FRONTLINES

SPRING 2016 VOLUME 36 ISSUE 1

WASHINGTON ASSOCIATION FOR
DESIGNATED MENTAL HEALTH PROFESSIONALS

Letter from the President

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Greetings Fellow DMHPs,

Winter is over and spring is here! As we transition from winter to spring we can see and feel changes all around us. Flowers are blooming, birds are singing and Washington Association of Designated Mental Health Professions is hard at work finalizing details for the Spring Conference and planning for DMHP Academy. We have received tons of emails from DMHP managers across the state asking when this training will happen. We plan to offer our first 40 hour DMHP Academy this coming fall for new DMHPs. For our Spring Conference, we are excited to have Dr. Matt Layton present on mental health and substance abuse. This topic is timely and relevant with the integration of chemical dependency and mental health treatment. We will also have Jessica Shook from DBHR speak about recent bills passed and what they mean for the work we do.

This past legislative session brought two ITA related bills forward that will change DMHP work. In the ever evolving world of ITA law, these bills will impact the current mental health crisis system by increasing the volumes of referrals DMHP offices will receive, and further impact the bed capacity issues we already face in this state. Any changes to improve care for individuals in mental health or substance abuse crisis are desperately needed, but we know that the system, as it stands currently, will be greatly impacted without increases in treatment beds and crisis staffing.

With the passage of E3SHB 1713 and the changes coming to our work in 2018, we can expect an increase in referrals to our offices. Along with mental health ITA evaluations, DMHPs will begin doing Chemical Dependency ITA evaluations as well. Like mental health ITAs, CDITA detentions will be contingent on bed availability. This bill requires that one secure detox facility be developed by 4/1/18 and a second by 4/1/19. DMHPs are already hard pressed to find beds for individuals detained under 71.05 and now with the addition of chemical dependency ITAs without adequate detox beds available this is very concerning. We already know there is an extreme need for detox beds in Washington State, and 1713 will bring this issue to the forefront.

The other bill that will affect DMHP work is 2SHB 1448. We saw this bill introduced last year, and WADMHP sent letters and met with legislators expressing our concern about it.

Continued on page 4

"GREETINGS FROM DBHR…" Jessica Shook, March 2016

Hello DMHPs, from the Division of Behavioral Health and Recovery. I've been here now for a little over four months, and I'm still settling into my role as "the new Dave Kludt". I've embraced the title, since it appears to be my most reliable, and informative, introduction. These are big shoes to fill, but I'm honored to be in them.

For the past two months, the legislative season has consumed most of my energy. It is a short session this year, and it has been intense, particularly for involuntary treatment. There have been seven bills up for discussion this session that impact involuntary treatment practice to some degree. As of March 14, the legislature is currently in special session. Here are the most recent status reports:

HB 2603 Concerning firearms access by a person detained for involuntary mental health treatment
Providing for a process by which individuals detained by a DMHP can be referred to the prosecuting attorney for loss of their access to firearms, even if a 14 day commitment is not granted by the court.
(March 10 - By resolution, reintroduced and retained in present status)

HB 2794 Addressing initial detention determinations by designated mental health professionals
Individuals exhibiting dangerous or threatening behaviors involving a weapon at their initial contact with law enforcement must be assessed for detention by a DMHP. The officer must notify staff when the individual is transported to an emergency room or other facility for mental health assessment.
(March 10 - By resolution, reintroduced and retained in present status)

HB 2808 Amending the process for a person's immediate family member, guardian, or conservator to petition the court for the person's initial detention under the involuntary treatment act
A Joel's Law petition must be filed in the county in which the DMHP investigation occurred or was requested to occur.
(March 10 – Delivered to Governor)

HB 2893 Relating to procedures following certain initial detention determinations under the involuntary treatment act
Providing for a process by which individuals detained by a DMHP can be referred to the prosecuting attorney for loss of their access to firearms, even if a 14 day commitment is not granted by the court.
(March 10 - By resolution, reintroduced and retained in present status)

2SHB 1448 Providing procedures for responding to reports of threatened or attempted suicide (Sheena's Law)
When law enforcement has contact with an individual who has been reported to have threatened or attempted suicide, but that individual does not meet criteria to be taken into custody at the time they are assessed, the officer will refer the individual to a DMHP office for further assessment.

