THE NEWSLETTER OF THE WASHINGTON STATE DMHP ASSOCIATION SPRING 2013

Frontlines

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Letter from Luke Waggoner, President

Greetings fellow DMHPs,

I thought I would take some time in my first Letter from the President to tell you all a little bit about myself and what brought me to the WADMHP board. I am a northwest native who grew up in north Idaho and Central Washington. No matter where else I have gone I have always returned to this great part of the country. When I'm not busy being a DMHP and Clinical Manager I enjoy riding my bicycle all over the Walla Walla valley.

I have a Bachelor of Science degree in Psychology and a Master of Arts degree in Transpersonal Counseling Psychology. I started my behavioral health career in 2001 working as a mental health technician at a 60 bed acute and long term inpatient psychiatric hospital for adolescents. Since that time I have worked as a case manager at a community mental health agency, at a therapeutic high school, a group home for adolescents and a $45,000 a month adult residential program with all the bells and whistles. In 2007 I started my DMHP career here in Walla Walla and have since become the Clinical Manager for our Crisis, Supportive Housing and Jail services.

As a DMHP I quickly learned what you all have learned, that resources for those with the most need are in very short supply and seem to be shrinking daily. I started wondering how I could make my voice heard and have some impact for myself and my co-workers. My manager sent me to several WADMHP conferences where I started connecting with the larger group of DMHPs and the members of the WADMHP board. Finally in 2010 I contacted the board president, Robby Pellet, and let him know that I was interested in joining the board and in October of that year I became the

treasurer. Joining the board of the WADMHP helped me reach my goal by providing me a voice through participation in the DMHP Protocol workgroup in 2011 and the Single Bed Certification workgroup in 2012 and 2013.

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As WADMHP President I intend to continue our focus on support and education for DMHPs through our Frontlines newsletter, website, Facebook page, conferences and other trainings. Although we did not receive a contract from DBHR this year to provide DMHP Boot Camp, I continue to see this as a priority for the association and the board is looking carefully at how we can offer this training in the future. We will remain committed to presenting the voice of the DMHP at state workgroups and by providing feedback and testimony to the legislature on proposed legislation. If you would like to share your ideas or views with me send me an e-mail at president@wadmhp.org

Regards,

Luke Waggoner, MA, DMHP

WADMHP President

Editorial: Telemedicine in the Involuntary Treatment Act in Washington State- Pros and Cons.

Wikipedia describes telemedicine as the use of telecommunications and information technologies in order to provide clinical health care at a distance. It further describes telepsychiatry as the use of video conferencing to provide psychiatric services to underserved areas. The Veteran's Administration advertises that it has been using telemedicine since the 1940s with the use of phone services to allow veterans access to some aspects of health care. Two of the largest studies of telepsychiatry address the use of this new technology to provide psychiatric services to the people in the outback of Australia and on Native American reservations

in the US. Clearly the use of technology to allow access to psychiatric services for rural, remote and isolated people who are hundreds of miles away from any psychiatric care is a positive development. There are many studies that show that in the face of limited resources and the lack of access to psychiatric services telepsychiatry is a benefit, but there are no studies that show that video conferencing is better than in-person contact for mental health services.

Recently there has been pressure by a few hospitals to have Regional Support Networks consider substituting an in-person evaluation and assessment of individuals who are the subject of an evaluation for possible involuntary psychiatric detention, with an evaluation by video conferencing.

There are 4 states, North Carolina, North Dakota, Florida, and Hawaii, who currently allow the use of telepsychiatry in the involuntary commitment process. There are two aspects of the involuntary commitment process that telepsychiatry is being used for in those states. First, the initial petition can be 'faxed or emailed' to the court. The other, is to allow a court ordered evaluation by a psychiatrist or psychologist of the detained individual to be done generally in the first 24 hours, by video conferencing in order for the psychiatrist or psychologist to make recommendations to the court regarding further involuntary treatment. In North Dakota, the psychiatrist doing the evaluation by video conferencing can actually be located in a different state as long as they are licensed in North Dakota. The use of telepsychiatry is needed in those states, due to the lack of qualified psychiatrists.

