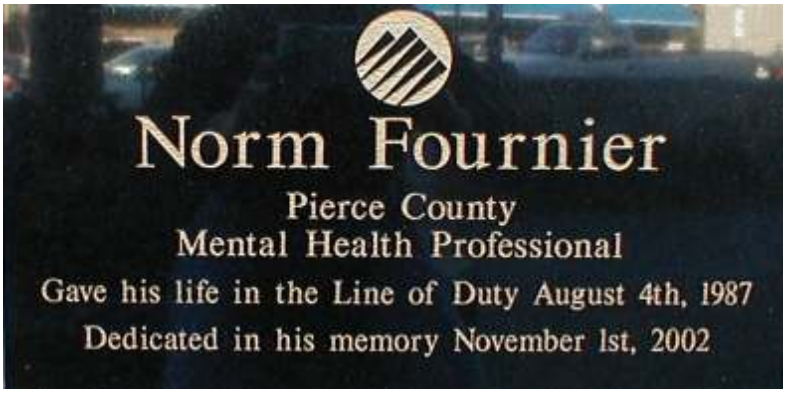
Frontlines

Newsletter of the Washington Association
Of County Designated Mental Health Professionals

Winter-Spring 2003 www.wacdmhp.org Volume , Number 1

Contents

CDMHP slain 15 years ago in Pierce County honored



These are the words etched on a marble plaque, placed alongside the names of 35 Firefighters and Law Enforcement Officers who also lost their lives while serving the citizens of Pierce County. Pierce County Executive John Ladenburg dedicated the memorial; also present were Norm's wife Clarice and his son Pierre. No one present that day questioned why we were there, but many people did question why we were there 15 years after Norm was killed while attempting to serve an Order of Apprehension and Detention on an individual who had failed to respond to a summons.

Lyle Quasim, former state Social and Health Services director who now serves as Pierce County Executive John W. Ladenburg's chief of staff, has long believed Fournier should have been recognized in a similar manner to that accorded law enforcement officers killed in the line of duty. "Norm Fournier walked the line between

PLEASE SEE **Fournier** ON 3

President's Letter

Welcome to all the new CDMHPs who have joined our association in the past year. One of my concerns as President of the WACDMHP and in the individual agencies I have worked in is retention of colleagues. In the seven years I have been a member I have witnessed what to me seems an incredible turnover of staff. It would not surprise me to think that of the approximately 300 CDMHPs across the state that about 30% leave each year to do something different. My advice to all of you that are new to this job: make self-care your first priority. No one is really going to know better than you how to care for yourself.

I find it ironic that professionals in the health care field often fail to care for themselves

PLEASE SEE **President** ON 3

Editor's Notes:

The theme of the WACDMHP conference this past fall, Hearing from Stakeholders, was a bold endeavor to hear voices from those whom we generally do not hear. Preparing the conference, Tim Justice sought out stakeholders who would represent different perspectives of individuals and entities that affect, or are impacted by, our work. It is not uncommon, during a conference presentation, to see some shaking of heads, expressing disagreement with the speaker. During this conference, there was an unusual amount of head shaking and some comments indicating the umbrage that some attendees took with some of the speakers.

The publication of an organization can serve many purposes that are usually determined by a number of factors. One of the primary purposes of the Frontlines *is to keep CDMHPs informed about events that affect their work. Although the less contentious and provocative path is generally easier to take, it rarely provides for richness and growth. After Mr. Richard's presentation at the fall conference, I asked him if he would share some of his thoughts in an article in the* Frontlines. *He agreed to write an article, and it is published in this issue. It is a hard-hitting article that some readers may find difficult to read. I have chosen to print Mr. Richard's article in its entirety with the hopes that it will encourage stimulating dialogue. I would hope that some of the readers would use the* Frontlines *to express their thoughts (pro and con) to his challenging ideas.*

In order to keep CDMHPs informed about current issues that impact their work, I have included an article about the lawsuits that Pierce County Regional Support Network and the Department of Social and Health Services have filed against each other. I tried to present an article that is factually correct, and in which the issues of both parties are presented in a balanced way. Although the issues of the lawsuits affect CDMHPs and their work, the Frontlines *has taken a neutral stance.*

Scott Kuhle

Please send articles, job listings, or other news to: Scott Kuhle, 340 NE Maple Street, Pullman, WA 99163, or Fax (509) 332-1608, or e-mail at skuhle@completebbs.com

What a heavy oar the pen is, and what a strong current ideas are to row in! - Gustave Flaubert, novelist (1821-1880)

WACDMHP Membership Application & Renewal

Name: _____ Home phone: _____

Address: _____ Work phone: _____

City, State, Zip: _____ Job Title: _____

Employer: _____ County: _____

☐ I am currently a WACDMHP member and want to renew my membership
☐ I am not currently a WACDMHP member and want Full Membership (must be a CDMHP)
☐ I am not currently a WACDMHP member and want Associate Membership (All privileges except voting)
☐ Enclosed is a check for $20.00 payable to the WACDMHP

Membership fee: $20 Charge my ☐ Visa ☐ MasterCard ☐ Check

Account Name: _____ Account number: _____

Signature: _____ WACDMHP Tax Identification Number: 923161171

www.wacdmhp.org

Mail application to: WACDMHP/ PO Box 5371/ Bellingham, WA 98227

FOURNIER

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Human services and law enforcement, and he often went on dangerous assignments," Quasim said. "This belated recognition is an attempt to make sure people are aware of Norm Fournier's sacrifice and that other human services professionals today are walking that same path. They are making enormous contributions to our community."

In addition to those who knew and worked with Norm, also present were a number of mental health professionals who never had the opportunity to work with him. They were there because he has shaped the careers of people who still talk of his values and beliefs. While we have lost a friend and mentor, his teachings still shape the practice of many who have the responsibility and privilege to train and supervise people entering the mental health field.

Norm was a pioneer in the area of hope and recovery. He taught us to value the hopes and dreams of individuals and families impacted by mental illness. He insisted that his staff dress professionally to show respect to those we served and for the honor of being able to work in this field. (It also gives us an opportunity to talk about Norm to co-workers today when asked why we are wearing a tie and jacket on dress down Fridays).

Norm's commitment extended to the community as a whole, his staff, and most of all his family. He encouraged crisis workers to practice case management to help individuals remain safely in the community before the term case management was in use. He envisioned a Crisis Triage Center and developed a design for the service, nearly 20 years before changes in funding allowed us to realize his dream in Pierce County (but I don't think we were able to improve on his original concept). Norm believed that all of his staff should give back to their community, through charitable work and donations. He coached our softball team (most of which were present for the memorial), he lent his car to a staff member who learned while on duty that his mother had died suddenly several hundred miles away, and then showed up at the funeral.

Norm died on a day that he didn't even have to be working. He had been in administration for several years, but when budget cuts made him choose between canceling vacations for his staff or

going back in to the field, he stepped right back into doing involuntary commitment evaluations.

Norm had worked for over a week with the individual who eventually took Norms' life and then his own. Norm was trying to develop an outpatient commitment option that would allow the person to remain in his community. At the time of his death, Norm's young son was quoted in the local paper as saying that he knew his father had died doing what he believed in and loved. It was inspiring to see his grown son and his fiancé at the memorial. It was easy to see Norm in his son.

To answer that question about why now, 15 years later? – It is never the wrong time to do the right thing. I believe Norm would agree.

By Dave Stewart

Dave is currently an administrator for the Pierce County RSN. He worked for Norm, starting in 1977, as a County Designated Mental Health Professional in Pierce County. Dave said about writing the article, "I was surprised how emotional it was for me to write. I thought the memorial dedication would be hard, but this was harder."

