC and boarding, clearly establishing RSN responsibility to

provide an adequate network of E&T services, medical clearance prior to DMHP investigation, WSIPP study re: estimating capacity needs for E&T services and assisted outpatient treatment.

Although many of these bills have a significant fiscal impact, the legislature appears to be very interested in passing mental health legislation. We can only hope that bills passed will have full funding!
As a reminder, during the upcoming WADMHP Association Spring Conference, June 17th, in Vancouver, we will be discussing implementation of any bills that pass during the session.

DMHP Training Survey Results: Thanks to those of you who responded to the short survey re: DMHP training. Below are the results of the survey. I will be continuing to work with the DMHP Assoc., RSNs and DBHR Administration to address DMHP training needs.

Do you support requiring DMHP Training Academy within first year as DMHP?
Yes – 20 offices representing 24 counties
No or with concerns – 6 offices representing 12 counties

Do you support requirement for ongoing training for DMHPs after first year?
Yes (every 3-5 years) – 20 offices representing 24 counties
No or with concerns – 6 offices representing 13 counties

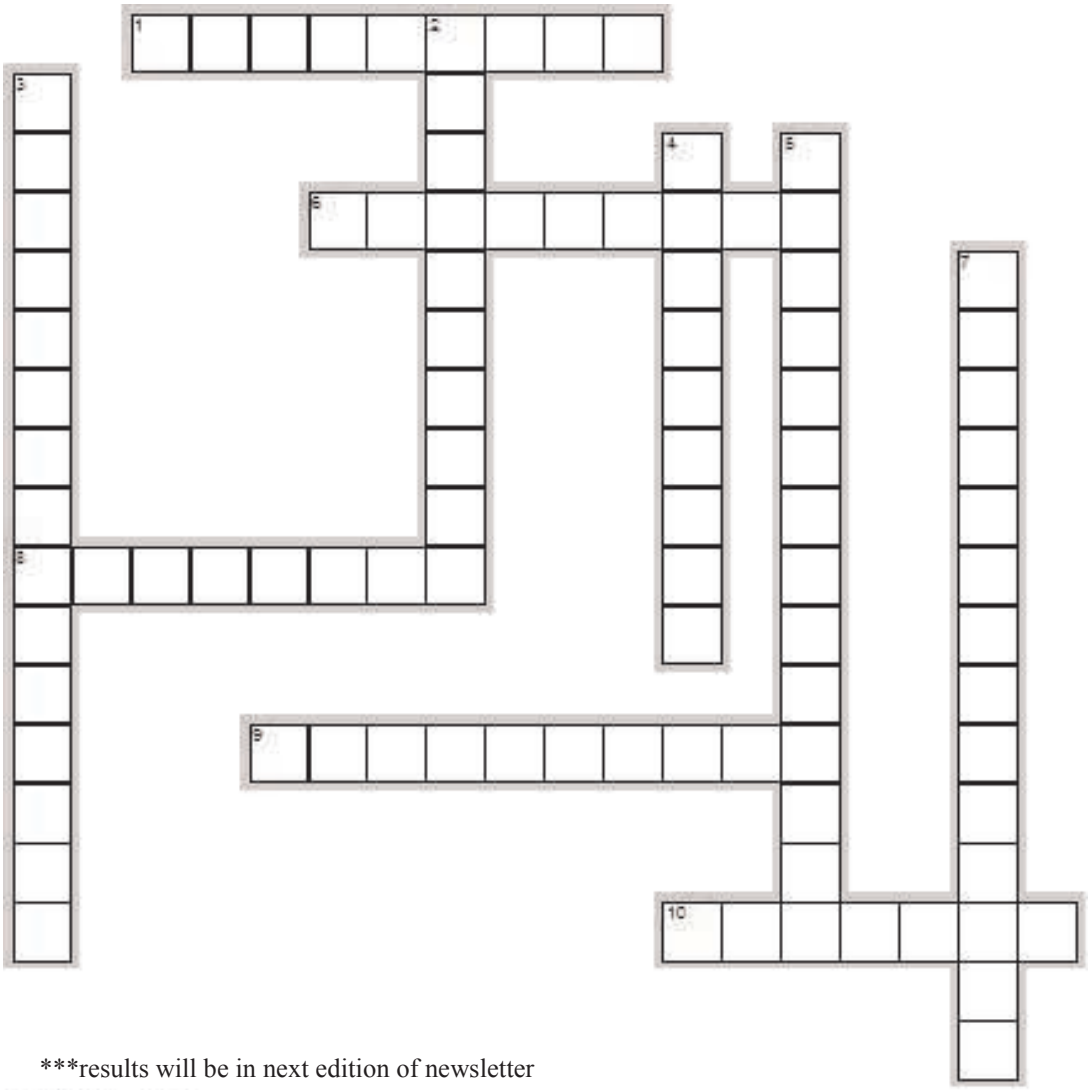
Do you support requirement for DMHP Managers to attend annual training?
Yes – 20 offices representing 26 counties
No or with concerns – 6 offices representing 10 counties

