Frontlines

Washington Association of Designated Mental Health Professionals

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Kitsap County DMHP killed in line of work

On November 4, 2005 a Designated Mental Health Professional was killed while evaluating a client in order to determine the need for inpatient treatment. Marty Smith, a veteran DMHP at Kitsap Mental Health Services, was beaten and stabbed by a man with a history of mental illness.

There was a visitation for Marty from 3 - 5 pm on Thursday, November 10, at The Stone Chapel. The memorial service was held on Friday, November 11 at 1:00 p.m. at The Stone Chapel, 22772 Foss Road in Poulsbo. A reception for family and friends immediately followed the service.

The *Frontlines* was granted permission by the *North Kitsap Herald* to print the following article accounting the events that led to Marty's death.

By Charles Melton
November 09, 2005

POULSBO — A mental health worker responding to call from a concerned mother was killed in a violent altercation Friday evening after he called 911 for assistance. Poulsbo Police Department's officers received the emergency call from the Vikings Crest condominiums shortly before 5:30 p.m. and when they arrived minutes later, they found Marty Smith, 42, of Poulsbo, dead.

Smith, a County Designated Mental Health Professional with Kitsap Mental Health Services, was attempting to have Larry William Clark, 33, of Poulsbo, admitted for a mental evaluation because Clark's mother believed he presented a danger to himself and others.

Clark was formally charged with murder in the first degree in Kitsap County Superior Court on Monday and bail was set at $1 million.

After being read his rights after the incident, Clark confessed that he murdered Smith, according to the statement of probable cause filed in Kitsap County Superior Court Monday.

"We received a call at 5:26 p.m. and we had a fairly quick response," said Poulsbo Police Sgt. Bill Playter Monday morning.

Smith was already deceased when officers arrived on the scene, Playter said. "This was an isolated incident and the person responsible is in custody," he said. Clark was a Level II sex offender, but officers were unaware he was living in the city until the incident, Playter said.

Marty Smith

Under Washington state law, law enforcement is only required to give the public notice of Level III sex offenders living in their communities. A search of the state's sex offender Web site showed Clark is a Level II sex offender with a Viking Crest address.

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"He had a history of incidents but not from our department," Playter said, noting that it is unclear how long Clark had lived in Poulsbo.

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The homicide is the first in Poulsbo since 1987 when a murder-suicide took place involving a husband and wife, Playter said.

Angry outburst

According to the statement of probable cause, Smith had gone to Clark's residence at the request of Clark's mother. Clark's mother wanted Smith to talk to him about being a possible threat to himself or others and Smith attempted to talk Clark into a voluntary commitment for a mental evaluation, the statement read.

When Clark refused to go voluntarily, Smith called 911 and was requesting assistance to have Clark involuntarily taken for evaluation, it read. Clark then became enraged, threw him against a glass hutch and beat him with his fists until Smith was in shock and incoherent, it read.

"At that time Clark told Smith he was going to die," it read. "(Clark) went into the kitchen obtained a large carving type knife and returned to the dining room where he proceeded to stab Smith repeatedly in the chest."

Clark was taken into custody outside the apartment immediately thereafter and medic personnel who arrived on the scene pronounced Smith deceased, it read.

First killed in the line of duty

Smith is the first worker to die in the line of duty since Kitsap Mental Health began its services 27 years ago, explained Rebecca Wilson, KMHS director of community relations. "Right now our focus is with Marty's family and our KMHS family," Wilson said, noting that the outpouring of support from individuals and agencies has been tremendous.

Smith had been a full-time employee since 2004 and was one of about half a dozen workers who responded to calls from law enforcement and families when individuals presented a danger to themselves or others, she said.

"We have guidelines and safety is first, but each individual circumstance is up to the judgment of the individual," she said.

KMHS already has had a quality assurance process in place for a number of years to review its performance, she said.

No signs of trouble

Clark gave no signs of potential trouble while he was living at the Viking Crest location, said Laura Harris, association manager for CFA Properties.

"I don't believe he had been there very long, and I believe he was living with his mother who was an owner," Harris said, noting that units at the property are individually owned. Harris' mother purchased a unit and had been living there before he moved in with her, she said.

"We have an on-site manager and it's a pretty tight community, so everybody's leaning on each other," Harris said.

There are two ways of spreading light: to be the candle or the mirror that reflects it. -Edith Wharton, novelist (1862-1937)

Marty Smith Memorial Fund

The Kitsap Mental Health Services Development Office has opened a Marty Smith Memorial Fund in honor of Marty and support of Marty's family. Contributions to the Marty Smith Memorial Fund, may be made at any Kitsap Bank Branch, or may be mailed to: Marty Smith Memorial Fund, c/o Kitsap Bank, PO Box 660, 10488 Silverdale Way NW, Silverdale, WA 98383.