Within 24 hours of receiving the referral (not including weekends or holidays), an MHP must attempt contact with the individual. This attempt or contact must be documented. The Washington Association of Sheriffs and Police Chiefs (WASPC) must develop and adopt a model policy for use by law enforcement agencies. All Washington law enforcement agencies must adopt this policy and develop criteria and procedures by July 1, 2017. (March 10 – Delivered to Governor)

3SHB 1713 Integrating the treatment systems for mental health and chemical dependency
As of March 8, there are two amended versions of this bill.

The first proposed amendment strikes the implementation plan and instructs the Washington State Institute of Public Policy (WSIPP) to further evaluate involuntary chemical dependency assessment and treatment processes in use in other states, and reevaluate the pilot study data from the WA state secure detox pilot program. There are also provisions to extend a B&O tax exemption for community programs that provide chemical dependency or mental health treatment, and some changes to inpatient and outpatient chemical dependency treatment for minors.

The second proposed amendment calls for a phased implementation plan for integrated involuntary mental health and chemical dependency treatment, beginning April 1, 2018 and continuing until July 1, 2026 until all regions in the state are phased in. It calls for the development of a task force to align regulations between behavioral and physical health care. Additional provisions add chemical dependency specialists to the list of professionals who can sign a petition for involuntary

treatment, describe the payment process for county prosecutor services in involuntary chemical dependency court hearings, and prescribe the same changes to inpatient and outpatient chemical dependency treatment for minors as the first amendment. (March 10 – By resolution, returned to House Rules Committee for third reading)

SHB 2541 Providing for less restrictive involuntary treatment orders
This bill makes modifications to the process for assisted outpatient treatment, specifically shifting the responsibility for determining treatment to the outpatient treatment provider - noting that the mental health professional petitioning the court is only required to make recommendations for treatment, and the court must only name the mental health provider responsible for providing treatment in the court order. The mental health provider providing outpatient treatment is only required to notify the court when significant changes are made to the treatment plan, such as adding or dropping a type of service. (March 8 – Delivered to Governor)

I'm excited about the rest of 2016, once we all survive this legislative session, particularly the WADMHP Spring Conference in June, and the upcoming DMHP Academies that are being planned right now. I would like to have a chance to meet you all, and learn how you're doing the incredibly difficult work we do, so that I can bring that information back to DBHR and put it to good use. Until then, please reach me at shookjm@dshs.wa.gov.

Be safe, Jessica

THANKS KIN

Kincaid Davidson after many years of working and supporting the WADMHP finally stepped back and turned the reins of conference registration over to Gary Carter in 2015.

Thank you for your many years of service to the Washington Association of Designated Mental Health Professionals.

Kincaid began working in 1988 as a County Designated Mental Health Professional (as we were called then) in Whatcom County. Later, he moved to Skagit County where he also worked as a CDMHP. Kin was first voted to the WACDMHP board as the secretary in 1994. He wrote an extensive article about mental health and nursing home care in 1994 for the Frontlines. In 1995 he was voted in as the President of the WACDMHP and held that position until the end of 1998.

During his tenure as the President of the WACDMHP there was proposed legislation seeking to empower non-DMHPs to be able to petition for detention and to establish a court ordered outpatient treatment. We have been struggling with the same issues for many years. The first DMHP Boot Camp was offered at the Spring Conference in 1996. It provided a basic training for DMHPs including information on Integrated Crisis Services, Mental Status Examinations, Complete Child Assessment, Developmental Disabilities, Less Restrictive Challenges, and ITA drugs and alcohol. 86 CDMHPs attended that first Boot Camp.

It should also be remembered that Kin worked tirelessly over the course of 6 years to bring to fruition the Guideline for ITA Investigations in Nursing Facilities which was published in 1996. This Guideline has been so useful that it has been included in the DMHP Protocols as the Appendix D: DMHP Investigation Checklist.
It was during Kin's tenure as President that the first DMHP Protocols workgroup was put together. The WADMHP sent a representative to the workgroup hosted by DSHS Mental Health Division's David Weston and the first protocols were enacted in 1999.

Since his retirement from the WADMHP board he has continued to support the Association by creating a database of members, conferences, and conference attendees. He accepted the registrations for the spring and fall conferences as well as making the conference folders which included the certificates of attendance to the conferences. He has managed the association's post box for many years. He was the smiling face at the registration table at our conferences for over 15 years. He was always ready with a can do attitude.
Thank you Kincaid for all you have done for DMHPs across the state for these many years.

President's letter continued...