DMHPs have seen the use of telemedicine become a part of our practice with the use of language interpreters by conference phone or video conferencing. This is not been entirely successful as the technology is not problem free. It is not uncommon that the transmission is delayed or distorted, or the microphone is unable to adequately pick of the voices in the room leading to limited communications. DMHPs continue to prefer to have in-person interpreters to maximize the quality of the communications during the interview with the person being evaluated for possible involuntary commitment. Although it is true that there has been progress in technology and we have become increasingly dependent on technology as a society, there are still times when due to unforeseen events technology is not available or not adequate.

I believe that the use telepsychiatry could be a positive resource in the face of the difficulties faced by hospitals who are called upon to board detained individuals and do not have access to psychiatric services within their hospital. The use of telepsychiatry would allow the detained person who is being boarded on a Single Bed Certification at a hospital without psychiatric services, to at least get pharmacological treatment by allowing the hospital to consult with a psychiatrist by phone or video conferencing regarding medication management of the detained patient. Of course this consultation would come with a cost.

The other positive use of video conferencing would be when testimony by the Designated Mental Health Professional is needed by the courts. As there are only 9 counties that have hospitals or Evaluation and Treatment facilities where court hearing occur for further involuntary treatment beyond the first 72 hours, DMHPs from many counties are burdened by and taken away from their primary function of serving the people in their county, when they have to travel hours to testify in person. The use of telephonic or video conferencing technology would allow the DMHP to testify from their office. This would allow the Respondent at an involuntary commitment hearing to hear testimony directly from the DMHP and to cross examine the DMHP directly as well, protecting the Respondent's legal rights.

There have been various arguments posited for the use of telepsychiatry in the evaluations for involuntary commitment. But generally they fall into 2 major points. The first is resource management and the other is safety. Involuntary commitment costs could be reduced by using video conferencing to do evaluations resulting in the need for fewer staff who remain in an office that could be located anywhere in the state or even outside of the state. The DMHPs are safer because they do not have to drive at night or in bad weather, and the DMHPs are safer as they do not have to have direct contact with the mentally ill.

At first glance it would appear that video conferencing would bring financial rewards. But like many resource management strategies the use of video conferencing in involuntary commitment evaluations only shifts the costs. While there may be less need for so many DMHPs across the state, there would be a significant burden placed on police departments to see more potentially mentally ill that may be a danger to themselves or others, in the community and then to have fire departments see the person and clear them medically in the community, and then for an ambulance to transport the person to a local hospital emergency room. There would also be a significant burden placed on the hospital ER staff, because in addition to the usual duties regarding evaluating and treating the person medically, they would also have to fax all the relevant information to the DMHP office including police reports, ambulance reports, ER doctor notes, labs results, social worker notes, declarations or statements from social workers and possibly other ER staff including doctors, the contact information of any known potential witnesses and the information they may have, and any restraint reports. The social worker and doctor would need to be available to speak by phone for consultation and possible clarification of their notes. ER staff would have to manage the video conferencing equipment including trouble shooting any technological problems. And if the person who is being evaluated is ultimately detained the ER staff would be responsible for managing the involuntary commitment paperwork and for serving copies of the faxed detention paperwork to the detained person as well as arranging transportation to the indicated Evaluation and Treatment facility.

While it would seem that involuntary commitment evaluations could be done faster if done by video conferencing, I would suggest that DMHP offices would still be triaging cases and it would not be evaluations on demand as other telemedicine services seem to be.

While it is true that DMHP safety may be enhanced by not having physical contact with the mentally ill person. Once again the burden is simply shifted to others such as the police and ER staff.

Designated Mental Health Professionals come into contact with the most disenfranchised members of our society, the acute and chronically mentally ill. These are often individuals who are further marginalized by the lack of housing, or income or a purpose in life except to make it through the day. These are people who we often try to not acknowledge when we meet them on the street as they may be disheveled or unwashed, or acting odd or begging for money. For the Designated Mental Health Professional to be distanced from these people by the use of a video monitor only further enforces those experiences of being marginalized and disenfranchised. It is through our direct contact with the people we are asked to evaluate for possible involuntary commitment that we are able to bring some human dignity, respect and compassion to an often frightening situation that these people experience.

