Frontlines

Washington Association of Designated Mental Health Professionals

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SENATE RESOLUTION
8694

By Senators Rockefeller, Oke, Hewitt, Schmidt, Berkey, Delvin, Thibaudeau, Doumit, Benson, Kastama, Mulliken, Swecker, Esser, Brandland, Stevens, Deccio, Keiser, Sheldon, Hargrove, Weinstein, Pridemore, Parlette, Jacobsen, Kohl-Welles, Johnson, McAuliffe, Haugen, Rasmussen, Eide and Fraser

WHEREAS, Marty Smith, a loving, caring father and devoted husband who served the most vulnerable members of the community with passion as a County Designated Mental Health Professional, was brutally killed on November 4, 2005, at the hands of a critically ill patient for whom he was attempting to provide care; and

WHEREAS, Hundreds of Designated Mental Health Professionals and crisis workers, endanger their personal safety, and even their very lives in responding twenty-four hours a day, seven days a week, to calls for help from a patient's family, friends, loved ones, and others throughout the state; and

WHEREAS, These dedicated professionals, armed with their knowledge, skills, and commitment to provide the highest quality of care, have the special ability to provide unique care for the most critically ill patients; and

WHEREAS, Their selfless commitment and personal compassion assure the highest care of the patient and greatest safety of the community in which they serve;

NOW, THEREFORE, BE IT RESOLVED, That members of the Washington State Senate of the 59th Legislature salute Marty Smith's dedication to caring for his patients, and recognize the supreme sacrifice he has made in carrying out this dedication; and

BE IT FURTHER RESOLVED, That members of the Washington State Senate of the 59th Legislature unite in extending their deepest and heartfelt sympathy to each member of Marty Smith's family; and

BE IT FURTHER RESOLVED, That members of the Washington State Senate of the 59th Legislature express appreciation to the County Mental Health Professionals and crisis workers whose willingness to accept grave personal risks daily in order to provide the highest quality health care to the most dangerous, yet vulnerable, patients serves as a testament to their exemplary commitment to the people of this state.

I, Thomas Hoemann, Secretary of the Senate,
do hereby certify that this is a true and
correct copy of Senate Resolution 8694,
adopted by the Senate
February 3, 2006

THOMAS HOEMANN
Secretary of the Senate

President's Letter

It is often said that nothing in life is certain except change and death. This saying fits well with the profession of DMHPs at any time. Unfortunately, with one amongst our ranks being killed in the line of duty in the past year, the death part of this statement is more uncomfortably familiar at present.

The importance and risk of DMHP work is something I have never taken for granted. In this profession, we have accepted the opportunity and the challenge to engage mental health clients, their families, friends, and allied providers in their most perilous, and at times, most desperate moments. I know that DMHPs do not take the responsibility to those they serve lightly. Equally, I hope that DMHPs do not take their own safety lightly.

Contents

The recent death of Marty Smith (Kitsap County DMHP) necessitates assessments of outreach protocols for DMHPs. In review of processes, one item that immediately comes up is that there continues to be no specific statewide training of any kind for DMHPs, and specifically no consistent statewide training for safety. The WADMHP Association spring conference will offer a presentation on safety in outreaches, but this will reach only a limited number of professionals. Additionally, this training is only slated to occur at the spring conference and not as an ongoing topic. In conversations with people from DMHP offices, the MHD, and RSNs over the past several years, the idea of safety in outreaches as a conference topic has occasionally come up, but had not been pursued until this tragedy.

The lack of consistent training for DMHPs has been recognized in the past at the state level and, for a short time, the state was funding a DMHP "Boot Camp." As is often the case with needed and well intentioned programs, the funding for these trainings was cut. The State has continued to provide funding to the WADMHP Association for our conferences and workshops and is specifically funding the presentation on safety at this spring's conference. The WADMHP Association will continue to work with the MHD, RSNs and individual agencies to provide needed trainings for DMHPs as education is one of the primary missions of the association.

It is unfortunate that it often takes tragic events to create evaluation and needed change within systems. As DMHPs, both Marty Smith and Norm Fournier (a Pierce County DMHP also killed in the line of duty) were involved in a complicated set of circumstances that resulted in the tragic loss of their lives. It is worth noting that Marty had been a DMHP manager and that Norm was still in the role of managing Pierce County DMHPs.

Training and knowledge will never fully eliminate the risk to us in this profession just as there is not a fail safe system to be 100% certain that the people we evaluate will be safe to themselves and others after our contacts with them. However, as we have learned a multitude of techniques that assist us in intervening with clients clinically, we also need to increase our skills through education and consultation in order to analyze situations as they are progressing to accurately assess circumstances and our personal safety during outreaches.

I respectfully disagree with my good friend Scott Kuhle, Editor of the *Frontlines*, in his assessment that DMHPs should not be doing outreaches into the community. I believe that the work of DMHPs is in large part best done in the community and that proactive outreach often results in a person voluntarily accepting needed interventions and averts further crisis or decompensation. I also acknowledge that I have most often worked in RSNs that have community outreach as an expectation and that these County and RSN specific requirements dictate DMHPs responses to some extent.

Regardless of local requirements, as emergency responders, we are supposed to first assess the situation for risk to ourselves. If we are not safe, then we cannot successfully perform our professional duties for others. I agree with Scott that regular training and education are part of what is needed to prepare DMHPs and allied professionals to engage the community in ways that provide protection for ourselves as well as those we serve. This is an area

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that the WADMHP Association will continue to ponder and will look for ways to do our part for DMHPs statewide.

As this *Frontlines* issue goes to press, change is occurring in Pierce and North Sound RSNs in the form of a pilot project resulting from Senate Bill 6793, which was signed into law last year. DMHPs in these 2 RSNs will be authorized to detain people under a new combined chemical dependency and mental health ITA law. This specific portion of this omnibus law requires secured detox units to be created in order to have facilities to send individuals who are imminently at risk to themselves or others due to intoxication or chemical dependency for 72 hour involuntary commitments. These facilities will then go to 14 day hearings with respondents when clinically indicated just as in RCW 71.05.