Does your agency provide training specific to your role as a DMHP?
Yes – 17 offices representing 25 counties
No – 9 offices representing 9 counties

By the time you are reading this, the 2014 DMHP Protocols will have been distributed. If you do not receive a copy of the protocols they are posted on both the DBHR and DMHP Assoc. websites.

One last thought – During the current legislative session DMHPs have often been pointed to as the problem with our involuntary commitment system. Those of us who are more intimately a part of that system realize that what ails our involuntary system is a combination of many factors, most notably a shortage of resources. At the same time I encourage each of us to listen carefully to concerns and each do our part to help address the concerns.
As always, thank you and be safe!

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



***results will be in next edition of newsletter

ACROSS

1. Shall provide uniform development and application of criteria in evaluation and commitment recommendations, of persons who have, or are alleged to have, mental disorders and are subject to this chapter and shall be updated every three years
6. A decision by a physician or psychiatric advanced registered nurse practitioner that a person should be examined or treated as a patient in a hospital
8. State or condition of being likely to occur at any moment or near at hand, rather than distant or remote
9. Lawful confinement of a person under the provisions for chapter RCW 71.05
10. Involuntary detention under provisions of this chapter uninterrupted by any period of unconditional release from commitment from a facility providing involuntary care and treatment

DOWN

2. Determination by a court that a person should be detained for a period of either evaluation or treatment, or both, in an inpatient or less restrictive setting
3. Condition in which a person, as a result of a mental disorder is either in serious physical harm resulting from failure to provide for his or her essential human needs of health and safety or manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety
4. Termination of hospital medical authority. Commitment may remain in place, be terminated, or be amended by court order.
5. Class of drugs primarily used to treat serious manifestations of mental illness associated with thought disorders
7. Any organic, mental, or emotional impairment which has substantial adverse effects on a person's cognitive or volitional functions

I moved from Germany to Seattle in 1992 and finished graduate school in 1994. My first job in the mental health field was on a voluntary crisis team where I worked form 1994 until 2001. Despite having had very different plans like private practice, long-term therapy and all that, I realized quickly that I loved crisis work.

I became a DMHP with Snohomish County in 2001 and have been managing the team for the last five years. I am still passionate about DMHP work in general and am interested in legislative issues.

Outside of work I love fencing, skiing, traveling and cooking with lots of different spices.

Letter from the President Continued...

As I write this letter, I do not know how the bills affecting our work will be amended or how our work will change. I do know that with the addition of many of the proposed bills, our psychiatric bed crisis will continue to be a major issue. We need additional beds and funding for the proposed bills being introduced this session as well as for the bed crisis that has been in existence for years. This is the time for each of you to write our representatives and senators and let them know what is happing at the ground level daily. Without our voices, I fear that the people we see will continue to get subpar treatment for their mental illness or worse, will die because of these changes.