The bill that passed this year is similar, but has dropped some of the past requirements. The bill previously stated that an ER social worker could not discharge someone brought in by law enforcement for suicide attempts or ideation without first being seen by a DMHP, and did not take into account the possibility of the individual receiving voluntary treatment. The previous bill also required that a DMHP must respond within 12 hours from the time of referral to assess a person that has expressed suicidal ideation or made a suicide attempt. The bill as passed this year requires that an MHP attempt to contact the person within 24 hours from the time of referral and to document that attempt. There continues to be lingering concerns about this bill. If an individual has attempted suicide or is making active threats, assessment should happen in a safe location as soon as possible. We know that the most critical time for someone in crisis is the first 24-48 hours and giving a person 24 hours (excluding weekends and holidays) allows for time to secure means to follow through with the plans. It also leaves law enforcement officers in a situation where they have to make an assessment of the individual and the situation that they may not feel they have the training to do. The bill calls for The Washington Association of Sheriffs and Police Chiefs to develop policy, criteria, and procedures to refer individuals contacted to DMHP offices be developed but not until 7/1/17. It is unclear at this time how offices will receive referrals and what the specific criteria for those referrals will be.

As our work continues to evolve, we as DMHPs will need to adapt our practice to meet the changes ahead. To successfully do this work, DMHPs have to be able to shift and adapt to different situations and the needs of the individuals being seen at the time. We never know what each day will bring and must be flexible and ready to respond to complex and challenging circumstances. The changes in ITA law that have occurred over the last few years have given DMHPs the opportunity to adapt and change as a whole. It is clear that as we change our practice and add additional components to our work, the larger mental health and substance abuse system will need to adapt and expand to accommodate these changes.

It is important to remember that like the seasons, change happens whether we are ready or not. Although the changes we are seeing as DMHPs are happening rapidly, being able to look at these changes from different angles, and adapt and change to be effective in different situations is something we are already skilled at. We at WADMHP will continue to disseminate information through Quarterly Manager Calls, Conferences, DMHP Academy, the WADMHP website, and Frontlines as these changes occur. Our goal is to remain a constant in a climate of change. We look forward to working through these changes with you and we hope to see you at a conference, Academy, or talk to you on a Quarterly Manager call in the near future.

Sincerely,
Tiffany Buchanan, LMHC, DMHP

NEW SECRETARY and TRESURER OF WADMHP EXECUTIVE BOARD

Shelby Whitworth has been a DMHP with Spokane County since 2002. She is currently a Team Leader in Crisis Response at Frontier Behavioral Health Services in Spokane, WA. I was hired with Crisis Response right out of graduate school. In fact, besides my internship, this is the only job I have had in the mental health field. I knew quickly during my practicum at the Counseling Center at Eastern Washington University that my favorite part was the crisis walk ins we did in the afternoons. The idea of not knowing what the next client may need or what was going on, appealed me. Working in Crisis Response has provided me the opportunity to constantly challenge myself and daily add to my clinical skills. I love being a DMHP and working with not only clinical assessments but also the law and Courts. It has always been a passion of mine to learn the law and at one time I wanted to go to law school. My decision to get a graduate degree in psychology instead of law came down to my desire to help individuals and my underlying curiosity of why we do what we do. I love what I do and I could not imagine doing anything else. I look forward to being a part of the WADMHP Association.

Robby Pellett attended Antioch University Seattle and graduated with a Masters of Art in Psychology in 1994. After working as a child and family therapist and Children's Crisis worker he became a CDMHP in Pierce County in 1999. Since then he has worked as a DMHP in King and Thurston Mason Counties and is now working as a DMHP and therapist in Wahkiakum County. Robby attended the DMHP Boot Camp in 2001. He joined the WADMHP in 2006 as a Vice President. He also served as the President before retiring in 2012. He has been a part of the DMHP Bootcamps since 2006 often teaching about safety and the RCWs, and behind the scenes providing logistical support. He is honored to be returning to the Board in the position of treasurer.

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A Needle in Eastern Washington's Psychiatric Haystack

"Finding a psychiatrist willing to practice in an inpatient setting is like looking for a needle in a haystack"
Travis Singleton, Sr. Vice President – Merritt Hawkins
United States leading search firm - physician recruiting

The opening quote accurately reflects the experience of a DMHP looking for a psychiatric hospital bed. On finding one I've seen DMHPs high-five, fist-bump, and even "jump bump" like Seahawks scoring a touchdown! How to explain such behavior among non-sporting professionals?