PRESIDENT

CONTINUED FROM p. 1

emotionally, physically, and spiritually. In general the professionals who fail to care for themselves may still retain great clinical skills, but develop attitudes that fall short of compassionate. I not only want to develop great clinical sophistication, but I work best when my skills are complimented by a gentle and open heart towards broken people.

In the ideal world your team members and your supervisor are responsible, in part, for assisting you in maintaining your balance. However, are we really open to hear what they have to say and are we courageous enough to say what has to be said to our colleagues? When there are only 300 of us, I believe it is imperative that we challenge ourselves and each other to do the best we can for ourselves and not be thrown out of balance in continually putting out

energy for others. And if you are a supervisor, what are you really doing to support your staff and have you asked them recently what you can do to support them?

A special thank you to Tim Justice (Whatcom) who is outgoing Vice President. His ability to clearly articulate the multifaceted issues of our profession has amazed me. And welcome to Dani Geissinger, my colleague at South Sound Mental Health in Thurston/Mason counties, who is replacing Tim. Her energy, ability to organize, and connections, along with her knowledge of clinical and administrative CDMHP functions will be a great addition to the Executive Committee.

Finally, I have updated our agency e-mail list so that every CDMHP agency/office in the state is current as of this publication. My attempt is to send out a monthly e-mail to all members just keeping you up to date as to legislative, training, and conference dates. Be looking for a sign up sheet from your supervisor to get on this mailing list, or just email me at matt@wacdmhp.org and I will put you on the list. Thanks.

Matt Goodheart,
President WACDMHP

Pierce County RSN sues MHD – DSHS files counterclaims

DSHS was named defendant in a Pierce County lawsuit filed against the State over access to beds at Western State Hospital. The purpose of the action is a determination by the court regarding the State's and DSHS's obligations under the State Constitution and the RCWs to "foster and support mental health institutions" in the state. The RSN is also asking for full access to beds at WSH, as needed, for detained patients, and a declaratory judgment defining the scope of DSHS's obligations under State law to adequately fund and support sufficient numbers of mental institutions to care for persons involuntarily committed for mental health evaluation and treatment.

Pierce County Regional Support Network (PCRSN) asserts that the Washington State Constitution and the Revised Code of Washington (RCW), clearly identify the State of Washington as having the ultimate responsibility for the commitment of involuntarily detained (90 and 180 day) individuals in the state. In Pierce County, WSH is the only non-federal facility certified to accept 90 and 180-day commitments under RCW 71.05 and all commitments under RCW 10.77.

The RSN determined that it was necessary to file the lawsuit because Western State Hospital, since June 1, 2002, has repeatedly refused to permit PCRSN to access beds for 72-hour emergency detentions, as well as involuntary commitments longer than 14 days. The suit alleges that WSH places involuntarily detained patients on a waiting list pending availability of beds at the hospital, rather than admitting them. As a result, PCRSN has had to use other beds in community facilities that are not statutorily authorized to serve involuntarily committed patients. The PCRSN claim against the State is partially based on the following Causes of Action:

1. The State has a constitutional duty to "support and foster mental institutions in the state". The State failed to meet this constitutional obligation.
2. The Washington State constitution forbids legislative impairment of private or public contracts. The State has substantially impaired it's contract with PCRSN by enacting legislation which reduces access to bed capacity at WSH for voluntarily and involuntarily committed patients.
3. Violations of the Administrative Procedure Act. The issuance of single bed certifications to PSBH and other community hospitals violates WAC 388-865-0203(3) and WAC 388-865-0504(2).

The PCRSN states that it is willing to pay for beds over its allocation as long as the RSN receives the funding associated with reductions in the allocation. However, the RSN asserts, that under the Washington State Constitution and RCWs, it is the State, not the RSN, which has final responsibility for patients committed for longer than 14 days. The RSN maintains that it will become impossible for the RSN to fulfill its responsibilities under the contract, if the State is able to continue to shut down beds and transfer the responsibility to the RSNs without transferring the resources to the community.

Since the earthquake, there have been reports of detained individuals being kept in an emergency department for long periods of time because CDMHPs could not find psychiatric beds. At one time CDMHPs were seeing themselves as "bed brokers" as they called psychiatric units up and

down the I-5 corridor trying to find a bed for a detained individual. There are reports that detained individuals were sent as far as Spokane for inpatient evaluation and treatment.

Counter suit

On December 30th the Department of Social and Health Services (DSHS) filed counterclaims in response to the November 20th lawsuit filed by Pierce County. The counterclaims state that Pierce County and the RSN breached provisions of their contract with the department and failed to meet contractual obligations. DSHS also denied a long list of allegations made by Pierce County and its RSN in their original lawsuit. Specifically, DSHS claims Pierce County violated the contract with the state by:

- Failing to report to DSHS a patient's death at Puget Sound Behavioral Health Hospital. The incident prompted a federal investigation which could have jeopardized federal mental health funding because of safety concerns about the Pierce County facility
- Failing to provide community placements for Pierce County residents ready to leave Western State Hospital
- Sending more patients to Western State Hospital than allowed by the contract
- Failing to respond to census alerts from Western State Hospital. The contract requires the county to divert patients from the state facility and expedite discharges from it when the hospital approaches full capacity
- Failing to comply with fiscal provisions of the contract

"We had hoped to resolve these issues with Pierce County without spending limited resources on litigation against a fellow governmental entity," said Karl Brimner, director of the DSHS Mental Health Division.

"Unfortunately, Pierce County began these legal proceedings and we have no choice except to vigorously defend the state from these claims. The fact is that the county and its Regional Support Network are resisting the Legislature's direction for home communities to support and help the mentally ill and reserve state mental hospitals, such as Western State, for people who truly need hospitalization at a state institution," Brimner said.

The full copy of the DSHS's news release may be found at www.wa.gov/dshs.

The best cure for worry, depression, melancholy, and brooding, is to go deliberately forth and try to lift with one's sympathy the gloom of somebody else.

-Arnold Bennett, novelist (1867-1931)

Members elect 2nd Vice President

Members attending the fall 2002 conference elected Dani Geissinger-Rodarte 2nd Vice President for a two-year term. She replaces Tim Justus who completed his term. Dani brings many gifts to the association. As former HR/PR Director of Neiman Marcus, Dani is well prepared to bring together the fall conference that is tentatively planned for either Vancouver or Ocean Shores. Dani graduated from Chaminade University in Hawaii with a MSCP and has been doing crisis intervention work since 1990. She has been a CDMHP in Thurston/Mason counties since 2001.

Her diversified work experience includes individual, group and family therapy, inpatient care, and working with sex offenders in a prison system. She notes that, "I prefer crisis work and brief intervention treatment to empower the client versus encourage dependence."

Dani said that she and her husband, Daniel, currently have no children, but have decorated their home with 42 houseplants. Her hobbies include travel, gardening, and shopping for bargains

To laugh often and much; to win the respect of intelligent people and the affection of children; to earn the appreciation of honest critics and endure the betrayal of false friends; to appreciate beauty; to find the best in others; to leave the world a bit better, whether by a healthy child, a garden patch or a redeemed social condition; to know even one life has breathed easier because you have lived. This is to have succeeded.

-Ralph Waldo Emerson, writer and philosopher (1803-1882)

WACDMHP and ESH present 14th annual spring workshop

The WACDMHP and Eastern State Hospital will conduct their annual ESH Spring Workshop on Friday, March 7th in the Activity Therapy Building at ESH. Julie A. Janssen, M.D, will present the workshop. She has a private psychiatric practice in Wenatchee, and is the Clinical/Medical Director of Okanogan County Counseling Services in Omak. She is board certified with the American Board of Psychiatry and Neurology, and in Geriatric Psychiatry.