It could also be argued that to allow a DMHP to remove a person's civil liberties and force a person involuntarily into psychiatric detention to be subjected to involuntary medications which have serious side effects including possible death, when the only contact a DMHP has with the person is remotely through the use of video conferencing is an infringement of the person's constitutional civil rights. We do not yet allow police to detain a person without informing the person in-person of their rights.

As is noted earlier in this paper while there are many studies that show the usefulness of telepsychiatriy in areas where there are no psychiatric services available, there are no studies that show that telepsychitary is better clinically then in-person contact.

Currently DMHPs are the only people designated to perform initial detentions and we are available in every county to see people in a timely manner. There is no shortage of DMHPs at this time.

We provide significant clinical skills in performing our duties of evaluation and detentions under the Involuntary Treatment Act which would be hampered by the use of video conferencing.

And lastly but most importantly the people who are referred to DMHPs for evaluation for possible involuntary commitment deserve the dignity, respect, and warmth of compassion that being physical present in the room with them provides.

Robby Pellett

WADMHP President Emeritus

Letter in Support of funding for the Designated Mental Health Professionals Boot Camps.

As the President Emeritus of the Washington Association of Designated Mental Health Professionals, I am writing in support of funding for the Designated Mental Health Professionals Boot Camps (DMHP Boot Camps) by the Washington State legislature.

The Washington Association of Designated Mental Health Professionals has been coordinating and facilitating the DMHP Boot Camps since about 2006. Over the years we have provided training for over 200 Designated Mental Health Professionals across the state.

For many agencies the DMHP Boot Camps provides a strong component of their training for new DMHPs. In addition to crisis intervention skills including working with special populations, the DMHP Boot Camp provides strong training in the essential skills for DMHPs such as investigative process including evaluation of harm to self or others and grave disability, petition writing, the DMHP Protocols, and a strong foundation in the laws regarding the Washington State Involuntary Treatment Act for adults and children. Although not all counties have the legal means for DMHPs to carry out all the duties of a DMHP, the DMHP Boot Camp gives them a chance to study and understand the full spectrum of DMHP authority and responsibility per the law. This provides an opportunity for consistency in the training of DMHPs across the state.

The DMHPs who attend the DMHP Boot Camps consistently rate the training as very good or excellent. DMHP managers have also given the Washington Association of Designated Mental Health Professionals very positive feedback regarding the DMHP Boot Camps. But the best feedback is that DMHP managers continue to send their new and experienced DMHPs to the DMHP Boot Camps year after year. The Washington Association of Designated Mental Health Professionals has used the DMHP and the DMHP managers' feedback for continuous quality improvement of the DMHP Boot Camps. We feel that the quality of the DMHP Boot Camps have improved over the course of years that we have been involved in their coordination and facilitation.

The Washington Association of Designated Mental Health Professionals hopes that there can be continue funding of this vital and critical training for DMHPs across the state. We look forward to providing the DMHP Boot Camps, for years to come.

Robby Pellett DMHP

WADMHP President Emeritus

LEGISLATIVE UPDATE

Greetings from Lacey/Spokane,

The current legislative session has been filled with proposed bills related to behavioral health. As of this writing there are a number of proposed bills that are still alive regarding; Superior Court Commissioners authority (SSB 5165), statements made by juveniles during mental health screening (HB 1724), improving the adult behavioral health

system (E2SHB 1522 & 2SSB 5732), requiring Designated Mental Health Professionals (DMHP) to provide documentation of their decision to not detain when a physician provides a declaration opposing the decision (SSB 5456), development of a statewide database of mental health commitment information (SSB5282), accelerating changes to mental health involuntary commitment law (2SHB 1777), concerning mental health commitment law changing standard from imminent to substantial likelihood (ESSB 5480), transfers of clients between RSN's (ESSB 5153), facilitating treatment for persons with co-occurring disorders by requiring development of an integrated rule (ESSB 5681), standards for detention of persons with mental disorders (HB 1963), concerning detentions under involuntary treatment act (SSB 5456).

In addition there are also a number of forensic related bills that address; criminal incompetency and civil commitment (SHB 1114 & ESB 5176), competency to stand trial evaluations (2SHB 1627 & SSB 5551), notification of release of persons following dismissal of charges based on incompetence to stand trial (ESB 5221).