The state legislature is slated to review the results of these pilot projects in the 2010 legislative session. If the legislature determines that these pilot programs were a success, then they will decide whether or not to change permanently to this new combined ITA law statewide. The WADMHP Association will continue to update its members about this process as it develops.

The DMHP protocols were reviewed this year per legislative mandate. Participating in this process were DMHP representatives from 9 counties (8 RSNs) as well as the WADMHP Association. The process resulted in a thorough review with very limited changes. The importance of DMHP voice in this process cannot be emphasized enough.

The DMHP protocols are now part of all RSN contracts within the state. The practical implication of this of course is that DMHPs are expected to act in accordance with these protocols and that failure to do so creates a variety of possible implications. Specifically, in the case of a negative outcome immediately following a DMHP contact, attorneys and other experts in the field will consider the protocols standards of practice. In litigation, failure to follow established standards of practice is one of the primary arguments used to attempt to prove culpability.

It is also true that the MHD has additional tools to audit us. One of the main goals of the protocols was to give advocates and allied professionals a roadmap of DMHP response. Therefore, people have a reasonable expectation that these protocols will be followed. At some of the protocol review meetings, advocates and allied providers had well organized and professionally presented requests for additions that would have added numerous specific and detailed requirements. While these additions were well intentioned they would have added undue work to some client encounters. Without DMHP representation at these meetings, some rather arduous processes would have been added to the protocols. By law, the next review of the protocols will be in three years. Thank you to all who participated. Please know that your input is important to this process and that the WADMHP Association will continue to take our collective best ideas forward.

The association is taking needed steps to change our name from WACDMHP to WADMHP. It is very difficult for me to leave off the C when mentioning our profession. Almost three decades of tradition can be changed with a new law, but the new way just doesn't seem to fit, at least yet. Now people can joke about us officially being the DMHP's (pronounced DUMPS or DUMPHs) that they always thought we were.

There continues to be pressure from the state and advocate level to look at non-emergent detentions and to fully implement this in legally and clinically appropriate ways. This presents many new challenges for well over 75% of the DMHP offices and county superior courts statewide. The challenges are even more complicated for counties that do not have inpatient facilities.

The WADMHP Association continues to be involved in a variety of ways in the mental health system within the state. We continue to attempt to offer our, at times unique, perspective to the mental health system as a whole in attempts to provide guidance to decisions being made about our profession. The association will continue to ask for members to provide us with feedback on issues affecting the DMHPs and on ideas for training topics as well as articles for the *Frontlines*.

The executive committee email addresses and contact information is available on the website wacdmhp.org. Your input is always welcome. I feel truly honored to be employed in a profession that so significantly impacts the people and communities it serves. I am confident that each of you are aware of the gravity of the work you do. I hope that each of you are able to appreciate the importance of the work we do with each community and client contact that you have and that this awesome responsibility and its attending complications does not outweigh the inherent rewards of this honorable profession.

Ian Harrel, President

Editor's Notes:

I just returned from a refreshing bike ride, so am energized to write some thoughts in my Editor's Notes. Although my comments may be a bit disjointed because they are reflective of the stream of conscious that I experienced while riding I want to share some of these thoughts with persons whom I greatly appreciate and value, the readers of the *Frontlines*.

Yesterday, I attended the excellent conference at Western State Hospital. I want to express gratitude to our colleague, Jim Jones, for all of the time and effort that he gave to preparing this productive and stimulating workshop. The content of the two presentations was excellent, and many of those attending asked good questions.

During the breaks, I walked outside to enjoy some of the balmy coastal weather - a treat for someone from the Palouse, - and walked into a different world, a world that I don't often experience. It's a world that I need to experience, at least occasionally, in order to perform my DMHP job well.

Walking about the campus of the largest psychiatric hospital west of the Mississippi, I realized that most, if not all, of the patients had been evaluated by a DMHP, and detained on his or her professional judgment. Whenever a DMHP makes a decision to detain, or not to detain, an individual, she or he is making a decision that will affect the client's life profoundly, and often for life.

Last week, I evaluated a college student who was having what appeared to be her first manic episode. Although she tested positive for THC, her toxicology screen was negative for other street drugs – despite reports by some of her friends that she used polysubstances.

When doing our evaluation, we consider many factors: Is this a mental disorder? Can the person be treated successfully in the community? If so, can he make a good faith agreement? If it is a drug induced psychosis, is psychiatric inpatient treatment appropriate? All of these questions are factored into our knowledge that the longer a mental disorder goes untreated the more serious the symptoms become, the more entrenched they become, and the more resistant to treatment they become.

Walking about the campus, I saw persons whose faces and bodies bore the ravaging effects of chronic and pervasive mental illness. People walking alone, and indeed alone; people walking in pairs – yet in their heads alone; people walking just to be walking – with no place to go, no dreams to fulfill.

There were people whose brains would not shut down with unwanted sounds and voices, people whose brains would not start up or move beyond pervasive and perseverative thoughts, and people who seemed only interested in their next cigarette,.

Some patients sat, sat, and sat, with no place to go because their brains would not take them anywhere; there were those that walked, walked, and walked, going no where because their brains couldn't take them anywhere.

These are the individuals that we mental health professionals and DMHPs have chosen to serve. These are the individuals who are often so currently broken on the inside and outside that they have been cast aside by society. Because their illnesses can be costly to fix, they can be, and often are, warehoused. Too frequently societal attitudes and values pervade our mental health delivery system, and these individual's are given treatment that is the least costly, and/or supportive of recovery. I think that it is imperative that DMHPs, because of our unique role in the mental health system, resist any attempts to be co-opted to make decisions based on anything less than the highest standard of clinical care.

Yes, I think that it is an invaluable experience walking about the grounds of WSH and try to get inside the minds and hearts of those walking the grounds. It is easy to call them patients, but they are more than patients; they are persons, persons who have, unlike you and me, been denied the joys and richness of life and relationship that we take pretty much for granted. Some of them may never experience the lives that we know and cherish.