The workshop is being organized by Vicki Bringman, Program Coordinator of Acute Care at Okanogan Behavioral Health Care, and Ronda Kenney, Compliance Process Improvement Specialist**,** of Eastern State Hospital. The workshop is limited to 40 participants.

For further information about the workshop, contact Ronda Kenney at 509-299-4227 or Vicki Bringman at 509-826-6191

Brainstorming

Session #1: Navigating the Brain Maze – 9:00 am to 10:30 am

Although function cannot always be localized to a structure in the brain, this session will provide basic principles about various tasks of the brain and how they are integrated to perform the skills of daily life and interactions.

10:30 to 10:45: BREAK

Session #2: Leave No Brain Unturned – 10:45 to 12:15

This session will guide the participant through a structured approach about how to evaluate the impaired brain, which has implications for treatment planning. There will be a special emphasis on the geriatric brain.

12:15 PM to 1:15 PM: LUNCH

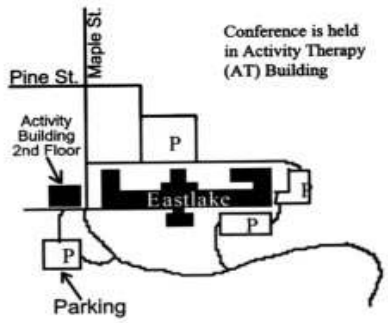
Session #3: Medical Mimics – 1:15 PM to 2:45 PM

Adequate treatment of psychiatric conditions requires an accurate diagnosis. This session will explore a gamut of medical conditions that can masquerade as psychiatric illness, and vice versa.

2:45 PM to 3:00 PM: Questions and Answers

Directions to the workshop

- From Spokane: Take I-90 west to exit 272. Follow Highway 902 into Medical Lake and pass a three-way stop; turn left on Howard (7 miles from the freeway exit), and go up the hill to ESH. Parking on left.
- From Spokane on US Highway 2: Turn on Brooks Rd. (approximately 1 mile west of FAFB). Follow Brooks Rd. into Medical Lake. Turn right on Howard. Make a right turn at the stop sign (4th Street) and go up the hill to ESH. Parking on left.
- From Western Points: Take I-90 to exit 264. Go across freeway on Salnave Rd. for 5.2 miles. Turn left at Fancher Connection, which turns into Pine St. Make a right turn at Maple Street Parking on right.



Use registration form on next page

REGISTRATION FORM

Eastern State Hospital
2003 Spring Workshop
March 7, 2003
Medical Lake, Washington

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Employer: _____ County: _____

Registration fee: WACDMHP members is $40.00 and non-members is $60.00

Enclose a check or money order payable to **WACDMHP.** No vouchers or purchase orders

Detach and mail this form with payment to: Ronda Kenney
Eastern State Hospital
P.O. Box 800.
Medical Lake, WA 99022

State Hospital provides medical stability criteria

Since ESH is not equipped to adequately treat patients who are in a medical crisis, the medical staff have developed admissions criteria. Dr. Floura, ESH Medical Director, has determined that all patients referred for admission to Eastern State Hospital shall be medically stable. The ESH medical staff discussed the criteria with ER Directors in the hospital's catchment area. When ESH receives pre-admission information from the CDMHP, there is also a physician-to-physician contact in order to determine the medical stability of the patient.

If any patient requires a general hospital level of care, he/she does not meet the criteria for admission to Eastern State Hospital. It is recommended that each patient receive a physical examination with lab tests, such as CBC, CMP and, if indicated, drug screen and blood alcohol level prior to admission.

Identifying medical stability

The criteria for identifying medical stability include: hemodynamic stability, normal electrolyte range, blood alcohol level below O.15, EKG, and cardiac enzymes in normal range (if history of acute chest pain within the past 24-48 hours).

The medical staff have determined that the following conditions are *contraindications* for admission to Eastern State Hospital.

a. Medical condition requiring general hospital level of care.
b. Medical condition requiring services of an emergency department.
c. An imminent terminal medical condition, and/or patient needs hospice level of service.
d. Blood alcohol level above O.15.
e. Acute electrolyte imbalance.
f. Delirium from any cause - impending DTs, substance abuse, drug overdose, metabolic encephalopathy, head trauma, toxic substances, or any other medical condition.
g. Patient in need of renal dialysis.
h. Patients with history of acute chest pain and/or shortness of breath who have not had an emergency department workup to rule out myocardial infarction, pulmonary embolism, asthma, etc., and have not been stabilized prior to transfer.
i. Patients on continuous IV analgesics or sedatives.
j. Patients on anticoagulants without current prothrombin time and INR

k. Diabetic patients without a current blood glucose level.

Communication requirements

ESH has established the following communication requirements for medical stability prior to admission:

a. Patients with acute medical conditions should receive a medical evaluation by a physician or medical licensed independent practitioner within the previous eight hours, including appropriate laboratory workup, and documented medical stability.

b. Physician to physician discussion regarding any patient whose medical stability is questionable is required.

c. Information normally is sent with the patient but may be faxed prior to the patient's arrival. When the patient is not medically stable the referring physician is notified that ESH will not accept the patient until the admission criteria are met.

This is why it is important for the CDMHP to communicate with the physician in the ER prior to serving the patient the detention papers and informing him/her of his/her pending admission to ESH. The 72 hours start running at the time that hospital gives provisional acceptance. There have been times when the patient has spent 12-24 hours of the 72 hours in the ER prior to admission. That cuts short the time for evaluations and petitions that are being filed with the court.

d. Medications

The transferring facility is to be asked by the ESH staff member communicating with them to send all patient medications with the transporting personnel.

If the patient is on a new medication or a special medication that may not readily be available at ESH during the night or weekend (for example an antibiotic, cardiac medication, inhalers for asthma, etc., or other medication that may not be on the ESH formulary), the transferring facility is to be asked by the ESH staff member communicating with them to provide a 2-3 day supply of that medication.

Legible copies are needed of all information obtained by the referring physician and emergency department/clinical staff, including medication records from nursing homes or hospital, copies of advance directives, CODE status, guardianship/ POA, and civil commitment papers.

Editors note: Western State Hospital has been contacted for their medical stability requirements. They did not arrive in time for this edition.

Authority without wisdom is like a heavy axe without an edge, fitter to bruise than polish.

-Anne Bradstreet, poet (1612-1672)

Status of developing model documents

Two years ago the Executive Board formed an ad hoc committee to develop a set of model documents that are used for detention and LRAs in the state. The executive board hoped to provide agencies with model documents that reflect current law. (The model documents in the Mental Proceeding Rules (MPRs) are out dated and no longer reflect changes in the law.)

When the ad hoc committee met after the spring conference at Sun Mountain two years ago, little did the members know what they were biting off. Their one-year time line has turned into a two-year process.

The committee's first step was to ask a number of agencies around the state for copies of the documents that they used for detentions. After receiving many samples, the committee developed prototype documents, and sent them to all of the agencies, asking for comments and suggestions.

The committee received comments and suggestions from about half of the agencies in the state. The committee revised the documents using these suggestions, and is now ready to begin the next phase.

The next step is to send the revised documents, which are based on this feedback, to prosecuting attorneys and agencies around the state for further comments.

The final step will be to send the model documents to the Supreme Court for incorporation into the MPRs. If approval is given by the Washington Association of Prosecuting Attorneys and CDMHP agencies, they could then be published in the MPRs as model documents for agencies to use. Agencies may design their own documents using the model as a guideline. (Some agencies have the understanding that they would need to adopt these documents. That is not the goal. The goal is to provide *model* documents in the MPRs that agencies may use if they so desire.)