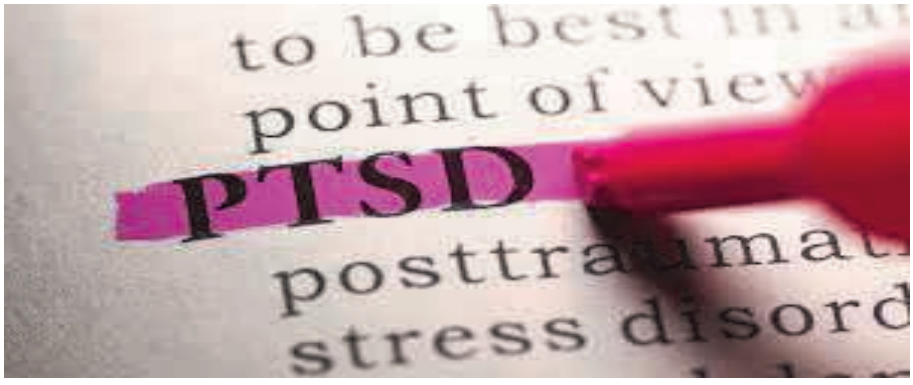
-Tiffany Buchanan, LMHC, DMHP

Examining Trauma within Crisis Response

By: Leatha Goar, MA DMHP CCTP

On January 12, 2015, King 5 News in Seattle posted a news story regarding the US Army deciding to give mental health assessments to the National Guardsmen who assisted with the clean-up and recovery at the OSO mudslide. A Washington National Guard spokesperson reported that this is the first time guardsmen will be screened following a domestic mission. Guard Captain Peter Stone was quoted as saying, "Typically when we respond, it's for forest fires, not a whole lot of traumatic events…There are guys who were not bothered while doing it, but they might be bothered now. It's part of post-traumatic stress, which you can get from anything." In 2008 the US military services began conducting mental health assessments on all service members, but only when returning from deployments overseas. Captain Stone ended the King 5 story by stating that he hoped screenings would become routine for any domestic National Guard deployments that might result in mental stress.

So, what has this to do with DMHPs? The nature of our work exposes us to all forms of trauma on a daily basis and many of us do not receive the support we require to remain healthy both on the job and in our personal lives. With this article I would like to open a discussion about trauma and how it intersects with mental health crisis services, beginning with a discussion of the nature of trauma within our work. There are as many different definitions of trauma as there are those who have experienced it. A place to find a common language for trauma can be found in the definition of PTSD in the DSM-5 within the first criterion for diagnosis. Criterion A states that trauma is exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: 1) Directly experiencing the traumatic event(s); 2) Witnessing in person the event(s) as it occurred to others; 3) Learning that the traumatic event(s) occurred to a close family member of close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental; 4) Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g. first responders collecting human remains; police officers repeatedly exposed to details of child abuse). Do you recognize yourself and your teams within this definition? Within Criterion A points 1 and 2 can be considered primary trauma. How many of us have been threatened with physical harm or death in the course of an ITA investigation? How many of us have been threatened with sexual assault? Criterion points 3 and 4 can be considered secondary trauma which we also experience as we hear the stories of those we serve. Both primary and secondary trauma are inherent not only in crisis work, but any work that puts one in contact with the inner workings of the human mind.



In response to this fact Sigmund Freud wrote, "No one who conjures up that most evil of those half-tamed demons that inhabit the human beast, and seeks to wrestle with them, can expect to come through the struggle unscathed." Therefore, it is not only important to understand trauma as a part of our work, but to recognize how it affects us. Our work is painful. The function of pain is to get our attention. It is what we do with the pain that defines us.

