Frontlines

Washington Association of Designated Mental Health Professionals

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President's Letter

Summer, 2012

Dear Sister and Brother DMHPs,

The sun is shining after a wild night of spring rain and wind. The streets are full of blooming plum trees and daffodils are blossoming along the freeways and in fields. Spring has come again.

This summer, we are planning an exciting DMHP training at the Behavioral Health Conference on June 20th, with a focus on Traumatic Brain Injuries. We will also review the newly revised DMHP Protocols and the recent changes in ITA law. I hope to see you all there.

This year's Fall Conference will be at the Sun Mountain Lodge on October 17 and 18. The main topic will be Ethics for the DMHP. We had such a great response to this presentation a couple of years ago, the WADMHP board decided to have Traci Crowder back every three years to present on Ethics. She will have new ethical dilemmas to challenge us and our ethical decision making process. I look forward to seeing you there to share your points of view.

Considering ethical dilemmas, I would like to share with you an ethical challenge with which I have been struggling for a number of years. It is the dilemma of detaining a person and then finding there are no Evaluation and Treatment facility beds. The lack of Evaluation and Treatment beds has been addressed by the Department of Social and Health Services through the now ubiquitous Single Bed Certification, allowing any hospital bed to act temporarily as an Evaluation and Treatment facility bed. It seems like it was only 6 or 7 years ago I could expect an individual I detained and boarded on a Single Bed Certification in an Emergency room, would be transferred within hours to an Evaluation and Treatment Facility. Then it became days. Now it is not uncommon for the individuals I detain to spend their entire detention, not in an Evaluation and Treatment bed, but in an emergency room or in a hospital hallway or in a Med/Surg bed.

We detain the most ill members of our society and, instead of them getting the most effective and comprehensive care, they are getting only a minimum of care. I have come to understand this is a nationwide phenomenon, as a brief Google search indicates. An American Medical Association's Council of Medical Services report 2-A-08 entitled "*Access to Psychiatric Beds and Impact on Emergency Medicine*," quotes a 2004 report (CONTINUED Page 14)

Editorial: Changes

by Kerry Schafer

Today as I'm sitting down to edit this newsletter, I'm a little saddened to realize that this is the last edition of the Frontlines for me. We have come to a parting of the ways.

Gary Carter wrote an article for this edition in which he makes the point that performing ITAs is not meant to be therapeutic, and that it is a procedure light years apart from the standard counseling goals of promoting growth and autonomy in the clients we serve.

After working for five years as a DMHP, I've made the decision to move away from crisis work and into the role of working collaboratively with clients toward healing and maybe even health.

Doing DMHP work has been life altering for me. I can't imagine a job that could have put me more on the frontlines – literally making life and death decisions multiple times a day.

I have to admit that there is nothing like a good adrenaline rush at midnight when the red and blue lights are flashing and things are moving fast and furious. Successfully juggling all of the many tasks involved in getting a client safely into an appropriate treatment bed is an amazing emotional high.

It is also exhausting. And on those occasions when there is no good outcome available - no appropriate bed, no counseling or medication resources, no financial or housing support - when we fail to find a way to help our clients in crisis to move into a place of healing, this can be devastating.

I'm proud to have served in this capacity, and I honor those of you who continue to show up and do this difficult and important work day after day and night after night. I'd like to thank the WADMHP Executive Committee for their friendship, support, and patience over the years. They are an amazing and committed group of professionals who are working overtime to try to change the system and it has been truly a privilege to work with them.

Frontlines *invites comments, feedback, and submissions. You can contact Kerry at (509) 685-0610, or at kschafer@co.stevens.wa.us, with suggestions, questions or concerns.*

David Kludt

Greetings from Olympia and Spokane

May, 2012

Greetings from Olympia & Spokane,

Much has been going on in the area of crisis services and Involuntary Treatment Act (ITA) since the last edition of Frontlines.

In February the Division of Behavioral Health & Recovery (DBHR) invited a number of stakeholders from around the state to meet and discuss issues related to the involuntary commitment and crisis systems. The meeting included representatives from Regional Support Networks, community hospitals, state hospitals, Washington Association of Designated Mental Health Professionals, Washington Community Mental Health Council, community mental health providers, and DBHR.