The committee hopes to have the revised documents ready to bring to the spring conference at Sun Mountain. If there is a perceived need for a discussion of the documents, and if the schedule permits, the committee will be available to discuss and take comments on them.

The members of the committee are: Neil Korbas and Carolyn Williams, prosecuting attorneys from Spokane County and Pierce County and David Weston of the Mental Health Division. Jan Dobbs and Scott Kuhle are the association's representatives.

Charity sees the need, not the cause.

-German proverb

Training at Eastern State Hospital great success

The Washington Institute for Mental Illness Research and Training completed the second of its five-day training programs for CDMHPS at Eastern State Hospital. The statewide CDMHP training was developed in order to provide new and current County Designated Mental Health Professionals with basic training that will promote increased statewide uniform decision making in regard to the treatment of individuals and the protection of the public, and more effective administration of Washington State Laws that deal with involuntary treatment for adults and children. The five-day series of CDMHP training were designed by the Washington Institute of Mental Illness Research and Training and the WACDMHP.

Thirty-four CDMHPS completed the 32 hour series in November. The participants represented Chelan-Douglas, North Central, Greater Columbia, Spokane, Northeast, and Timberlands Regional Support Networks. Representatives of two Federally Recognized Tribes, Spokane and Colville, attended the series.

According to Beverly Miller, Associate Director of Training at WIMIRT, "The participants rated the series as highly valuable to their practice and recommended further development of training using this model."

The follow are observations and thoughts about the training by four CDMHPs who attended the training.

FALL 2002 CURRICULUM

Medical Clearance Criteria
Kamaljit Floura, MD, Medical Director, Eastern State Hospital

Coordination of the ITA Process
R.J. Smith, PhD, Eastern State Hospital

How to Write a Petition
Jan Dobbs, Director of Urgent Care Services, Spokane Mental Health

The Treatment Delivery System for Children
Kathy Crane, Mental Health Division

Legal Framework and the Court Process
Neil Korbas, JD, Spokane County Prosecuting Attorney
Jonathan Mann, JD, Public Defender
Dan Burt, PhD, Sacred Heart Hospital

Risk Assessment
Gregg Gagliardi, PhD, University of Washington

Referrals and Investigation
Tim Justice, CDMHP Manager, Whatcom Counseling and Psychiatric Clinic

The System of Care for Persons with Developmental Disabilities
Bob Howenstine, Division of Developmental Disabilities, DSHS
Dan Peterson, Division of Developmental Disabilities, DSHS

The System of Care for Vulnerable Adults
Carol Sloan, Disabilities and Long-Term Care Administration, HCSD

Epidemiology of Suicide
Paul Quinnett, PhD, Director, QPR Institute

Alcohol and Substance Abuse Commitment
John Rothrock, Spokane County Chemical Dependency Commitment Specialist

CDMHP Protocols
David Weston, Division of Mental Health, DSHS
Beverly Miller, Associate Director of Training, WIMIRT

Walla Walla CDMHP

Greg Buhler wrote the following about the training.

A CDMHP needs to be part doctor, lawyer, judge, jury, psychiatrist, social worker, as well as compassionate firm and able to rely on these resources under extremely stressful circumstances. The work itself as any CDMHP knows is unpredictable, holds tremendous responsibility is adventurous, interesting, is unlike any other job and rarely if ever is black and white. However, becoming successful as a CDMHP, takes experience and training.

Due to the enormous amount of information given to the 44 in attendance (consisting of a few CDMHPs and many people in training to become CDMHPs) and the brevity of this article, I have limited my responses to just a few "pearls of wisdom" from this training.

I was impressed at the presentation concerning admissions criteria as it relates to physical health. It was made very clear that ESH and most E&T facilities will NOT accept anyone who has a medical condition. *(Editor's note: see* Hospital Criteria *on page 9.)*

The speakers that presented on documentation also hit home with me. A well-documented clear, accurate and concise ITA investigation narrative is imperative. One reason documentation is so important to me is because the prosecuting attorney and the defense attorney will use that document to substantiate whether the respondent stays in

the hospital or gets released. The loudest and clearest message I got from this portion of the training was, "take your time, don't let ER staff, or anyone else, rush you, do a thorough job, make use of affidavits from credible, trustworthy witnesses and let them know that they may have to testify under oath as to what they write down.

The main speaker concerning suicide, Dr. Quinnett, who has written many books on the subject, said, "There are two kinds of therapists, those who have lost a client to suicide and those that will." Some people will succeed. I liked to hear that realism because it shows that CDMHP work is not a perfect science. The unpredictable human element is always there.

All the speakers had relevant useful material. The final speaker, Tim Justice, spoke in a way that seemed evident that he has spent years working in the trenches as a CDMHP. He pulled all the information from this training together, and in his candid honesty said something that I have certainly felt at times and I suspect any CDMHP reading this can relate to, "Some times situations seem to get very complex and confusing." He was very firm about every CDMHP's responsibility to read, read and re-read the Protocols, know how to do a mental status exam, frontward and backwards, make sure people are aware of their rights and to use integrity, compassion, and gracefulness.

Adams County weighs in

Teresa Schotzko, a CDMHP in Adams County had this to say about the training. Tast November I had the pleasure of attending the CDMHP Training facilitated by Beverly Miller. The purpose of the training was to train CDMHPs across the State so the services we are providing are uniform, not only with process but paperwork. More paperwork, you may be wondering? No, luckily, it focuses on consistency from county to county. There were three significant aspects of this training. First, the core training and information of the training; second, networking with other CDMHPs from Eastside; and finally the CDMHP's role.

The CDMHP training provided a plethora of information. It presented different aspects of the ITA process. Hospital and legal references were discussed, including medical clearance, how the ITA process developed, and adequate information and legible writing of ITAs. Resources were offered by agencies such as Developmental Disabilities, Aging, and Substance Abuse, as well as additional information for risk assessments, investigations, writing petitions, and suicide prevention.

As a relatively new CDMHP, I appreciated the opportunity to dissect RCW 71.05 and discuss its different components. Is a person truly mentally ill? Or which gravely disabled criteria do I use? Can I use both gravely disabled criteria? What happens to this individual if their detention is continued? The opportunity to have others explain this process, and then discuss it, solidified my understanding of RCW 71.05 and 71.34.

Discussions surrounding the writing of petitions themselves were beneficial. As most fellow CDMHPs may know, there is a movement across the State of Washington to develop a model ITA petition. We were fortunate enough to be provided with a prototype, which included guidelines as to what to write and pertinent information to include.

It was also helpful for me to hear the different processes involved when responding to a crisis involving an elderly person, a person with a developmental disability, children, and persons who have substance abuse issues. Each case provided a different scenario and different resources to utilize. We have many diverse considerations when responding to crises involving the above populations.

During the training, I learned that dementia could cause symptoms similar to mental illness, such as delusions. However, such a case would not warrant a psychiatric hospitalization. Additionally, persons with developmental disabilities pose a set of difficulties, if they are low functioning, that may inhibit gathering information for an ITA investigation.

The situation with children is quite different. The resources for children are often so limited that, when in need of psychiatric hospitalizations, they often have to wait for a bed. I learned to focus my crisis response on how the family or friends are going to provide the safety and care for the child until a bed is available, or the child stabilizes and does not need hospitalization.

Dealing with persons with substance abuse issues is often a precarious situation. I feel fortunate to be able to call our substance abuse CDP counselor to provide support in the evaluation process. Persons, who are intoxicated and need hospitalization, have to get drugs or alcohol out of their systems before a hospital will admit them. This poses the question of how and where to let them sober up. Fortunately, I learned that there are laws to help in this process when other agencies aren't willing. Additionally, the CD presenters provided flow charts of organizational structures, allocated monies, and the criteria for eligibility for various programs offered by their agencies.