Will the young lady whom I detained be a person who spends much of her life walking the grounds of a psychiatric hospital, or will she be a person who reconstitutes and receives the necessary treatment that will normalize her life?

Although we professionals sometimes have difficulty using the word *love* in our work, we must have profound respect and dignity for those fellow human beings with whom we work. When we see only symptoms and brokenness, and no longer revel in the beauty, specialness, and pain of those with whom we are working, it is time to hang up our DMHP hats.

Scott Kuhle, Editor

Chronology of Events in Marty Smith's Death

Tony Sparber

On November 4th 2005, DMHP Marty Smith was killed in the line of duty. I was Marty's supervisor that day, and I would like to take the opportunity to tell you what I know.

On the day he died, Marty Smith was forty-two years old. He had been a DMHP for a little over 3 years. His peers regarded him as a safe and competent clinician.

He was a newlywed; having been married less than a year. He had three grown children, and a stepdaughter that came with the marriage. Marty loved motorcycles; he loved cigars, and loved to cook. I know he loved being a DMHP.

On that day, the man who murdered Marty was thirty-three. He was a single man with an 8-year-old daughter with whom he had little contact. He was diagnosed with schizophrenia several years before, and had been detained once in 2001 as gravely disabled. He had a long history of substance abuse issues; and had served time in prison in 1994 for 3rd degree rape of a child. He was living with his mother in her apartment, and was causing problems there.

Marty Smith

Marty took the phone call from the client's mother. She was worried. She said her son had been off his medications for at least two months, and was acting bizarrely. She said he had been leaving strange post-it notes around her apartment. He was also hiding in the bushes and surprising other apartment residents. More disturbing, he had recently taken an unhealthy interest in 13-year-old girl who lived in the area. Mom also suspected that he was using drugs.

Danger issues were discussed, and there was cause for concern. He was a young male with a diagnosis of schizophrenia and paranoia. He had a long drug history, and mom suspected he could be using. He had a criminal history that included a crime against persons. He was historically not med complainant and had little insight of his illness. It was also known that he had a history of making threatening statements to his mother.

At the same time, there had been no overt danger issues. His recent behavior was disturbing, but not really threatening. The topic of rather to bring police was discussed. Mom didn't want them there due to client's history of legal troubles. From overhearing Marty's side of the phone conversation, we know that he told the mother that he reserved the right to involve police, if he felt the need to bring them.

From the information that Marty had at the end of that phone call, there was no case for issuing a pick up order, but clearly something needed to be done. Marty agreed to go out and attempt a face to face with the client.

The Attack.

What happened next we know from the police report, the news, and from others involved in the case.

Marty arrived at the apartment a little before 5pm. He met Mom in the parking lot to decide how to best approach the client. Marty told mom that he would press 911 on his cell phone, so that, if help was needed, all he had to do is press the send button. Mom and Marty went inside the apartment to speak with the client.

The client agreed to speak with them and everyone sat down in the living room to talk. Per mom's report, the interview proceeded without incident. The client was calm, cooperative, and he showed no signs of psychological or emotional distress; nor did he present as intoxicated or high on drugs.

After about 20 minutes, Marty asked the client if he would agree to go voluntary to the hospital, and again per Mom, the client agreed. The client asked Marty if he could retrieve his shoes from his bedroom. Marty said yes.

PLEASE SEE **MARY SMITH** ON PAGE 6

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At 5:26 pm, Marty called 911 to arrange transport for the client to the emergency room for medical clearance. As Marty spoke with CENCOM, the client suddenly bolted back into the room. He pushed Marty into a glass hutch, and began pummeling him with his fists.

The 911 operator heard yelling; furniture breaking, the client's mother screaming, and dispatched police to the scene. The client broke off his attack and headed for the kitchen. Marty was at that point only semiconscious, and slumped into a dining room chair.

Tony Sparbar

The client returned with a large carving knife and proceeded to stab Marty numerous times. The 911 operator heard more screaming. In an effort to defend Marty, Mom broke a bar stool across the client's back. At this point, Marty was heard to utter the only words he said during the attack, "No, please, help". After stabbing Marty, the client turned toward his mother, she ran, screaming for help.

The client placed the knife on the couch and walked outside to wait for police. The 911 transcripts show other people from the apartment complex entered the apartment. Voices are heard to say, "Hang in there buddy," and "Help is coming." People moved Marty to the floor and attempted to make him comfortable.

The police arrived at 5:31. An ambulance was staged up the street and was given the OK to proceed to the scene. The ambulance crew pronounced Marty dead at 5:34.

The client was taken into custody without incident. Later that night, the client confessed to killing Marty; again calmly, without any signs of distress.

The aftermath

The morning after Marty died, I was sitting in our team room looking over the information that we had on this case, trying to make some sense of this tragedy. As I processed the information, a couple of sobering thoughts came to me. The first one was that no matter how many times I reviewed the material, I could find no information that indicated this attack was coming. People were obviously concerned; he had several of the markers for violence (young male, drug using, etc.) But we see a lot of people like that; and nothing in his history indicated he was capable of this level of violence. He had given no hint that he was escalating, that he was becoming a danger. None of the usual red flags for imminent risk were there.

My second thought was the chilling realization that had I taken that call, I would have done the same thing. I would have thought that there wasn't any information apparent that would give us grounds to have him picked up.

There were no actual danger issues expressed, no threats, and no history of violence when decompensated from which to build a case. I know that I would have decided to go out and, "have a look". If the client presented as a threat, or started to escalate, I would back out gracefully and try another approach. We learned later that no warning came.

The incident sent the whole agency into crisis. It was for all intents and purposes a death in the family, and it caused the same types of behavior that sometimes happens when a close relation dies. Relationships are reexamined, old wounds are opened up, trust is damaged, old questions and feuds reappear. We continue to struggle four months later.