The group was asked to identify key issues and concerns within the system that need to be addressed, with instructions to only identify issues or concerns that are within DBHR's scope of authority and available current resources. The group acknowledged that the shortage of involuntary commitment beds is a major factor while also acknowledging that current state funding is not available for increasing ITA beds.

The following issues were identified as the top priorities of the group:

- ✓ Single Bed Certifications (SBC)
- ✓ Designated Mental Health Professional (DMHP) Access to Information
- ✓ Voluntary & Involuntary options
- ✓ Expectations for DMHPs to locate a bed
- ✓ DMHP Training & Statewide Consistency of Application of ITA

A summary report including recommendations was provided to Chris Imhoff, Director DBHR and discussed with Regional Support Networks. The following issues were approved for ongoing work at this time:

1. SBC – **Recommendation:** DBHR should establish a workgroup to address a number of items related to the use and non-use of SBC. **Plan:** A workgroup charter has been submitted to Chris Imhoff. It is anticipated a workgroup will begin in late May or June.
2. DMHP Access to Information – **Recommendation:** Identify what information is required by statute, what information is and isn't available statewide, what are current barriers to access, and develop recommendations to address barriers and increase access to information. **Plan:** I am currently in the process of finalizing a work plan that will include input from the DMHP Association, DMHP Managers and other stakeholders as needed. (CONTINUED ON Page 14)

SPRING CONFERENCE

The DMHP annual Spring Conference will be held on June 20th at the Yakima Convention Center. The topic is Traumatic Brain Injury.

About the presenter:

Jane Kucera Thompson, Ph.D, is currently in private practice at East Slope Neuropsychology in Yakima where she sees a general adult population with disorders such as mild to severe traumatic brain injuries, dementias, hypoxic injuries, strokes, learning disabilities and ADHD, neoplasms, and other injuries. She does both neuropsychological evaluations and psychotherapy with brain injured patients to improve adjustment to their ongoing cognitive deficits and life changes. She has 11 years experience teaching, supervising, and testing adult students with ADHD and language-based learning disabilities at Landmark College in Putney, Vermont. She occasionally lectures on traumatic brain injury in Yakima at Pacific Northwest University and is also a consulting staff at Yakima Regional Medical and Cardiac Center where she primarily works on the Inpatient Rehabilitation Unit to consult on general psychological issues affecting patients' rehabilitation and neurocognitive issues.

Dr. Thompson earned her MS in Psychology and Ph.D. in Clinical Psychology from University of Wisconsin-Milwaukee in Wisconsin from 1996–2002. She completed post-doctoral neuropsychology fellowships at Harborview Medical Center/University of Washington, 2002-2003 and Vancouver General Hospital/University of British Columbia. 2003-2004.

REGISTRATION FORM

Washington Association of Designated Mental Health Professionals

2012 Spring Conference
June 20th, 2012
Yakima Convention Center
Yakima, Washington

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Employer: _____ County: _____

Position Title: _____

☐ WADMHP member ☐ Non member

Registration fee: $70

☐ A check payable to WADMHP is enclosed for: _____
Please note: Check or cash only

Signature: _____ WADMHP Identification Number: 91-1997711

Mail registration form to:

WADMHP, PO Box 5371, Bellingham, WA 98227

Or contact Kincaid Davidson at (360) 676 - 5162

2012 Spring Conference

Yakima Convention Center
Yakima, WA

Wednesday, June 20

07:30 am Registration and Breakfast

08:45 am Opening Remarks

9:00 am Legislative Updates

10:15 am Break

10:30 am Legislative Updates Continues

12:00 pm Lunch

1:00 pm Traumatic Brain Injurty

2:30 pm Break

2:45 pm Presentation Continued

4:30 pm Adjournment

CEU/CME 7 hours available

Places to stay in Yakima:

Red Lion Hotel Yakima Center
607 East Yakima Avenue
Yakima, WA 98901
$96.95+tax
(509) 248-5900

Holiday Inn
802 East Yakima Avenue
Yakima, WA 98901
(509) 497-7000
$97+tax

Holiday Inn Express
1001 East A Street
Yakima, WA 98901
(509) 249-1000
$97+tax

Howard Johnson Plaza Hotel
9 North 9th Street
Yakima, WA 98901-2522
(509) 452-6511
$77+tax single; $85+tax double

Cedars Inn
1010 East A Street
Yakima, WA 98901
(509) 452-8101
$69.99+tax single; $72.99+tax double

Complaints About Bad Outcomes:

A Case Study

All might agree that the job of the DMHP is challenging. Yet even while conceding that, the complaints can still come hard and fast when cases do not go the way people want them to. What follows is a series of written communications between the manager of a crisis team and the medical director of the community mental health agency in a Washington county.