We also talked about suicide and risk assessment. Imminence is one of the defining criteria for hospitalization. What is the probability that if I release this person they will commit suicide or homicide? Through the presentation and following discussions, I learned that my gut feeling is often right. If someone isn't being honest about his or/her behavior and/or actions, he or she is in need of extra care and support. I have learned to take into consideration where a person is on their "path to suicide" or homicide, and what, if any, resiliency factors are in place, or could be put into place, for those who have suicidal ideation.

The training was much more than handouts and lectures. You may be thinking to yourself, "I know 71.05 and I know how the hospitals operate, I talk with them weekly," but for me the opportunity to network was invaluable. I had the opportunity to talk with and interact with other CDMHPs on the Eastside of the state. I live in one of the most rural and least populated counties in the

state, so it was helpful for me to hear what other CDMHPs are doing, especially those from other rural areas. I learned how different counties are utilizing the law to aid them in accessing resources for their clients, how they are writing their petitions, and how they are interfacing with other agencies.

The final component of the training was the clarification the CDMHP's role. Foremost is responding to and evaluating the person in crisis, but there are other roles involved. I am also an advocate for the person in crisis, advocating to their families, other organizations, and hospitals. What can I do to aid this person right here and now? What supportive services can I access to aid the person in either going home, or in acquiring a hospital bed? The training gave me additional tools to provide adequate services.

My second role of responsibility is education. Often, referring agencies have different points of view towards persons with mental illness. At times, I have met with resistance or fear, and needed to educate others on my role, my prescribed "power", or lack there of, and RCW 71.05 or 71.34. This is an ongoing process. Networking taught me that this role of educating is one of the challenges that each of us deals with during ITA investigations. I learned different phrases or explanations that might decrease the amount of time spent on educating others while doing investigations.

Overall, the information, the networking, and understanding of the roles of a CDMHP that I received in the training, have improved me as an investigator. I have a better grasp of RCW 71.05 and RCW 71.34, as well as a better understanding of the support agencies we interface with during a crisis. I think that the content of the conference was fantastic, very informative, and well worth the time I spent away from my CDMHP work. I want to express gratitude to the presenters who gave time to come, some flying in from the Westside. They provided useful information, resources, and phone numbers of contacts so we can access support services for individuals in crisis. I encourage other CDMHPs, new and old, to attend this training in the future. The information and time to network is well worth your time.

Pend Oreille County well represented

Wendy A. Bauer and Sherry Bashaw of Pend Oreille County wrote the following about their training experience. We would like to thank Beverly Miller and the Washington Institute for Mental Illness Research and Training program for allowing us the opportunity to learn more about the important job of being a County Designated Mental Health Professional (CDMHP). This training provided vital clarity and knowledge for new and seasoned therapists. The training was designed to strengthen a challenging, yet rewarding responsibility.

This indispensable training enhanced our abilities as CDMHPs, and we want to share the highlights with those who were unable to attend.

Dr. Floura began by explaining the admission process into Eastern State Hospital, particularly the importance of obtaining medical clearance before patients are admitted. This particular admission criterion is significant because the hospital does not have a medical unit to deal with medical emergencies. (See article on Medical Criteria page 7) Dr. R.J. Smith gave us a greater understanding of the helpfulness of using the same standardized paperwork and language. How, for those who have to decipher and understand what was experienced in the field, the paperwork must tell a story about the events and situations surrounding the face-to-face intervention using more actual quotes than summarizing. Jan Dobbs provided clear examples of how to write a more effective petition by using clinical terms with examples of the behavior that validates such a term in order to substantiate a decision to revoke. The individual does not have to have a formal diagnosis, but must meet the clinical criteria in the DSM-IV-R symptomology for Axis I.

Kathy Crane educated about the five state funded Children's Long-Term Inpatient Program (CLIP) facilities. There are 96 beds statewide. A child qualifies for a CLIP bed after their case is reviewed by the CLIP Administration. They will review what other least restrictive alternative (LRA) options have been exhausted, that the child must meet the criteria for severe psychiatric disturbance that would warrant such a level of care, and if the child has been placed on a 180-day restrictive orders.

Neil Korbas, JD interpreted the legal court process of detentions and revocations. As CDMHP's, we have the power to interfere with an individuals civil rights. This gives us an enormous amount of control that always needs to be considered before taking away a person's right to make their own choices within due process of the law.

Jonathan Mann, JD stressed the significance of his job as a public defender when it comes to the documented information he has to review. If our paperwork is too vague, or not clearly depicting the picture of that client in crisis, then Mr. Mann will have an easier time proving the person does not need to be hospitalized. Dr. Dan Burt reviewed the specific details of what a court evaluator needs, such as where to send paperwork, having legible handwriting, using standardized formats so they are all easy to follow. He encouraged CDMHPs to provide the witnesses phone numbers and use their quotes rather than summarizing, a copy of the police report with the officers badge number and phone number, the client's age, and social security number.

Dr. Gregg Gagliardi spoke on his role as a clinical forensic evaluator. He reviewed the two determining factors of expert opinions for competency to stand trial: 1) The mental status at the time of the competency of the evaluation and 2) The performance on specific competency instruments, such as the Specialized Risk Assessment Tools and the MacArthur Competency Test. Tim Justice gave clearer focus around the referrals and investigation process with looking for five pieces of evidence that are required for emergency detainment. The first being reviewing the complaint and investigating all of its pieces. Is there a true mental illness there? Next, is their dangerousness a result of the mental disorder?

Are they eminent with time frame and severity? Lastly, what LRA's have been explored, offered, or initiated that have failed due to poor faith or inability to utilize what was offered.

Bob Howenstine and Dan Peterson gave meaning to the systems of care for the Developmentally Disabled population with offered services. They defined and reviewed a DD client's struggles as well as how to better handle such client interventions with specific interview techniques to assess appropriately.

Carol Sloan's educational focus was the risk factors and long term care of the aging population. She stressed that this group is vulnerable to abuse, neglect, and financial exploitation. The authority and limitations of Adult Protective Services and mandatory reporting with specific examples of times when it's appropriate to report.

Dr. Paul Quinnett who is the director of Question, Persuade, Refer Institute (QPR), illustrated the vital aspects of suicide intervention and prevention. He challenged our knowledge with current statistics that 60% of all suicides had alcohol involved and dispelled myths that those in their teens and early 20's are not the only ones at risk. A path to suicide can be changed by developing a "wall of resistance" that consists of removing the methods, developing reasons toward motivation to live and the coping skills to divert/block their quickened pace down the path to self-harm. Dr. Quinnett clarified the five acute risk factors of suicide being severe psychic anxiety or turmoil, incessant rumination on that turmoil or anxiety, global insomnia for three to four days, delusions of catastrophe, and resent alcohol use with or without previous history. Then providing the five A's to a good outcome which are an accompanied referral, accurate diagnosis, an aggressive treatment plan of medication and therapy interventions, adequate levels of communication about the suicidal feelings and a well organized after care plan.

We ended our five-day training with John Rothrock presenting the chemical dependency (CD) component. He provided a list of referral agencies that are offered in Spokane. The differences in the involuntary commitment for detox services and inpatient treatment stay process. He discussed how CD treatment could help clients and the significance of a referral at a crisis contact, to CD services.

Over all we were very pleased by the information we gathered at this training and will become more effective crisis intervention specialists. There were a few ideas we had that would have enhanced the experience even more. Ideas of allowing a tour of the facility in order to understand the impact of experiencing a hospitalization to a client from the inside and for the speakers to not point out specific agencies that do or don't perform well with their protocol paperwork. But these are minor, compared to the broader perspective we have gained in the importance of our role as a County Designated Mental Health Professional.