Each of these proposed bills if passed and funded could have significant impact on our system of care and the work of DMHP's. Of particular interest is SSB 5480/2SHB 1777 that would accelerate the implementation date of (SHB 3076) and the new involuntary commitment standards to July 2014. Also of interest is HB 1963 that would among other things, amend RCW 70.96B.045 & RCW 71.05.050 changing the standard for involuntary commitment from "imminent" "to substantial likelihood". SSB 5456/HB 1778 would amend RCW 71.05.153 & 71.05.150 related to non-emergent detentions. This bill would also require DMHP's to "seriously consider" observations and opinions of physicians when considering involuntary detention and would allow the physician to write a declaration that the DMHP would be required to respond to in writing, if the physician does not agree with the decision not to detain. The bill also would amend RCW 71.05.020 related to underlying medical conditions and rights to provide medical treatment against a persons will.

As I mentioned above, each of these bills could have significant impact and many of them if funded could address serious issues in our behavioral health care system including, concerns related to our State crisis system. Our Administration is working hard to inform the legislature of our needs and the costs associated with those needs. It is encouraging to see that the Governors proposed budget includes funding to support the behavioral health care system. As we all are well aware the legislature has many budgetary challenges and we remain hopeful that our behavioral health care system will receive the funding needed.

I hope to see you at the next DMHP conference in Yakima on June 19th. We will be reviewing any new passed legislation from the current legislative session.

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

David Kludt

Intros

New Board Member Bios

Wendy Sisk

Second Vice President

I grew up in a small farming community in Eastern Washington. While completing both my undergraduate and graduate work at Central Washington University, I volunteered as a Domestic Violence/Sexual Assault Advocate for 4 years. As an advocate, I would rush to the ER to help women in distress. Who knew this would set the tone for my career? After completing my graduate studies in 1998, I worked in the Seattle area providing psychiatric assessment for Fairfax Hospital (often rushing to various ERs in the middle of the night). I later migrated to an outpatient provider in Seattle where I completed assessments for adult group home placement and intakes. Somehow I was talked into providing after hours crisis response for the agency as well. In 2002 it became clear that it was time to migrate further west, and away from the city. I have been at Peninsula Behavioral Health in Port Angeles since. I started as a case manager and migrated to crisis services after about a year and a half. In 2004 I began filling in as a per diem DMHP and in 2005 took on the role full time. After 5 years as a full time DMHP, I assumed management of the team. I am presently supervising our DMHP staff as well as our case managers. I remain as passionate about crisis as ever.

Jessica Shook,

Treasurer

I started working in community mental health in 2006 when I took a position as a jail transition case manager in Lewis County. About a year later, I started doing crisis and DMHP work, then went to do crisis work in Pierce County in 2008. I've been a DMHP in Pierce County since early 2009. I'm excited to join the WADMHP executive committee and have an opportunity to give back some support to the community of professionals that's supported me. I firmly believe that what we do is important and difficult, and we need to take care of each other. We have an opportunity to be with people in their most traumatic moments and keep them safe. I feel good about that.
When I'm not at work, I'm playing outside, trying to keep up with my toddler, cooking something new, and wishing I could go to more concerts.

Jim Trivelpiece

Frontlines Editor

I am originally from Oregon. At 18 years of age I left the small farming community of my home, and emigrated to University of Oregon. This was in 1966, when academia and much of the rest of the culture was in turmoil. From there, I married and moved to Boston. I worked as a researcher for a psych research facility in Waltham Mass. BF Skinner spoke at the grand opening of the facility, about how we were on the verge of a new world where inner drives and inner motivations would fall to constructing environments that would reinforce desired behavior. In the interests of social propriety I will not print my own inner response to this notion.
I come to Palouse River Counseling and DMHP work after 20 or so years as a clinician in the Idaho mental health system.
I am racquetball player of 30 some years, and have a wicked z-shot.
Two nights a week I retire to the dojo to practice aikido.
This issue of Frontlines was brought to you by ample amounts of dry-processed Ethiopian small-lot coffees, lightly prepared at home.

WADMHP

SPRING CONFERENCE

Julie Jensen PhD

Geriatric Mental Health

Registration fee- -$70.00

JUNE 19TH 2013

Remember, mail in your check to cover the registration fee.

Mail payment to:
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