Some good has resulted. The team members are closer than they have ever been. We have instituted procedures to insure outreaches are discussed and processed before anyone goes out alone. There is legislation working its way through the state legislature that addresses some of these concerns and while people may not agree with the bill as it's written, the fact that it has attracted state level attention feels promising.

Overall, we are still coming to grips with this tragedy. Our sense of security has been damaged, and maybe that's a good thing. Helen Keller said, "Security doesn't exist in nature, nor do the children of men as a whole experience it." Maybe we need to remember that the next time we are concerned, but can't explain why. I know the next time that a person says, "I'll dial 911 on my cell phone, if we have trouble…" I'm going to see that strategy in a very different light. Marty would have expected us to use this event to move forward, and I for one intend to honor his spirit.

Be safe out there.

Tony Sparber, MSW, DMHP is the director of Crisis Services at Kitsap Mental Health Services in Bremerton.

Remember, we all stumble, every one of us. That's why it's a comfort to go hand in hand.

-Emily Kimbrough, author and broadcaster (1899-1989)

LEGISLATIVE UPDATE

The Future of RSNs as Local Mental Health Authorities

Gary L. Rose

The 2006 Session began January 9th. Today (February 20th) is the 43rd day of the 60 day regular session. The Washington legislature convenes every year. The session immediately prior to a new biennium is a longer budget-writing session lasting 90 days. That was the case last year.

I'm going to focus on two issues of interest to DMHPs. Both are contained in SB 6793, but for ease of understanding, I'm going to discuss each issue in separate articles.

Last year HB 1290, the Cody bill, passed requiring existing RSNs to "qualify" for future contracts with DSHS/MHD through a formal Request for Qualification (RFQ) process. RSNs which could not successfully qualify would then be available on a competitive bid process to any entity (including for-profit managed care companies), not just Counties. This is the reason that the word "County" was struck from "County Designated Mental Health Professional" throughout the RCWs last year, because in future years other entities could be designating DMHPs, not just Counties.

The RFQ process was conducted last fall. The RFQ was released on October 1st and responses were due December 1st. All fourteen RSNs submitted timely responses. The RFQ was rigorous. Responses and the required copies ranged among the RSNs from 25 to over 100 five-inch notebooks! No fooling, Greater Columbia RSN rented a U-Haul trailer to transport their submission to Olympia!

The RFQ was conducted by Medical Administration Assistance (MAA), which is within DSHS, with help from MHD staff. The process mirrored the contracting process for Healthy Options, which is also conducted by MAA. DSHS contract with a national firm, Mercer Human Services Consulting, who provided the training and assistance in preparing the RFQ, and provided technical assistance in the design of industry standards. The reviewers were supposed to be unbiased, and used a scoring system. Of 100 possible points, a score of 70 was required to "substantially meet the requirements of the RFQ".

The results were announced early in January. The successful RSNs were: Clark, North Sound, King, Southwest, North Central, Pierce, Greater Columbia and Timberlands. A protest process was allowed, and Chelan-Douglas (with a score of 69.8) joined the "successful" responders upon protest. Those RSNs which were not successful were Thurston-Mason, Peninsula, Northeast, Spokane and Grays Harbor. According to HB 1290, there would be a Request for Proposal (RFP) released for these regions on March 1st, and any entity could submit a proposal. The new contract with DSHS/MHD would start on September 1, 2006, and last one year.

BUT, Senator Hargrove, the Committee Chair of Human Services and Corrections, thought there would be a period of corrective action allowed, for any RSN that was not originally successful, prior to initiating the competitive RFP process. That was not included in HB 1290.

This year Senator Hargrove introduced SB 6793, which has now been amended. It is our understanding that Representative Cody, Senator Hargrove and the Governor's Office have all agreed to these changes. If that is true, then this bill is likely to pass and to be signed by the Governor. Here are the key points regarding the procurement process of amended SB 6793 (Part II Contracts and Procurement Process).

Legislative Intent: "The legislature did not intend to create statutory causes of actions for regional support networks with the provisions of chapters 71.05 and 71.24 RCW. The purpose of this act is to make retroactive, remedial, and technical amendments in order to resolve any ambiguity about the legislature's intent prior to September 9, 2005."

Request for Qualification: The results of the RFQ stand, with no opportunity for a period of corrective action, as I read the bill.

Request for Proposal: DSHS/MHD will utilize a procurement process for those regions that did not substantially meet the requirements of the RFQ, but it is now limited to "county authorities and nonprofit entities", thus eliminating the opportunity for for-profit managed care companies to submit a proposal. The RFP will begin March 1st and proposals are due May 31st. The respondents will be notified of the outcome in June. "Prospective RSNs that are unsuccessful shall be provided with a detailed briefing regarding the deficiencies in the proposal and provided with an opportunity to respond prior to the final determination on the request for proposals."

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Never esteem anything as of advantage to you that will make you break your word or lose your self-respect.

-Marcus Aurelius Antoninus

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The Next Contract: The time period for the next DSHS/MHD contract is September 1, 2006 through August 31, 2007.

Gary's Interpretation:

The RSNs that were successful with the RFQ will complete their current contract and be awarded a new contract with DSHS/MHD, September 1, 2006 through August 31, 2007. They will not participate in the RFP, and will avoid any possibility of any entity bidding against them. They are secure. The RSNs that were not successful with the RFQ will have to respond to a competitive RFP, to be released by March 1, 2006, for which other counties or nonprofit entities could bid. The amended bill language states "Prospective RSNs that are unsuccessful (with the RFP) shall be provided with a detailed briefing regarding the deficiencies in the proposal and provided with an opportunity to respond prior to the final determination on the request for proposals." That opportunity does not appear to be available to a nonprofit entity. If finally successful, the prospective RSN will be awarded a new contract, September 1, 2006 through August 31, 2007.

State Hospitals and DMHPs

SB 6793, Senator Hargrove's bill dealing with the procurement of RSNs process contains significant changes regarding the utilization of, and payment for, the State Hospitals, and an added responsibility for DMHPs.