When we bury the painful experiences of workplace trauma it informs how we interact within any given crisis. A reflection of this can be found in the writings of Pema Chodron. She stated, "Without realizing it we continually shield ourselves from this pain because it scares us. Based on a deep fear of being hurt, we erect protective walls made out of strategies, opinions, prejudices, and emotions." We begin to act through agendas that protect ourselves rather than being fully present to the situation in front of us. When we are fully present we have access to our entire skill set to meet the challenge of the crisis. When we act through an agenda it defines how we respond. It is important that we act through the skill set we have carefully crafted through our experience rather than allowing the buried wounds of work place trauma to dictate our actions during a crisis. When we come from a place of self-interest and protection we become part of the crisis rather than managing it, putting ourselves at risk. Learning to manage the effects of trauma in our work makes us better clinicians as well as healthier individuals and creates renewed purpose within the work itself.

Unresolved trauma also leads to compassion fatigue which not only affects us in the work place, but on a personal level. Compassion fatigue occurs when we have unresolved trauma combined with burnout. Maslach, Goldberg and Leiter define burnout as "a psychological syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment." In other words, when out psychic load becomes too heavy from carrying unresolved work place trauma and we begin to work through the ideal of protecting ourselves from further pain, we become emotionally exhausted and unable to gain satisfaction from our work. This dissatisfaction has the capacity to extend into our personal lives as we struggle with the heaviness of our existence. How do we then come to terms with all our work experiences and remain healthy? Reach out to others. Face the trauma and work through it. Do not fear the inevitable pain that occurs when you work with people who are at their most vulnerable point. Remember that you have control over how the work changes you with the clear realization that there is not a way to do out work without experiencing pain.

What do you think?

Contact me at leathag@kmhs.org.

Letter to Senator O'Ban in Response to SHB 1448

March 23, 2015

RE: SHB 1448

To Senator O'Ban and the Senate Committee:

The Washing Association of Designated Mental Health Professionals (WADMHP) opposes SHB 1448 and would like to respectfully suggest further changes to this bill be considered:

WADMHP is concerned that SHB 1448 puts both the individual in crisis as well as the Mental Health Professional (MHP) following up on the referral from law enforcement hours after the threat has been made and law enforcement has left the scene in danger of harm or death.

The first 24-48 hours after initial crisis often is the most critical time for an individual to act on their threat, the need in crisis situations is for immediate intervention. Allowing the potential for follow up with a MHP to occur as many hours or days after a contact with law enforcement will give an individual the time needed to obtain weapons and/or follow through with plans for suicide or homicide.

For safety reasons DMHPs frequently request law enforcement to assist us when responding to calls where weapons may be involved or there is a history of violence or its an unknown situation. The same requests will occur for MHPs responding to law enforcements' referrals after contact with an individual in crisis. If the MHP referred by law enforcement attempts to follow up with the individual and is unable to find them due to the individual being homeless or because they have left the location where law enforcement made contact, the MHP will need to request an attempt to locate, adding additional impact to heavy volume of calls law enforcement already respond to.

WADMHP offers the following solution to this issue as well as possible solutions to the gaps in the mental health system. We believe these changes to the current system would improve the lives of people living with mental illness, provide a safe effective way to outreach to individuals in crisis, as well as provide a cost effective solution to the current need for increase in psychiatric beds.

Letter to Senator O'Ban in Response to SHB 1448

-WADMHP would like to suggest funding be provided for all law enforcement agencies to train officers in Crisis Intervention Training (CIT) at the full 40 hour training level. This will improve law enforcements' skills in managing mental health crisis.

-Rather than have an MHP respond to the scene hours after the crisis contact occurred, we ask that the committee look at developing a system where crisis intervention MHPs are available to respond with law enforcement and provide immediate response. This is available at present with DMHP teams however it is dependent on them not being on other emergent cases on scene somewhere else. This intervention is safer for the individual in crisis and the MHP responding to the referral, as well as likely safer for the law enforcement officer as well. WADMHP believes immediate intervention will ensure better outcomes. This will also decrease the workload for law enforcement agencies involved in the call as they will not be responding to the same individual twice.