The point of this article is to simply air common misconceptions and assumptions about the work of DMHPs that lead to misunderstandings and often mistrust and suspicion. The individuals involved are all good people who mean well, and have good clinical understanding and interpersonal skills. It is hoped that the response included here might serve as a reference for any who find themselves in similar circumstances.

The interaction begins with an email that was sent to the manager of a crisis team. It came from the medical director of a local community mental health center and in addition to the manager, it was addressed to the local agency's Associate Executive Director (second in charge of the agency), the agency's Risk Manager and the crisis team's manager's boss. The note and responses that follow are essentially copied from the original communications with identifying information altered or obscured in order to maintain privacy of those involved. That is not the point of this article, which again is to identify and acknowledge a common challenge across all counties.

---**THE EMAIL**---

Subject: complaints about lesser restrictive choices resulting in bad outcomes

Hi,

I want to make you aware of a case that came up yesterday in our weekly case review meeting. The client under review was able to pull it together briefly enough to convince the DMHP to use a lesser restrictive alternative, but if the DMHP had looked at the documentation evidence in the chart, and perhaps pressed the client a bit more, could have resulted in a detainment that would likely have prevented the outcome we got.

This very psychotic person was evaluated by the DMHP before he disappeared after his lesser restrictive choice expired and has not been heard from in months. His doctor here expects he will not survive or may already be dead.

I would like you to review this case (there are probably others like them) with a view to the decision-making of the DMHPs vis a vis clear evidence in the record that the lesser restrictive alternative is not going to work compared to the client's ability to make sense for 20 or 30' when they are with the DMHP. I know this is the grey zone, but the bad outcomes suggest we are not using the E (evaluation) enough of our E&T in cases like these.

Of course, during the meeting I completely stood up for the DMHPs, the challenges of decision-making they face, and spoke of how the real problem is the law, not the DMHP's decision-making. The inpatient doctor that you often work with likewise suggested that the providers need to communicate with DMHPs about cases like these. The providers countered that in the evening or night when the interaction is occurring, they are not there to talk with the DMHP and everything is already very well documented in the record.

I wonder about talking about this in our Systems meeting this week.

Thanks,…

---THE INITIAL RESPONSE---

> Thank you for the notice about Systems and thanks for not taking sides in your meeting. I will review the notes on both cases and see if I can interview the involved DMHP before the meeting tomorrow.
> I want to caution all those addressed here to not expect a lot to come from this discussion for two reasons. One is that Systems is for system-level discussions and I feel that what may be important to know about these cases is not at that level, it is on the individual case and DMHP level. Secondly, the scrutiny needed to understand what happened in these two cases will take time and I won't have enough of that to be fully ready by tomorrow.
>
> I am compelled to add that it is a bit intimidating to prepare for a meeting with an agenda like this: discussing in a group setting people's discontent over a subjective, high risk and complex process and judging it based upon what the client does following the contact. There is no research or practice model that successfully can identify or predict who will ultimately come to harm. Similarly, the notion that one can judge the validity of a particular assessment based upon its outcome is faulty.
>
> It is the investigation and then how that interview was managed that is far more important in determining if something is wrong about the process. That is, determining to what degree did the DMHP demonstrate an understanding of the key elements of risk and did they demonstrate skill in the interview to get to the essential facts upon which to make a decision.
>
> As I have said, this sort of scrutiny takes time and I may not have what you all hope for by including this on the agenda. I will certainly prepare as much as I can for the meeting though and take what we discuss as part of my own investigation into what the nature of the complaints ultimately become.
> For the good of the Order!

Consequently, the case review was taken off the agenda so there was time for the manager to look into the case. But sadly in the days that followed the physician's fears were confirmed. The client was found to have died due to suicide. The crisis team became aware of the inquiry and was obviously upset and defensive.