KMHS would be happy to forward on to the bank any contributions that are dropped off at KMHS office, 5455 Almira Drive NE, Bremerton, WA 98311.

The memorial fund will be open through January 31, 2006. For more information about the Marty Smith Memorial Fund, please contact KMHS Foundation at 360-415-5801.

Pam Keller, Executive Assistant at Kitsap Mental Health Services, wishes to express gratitude on behalf of KMHS to "all of our friends in the community for your wonderful words of support."

President's Letter

Tragedy has stuck, now a DMHP on November 4th, 2005. The DMHP profession throughout the state of Washington, case managers and mental health providers and all first-responders see again the harsh reality of what it means to work in the real world helping real people who suffer from real pain.

Many of you know that the first DMHP death in our Washington ITA system was Norm Fournier, November 4th, 1987, in Pierce County. Norm was a DMHP supervisor covering for a vacationing staff member when he was killed. He had been working with the client for about a week trying to create an outpatient commitment option that would allow the individual to remain in the community. He had been the person's door, separated by a screen door with two law enforcement officers at his side when he was struck by the bullet that killed him.

At this early date little of the facts are known about Marty's death. We do know that Marty had responded to a mother's call to evaluate her son, the second call she made to Kitsap Mental Health Services' Crisis Response Team that week. Marty had conducted the investigative interview, like his colleagues often do, in the client's home. The individual's mother was present during the interview. The lethal knife attack followed Mr. Smith's decision to detain and call for an ambulance.

It, of course, is outrageous that a professional human services worker should be killed "in the line of duty." We're the good guys, aren't we?

Marty was at a wonderful place in his life having recently realized two of his dreams. Last December he married and was obviously very happy and he had just taken ownership of a new Harley Davidson motorcycle a few months before he was killed. Further, he enjoyed being a DMHP and felt Kitsap Mental Health Services was "the best place' he'd worked. It was a nice story.

As time goes on, we will no doubt learn more of the detail of how this happened. This is important because we could learn from this loss. The Association is planning to dedicate some of the time we have at the Spring Conference at Sun Mountain (April 23 – 14, 2006) for this issue. This will probably meant that we discuss issues of safety, best practice, managing history of violence and so forth.

I'll say one more thing in parting, remember that we have the WATCH website to check individual's arrest and conviction history, state-wide. You must establish an account with the Washington State Petrol before using the database. The introductory information states there is a hefty per-search fee yet that is waived for non-profit agencies. You can get to the information about establishing an account by going to https://watch.wsp.wa.gov/

So, go out and do the hard things we are called to do. And, be safe.

See you at http://www.wacdmhp.org/board/

Gary Carter, President

Marty Lee Smith

JULY 31, 1959 TO NOVEMBER. 4, 2005

** VETERAN **

Marty Lee Smith, 46, of Poulsbo died Friday in Poulsbo.
Born in Vincenzia, Italy, to Waldon and Sylvia Carol (Weise) Smith, he graduated from South Kitsap High School. He served with the Army.

Mr. Smith earned a psychology degree from Evergreen State College and a masters degree in counseling/psychology from St. Martin's College.

He had worked with Kitsap Mental Health Services for 1 years.

He was a member of VFW Post 10018 in Tacoma.

He enjoyed motorcycles, woodworking, oil painting, cooking and music.

His mother preceded him in death.
Surviving are his wife, Yolanda Marie (Garcia) Smith; his father; children, Morgan (Debra), Michael and Heather (Scott); and sisters, Mechell and Kim (Randy).

Visitation: 3 to 5 p.m., Thursday, The Stone Chapel, Poulsbo.

Service: 1 p.m., Friday, The Stone Chapel.

Association Website & Message Board

Click on **wacdmhp@org** for information about the laws, conferences, workshops, and job board.

Message Board: Go to www.wacdmhp.org/board. Click on Register in the top bar. Fill out the required information: User name; E-mail address; and a Password, and then click Submit. Then go to Login and login with your User name and Password.

To troubleshoot: Contact Gary Carter at garyc@kitsapmentalhealth.org

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It is with pride that this issue of the *Frontlines* is dedicated to Marty Smith. The death of any professional killed in the line of duty shocks and grieves the community, but when it is one who is doing the same work and attends the same meetings, workshops, and conferences, it strikes home more forcefully.