Planning for next series

Beverly Miller is beginning to plan for statewide CDMHP training in 2003. The first training will be held west of the mountains in the Spring and the second east of the mountains in the Fall.

A meeting has been scheduled on Friday, January 31 to discuss and shape the direction that the free CDMHP training should take in 2003. Stakeholders are invited to attend the meeting that will be held from 10 am to 12 noon at The Washington Institute for Mental Illness Research and Training, at Western State Hospital. Contact Beverly Miller at (253)761-7562 or beverly@u.washington.edu if you plan to attend or have questions.

Contributing to this article: Greg Buhler is a CDMHP in Walla Walla County. He has been a CDMHP for over 4 years. He is a licensed mental health counselor and has done crisis intervention work for several community mental health facilities. He has worked in inpatient and outpatient psychiatric units with adolescent and adult populations.

Teresa Schotzko is a CDMHP at Adams County Community Counseling Services in Ritzville, where she has worked for the last year and a half. Teresa received her MSW from the University of Wymoning in 2001. Teresa provides therapeutic services in addition to working as a CDMHP.

Wendy A. Bauer, MA, AT, RC
Sherry Bashaw, MS, LMHC, CDMHP

New domain name, new design

The WACDMHP's website has a new design as well as a new domain name. Kelly Carter, the daughter of Gary Carter, association treasurer has designed the site so that it is easy to browse. Please let executive board members or Kelly know what you would find helpful to have on the site. The association bylaws are on the page. Look on the web page for updates about workshops and conferences.

The Job Board is a resource that agencies, looking to hire CDMHPs and other clinical staff, can use in their search. An agency can send an e-copy of the description of the job on the website and the Web manager will put it on line.

Some people are still trying to use the old website and are frustrated, so mark the new domain in your Favorites.

The Washington Association of County Designated Mental Health Professionals and Western State Hospital present:

Geriatric Crisis Intervention

Featuring

Don Slone, Ph. D.

Dr. Slone is a psychology supervisor in the geriatric unit at Western State hospital. He has been in the mental health field for over 20 years and has specialized in the management of behavior problems in dementia patients for 14 years. A coordinated team based approach is emphasized. Dr. Slone has been actively training and publishing in this area. He works with some of the most difficult to manage geriatric patients in Western Washington and provides practical illustrations of effective intervention strategies as well as team coordination approaches.

Sally Plumly, A.R.N.P.

Sally Plumly has been a psychiatric nurse for many years and an ARNP since 1986. Her interest and passion is to work with the Older Adult Population. She has done so via Good Samaritan Mental Health for over 10 years, formerly as part of the Geriatric Evaluation and Outreach Team in Pierce County and currently she provides assessment and medication management for older adults in the community, at Luckett House (a geriatric ARTF), and in nursing homes.

George Dicks, B.A., G.M.H.S.

George Dicks has worked in the mental health field for over 30 years and in geriatrics for over 20 years. He is currently the lead clinician at Harborview Geriatric Psychiatry Service. He has been on the faculty at Edmunds Community College in Social and Human Services for over ten years.

Friday, February 28, 2003

8:00 AM-8:45 AM: Registration
8:45-9:00 - Introductory Remarks
Jan Gregg,, WSH C.E.O. and
Matt Goodheart, WACDMHP President
9:00-10:30 - Behavior Problems versus Curing Dementia, Delirium, and Depression: Don Slone, Ph. D.
10:30-10:45 - Break
10:45-12:15 - Behavior Management Strategies: Don Slone, Ph. D.
12:15-1:15 - Lunch.
1:15-2:15 - Geriatric/Psychiatric Emergencies—A Medical Perspective: Sally Plumly, A.R.N.P.
2:15-3:15 - Behavioral Approaches and Using the Environment: George Dicks, BA, G.M.H.S.
3:15-3:30 - Break
3:30-4:15 - Panel Don Slone, George Dicks, Sally Plumly

- The conference fee for members is $40.00 and for non-members is $60.00. This includes lunch, refreshments, and snacks.
- **Special:** If you register as a non-member ($55 fee), you can receive one-year WACDMHP membership and newsletter without additional charge. Enclose a check or money order payable to *WACDMHP*. No purchase orders please.

- Lunch is included in the registration fee. Registrations are limited to the first 125, so register now.
- **NO** day of conference registrations will be accepted. Registrations postmarked after February 20, 2003 subject to space availability.

Directions to WSH from I-5

Take exit 129 (South 72nd Street and South 84th Street). If coming from the south, this exit will say to L.H. Bates Voc. Tech. There will be a sign pointing left to South 74th Street. If coming from the north, stay in the right lane for South 74th Street. At the yield sign turn right.

Head west on South 74th Street. After crossing Bridgeport Way, the name of the street will change to Custer. Stay on Custer-and watch for a sign pointing right to Western State Hospital and Pierce College. This street merges with Steilacoom Blvd. at the Stellar Mart; stay on Steilacoom Blvd. until you reach the hospital. The main entrance of the hospital has a stoplight, turn right into the hospital grounds.

Now that you are on the hospital grounds, just stay on this road and it will take you to East Campus. Along the way, you will pass the main administration building on your left, then follow the event signs to the East Campus dining hall.

For further information contact Skip Stephan at (253) 756-2977 or James Jones at (253) 798-2709.

REGISTRATION FORM

Western State Hospital
2003 Spring Workshop
February 28, 2003

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Employer: _____ County: _____

☐ WACDMHP member ☐ Non member
Would you like to become a WACDMHP member at this time? Y___ N__
Are you a WSH employee? Y___ N___ If so, we will bill WSH for your registration.
Are you currently a CDMHP? Y___ N___
Registration fee: WACDMHP members is $40.00 and non-members is $60.00
Enclose a check or money order payable to **WACDMHP.** No purchase orders please.

Signature: _____ WACDMHP Identification Number: 923161171

Detach and mail this form with payment to: Staff Development
16-223Western State Hospital
9601 Steilacoom Blvd. S.W.
Tacoma, WA 98498-7213

Washington's Treatment System is "Gravely Disabled and Dangerous"

By Tom Richardson, former President of NAMI Washington

CDMHPs have too often been the people NAMI members "love to hate." Your responsibilities under present law often put us at odds; you insuring our "right to be crazy in the street" (up to proving our "dangerousness") and us wanting early access to effective treatment. The concept of "grave disability" seems to us to embrace any untreated serious mental illness. An interpretation generally misconstrued by you and by the courts as something that only counts when an untreated, seriously ill, and abandoned person is at death's door from self and society's neglect.

It is my hopes that those among us who are recovering from these devastating illnesses, our friends and families,

CDMHPs, cops, judges, providers, and legislators can all begin to work together to improve the timeliness of access to and delivery of Washington's treatment and rehabilitation services.

As you may well know, NAMI is a national organization. In Washington we have about 7,000 members in 26 local affiliate organizations across the state. Historically, most of our members have been relatives of people with serious mental illnesses – parents, siblings, and children - or friends of people with serious mental illnesses. But with the newer medications and more and more recovery being realized, NAMI is becoming a recovering consumer organization – today approximately 20% of our members are adults you may have at one time or another judged as "dangerous enough" – or "not yet" - in the course of your workday. NAMI continues to be an almost exclusively volunteer organization providing support, education, and advocacy.

Understanding that mental illnesses are neurobiological brain disorders, that treatment works, that people can and do recover from such illnesses, and that early treatment is better than late treatment forms the basis of our views on the system. NAMI's principal task at the state level is to turn the stigmatizing focus of the media - and of the people's legislature - into understanding and timely and appropriate medical intervention.

Bad Treatment Costs Money—And Lives!