Psychiatric Downsizing

Psychiatric downsizing that began with de-institutionalization in the 1960's has become the standard in emergency psychiatric care. The Merritt report[1] from which the opening quote was drawn also notes that psychiatrists are aging out of practice at precisely the time when demand is spiking: 48% of practicing psychiatrists are expected to retire in the next five years. To DMHPs this is as horrifying as being notified of an unexpected IRS audit at the same time you discover your briefcase with Protected Health Information has suddenly gone missing.

Indeed….bed capacity has dropped nationwide by 95% since 1955, from 340 / 100,000 to approximately 17 /100,000 nationwide. Washington State comes in at something like 15.3 /100,000 the last time that figure was checked. The consequences of this trend are well documented and known to us all: increased personal suffering, burden on families, homelessness, an explosion of the mentally ill in jails and prisons, overcrowding in emergency rooms, and an increase in violent crime. If you've not read it, E. Fuller Tory's report of the Treatment Advocacy Center, *The Shortage of Public Hospital Beds for Mentally Ill Persons* (circa 2008) is both depressing and validating. One is left with a sense of "I told you so" indignation upon finishing the brief read.

It would be inappropriate to ignore the post-*in Re D.W.* efforts made by our legislature to increase capacity and we should all rightly thank them. Still, as the statistics show - we're really only talking about that proverbial drop in our psychiatric bed bucket. Not to mix metaphors, but the solution *does seem to be a needle in a haystack*. We need so much more and if the Merritt company is correct these recent efforts will fall far short of the mark.

Single Bed Certifications and Efficiency

We've heard the arguments about Single Bed Certifications (SBCs) from both perspectives. On one hand psychiatric purists contend that SBC's are pseudo-treatment, lack milieu, and make the problem worse by pretending to provide treatment; on the other hand, pragmatists believe *any treatment is better than no treatment or jail*. The dispute is not unlike a convention of abstinence-model AA folks vs. controlled drinking advocates; both sides have their points. Regardless of ideology, real solutions must balance available resources with client and public safety.

We live in a post *King vs. Burwell* world. The *Affordable Care Act* suggest*s* population health management through accountable care organizations and innovation is the word of the day. Single Bed Certifications may offer innovative systemic benefits when viewed not as pure psychiatric treatment but *as an interim step in the continuum of psychiatric care*.

Sounds like jargon? Perhaps, but let's look at what that really means.

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[1]New Report Shows Demand For Psychiatrists At An All-Time High 'Silent Shortage' of Mental Health Specialists a Looming Crisis; PR Newswire 7-15-15

Fundamentally, Accountable Care Organizations take responsibility for outcomes - community teams and associated providers buy into the mission and make sacrifices for the greater good. It's a culture where *win-win* generally means clients win, public safety wins, and healthcare professionals work smarter. Pardon the plug, but that's Wenatchee and Chelan-Douglas and there is no sense contemplating SBCs if your community doesn't have good stakeholder relations. If that's the case, work here first.[2]

Next, psychiatric bed space arguments generally focus on capacity. What we *don't* hear about are strategies to make better use of the beds we have.

Back in 2005 I wrote a *Frontlines* editorial about the impact of contingent or manipulative suicide threats on our system of care. The article asked if these clients should even be detained. Yet after glumly mulling over the seeming wastefulness of it all I wasn't able to say we shouldn't detain such clients or that they shouldn't have access to care. When they meet criteria, of course these clients should be detained because it saves lives.

Ten years later and after a six year stint in Nevada (where they have even fewer beds) that question has changed and expanded. Should these clients and other high utilizers always be placed in our most costly levels of care? Should first time detainees always have to go away to another community? If someone can benefit from brief, local stabilization, doesn't the Involuntary Treatment Act require us to provide care in the least restrictive and most appropriate setting in the community?[3]

Single Bed Certifications may not provide the most comprehensive psychiatric care available but they can be used to establish medical necessity for access to higher levels of care. For non-violent patients SBCs provide a safe setting in which to explore initial treatment strategies that stabilize patients who can benefit at that level of care.

A provider referral to specialty care is not a novel idea: managed care has been doing it for at least 20 years. If we wouldn't expect to initially take our child to a pulmonologist for treatment of a cough, should we expect to send all our detained clients to the most advanced emergency psychiatric facilities in the state?

Arguing solutions for the "psychiatric boarding" crisis, Alakeson et al (2010)[4] and others recommend strategies which make more efficient use of existing psychiatric beds. Johns Hopkins University, for example, operates the successful *Meyer 3 Short Stay* service. This modality targets severely mentally ill patients admitted from the ED and outpatient programs with a goal of rapid stabilization and step

down. Services are available for the population aged 18 to 64 and focus on multi-disciplinary treatment using community psychiatry principles, addressing psychosocial needs, working with families, all integrated with other services in the community. They keep most of them out of psychiatric institutions.