Below is the written review and defense of the case minus the chronology of events summarized from the chart.

---FINAL RESPONSE---

To begin, I think that you can appreciate how these complaints are about the fundamentals of DMHP work broadly and if true, represent a very serious indictment of a unit's clinical skills and preparedness to do the work they are responsible for. Beyond that, such deficits also call into question the quality of leadership available to the team. So, I suggest that beyond this review, it would be valuable to bring the case to the next Risk Management meeting so that it can be formally reviewed if that hasn't already been decided.

After reviewing the record and with the specific complaints in mind, I believe it is clear that the concern CRT failed to carry out their duties is misplaced. According to the record, DMHPs were available and involved at key points throughout the time in question. With little exception the record reflects their routine review of client's chart before seeing the clients and the information gained was appropriately applied to the case as it unfolded. As for the concern that the DMHP didn't push hard or dig deep enough to get to essential facts, this is less obvious. But, I think we can see enough from the individual entries and from the overview of the case that there isn't any overt action or lack of action that demonstrates inadequate preparation, deficient skills or the presence of any overt errors in judgment. I am interested in your opinion, especially of the latter point.

On the surface, the specific concerns identified by the physician in the review of the client's chart do not meet the criteria necessary for a detention, individually or as a whole. They constitute grounds for great concern for any clinician and a request for investigation plainly is warranted. But it would be best in terms of agency and individual risk management that individuals concerned about or in disagreement with another professional's action not document their opinion in the official record. If a colleague is of the opinion that another professional has, again, in their opinion, failed to carry out ethical or appropriate standards of care there certainly is cause, even an obligation to follow-up, it must be done in another more appropriate venue then documenting it in the client's medical record. (The physician's note conclusion as reported in the record was that "…the client should have been detained…")

These are the conclusions that I have reached alone in my review. I would like to hear from you what you see in the record and in my summary of the most important points.

Make of this what you must but the intention of this article is not fault finding. Without intimate knowledge of our limitations and informed only from the perspective of a provider, attributions of poor practice will most certainly be made. Our challenge is to articulate those differences in roles and stay engaged. We are the only ones with this role and the community needs to be able to trust us. That is another aspect of how impossible this job can be.

Mike's Story: Death with Dignity

By Arline Hinckley, ACSW
Compassion and Choices

Mike was a young eastern Washington man diagnosed with ALS (Lou Gehrig's Disease) in June of 2008. From the time I first met him, he made it clear that he wanted the option of using the Death with Dignity law and he had begun talking with his doctors about this in November of 2008. One of his doctors had unequivocally refused to help. Another had expressed support for the law and agreed to prescribe for Mike.

Because of Mike's distance from Seattle, most of our contact was by phone. His condition was deteriorating but he was confident his doctor would help. Several months passed and Mike began to feel his doctor was dragging his feet. As time passed and his ALS took its toll, Mike became extremely frustrated by being led on by the doctor who continued to continue to promise to prescribe.

We talked frequently over the next few days and Mike was very grateful when I offered to be with him for the next doctor's appointment, a house call scheduled for late on a Friday, just before the doctor was to leave on vacation.

The doctor was early for the appointment and, when I arrived, he had already told Mike he would not prescribe after all. (I don't think he was an evil person – I think he sincerely wanted to help Mike but was pressured by his family and partners. (He had all the paperwork done – 2 oral requests documented, consultant's form, psych evaluation, Mike's written and witnessed request for meds.)

Mike was lying in his recliner, sobbing, head twisted so he faced the wall. He would not look at me until well after the doctor had left. There were many tears and many choice words for the doctor. Mike said again, as he had several times, that this was the story of his life – people saying they would do something for him and then not following through. He was polite when I told him we would "work on this" but I think he had lost all hope. He talked about the loaded pistol in his bedside table and about taking all his various meds at once. After much conversation, I asked him to promise me that he would not use the gun or meds before Monday when I would have more information for him. Although I think he trusted me, he said he could not promise me anything. (I seriously doubted that he could manage using the gun or meds. Nevertheless, that was a pretty uncomfortable weekend for me although Mike and I spoke every day.)