Legislative Intent: "It is the intent of the legislature that the community mental health service delivery system focus on maintaining mentally ill individuals in the community, and reserve the use of state hospital beds for the provision of long-term inpatient care."

RSNs are to evaluate 90 and 180 day petitions: See Section 5. "The RSN shall (10) Evaluate all initial petitions for ninety and one hundred eighty-day involuntary commitments under RCW 71.05.280 to determine whether the needs of the individual can be met through community support services in a less restrictive alternative to detention."

RSNs are to provide 100% of all E&T services up to seventeen (17) days within it's boundaries. See Section 6 (6) (c). The present law requires 85%, so this is an increase of 15% of initial detentions in community hospitals and E&Ts. There continues to be an exception for RSNs to use beds in "neighboring or contiguous regions" with permission of the secretary of DSHS; there is also an exception for using state hospital beds.

Part IV, Involuntary Treatment: Section 202 adds a new responsibility for DMHPs. In the process of filing the petition for ninety day treatment, these words are added: "The DMHP shall also immediately provide a copy of the petition and documentation of the less restrictive alternative review to the regional support network and the state hospital."

State Hospital Priorities: Section 203 (1) (c) says "The department may establish admission priorities at the state hospitals in the event that the number of individuals presented for admission exceeds the capacity at the state hospitals pursuant to RCW 43.88.110."

In addition, the bill directs the Joint Legislative Audit and Review Committee (JLARC) to "conduct a performance audit of the request for qualifications process." Specifically, the audit is to assess the extent to which the RFQ requirements "comport with, exceed, or fail to address federal or state law; the consistency of scoring across RSNs; the extent to which the evaluation criteria were uniformly applied; the extent to which the RFQ requirements add new administrative costs not required by federal rules and state law and the extent to which the process impacted the availability of resources for direct services."

There is very significant (and problematic) language that RSNs cannot sue the state (see New Section 3) pursuant to the administration of this chapter.

Here are some resources for additional information.

- The website for tracking bills: http://www1.leg.wa.gov/legislature
- HB 1290, the Cody bill, as passed last year: http://www.leg.wa.gov/pub/billinfo/2005-06/Pdf/Bills/Session%20Law%202005/1290-S2.SL.pdf
- SB 6793, the Hargrove bill, as proposed this session (the amendment is not on the website as of this writing, but should be there by the time you receive the Frontlines: http://www.leg.wa.gov/pub/billinfo/2005-06/Pdf/Bills/Senate%20Bills/6793.pdf

Gary Rose, the former RSN's representative to the WADMHP, will participate at the spring conference on a panel discussing the legislation passed this session that affects DMHPs. Gary resigned as Administrator of Timberlands RSN and is currently self-employed, providing consultation and special projects in public sector mental health for BHO, a County and an RSN, but has no formal ties to them. He is doing business as Gary L. Rose Consulting.

As no roads are so rough as those that have just been mended, so no sinners are so intolerant as those that have just turned saints.

-Charles Caleb Colton, author and clergyman (1780-1832)

WADMHP

2006 Spring Conference

Sun Mountain Lodge

Day One: April 13th

Working with Individuals who are, or may be, violent

Presenter

Jesus M. Villahermosa, Jr

The Mental Health Division is generously co-sponsoring, with the Washington Association of Designated Mental Health Professions, this full day presentation on interacting and responding to clients who may be at risk of harming the professional or others.

Morning Session:

7:45 - Registration
Breakfast
8:30- 12:00 – Presentation - Jesus Villahermosa

Afternoon Session:

1:00-3:15 – Presentation continued
3:30-5:00 – Legislative update with David Kludt, Gary Rose, and Ian Harrel
7:00 – Evening hospitality

Day Two: April 14th

Why DMHPs lose sleep at night: a review of sleep disorders and modern developments

Presenter: *Tim Truschel, MD* – Medical Director of Evergreen Counseling Center, Hoquiam, WA

New officers appointed for two positions

One retained as Treasurer

In January, the association secretary, Shelly Ray, submitted her resignation to the association's president, Ian Harrel. Shelly has taken a new position with Behavioral Health Options, and is not able to give the time and work needed for the WADMHP. Additionally, she is no longer a DMHP.

The association has greatly benefited by Shelly's thorough and dedicated work, and wishes her the very best in her new position.

Jami Larson, 1st Vice President

Scott Kuhle, who had been elected 1st Vice President at the Fall Conference, offered to move laterally to serve as Secretary, and the Executive Committee approved of Scott's appointment as Secretary at their January teleconference. Ian Harrel, President asked Jami Larson, Program Manager at Cascade Mental Health Care, if she would be willing to serve as 1st Vice President. She agreed, and the Executive Committee voted to accept Ian's appointment of Jami to the position of 1st Vice President at the January teleconference.

The primary responsibilities of the 1st Vice President are to plan the fall conference and assume the role of the president in his absence.

Jami Larson

Jami is Program Manager of Crisis Services at Cascade Mental Health Care in Lewis County. She obtained her B.A. in Psychology and Multicultural Counseling at Evergreen State College in 1997, and obtained her Master of Social Work from the University of Washington on the Tacoma Campus.

Having been in the field of community mental health for eight years, Jami has worked as a case manager, brief intervention therapist, hospital liaison, and provider of crisis services as a DMHP.

Jami lives in Olympia with her partner, Camille, of 7½ years. When not at work, she enjoys spending time with friends and family, surfing, backpacking, or reading a good book.

Don't say you don't have enough time. You have exactly the same number of hours per day that were given to Helen Keller, Pasteur, Michaelangelo, Mother Teresa, Leonardo da Vinci, Thomas Jefferson, and Albert Einstein.

-H. Jackson Brown, Jr., writer

WADMHP Closes Message Board

The WADMHP message board is off-line. This service, which began in the summer of 2005 and was aimed to provide a ready and casual means for all Washington DMHPs to interact, was unexpectedly over-run with what is called a BOT.