[2] *The Community Mental Health Gospel* by Confluence Chief of Nursing Tracey Kasnic.

[3] RCW 71.05.010 (e)(f)(g)

[4] Alakeson, Pandi, & Ludwig: A Plan to Reduce Emergency Room 'Boarding" of Psychiatric Patients. Health Aff **September 2010** vol. 29 no. 9 **1637-1642**

Outcomes tell the story. Like other regions, the Chelan-Douglas area intermittently struggled with being above census at Eastern State Hospital (ESH) for several years. Within one month of opening MU-1 this problem disappeared and has not recurred.[5] The evidence that MU-1 and the SBC rule is making more efficient use of ESH (and other high-level psychiatric resources) is briefly outlined in the paragraphs that follow.

Outcomes

For the period 9-1-14 through 9-20-15, of 210 individuals detained in Chelan-Douglas, 27 either went directly to ESH or were subsequently transferred there. This represents an ESH utilization rate of 12.8%, a significant decrease from 29.5% prior to MU-1. Put another way, prior to MU-1-SBC, roughly one in three detentions went to ESH: after MU-1, roughly one in eight.

Of 210 detentions during MU-1's first year, 143 or 68% were initially detained to MU-1. They were all diverted out of the existing state system of emergency psychiatric care. Of these, 131 or 62.4% were successfully treated and returned to the Chelan-Douglas system of care *without requiring emergency treatment in other venues*. Assuming total ambulance transportation cost of $2000 per detention, simple math shows savings exceeded a quarter million dollars for Chelan Douglas' ambulance reimbursements alone.[6]

Significantly, no suicides or homicides were identified among post MU-1 discharges during the period.

The majority of clients admitted were believed to be capable of benefiting from the level of care provided at MU-1. A few very complex cases were placed and ultimately managed by the MU-1 / CFCS teams. In no cases were EMTALA holds required, although as many as 5 cases were the subject of EMTALA hold and "no-bed report" discussions.

Individuals from around the state received care at MU-1 and discharged back to their home RSN. Invariably, Chelan-Douglas residents were provided with follow up mental health and medical appointments, most cases assertively pursued by the CFCS Mobile Outreach Team. Several key cases received court-ordered LRA at discharge.

12 individuals originally placed at MU-1 (5.7%) required services that ultimately exceeded the scope or duration of MU-1 and were transferred to another E&T. This relatively small number would seem to validate clinician and physician judgments regarding patient needs and the SBC process.

40 cases, or 19%, were initially detained to an E&T. Many of these cases were youth not served by MU-1.

Overall hospital length of stay (LOS) increased significantly pre and post MU-1: Pre-MU-1 mean LOS was 2.64 days; post-MU-1 mean LOS was 5.7 days.[7]

This increase appeared to be progressive. As more staff and services became available it was evident that more complex clients were able to be treated and for longer periods of time.

ESH utilization numbers deserve some comment given the importance of this outcome to the RSN and reinvestment in the Wenatchee system of care. The utilization rate alone understates the impact of MU-1 Single Bed Certifications on the community system of care in a number of ways.[8]

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[5]Knock on wood!

[6]Reinvested in the community those savings could pay the salaries of a DMHP Mobile Outreach Safety Team like those in Seattle or Reno, embedded with law enforcement. We can dream, can't we?

Indirect SBC Benefits: Jail Diversion and Non-emergent Detentions

First, reduction in overall ESH utilization allowed the DMHP team to conduct a series of jail diversion detentions. A significant goal for Wenatchee's community team was to improve access to emergency mental health treatment for individuals in jail. Thus, the SBC at MU-1 created an indirect impact on overcrowding in the Chelan County Jail by freeing space at ESH. Jail detentions went from zero in the previous 10-15 years to approximately 8 in the year following MU-1. In human terms, the MU-1 initiative reduced the burden of suffering for both incarcerated individuals and jail staff who are required to make due providing treatment under circumstances generally not conducive to effective psychiatric care.

In cooperation with Wenatchee Police, Chelan County Courts and Jail, MU-1 has accepted jail holds for individuals meeting detention criteria displaying internalizing behavior (generally self-destructive acts) and low flight risk, further reducing demand on ESH which was previously the only facility known to accept jail holds in Eastern Washington.