The only death of a Designated Mental Health Profession in Washington before Marty was Norm Fournier, a Pierce County CDMHP who was killed on August 4, 1987. It was nearly 15 years before Norm was appropriately memorialized - see the article in the Spring, 1003 issue of the *Frontlines* - for his contribution and dedication to his service as a CDMHP. His colleagues are determined not to permit that to happen again.

Marty's death re-ignited concerns about safety. In an interview by Seattle Times reporter Jonathan Martin for an article on November 8, 2005, I was asked some questions about DMHPs responding to crisis situations. I told Mr. Martin that it is the practice of our agency not to do evaluations for involuntary hospitalization detentions in homes. Some DMHPs told me that they thought that I had been misquoted. I wasn't. We think that evaluations should be done in hospitals for a number or reasons: 1) generally, emergency departments provide an environment assuring safety; 2) the evaluation, being done in a professional and medical setting, communicates a message to the client that we think is valuable; 3) medical and other causes of psychotic-like symptoms can be ruled out by a medical screening and tox screen; 4) the medical staff can use medications to calm an agitated patient; 5) the medical clearance demanded of most E and T facilities can be done; and finally, 6) there can be hospital to hospital transportation by a medical team.

Some people think that DMHPs should evaluate people in the community. This typically flies in the face of good standard of care, and, as we can see in Marty's case, good standard of safety. It may be appropriate for case managers to provide service in a client's residence, but it is a rare case that an evaluation for involuntary detention be done anywhere other than a hospital.

I was not being flippant when I said to the reporter, "This [issue of where evaluations are done] to me is extremely important: If a person shows any concerning behavior, I retreat. I'm not trained as a policeman. I don't have a black belt." I was implying with this statement two important ideas about DMHPs' response to do an evaluation: 1) unlike policemen and firemen, DMHPs do not have to respond as immediately in order to perform their jobs professionally; and 2) DMHPs should never become involved with restraining or "taking down" a client or respondent. An experienced DMHP maintained many years ago that we didn't need to slide down the fire pole in order to respond to a request appropriately.

Not only don't I have a black belt, but I am not trained to safely restrain people physically, nor do I think that it is a function of my role as a DMHP to ever restrain a person. The training for learning to physically restrain a person is intensive and needs to be practiced regularly. When an under trained, or poorly trained, person tries to restrain someone, he or she puts the client and themselves at increased risk. Law enforcement officers are trained to control agitated and violent individuals, and I have yet to meet an officer who has refused to become involved when a client shows any inclination of becoming violent. The law enforcement officers I have worked with are compassionate and understanding.

I have been asked about the importance of stopping a person whom I am evaluating from eloping. I let a person elope and call the police. Clients or patients are usually quickly apprehended, and the elopement provides evidence that the respondent cannot make a "good faith agreement" to voluntary treatment.

Some would argue that police or two DMHPs going together provides sufficient safety. Probably not. But that begs the question of why any DMHP would be doing an evaluation in a private residence where the medical facilities necessary for ruling out other causes of symptomology and medical stahility are not available.

Twenty-five years of publication

This is the first issue of the 26th year that the *Frontlines* has been published. I want to acknowledge all of my predecessors who have contributed their time and talent in order to keep the *Frontlines* alive and well. Over the years, many DMHPs have contributed articles that have enriched their colleagues. These articles often provide the most stimulating conversation among DMHPs. If you have an issue or topic of interest, please contact me.

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

Scott Kuhle, Editor

In Memoriam

From: Tony Sparber
Sent: Tuesday, November 29, 2005 8:47 AM
To: Our Fellow Designated Mental Health Professionals
Subject: Marty Smith

Thank You,

As you have no doubt heard, a colleague of ours and long time DMHP, Marty Smith, was attacked and killed during an evaluation at a client's home November 4th, 2005. Marty's death stunned the local human services community, and we know the shock of this tragedy was felt in homes and offices across the State.

We want to take a moment to thank you all for the great out pouring of concern and support that we received during some very difficult times. Marty's funeral was standing room only; and widely attended by DMHPs from several counties. Many others sent flowers and cards; as well as contributed to a fund set up in Marty's honor. There were also many phone calls to the team, offering help and support.

Marty was proud to be a DMHP, and this large showing of respect and support helped Marty's family understand why he loved this work. It was also validating and greatly appreciated by his team mates here at Kitsap Mental Health.

We also want to single out Judy Snow and the Pierce County folks for stepping in to provide coverage in our county (Kitsap) during the funeral. Their help allowed everyone that worked with Marty to attend the services.

It was very gratifying to see DMHPs come together to help each other when the chips were down. It is one more reason to be proud of who we are, and what we do.