Sometimes it seems that nearly every bizarre event involving someone with a serious mental illness draws media attention – and then sometimes legislative attention - to the need to "do something!"

The media - and then the legislature - jumps on events like Seattle's retired Fire Captain Stan Stevenson a few years ago to Texas' Andrea Yates last year to more recent and local events where a cop gets killed seeing if someone is either "too dangerous" or "yet dangerous enough" to call in a CDMHP. The current Seattle media case (Thomas Gergen being turned away from hospitalization twice in a few days, including 6 hours before killing his pregnant wife and shooting himself in the head) gives us pause once again to consider the appropriateness of current access laws and policies.

As you know, such events are too frequent and too painful. In the minds of the members of NAMI Washington, such everyday events as you all face in your work are not only painful, they are, frankly, unforgivable.

If only the "system" responded to the symptoms of each individual's illness early and appropriately, then most of these headline making incidents – and a lot of lives lost less publicly to suicide, incarceration, or homeless wanderings -- would be avoided. Very often, it was the judgment of a CDMHP the day or week before that made the difference between "in time" or "too late" to prevent an unfolding disaster.

Our overall goal is to create a mental illness treatment system that gets people into effective treatment early in their illness and then maintains long term cognitive stability and support as they struggle to achieve a meaningful recovery from the devastation of their lives.

To achieve our goals, we recognize that we must join together with others who may have a different intimate perspective on mental illness than we do, but who nevertheless share our desire for a more effective public treatment system – one that saves lives and even saves the taxpayer money.

CDMHPs constitute such a group with whom we are interested in becoming allied. So are police and sheriffs officers. So are psychiatrists and other mental health professionals. So are all of us who know first hand what the shortcomings and outright failings of the current system cost individuals -- and cost the taxpayers.

So there is no misunderstanding, however, I want to make clear how many recovering consumers and many family members and friends of untreated consumers feel about CDMHPs. We may understand intellectually one thing, but our feelings tend to be something quite different on the subject of CDMHPs.

You seem to piss everyone off no matter how you do your job:

- Why couldn't I get this treatment earlier? You think its fun going down hill into the pit of insanity! Try it sometime.
- Why can't my daughter get treatment before she slits her wrists or becomes completely vulnerable to the mean streets? You don't think she is sick enough yet!
- You guessed wrong yesterday when you were asked to commit this person for treatment!
- So my neighborhood cop has to put his life at risk to go see if this person in a psychiatric crisis is dangerous enough yet today to get medical treatment for their known illness. Or,
- So my son is being taken to jail today because of his untreated mental illness. Or,
- So my mother was left untreated, free to attempt suicide.

Why do CDMHPs make people wait until they are so sick that it takes a ton of taxpayer money and overburdened professional time trying to put humpty dumpty back together again? <u>Because, that's your job</u>! Don't you know that even with everyone trying hard, Humpty Dumpty can't be put back together again?

In the 1970s you all were being invented and the drive toward the present system of Involuntary Treatment was illustrated with institutions reminiscent of England's Bedlam – which by the way, I visited in London last year – it's now, somewhat appropriately, a War Museum. Back then, a wife might be "put away" because her husband was having a mid-life crisis. Back then, we were all into civil rights and the freedom to be whatever we wanted to be – and besides, it was going to be cheaper to close down the institutions. It was to be so simple -- give

those people some new medication and send them back to their families to take care of --at their own expense.

That was the mood of the nation and of the legislatures 30 years ago when we developed the present parameters on everyone's "right to be crazy in the street." You all are still accepting the responsibility first and foremost for protecting that "right." But, we have learned a few important things in the last 30 years.

It isn't all working out the way we expected, but 30 years later we are still doing the same thing day after day. In the "Big Book" of Alcoholics Anonymous – in the old one that I read anyway – it defines insanity as "doing the same thing over and over again and expecting different results." Why aren't you complaining to the powers that be?

Do NAMI members understand the role of CDMHPs in Washington? Intellectually we do. About a year ago, M. Zakova Savic, a Whatcom County CDMHP, wrote an article entitled *CDMHPs and the Ethics of Ambiguity*. I refer to part of it here to illustrate that NAMI members do understand the difficulties you often face in carrying out your legal and assigned responsibilities as CDMHPs.

In the opening paragraph, Ms. Savic says, "To pronounce that CDMHPs face a plethora of ethical, moral, and legal dilemmas would be a gratuitous understatement. There are continual hurdles to throw us off balance in a position that calls for cautious and decisive action."

You have a tough job

Finding fine lines in a murky system isn't easy. We have a public treatment system that doesn't want to waste money, but is very short sighted. And, we have a court system that is more oriented to protecting one's "right to be crazy in the street" than one's right to functional cognition and a life of opportunity and promise. You are right there in the middle – with us!

As an advocate, changing minds after 30 years of thinking about mental illness as a hopeless condition that costs too much money is my job. But it's also your job – not the one you are being paid to do, but no less important.

It's time; it's past time, for a change in how we as a society approach people who are living in our communities with untreated serious mental illnesses.

Today, you get paid to keep me and mine from getting the medical attention that, as a mental health professional, you know is needed to deal with the illness.

Today, you know that if I got treatment now, it would save me and the taxpayer a lot of grief. Oh, but I don't want it!

Today, you know that every trip into the pit permanently destroys another bit of my cognitive potential, even if I got good treatment on the rebound. Oh, but it's my right to go into the pit!

Today, it's fairly early in my gradual decompensation into the pit of untreated mental illness; I'm NOT YET "dangerous." So, let's wait!

Today, I don't want any treatment, there is nothing wrong with me, and everyone else is crazy.

Today, your job – as we see if from a family and recovering consumer point of view – is to keep me from getting the medical attention you know I need - but that I don't want - until I'm so sick that I'm about to cross that magical and very fine line from harmless to dangerous.

Let's rethink this system together!

Because lawmakers decided 30 years ago that "dangerous" was a good place to begin to give people treatment, Washington invented the system of County Designated Mental Health Professionals to protect people like me from getting treatment I clearly need, but don't want – even when my brain isn't working right and everyone knows it – except me!

Sometimes, you get it right and just before I might commit suicide or assault someone; you step in and stamp me with a 72 hour hold.

BUT, sometimes you get it wrong – and I die or get arrested or a retired fireman walking home from a Mariners game is killed – at best, I get sent to a hospital psychiatric ward where they try in vain to put my brain back together again -- at a cost of $135,000 per year.

Should society protect my right to be "crazy in the street" (up to the point of being dangerous) with the same vigorous standards that we protect my right to be treated fairly when I am accused of a crime? To ask the same question more directly to my point, "Don't I have an inherent right to be protected from untreated insanity? Must I become very poor, very seriously ill, and even dangerous before I get treatment for a serious biological illness?"

Should the treatment decision for any illness – mental or otherwise - be based on protecting society (including myself) from violence? Or, should it be based on assuring that we all get timely and appropriate medical treatment for what makes us sick? In this case, for what robs us of the essence of ourselves and of our potential as sentient human beings – and rarely, but sometimes, moves us to violent behaviors that endanger ourselves or others?

What about "Gravely Disabled" you might ask?

Well, from our common experience, what about it indeed! It's there in the law, but what does it mean in practice?

It obviously is not defined as anyone with a shred of common sense would define it. Having lost my ability to perceive reality in the same way that the next 1,000 people perceive it, and then acting on my absolutely unique perception, would seem to me to constitute a "grave disability." But not in this business!

If I am not insisting on going out into the snow without clothes on because I'm impervious to cold, if I'm not close to starving myself to death because I know that the CIA is poisoning all my food, if I'm not running into freeway traffic because my neighbor's dog is God and He

told me to chase cars – then, it seems, in Washington I'm not "gravely disabled."