Second, the MU-1 initiative[9] allowed for the local development of non-emergency detention procedures required in RCW 71.05.156. Emergent detentions are the routine DMHP activity statewide, and generally the only detention activities practiced in Eastern Washington. With MU-1 as a resource for initial stabilization and court hearing for 14 days, Chelan-Douglas RSN is now able to provide limited access to hospital care without having to wait for patients to become imminently at risk of harm to themselves, others, or so gravely disabled that they require prolonged ESH stays.

The first non-emergent detention, for example, was required to stay only one month at ESH as the case was partially stabilized prior to transfer. Non-emergent detentions are complex and time consuming, in some cases requiring 24 legal and clinical activities which must all come together within a single 24 hour period. In other words, they are not likely to become the norm and represent about 15% of detention type in some Western Washington Counties. Additionally, the capacity to conduct non-emergency detention seems very likely to minimize community need for Petitions under Joel's Law.

Feedback from clients suggests they appreciate MU-1 for several reasons. Staff are well-trained, courteous, and most of all *they understand Central Washington culture including its industries, places, and people.* Clients report that they appreciated not having to go far away to potentially frightening places "in the big city." Local providers are able to visit patients on MU-1 and participate in multidisciplinary care conferences. Finally, and perhaps most significantly, discharge planning occurs in real-time as hospital liaison and community providers collaborate on wraparound aftercare plans.

Taken Together…

A time of increasing demand and decreasing resources requires new ways of thinking and new models of psychiatric care. Quite frankly, there's already more than enough business to go around. Initial data from Chelan Douglas suggest the Single Bed Certification model when properly employed, improves the system of care not by adding new capacity but by making better use of that which we already have.

For those who are looking, MU-1 and the SBC may be a needle in Washington's jumbled psychiatric haystack.

- Eric Skansgaard, DMHP

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[7]LOS findings can be partially explained by the fact that prior to MU-1 many cases were rapidly transferred to ESH or other facilities rather than being treated locally.

[8]New Legislation in SB 6656 appears likely to restructure services to virtually require local diversion like MU-1.

[9]The joint MU-1 Initiatives involved Confluence Health, Catholic Family and Child Services, Wenatchee Police Department, the City of Wenatchee District and Chelan County Superior Courts / Prosecutors / Public Defenders.

2016 SPRING CONFERENCE
"Substance Use/ Abuse and Civil Committment"

Wednesday, June 22

07:30 am Registration and Breakfast
08:30 am Opening Remarks
08:45 am Legislative Update: w/
Jessica Shook and Ian Harrel
10:30 am Break
10:45 am Substance Use
12:00 pm Lunch & Business Meeting
1:30 pm Substance Use
2:30 pm Break
2:45 pm Substance Use
4:30 pm Adjournment

presented by
Dr. Matt Layton
Convention Center
YAKIMA, WA

ABOUT OUR PRESENTER:

Dr. Layton earned a B.A. in Chemistry with Distinction from the University of Kansas and an M.D. and Ph.D. in Pharmacology from Kansas University Medical Center. He completed psychiatry residency training at the University of Washington in Seattle and served as Medical Director for the Inpatient Psychiatry unit. Dr. Layton moved to Spokane in 1999 and was Spokane Mental Health's Medical Director from 2000-2008. He is a Clinical Professor in the University of Washington Department of Psychiatry and Behavioral Sciences and served as Program Director for the University of Washington Psychiatry Residency Program Spokane Track from 2005-2014. He is a Clinical Associate Professor in the Washington State University College of Medicine and Medical Director for the WSU College of Nursing Program of Excellence in Addictions Research, as well as Adjunct Professor in the WSU College of Pharmacy and the Psychology Department. Dr. Layton is board-certified by the American Board of Psychiatry and Neurology. He is a Distinguished Fellow of the American Psychiatric Association and a Fellow in the American College of Psychiatrists. He is also a member of the American Medical Association, Washington State Psychiatric Association, Washington State Medical Association, and the Spokane County Medical Society. He has published numerous scientific articles in the fields of psychopharmacology and neuroimaging, presented research findings in national and international forums, and received awards from the National Alliance for Research in Schizophrenia and Depression, National Institute of Mental Health, American Federation for Clinical Research, American Psychiatric Association, and Washington Community Mental Health Council, as well as numerous outstanding faculty and other teaching awards.

REGISTRATION FORM
SPRING CONFERENCE 2016
Washington Association of Designated Mental Health Professionals

JUNE 22, 2016
Yakima Convention Center in YAKIMA WA

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CALENDAR

OCTOBER 13-14 016
wadmhp fall conference
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JUNE 2017/ TBA
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