When I called Mike on Monday to tell him we had a doctor in Everett who would see him, he was ambivalent. He simply could not believe anyone would help him and he didn't want to make the arduous nearly 300 mile trip over only to be disappointed again. By this time, his ALS had advanced to the point where he was completely dependent, needing to be carried to his wheel chair and often unable to find a comfortable position.

With encouragement over the next several days, he decided to come but almost called it off twice. He asked me to be with him and his friend for the appointment. The doctor was kind and compassionate and, when Mike left her office, he knew she would be faxing a prescription to his pharmacy.

I can't tell you the difference that appointment made in Mike. His eyes were clear, he was smiling and what body language he could muster spoke of hope. He kept repeating that he never believed anyone would help him and he was stunned by the doctor's compassion. He even said he would have kissed the doctor if he could have. (She is very attractive, a fact not lost on Mike!)

Mike chose a day about a week after getting his meds. I talked with him every day and he was quite emotional, hoping for a sign from God that he was doing the right thing. He reluctantly agreed to have me and another volunteer with him but he wanted no one else. He wanted to take the meds late enough at night that he would have no visitors. He was concerned about us, offering to put us up in a hotel and making sure there were clean linens on the beds so we could sleep before heading back to Seattle.

We were about 15 minutes late getting to Mike's and he was worried that we weren't going to come after all. He had, as he put it, gotten "spiffed up" for the occasion – haircut, shave, clean clothes. He was calmer than I had ever seen him. He said when he was in high school he had read John Steinbeck's *Of Mice and Men.* It had made a lasting impression on him, especially the part where George shoots Lenny so he won't have to face a lynch mob. That afternoon, Mike had sent his caregiver on an errand and, coincidentally, the movie came on TV. He watched it, crying the entire time, but when it was over, he felt he had received his sign from God.

Mike was very much at peace with his decision and looked forward to seeing what came next. (Either, as he put it, "a long dirt rest" or a chance to see the people and dogs he had lost.) He joked with us as we helped prepare the medication ("now girls, don't spill any of that good stuff") and made sure we knew where the Jim Beam was for later. He took the meds quickly with great determination.

I believe Mike was unique, even as he was dying. After taking the meds, he had several huge yawns. He continued to try to talk and, although we could not decipher what he was saying, the tone was happy and it didn't seem directed towards us. Just before coma, he howled a couple of times – again a happy sound. It may just have been the endorphins kicking in, but I prefer to believe he was greeting the dogs he had loved so much.

The Washington State Death With Dignity Act passed on November 4, 2008, and went into effect on March 5, 2009. This act allows terminally ill adults seeking to end their life to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents who have less than six months to live.

ITA: A Legal Action Not a Therapeutic Intervention

Gary Carter, LICSW, DMHP
Crisis Response Team Supervisor
Kitsap Mental Health Services

About a year ago I wrote about my observation that there will always be conflict around our work as DMHPs. Sadly, most customers are disappointed when we do not detain and some are angered by the process that leaves an at-risk client in their care. Outrage and sometimes blame is often directed at the individual DMHP with the implication that we "don't get it" and/or we don't care or aren't well trained enough to intervene.

With that stated I would like to offer a simple paradigm for why this happens, why this conflict is an essential component of good practice as a DMHP and finally, what to do about the strain that results. It is necessary we understand this, not shy away from it and ultimately, address it each time it comes up.

If we can directly and personally acknowledge this 500 pound gorilla to the community we serve, we will rid ourselves of the historic negativity that surrounds our work and so often destroys the trust others might have in us. Besides providing us with a defense, It can be the doorway through which we might see the deep and unique value we bring to our clients and to the communities we work in.

Let me start by attempting to describe, in very general terms, the values and goals shared by case managers, therapists and prescribers. There is consensus, I think, that the goal involves equipping clients to be as independent and self- directed as they are capable of being. The aspiration is to move clients as far up Maslow's Hierarchy of Needs as they can independently maintain. Seeing a client move up to a new level - well, that's a good day.

In order to accomplish this, professionals share certain values and ethical principles that allow them to work very intimately with individuals and yet preserve their independence. Through the ethical use of diagnostics, boundaries, therapeutic models of intervention, and termination practices, professionals avoid insinuating themselves and their limitations into the client's life. Professional training isolates a client's specific needs, identifies their unique strengths, and leads to the application of relevant and appropriate interventions dispensed at an optimal rate and intensity that reflect the individual's unique qualities. The focus on the individual is never ignored. "One size indeed does not fit all."