CDMHPs just don't invoke "grave disability" as often as those of us who view this system from my perspective think you should. Why not?

We know that it isn't because you don't want to invoke "grave disability." The courts won't uphold it! When my granddaughter gets her public defender to claim her "right to be crazy in the street," the court lets her go. From the point of view of recovering consumers and family members of those who are untreated, "grave disability" is not being used in the way anyone with common sense would use it. In practice, in Washington, the concept of "grave disability" is an evil deception perpetrated on the sick and the innocent.

Still, CDMHPs are the people who piss us off the most. We get mad sometimes at the Case Manager who doesn't have time to do this or that, just because they have 57 other people on their case load. We get mad sometimes because the psychiatrist decides to reduce the dosage of an effective medication just because it seems to be working so well. We get mad at the administrator who tells us that we can't get dental treatment just because the reimbursement for dentists is so low that no dentist in our area will take government insured clients like us.

BUT, it's the CDMHP who says, "No treatment today because you just aren't sick enough, "dangerous enough" – yet. Come back tomorrow or next week and we'll see if you've gotten bad enough to give you the treatment we all can see that you really need."

Anosognosia

Anosognosia is the "lack of awareness that a person has about having a serious illness." I have a close friend with a long history of serious bipolar disorder. He's very bright. He's got a very elaborate fixed delusion that is constantly reinforced by the media about how there is a worldwide conspiracy of capitalists and war mongers and politicians who want to kill people – for profit. [Makes you wonder sometimes, who is crazy here.]

The news gets him down and he even gets suicidal once in a while. At those times he will go to a hospital early in his depression and ask to be checked in for treatment. He knows that he can get by the CDMHP hurdle if he tells you that he is having suicidal thoughts. "I don't want to wait until I'm so down that I'm really suicidal," he's told me, "it's hard being suicidal, and it's scary. They let me in if I tell them the symptoms of my illness that allows them to let me in. So I tell them what they need to hear when I need to get some intensive help."

Unfortunately, everyone isn't as bright and introspective about his illness as my friend. My son certainly isn't. A few months ago my son was described by his Western State Hospital psychiatrist in much the same way as I might describe my close friend, "intelligent and articulate. … fully oriented … no gross impairment of memory, reads and writes well, …." And, like my friend, my son has a long history of paranoid delusions; his involve the CIA and conspiracy to do evil.

But, unlike my friend with bipolar disorder, my son does not believe he is ill. Without such awareness, of course, he will not monitor himself; he will not seek medical attention when an episode of psychosis starts to overtake him. He will not give you the answers you need to allow him the treatment he needs – indeed, he will contest with you to see if he is smart enough to give you false answers that he has come to understand will keep him "free;" answers that will keep him away from treatment for as long as possible.

My son has never been suicidal – yet – but he has been homicidal. And he has learned what not to say to CDMHPs when he is being tested for "dangerousness." He's gotten into jails and hospitals based on actions rather than words. Increasingly, he has left a trail of victims behind him, including himself. Two months ago, he was moved from Western State Hospital to Jail to McNeil Island because of actions he took while under care at the hospital.

Could WE design a better System?

I don't want to go back to the easy abuse of those who are not perfectly "normal." I don't want to go back to a system that would abuse even the oddly eccentric -- something I like to claim to be myself.

But, I do know that we don't yet have a good system of timely and appropriate treatment for my friend or for my son. Nor for the 10% of those with serious mental illnesses who commit suicide or for those thousands who go to jail and prison for failure to get into treatment for what ails them or for the 60% of the homeless whose lives are wasted for want of treatment for a mental illness.

There has to be a better way. Cops on the street know it. Judges on the bench know it. You know it. I know it. Karl Brimner knows it. The Governor and the Legislature and the people who elect them don't seem to know it – yet!

We need to find and use best practices from anywhere in the world. We need to measure what the system of treatment accomplishes - how many people recover, how many reintegrate into the mainstream of community life? We need to understand and act on the difference in outcomes between treatment denied and treatment supplied.

As we find better ways of saving lives – and money, we need to embrace them. The cheapest mental illness treatment system will be the one that helps more people to recover their lives following the devastation of a mental illness.

The higher we soar, the smaller we appear to those who cannot fly.

-Friedrich Wilhelm Nietzsche, philosopher (1844-1900)

2003 Spring Conference – Sun Mountain revisited

The Washington Association of County Designated Mental Health Professionals will hold its Spring Conference at Sun Mountain Resort on April 17th and 18. The purpose of the two annual conferences is to provide specialized training for CDMHPs on topics that directly affect their crisis intervention and detention evaluation.

Each conference is organized by one of the WACDMHP's vice-presidents. Ian Harrel, Cascade Mental in Chehalis, who is organizing this conference, has designed an agenda that will provide an opportunity for participants to learn about intervening with people who have special needs.

The first day of the conference will focus on ideas that will assist CDMHPs in their evaluations with persons with developmental disabilities.

The second day of the conference will focus on youth who are in crisis.

CEUs will be given for each of the two sessions.

Executive Board Meeting

The Executive Board will meet on Wednesday, April 16th in the reception suite at the Sun Mountain Lodge. David Weston, the association's liaison with the Mental Health Division, and Gary Rose, the association's liaison with RSN Administrator's, will attend part of the meeting. The executive board meeting is open to all members.

Hospitality Evening

The traditional hospitality gathering will begin at 7:30 in the reception suite at the lodge.

The conference fee is $160 for both days and $95 for each day. This includes annual membership dues for the Washington Association of County Designated Mental Health Professionals. The fee also includes a subscription of the *Frontlines* newsletter, and breakfast and lunch on both days of the conference.

The room rate is $72.50. Cancellations are subject to a $15.00 handling charge. No refunds will be provided after April 7, 2002.

For further conference information, please contact Ian Harrel at (360) 748-6696. For registration questions, please contact Kincaid Davidson at 360-676-5162. Check the WACDMHP website for updated information

Plan on attending an exciting conference

REGISTRATION FORM

Washington Association of County Designated Mental Health Professionals
2003 Spring Conference
October 17, & 18, 2003
Sun Mountain Lodge, Winthrop, Washington

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Employer: _____ County: _____

Position Title: _____

☐ WACDMHP member ☐ Non member
Registration fee: $160
☐ A check payable to WACDMHP is enclosed for: _____
Charge to my: ☐ Visa ☐ MasterCard

Account Name: _____ Account #: _____ Expiration date: _____

Signature: _____ WACDMHP Identification Number: 923161171

Mail registration form to: WACDMHP, PO Box 5371, Bellingham, WA 98227.

WACDMHP

2003 Spring Conference

Sun Mountain Lodge

Day One: April 17

Morning Session

DSHS' Division of Developmental Disability and the Mental Health Division Collaborative Work Plan (The mediated settlement agreement between DSHS and the Washington Protection and Advocacy System)

Presenters:

Cheryl Strange - Division of Developmental Disability
Theresa Mahar - Mental Health Division

Afternoon Session

Mental Retardation and Mental Illness: Basic Concepts and Clinical Implications

Presenter: *Tom James, PhD* - DDD Region 5 Field Services Psychologist

Day Two: April 18

Morning Session

Children and Adolescents in Crisis

Presenter: *Dr. Tim Truschel, MD* - Child Psychiatrist, Evergreen Counseling Center, Hoquiam, WA

Afternoon Session

Other topics about youth in crisis. Content and speaker(s) to be announced.

WACDMHP

2003 Spring Conference

Stakeholder' Address:
(Concerns, Challenges, and Collaboration)

April 17th & 18th

Sun Mountain Lodge
Winthrop, WA

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