This is an automated program that seeks out message boards to then place general responses to posted comments that suggest personal interest in what has been written by a visitor. The automated note asks the visitor to respond using their personal email system.

This often then leads to some sort of un-requested solicitation from the company or website that paid the Bot-ter to develop the address-seeking program.

Twice our web-master attempted to clean up the site. But, without investing more time and money into cleaning up and protecting the site, the Association would, no doubt, continue to be unsuccessful in keeping the site uncontaminated.

But, time and money is not really the only obstacle to keeping the site clean. Although the association can afford the maintenance costs and this service nicely fulfills several of the Association's Purpose Statements the reality is that the message board was not used enough to justify the expense. First underused, now misused. The executive board decided to take it off-line for the present time.

The Executive Committee wants to know your thoughts or opinions in this matter. If you do have something to say about this, or other issues, please use the tools that remain: the website lists Executive Board member's emails, agencies and phone numbers. They are at your service and are interested in your work and concerns.

The Expanded Community Services Program

Jim Weinstock

The Expanded Community Services (ECS) is a statewide program initiated in 2002 to close wards at WSH and ESH, placing patients in the community with acute wrap around services to maintain residential placement.

Patients selected for the program would be patients with multiple barriers to placement including multiple hospitalizations, extended hospital stays, and a variety of behaviors (i.e. assault, noncompliant, sexually inappropriate behaviors, self-endangering behaviors, elopement risk). In addition, these would be patients with many refusals by facilities for placement due to the above. There are currently approximately 160 beds statewide with 35 beds in the eastern region resulting from a ward closure at ESH (about 30 beds) mandated to be done by Dec. 2002.

I signed on with Spokane Mental Health in Oct. 2002 and was hired to be part of the ECS team. DSHS Aging and Adult Services contracted with Spokane Mental Health to provide mental health services for the ECS program. The stakeholders were local RSNs, ESH, and Aging and Adult Services. Home and Community Services of Region 1 would broker the contracts and services for the state. Christine Renner of HCS is the point of contact for ECS services for our region.

Region 1 decided the ward closure at ESH would be a geropsych ward and the ECS patients would be mostly elderly patients from Geropsych, meaning usually elderly dementia patients with many barriers to placement without the right supports in place.

My first job with ECS was involvement in the screening process at ESH to select a pool of patients to initiate the ECS program. Involved were treatment teams from ESH, SMH, and RSN reps. One of the initial road blocks was lack of facilities willing to accept problematic patients from ESH even though they would be paid an enhanced rate (about $39/day per pt. above the Medicaid daily rate and have the benefit of ECS services for ECS patients. Since many of the patients would be going to skilled nursing levels of care in nursing homes, we had to find nursing homes to contract with. We had little initial success in Spokane, with facilities citing concerns about nursing home surveyors and regs re: antipsychotic meds, prns, and restraints. Many of the patients at ESH approved for ECS and awaiting placement were patients with higher than normalregulatory doses of antipsychotics, extensive histories of daily prn benzodiazepene use, and waist restraints in chairs or beds at nite.

A big advantage that I had in addressing these concerns was my brief experience as a certified nursing home surveyor in Yakima. I had an extensive knowledge of the regulations, monitoring and documentation requirements needed for medical justifications for all levels of acuity and care. In spite of reassurances to Spokane nursing homes that ESH patients with potential regulatory nightmares could be accepted for placement and then gradual dose and care reductions could be done while in placement and still meet regulatory mandates, we did not have much success with finding skilled nursing facilities. Fortunately we were able to contract with Tekoa nursing home for skilled nursing needs, and Sunshine Terrace ARC, Grand Manor CCF, Raymond Court Assisted Living, and Blake AFH for lesser levels of care.

Since program initiation we have lost Sunshine Terrace but have gained North Central Care Center (skilled nursing) and St. Joseph nursing home to provide options for placement closer to Spokane for elderly family members to visit ECS patients.

Advantage of ECS team follow-up on discharge: ECS team: RNs with geriatric mental health designation and Geropsychiatrist. Geropsychiatrist to see patients on a monthly basis for medication management and as needed prn for acute care issues. RNs to provide training to staff on behavior/medication management and to provide on going visitation usually on a weekly basis and availability on a prn basis 40 hrs. a week for questions and issues. ECS would also provide after hour coverage for management issues thru the SMH crisis after hours services and the availability of the on call psychiatrist. The coverage provided by the ECS team would more then meet any requirements for mental health and medication monitoring by the state nursing home regulators. I would remind the nursing homes that how many nursing homes have monthly psychiatric visitation, weekly and prn nursing oversight and prn coverage for any medication/ management issues. We also participate in monthly psychpharm meeting in facilities and any treatment team meetings requested by the facilities. Establishment of a good working relationship with our facilities has been especially helpful. Credibility has been a big issue. ECS has consistently responded when needed. Example: Speaking re: my

PLEASE SEE **ECS PROGRAM** ON PAGE 12

WADMHP/WSH 2006 Conference a success

Speaker receives raves

The annual WADMHP/Western State Hospital Conference that is co-sponsored by the Washington Association of Designated Mental Health Professionals and WSH was a success.

Jim Jones

Approximately 125 mental health professionals from the hospital and the area attended.

Jim Jones, a DMHP with Pierce County Crisis Services, has been a driving force with WSH to make this annual conference the success that it is.

Dr. David Scratchley, the outgoing Director of Clinical Education at Lakeside-Milam Recovery Centers, was the main presenter. His topic, "Differentiating symptoms of drug abuse versus mental illness," was educational. Being an engaging and dynamic speaker, Dr. Scratchley received high marks from the participants.

David Kludt, the MHD liaison to the WADMHP, and Ronda Kenney, Program Manger at ESH, have invited Dr. Scratchely to give a presentation on this topic at the Eastern State Hospital workshop this summer. They are working on a tentative date in August.

Dr. David Scratchley

Dr.Scratchley is writing an article for the August issue of the *Frontlines*.