A truly heart felt thanks to everyone. Be safe out there.
Kitsap County Crisis Response Team.

In Remembrance of a Colleague

Below is a letter that John Masterson sent to both the Olympian and the Sun (Bremerton) newspapers on Wednesday, November 09, 2005 8:43 AM.

Letter to the Editor

Last Friday evening a community hero, Marty Smith, was murdered on the job. I write to honor him and to honor his peers around the state. Marty was a county Designated Mental Health Professional (DMHP). This tragedy happened in the community of Poulsbo; however, it could have occurred in any community, in our community.

As a DMHP, Marty responded to mental health crises in Kitsap County 24 hours a day, 7 days a week. Marty and his peers throughout the state routinely respond to requests from families, friends, police and others. DMHPs go when and where they are needed, often alone, responding to the call for help. They go without weapons, armed only with their knowledge, their skills, and their commitment to care for very ill people. They go wanting to help, knowing they are the only ones authorized by law to require gravely mentally ill persons to be hospitalized against their will, if it is necessary. They are vital to the health and safety of the individual and to our communities. Marty's willingness to provide this service is a testament to his compassion.

DMHPs operate in the background, with most of us not knowing they exist until we need their help. Yet, almost daily they place themselves in situations of potential risk to help very ill individuals. Although events such as Marty's murder are rare, they point out the potential risk that is present every day for these dedicated mental health professionals.

I acknowledge Marty and his peers for their work, and I extend deepest sympathy from the staff of BHR to Marty's family and his co-workers at Kitsap Mental Health.

John P. Masterson

John P. Masterson is the Chief Executive Officer at Behavioral Health Resources in Olympia.

2005 Fall Conference provides excellent information

The WADMHP Fall Conference was held September 29 and 30, 2005 at the Federal Way Executel in Federal Way, Washington. The Theme of the conference was Trauma: Its impact on our patients and ourselves. On the first day, Dr. Steven Reed, with his assistant, Carolyn Erickson, presented all day on personality disorders to 42 participants. Dr. Reed is a psychologist in private practice in Bellevue, WA, who specializes in working with personality disordered individuals with trauma. He initially explained how traumatic experiences in early life coupled with specific dynamics of the parent-child relationship work together to create the three major personality disorder types.

Sharon Nations attending to details and business to keep the conference running smoothly.

In Narcissism the child's infantile grandiosity is not challenged by the parent, it is rather reinforced, and results in an individual who cannot see others at depth but uses relationships to mirror their own perfection to themselves, because they believe they are better than others and their way is the only way. Their underlying issue is that they are not understood and valued by the world, and they fear their own inadequacy.

In the Borderline Personality Disordered individual, the child was discouraged by the parent from developing independence, and loved and rewarded for being clingy and dependent. This person grows up to exhibit the helplessness and self-destructive behaviors of this disorder and to have a fundamental fear of being abandoned.

In the Schizoid Personality Disorder the young child has traumatic experiences with either a cold, indifferent or a sadistic parent, that teach him or her that relationships are not safe. They grow up to be avoidant of intimacy and their underlying issue is one of creating safety and avoiding danger emotionally.

After this explanation Dr. Reed and Carolyn acted out the dynamics of each personality disorder in a brief skit. This helped us to be able to recognize the three major personality disorder types quickly so that in a single-interview situation we could successfully engage personality disordered individuals by "speaking the language" of their disorder. i.e., to a Narcissist you would want to address the issue of being understood, to a Borderline you would speak to the issue of abandonment, and to a Schizoid safety should be addressed.

Dr. Reed spoke about risk assessment for the three types. Borderlines have the highest incidence of parasuicidal and suicidal behaviors. Even though we tend to be jaded by their frequent self-destructive threats, as a group they do comprise a majority of the completed suicides. Narcissists can be very serious suicide risks at the time when they feel their grandiosity has been deflated, especially by someone who holds important resources for their ongoing ego maintenance, like a spouse or a boss. Schizoids usually have few relationships. They tend to pick just one trusted person and that one individual is their emotional world. A Schizoid could be a serious suicide risk if they lost that one important relationship. In terms of danger to others, the Narcissist is the most likely among the three to act out against others. Antisocial and Sociopathic individuals also have high levels of aggression to others.

They then described how counter-transference by the therapist complicates working effectively with a personality disordered individual, be that in ongoing therapy or a one-time interview. These patients are usually seen as "difficult" because they bring up any unresolved "stuff" we have from our own past traumas. We then did a group exercise in which there was a role-play by one of us as therapist and one of us as patient, with a group of observers who acted out the parts of the therapists' transference figures (i.e. a parent, boss, teacher, who had traumatized the therapist in the past causing them to be challenged to work well with this patient).