DMHPs are thrown into a parallel reality that looks and often sounds familiar but is worlds – professions – apart. In this alternate universe we use the same language and many of the same skills as we have always used, but it is now in service of a different purpose with widely different

goals. We have different values than we once did and the ethics of our practice differs from all that we once knew and from the community we serve.

Metaphorically, while there is still gravity to hold us, all motion that is initiated in this reality results in wildly different results. Until we have lived in this new existence for a while there are often many unintended or unexpected outcomes we experience. This too is true for those earthlings we attempt to help. Until we figure out what is different and how to manage it, everyone is on edge. Yet, the good news is that once we do figure out how to handle our new powers, we will find we can in fact leap tall buildings in a single bound and withstand the onslaught of monsters we earlier had no idea even existed. That is, we can fulfill the nearly impossible task of helping people in their own dangerous orbit who are beyond help by the usual means.

To better describe this alternate reality consider the image of Justitia, Lady Justice. This familiar Roman figure originated in Greek mythology as the goddess of divine justice, Themis. For centuries her statue has been stationed outside of most courthouses and has decorated official art work and logos worldwide. She shows us by her gender that a just law is open and poised to protect its people from injuries and injustices in order to maintain their integrity as a civil body or group. Her blindfold depicts a disinterest or ignor-ance to individual differences and entitlements. Justitia serves above the individual and serves the group evenly and without prejudice.

The scales held in her left hand show the value of weighing facts and the evidence because someone's fate hangs in the balance. The rules of law require a court to provide proof, called evidence, that a law has been violated. This is done by accumulating relevant facts that ultimately may outweigh an individual's right to their guaranteed liberty. It isn't opinion or need, timing or talent, but factual evidence that the legal criteria has been satisfied that allow an arrest or detention to be made.

The double-edged sword held in Justitia's right hand also has many meanings. Justice works both ways - it punishes and it sets free. It is to be powerful, swift and final, cutting through deceit, privilege and the status quo. It has the power to help and to harm.

So, when we accept a case and begin our investigation, we begin accumulating facts that may deprive some of our most marginalized and powerless citizens of their freedom. The facts found in the case are weighted as to whether they meet the criteria necessary to invoke the law: likelihood of serious physical harm as a result of a mental disorder, and no viable voluntary options for a lesser restrictive intervention are available (The "Three Prongs" and Imminence will not further be discussed in this article.) We are not concerning ourselves as to what their needs are in order to implement a treatment plan, or even to extend a treatment plan. This is an action aimed to mitigate harm by means of deprivation, deprivation of rights and individual choice.

If the scales aren't tipped after the investigation, and the risk hasn't outweighed the individual's right to liberty, the person is left alone, to walk free in the midst of their unmitigated situation. It is all or nothing. Theoretically, the case meets criteria or it does not. You see, by being agents of the law and justice, we are acting on behalf of the law and its long-term dedication to greater good of the state's citizenry. Our mission is to protect on a higher and broader scale than our provider colleagues whose mission it is to restore individually unique people. Compare the two: protection through deprivation versus restoration through enhancement.

Saying it in yet another way, a court sanctioned detention is not, never was conceived to be, and should never be considered a therapeutic intervention. And no, it isn't the last thing we try in order to help someone when all other therapeutics have failed. Detention plays in a different ballpark. It is rescue through deprivation. In some cases it is restraint and injection of some of medicine's most powerful mind and mood altering drugs.

By its nature, the detention process deprives the client and the care-givers alike of the essential thing the helping community is working for - client self-determination and the civil liberty of citizens. The blunt and blind intervention of the law will never lead to self-actualization when it strips the person of their individual merit and qualities. As it is said, you cannot get a pear from an apple tree.

Asking for a detention in order to get a client something like a "med adjustment" is akin to advocating arrest in order to have some time away from daily demands and meet new people. Even if needed, this isn't the way to go about meeting those needs. You cannot ignore the means, the essence of detention or arrest. Incarceration is a deprivation of liberty, citizenship and dignity; it is antithetical to individuation, self-determination and Maslow's self-actualization. Again, the ends do not justify the means.