The final session of the workshop was given by Rebecca Bird, DCDS, Pierce County Involuntary Commitment Program, discussed the involuntary commitment process for Chemical Dependency.

ECS PROGRAM CONTINUED FROM PAGE 11

relationship with Tekoa, we have established a trust that has enabled us (ECS and Tekoa) to work thru some problematic episodes and maintain the patient in placement. Tekoa staff is gaining more and more knowledge and comfort in working with problematic patients and acute med management. With knowledgeable staff and comfort levels, acute care med changes usually requiring hospital environments can be made in residential facilities with ECS/facility monitoring.

How successful has the program been: We currently have 26 ECS patients in placement. We have a waiting list of patients that are ECS approved and are at ESH. We still have a need for more facilities willing to accept ECS patients and that is being addressed. Since program inception we have placed probably 50 patients overall with attrition thru death mainly. Of the failed placements (about 5) requiring rehospitalization, a consistent demographic has emerged. An ambulatory, demented, physically or sexually aggressive patient is not going to have much chance for placement outside of the hospital even with ECS supports. Residential facilities are not allowed to seclude and restrain except in extreme circumstances and then only for stabilization and transfer to a more secure facility (inpatient). It has been reassuring to the facilities that if hospitalization is required, CDMHPs have been very cooperative knowing that with ECS monitoring all less restrictive alternatives have been exhausted and all medical complications which may be causing the regression have been ruled out.

Financial benefits: Currently the cost of state hospital beds is anywhere from $600-700 dollars a day? ECS placement is (enhanced rate for the facilities over daily Medicaid rate plus ECS daily rate per pt. day) probably no more then a third of the hospital rate. Dorothy Fletcher at Tekoa recently told me she calculated the Tekoa ECS beds alone, 15 or 16 beds have saved the state over 2 million dollars since inception of the program.

Finally: I think about the recent lawsuit with Pierce County and WSH and the court rulings. The cost of adding hospital beds compared to the cost of residential placement properly funded and the right level of wrap around services. Maybe a study needs to be done on what really works and what doesn't. There will always be a need for state hospital beds for acute care treatment but not warehousing and possibly acute care med management can be done in the proper residential setting with supports.

Jim Weinstock works for Spokane Mental Health. He is the lead worker for the ECS program that is administered by Spokane Mental Health.

Washington State gets "D" grade from NAMI for mental health care system

Local advocates note progress

Gordon Bopp

In the first state-by-state analysis of the nation's mental healthcare system in over 15 years, Washington State receives a grade of **D**, the state organization of the National Alliance on Mental Illness (NAMI) announced today.

The national average is a D, confirming what a presidential commission has called "a system in shambles."

"Don't think for one moment that D is okay because it's the average," said Gordon Bopp, NAMI-Washington President. **"**The report simply underscores what the State Legislature and the Governor's office became aware of some fourteen months ago when a special joint executive/legislative task force on mental health services and funding issued a report calling for a transformation of the State's mental health system**.** Both the Legislature and the Governor's office responded by setting the stage for this transformation and we look forward to working with State leadership to create what we hope will be a national model of excellence.

"Today's D is a baseline to help measure future progress. We have already started building a mental health care system based on proven, cost-effective practices and the goal of recovery. That's what people with serious mental illnesses deserve. That's what the taxpayers deserve."

According to *Grading the States: A Report on America's Health Care System for Serious Mental Illnesses*, released by NAMI National in Washington, D.C. today, five states received grades in the B range, 17 states and the District of Columbia received Cs, 19 states received Ds, and eight states received Fs, Two states, Colorado and New York, declined to respond to a October- November 2005 survey on which the report is based.

For a full copy of the report, including state narratives, see **www.nami.org/grades.**

Grades are based on 39 criteria in four categories. Washington State received a **F** for Information Accessibility, **F** for Infrastructure, **D+** for Services and **F** for Recovery Supports. "Infrastructure" represents the state's forward-looking orientation based on priorities, innovations, data collection and planning.

Access to services depends on access to information. In a unique feature called the *Consumer/Family Test Drive,* NAMI members tested access to basic information through the state mental health department's Web site and telephone system. Washington State scored four out of a possible ten points and ranked 35th in the nation on the test drive.

The report commended Washington State for three innovations:

- Leadership commitment during 2005 budget crisis
- Mental health courts and jail diversion programs
- Transformation State Incentive Grant planning and coordination

"Urgent needs" identified for Washington State in the report include**:**

- Funding
- Hospital beds
- Eliminate regional disparities in community services
- Increased Regional Service Networks accountability
- Strong Mental Health Division leadership

"There are many areas that clearly need work," Bopp said. "The report helps identify them through scores on specific criteria and provides a checklist for change."

"Washington State was one of only seven states to receive a Federal Transformation Grant and this clearly indicates that we are on the right track to reconstitute our system of mental health services and care," Bopp stated.

In the immediate future, NAMI Washington will be focusing on housing, jail diversion programs, and support of evidence-based practices including Programs for Assertive Community Treatment (PACT) and community based support systems. NAMI Washington and community advocates are urging the state to provide services based on need and not on Medicaid eligibility.

"We want the Governor and state legislators to continue their leadership in acting on these needs," Bopp said.

Gordon Bopp is president of NAMI-Washington. He may be reached by phone/cell: at (509) 946-8291, or e-mail: grbopp@charter.net

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But man, proud man,
Dressed in a little brief authority,
Plays such fantastic tricks before high heaven
As make the angels weep.

–William Shakespeare, poet and dramatist (1564-1616) Used Fall 2002

National Council for Community Behavioral Healthcare

"The nation's community mental health provider organizations applaud NAMI for a timely report that highlights the inadequacies as well as strengths of the complex public mental health system. Although there might be disagreements about specific grades, we

PLEASE SEE **NCCBH** ON PAGE 15

2006 Spring Conference – Sun Mountain

The Washington Association of Designated Mental Health Professionals will hold its Spring Conference at Sun Mountain Resort on April 13th and 14th. The purpose of the two annual conferences is to provide specialized training for DMHPs on topics that directly affect their crisis intervention and detention evaluation.