-Currently within 71.05 and 71.34 a law enforcement officer only needs to believe a person needs to be assessed and they can take them into an emergency department or triage unit for an assessment. The WADMHP believes that current law and process is the appropriate remedy to a potential mental health crisis. Law enforcement in all jurisdictions we are aware of do this as a routine part of their work. Law enforcement can also call a DMHP to come to scene with them and do so across the state. Staffing often limits immediate availability of a DMHP and thus law enforcement transports a person to an emergency department for needed interventions and assessments.

-We ask that the no changes be made to the current system without appropriate funding to create these programs. The crisis system will need additional funding to employ MHPs to respond to law enforcement's volume of referrals and to be available for immediate intervention.

Sincerely,

Tiffany Buchanan
President
WADMHP

2015 SPRING CONFERENCE "PARTNERING WITH DEPARTMENT OF CORRECTIONS"

presented by DR. BART ABPLANALP at HILTON in VANCOUVER, WA

WEDNESDAY, JUNE 17th

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 DOC
2:30 pm Break
2:45 pm DOC
4:30 pm Adjournment
CEU/CME: 6 hours

ABOUT OUR PRESENTER:

Bart Abplanalp received his Ph.D. in Clinical Psychology from the University of Texas at Austin. He completed clinical and forensic postdoctoral work at the Court Diagnostic and Treatment Center (Toledo, Ohio), the Medical College of Ohio, and the Pretrial Evaluation Unit of Dorothea Dix Forensic Hospital in Raleigh, North Carolina. His primary areas of focus within these forensic populations were assessment of malingering, competency, and insanity. He began working for the Washington State Department of Corrections in 2001 and helped develop a Co-Occurring Disorders Therapeutic Community at McNeil Island. Dr. Abplanalp subsequently expanded the scope of his responsibilities to include work at the reception center in Shelton, the camp at Cedar Creek Corrections Center, and Lincoln Park Work Release, which serves the mentally ill and developmentally disabled population.

Currently based at DOC headquarters in Tumwater, Dr. Abplanalp is currently the Chief Psychologist – West, responsible for clinical oversight of mental health in Washington DOC facilities on the western side of the state. He also serves as a mental health policy advisor and as an expert witness for the American Civil Liberties Union and the Southern Poverty Law Center.

REGISTRATION FORM
SPRING CONFERENCE 2015
Washington Association of Designated Mental Health Professionals

JUNE 17, 2015
Hilton in Vancouver, 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 $

Make check payable to WADMHP
Please note: Check or cash only- through mail
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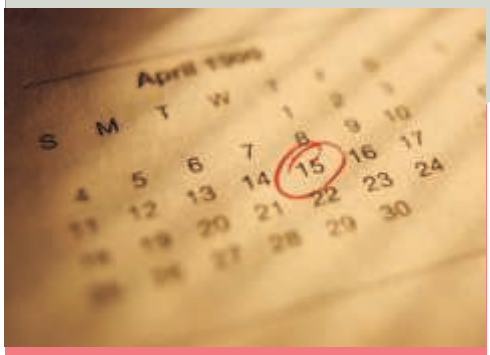
WADMHP Tax Identification Number:
91-1997711

Mail registration form to:

WADMHP, PO Box 977, Vaughn, WA 98329-0977

OR

Register Online at WADMHP.ORG!!



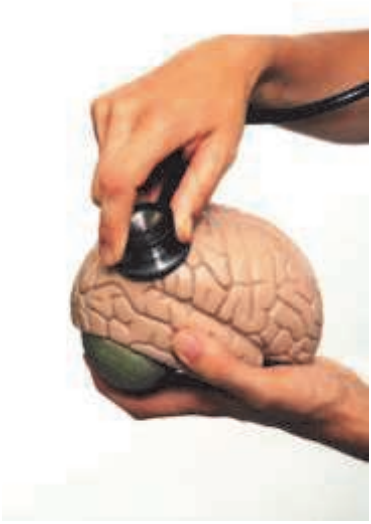
CALENDAR

OCTOBER 15-16, 2015
wadmhp fall conference

winthrop, wa

JUNE 15, 2016/ TBA
wadmhp spring conference

** Dates may change



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