So to frame this somewhat, the therapeutic community and the lay community ask for help when they have run out of resources, skills or yes, patience. There is no fault here, each and every one of us, all of the time, ask for help under these conditions. DMHPs exist in a unique niche and it *is not* at one far end of the continuum of care. We are on a different track, in another ballpark, an alternate universe where need does not drive interventions, individuality is not recognized, and care may not provided. We rescue individuals from serious harm by temporarily depriving them of their humanness.

Uncomfortably, it is ethical for us to ignore need and individual differences if the facts are not there justifying us to detain or revoke. It is appropriate for us to withhold our intervention in the face of suffering and deteriorating capacity. And it stinks. It is at times unbearable for the DMHP, but ethically, we must separate ourselves from our therapeutic instincts in order to provide justice and protection by the rule of law.

Even if we can see some value in these ideas, our customers, at all levels, may never see it. And, understanding these concepts doesn't in itself solve the problems we have with conflict and the distrust directed at us in our communities. All it does is allow us to free ourselves from blaming our customers for their silly referrals, unrealistic expectations and their overt hostility when we do not detain and risk remains in their lap. It also might free us from blaming ourselves for things we don't control.

Next time, I will attempt to finish this idea with practical ways we can stop this destructive and defeating process. There are ways to remain independent and at the same time responsive. We can decline to detain yet not abandon the client. The protection of liberty does not have to be expressed as abandonment. Not all will understand this at 4:30 pm on Friday when they pick up the phone to call the crisis team. But in the long run if we are willing to take the time, I completely trust that we can get to a place where we can be honored for the hard and hidden work that we do day in and day out. That will be next time.

(CONTINUED FROM PAGE 1) by the American College of Emergency Physicians that there is a national shortage of psychiatric beds. 70% of the responding physicians report that psychiatric patients boarding in ERs is an increasing problem. The Boston Herald in an article dated June 27, 2011 reported that psychiatric patients often wait days in ERs for a bed on a psychiatric unit. An article from the Portland Business Journal dated February 5, 2006, reads:

> "'There aren't enough psychiatric beds in the city to handle the amount of people needing them," says Jean Dentinger, supervisor of the involuntary commitment program in the behavioral health division of Multnomah County's Department of Community and Family Services. "It's an inefficient and expensive way to provide care," she says with frustration. "It's not good care for patients to sit in an emergency department in Medford (OR). We don't like it, they don't like it and the hospitals receiving them aren't happy either. But it's the system we have."

While I do believe our duty as Designated Mental Health Professionals is to first protect the individual and the community, I also believe the individuals we detain should receive the best clinical care as well.

I laud the work of the Single Bed Certification workgroup which met last year and the ITA Capacity workgroup that met this year, both of which the WADMHP actively participated in, to try to address the problem of the lack of Evaluation and Treatment facility beds. In particular I would like to highlight the efforts of David Kludt and others at the Division of Behavioral Health and Recovery to try to get DMHPs access to the state hospitals for the most violent people we detain.

Unfortunately I fear we may have to wait until a legal solution occurs before we experience any true relief and the people we detain have access to the quality of care they deserve.

On another note, we on the board of the WADMHPs are very happy with the response to a new program funded by the Division of Behavioral Health and Recovery and managed by the WADMHP, the Quarterly DMHP Manager's Conference Call. There has been good participation by DMHP managers from across the state who have the opportunity to share concerns, offer support and receive information. We are pleased to hear this program will be funded another year.

May you and your teams be safe out there.

Robby Pellett

President WADMHP

(CONTINUED From Page 3)

3. DMHP Training and Statewide Consistency of Application of ITA - **Recommendation:** Identify ways to enhance training opportunities for DMHP's and address factors impacting consistency in the application of the ITA. **Plan:** I am currently in the process of finalizing a work plan that will include participation from; DMHP Association, DMHP Managers, DMHP's, RSN's and other stakeholders as needed.

For additional information on these planned activities please contact me at david.kludt@dshs.wa.gov.

The three issues that we will be working on are certainly not the only issues that impact the crisis and ITA system, they are however critical issues that when addressed will improve our system and help support the work of DMHPs.

As always, thank you for the work you do and be safe!

David

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