Ian Harrel, President, who is organizing this conference, has designed an agenda that will provide an opportunity for participants to learn interacting with clients who are violent or may present with behavior which may escalate and become violent..

The first day of the conference will focus on ideas that will assist CDMHPs in their evaluations with persons who may be violent.

Jesus M. Villahermosa, Jr. has been a deputy sheriff with the Pierce County Sheriff's Department since 1981. He is currently a Master Patrol Officer in the University Place Detachment. He was the first certified Master Defensive Tactics Instructor for law enforcement personnel in the state of Washington and was also a Firearm's Instructor. He has been on the Pierce County Sheriff's S.W.A.T. Team since 1983 where he currently serves as the point man on the entry team.

Jesus Villahermosa,

In 1986, Jesus began his own consulting business. Since 1988, he has primarily focused specifically on the issues of school related and workplace violence. He has taught over 300,000 professionals across the United States and in Canada about issues regarding gangs, youth violence, workplace violence, school safety and rape and assault prevention. He has been the featured keynote speaker at numerous national and Canadian educational conferences. Jesus has also spoken to thousands of students all over the country in motivational assemblies regarding themes of choices, consequences and respect. Jesus served as a committee member on the Washington State Safe Schools Advisory Committee from 1994 to 1998. In June of 1997, Jesus began teaching as a guest instructor for F.E.M.A. at the Emergency Management Institute in Emmitsburg, Maryland where Emergency Management Services and schools are establishing partnerships to minimize the impact of youth violence in our nation's schools. In June of 1998, Jesus was selected to be one of the State's committee members on the Governor's Youth Violence Summit for Governor Locke. Jesus attended and completed a course taught by the United State Secret Services' National Threat Assessment Center in Washington, D.C. where targeted school and workplace violence prevention was the focus of the course. Only 26 to 30 police officers from around the United States are accepted into this course, which is only offered four times a year. Jesus has also spoken for corporate America on issues relating to workplace violence and has taught to some of the largest corporations in the country. Jesus' personal experiences as a law enforcement officer and SWAT Team member, past and present, in the areas of violence in our society, keeps his information fresh and up to date.

In addition to co-producing segments of The Sheriff's Report on AT&T Cable, he has been a guest or interviewed for a variety of radio and T.V. talk shows including CBC radio in Canada and NBC Nightly News with Tom Brokaw. He has been quoted in numerous national publications including The New York Times. Jesus has written a gang reference guide for education professionals and is featured in numerous videos covering topics such as Gangs, Breaking Up Fights, Use of Force Issues, and Campus Intruder Contacts. His thought provoking ideas are given with a humorous note and will surely inspire those in attendance in believing that they can help to make our schools and workplaces a safer place to learn, teach, and work!

On the second day of the conference Tim Truschel, MD, will give a presentation on sleep disorders. Dr. Truschel presented a well received presentation on children and adolescents in crisis at the 2003 Spring Conference.

CEUs will be given for each of the two sessions.

Executive Board Meeting

The Executive Board will meet on Wednesday, April 12th in the reception suite at the Sun Mountain Lodge. David Kludt, the association's liaison with the Mental Health Division.

Hospitality Evening

The traditional evening hospitality gathering will begin Wednesday at 7:30 and Thursday at 7:00 in the reception suite at the lodge.

PLEASE SEE **2006 SPRING CONFERENCE** ON PAGE 15

"Any fool can make a rule, and any fool will mind it."
-Henry David Thoreau (1817-1862)

2006 SPRING CONFERENCE CONTINUED FROM PAGE 13

The conference fee is $160 for both days and $95 for each day. This includes annual membership dues for the Washington Association of 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 $77.50 per evening for double occupancy. Reservations for Sun Mountain Lodge can be made by calling 1-800-572-0493.

Cancellations are subject to a $15.00 handling charge. No refunds will be provided after April 7, 2006.

For further conference information, please contact Ian Harrel at 360-528-2590. For registration questions, please contact Kincaid Davidson at 360-676-5162. For updated information, check the WADMHP website: www.wacdmhp.org.

The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little.

-Franklin D. Roosevelt, (1882-1945)

NCCBH CONTINUED FROM PAGE 14

appreciate the transparency of the methodology and the close look at the investments that states have made in their systems of care," said Linda Rosenberg, President and CEO of the National Council for Community Behavioral Healthcare.

The NAMI report is testimony to the fact that you get what you pay for. Evidence-based practices, although cost-effective in the long run, require increased reimbursement rates in the short run. Community mental health is unable to fulfill its promise because it continues to be inadequately funded.

The National Council for Community Behavioral Healthcare is a not-for-profit association of 1,300 behavioral healthcare organizations that provide treatment and rehabilitation for mental illnesses and addictions disorders to nearly six million adults, children and families in communities across the country.

The National Council and its members bear testimony to the fact that medical, social, psychological and rehabilitation services offered in community settings help people with mental illnesses and addictions disorders recover and lead productive lives.

Plan on attending an exciting conference

- C-l-i-p - a-n-d - m-a-i-l -

REGISTRATION FORM

Washington Association of Designated Mental Health Professionals

2006 Spring Conference

April 13th & 14th, 2006

Sun Mountain Lodge, Winthrop, Washington

Reservations: 1-800-572-0493

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Employer: _____ County: _____

Position Title: _____

☐ WADMHP member ☐ Non member

Registration fee: $160 for both days; $95 for Thursday; $95 for Friday

☐ A check payable to WADMHP is enclosed for: _____

Charge to my: ☐Visa ☐MasterCard

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

Signature: _____ WADMHP Identification Number: 923161171

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

WADMHP

Annual Spring Conference

DEALING WITH VIOLENCE

(Concerns, Challenges, and Collaboration)

April 13th & 14th

Sun Mountain Lodge
Winthrop, WA

Washington Association of Designated
Mental Health Professionals
PO Box 5371
Bellingham, WA 98227