After the transference figure and the therapist interacted directly, the therapist was much freer to work effectively with the patient. Our second day's

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presenter was Kate Boyle Grutz, a specialist in secondary traumatization who lectures at Seattle University and is a consultant to first responders in the Seattle area about how trauma work affects us as workers. She began her presentation by giving us a packet of self-assessment tools that we could take away to evaluate our own stress-resistance and stress coping style. We then did an exercise in which she asked each of us to write down three symptoms of stress we identify in ourselves from our work. We then circulated through the room silently reading each others lists. I was impressed with how many people don't sleep well and have headaches. She then said that most of our work involves what is called "directed attention", which means something that you have to focus on and inhibit distractions. This type of concentration is fatiguing, whereas "fascination", something that is no effort to attend to, is relaxing and allows our directed attention to rest. Things that produce fascination include exposure to nature or even pictures of beautiful natural scenes, flowers, pets, art, music. She said the most stress producing environment is a small, plain, enclosed office with no windows, art or personal touches. She encouraged us to have pictures of nature, flowers,and personal items in our workspaces. The final part of her presentation was an introduction to the biofeedback programs of heartmath.com. These are computerized games that reward the player with success when the player successfully lowers or maintains their heart rate at a low level. They can be seen at heartmath.com and purchased for personal or agency use.

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)

Opening remarks on trauma and stress workshop

The Friday morning presentation was given by Kate Boyle Grutz, a trauma consultant in private practice in Seattle. She teaches in the psychology graduate program at Seattle University, and does corporate de-briefings and supervision and consultation groups for therapists. In her work with individuals or small groups, she is interactive and process oriented. The following is her introduction at the fall conference:

I've never been in front of an audience as the presenter and I find the notion highly stressful. So, what you're getting right now is a presentation on transforming stress by a woman trying to manage her own stress, while doing something she doesn't really know how to do and doesn't remember what she was thinking when she said she'd do it!

Well, that's not entirely true. I do know what I was thinking about. I was thinking about the feeling of awe I experience after spending an hour or two listening to the stories of MHP's in King County, or the social workers in the ER at Harborview, or the clinicians in community mental health centers, who see people in their most dire moments and are able to stay present and attentive in the midst of crisis, chaos, and sometimes unspeakable sorrow, and to do it day after day. I also thought of clinicians, who left work that they had loved because of stress symptoms they couldn't control; elevated blood pressure; chronic pain; sleep disturbances; intrusive images; and depression. In the last few years, I've gained confidence that we can decrease the negative impact of stressful work and I'd like to offer what I've learned.

Let me give you a little personal background. About twenty years ago, I was the director of the Psychological Trauma Center at Seattle Mental Health Institute. The center was a component of the adult out-patient department, developed in response to a survey the staff conducted, which asked the question: "How many of our patients have a history of traumatic experiences." I no longer remember the percentages we came up with and I'm guessing they would not come as a surprise to you. But to us in 1986, the numbers were shockingly high. And so, as a team, we decided to educate ourselves about psychological trauma and its after-math and to try to understand better the ways in which trauma had wounded our patients and interfered with, or distorted the development of their personalities. We read, we studied and we attended conferences.

My own interest in trauma had begun much earlier in the 1960's, when I had the opportunity to study with two very different psychiatrists, both survivors of concentration camps during the Holocaust. One was Dr. Bruno Bettleheim at the University of Chicago; the other was Dr. Viktor Frankl, author of Man's Search for Meaning. Some of the ideas I'll be talking about spring from Dr. Frankl's notions about freedom.

As our department at Seattle Mental Health Institute continued to educate itself about trauma, I found myself growing increasingly interested in a sidelight of the topic. At international conferences on traumatic stress, after hearing speakers talk about their work in third-world prisons or refugee camps

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or sexual assault centers or emergency rooms, I found myself wondering, how the speakers were doing, how healthy they were, how they slept, how they experience their own lives and loves. So I made a point of talking with them and asking some of those questions. What I found was that all of those I spoke to, and there were many, had experienced painful changes in their own lives resulting from their work. One presenter, in answer to my question, told me that his stress responses had become increasingly exaggerated in the years since he began doing trauma work. He said that he frequently found himself experiencing a feeling of foreboding as he drove home from work, flooded with worry about the safety of his family. If he were to hear a siren while driving home, his heart would race, his palms would sweat, and he'd feel certain that his son had drowned in a pond near their home. He would arrive home shaken and exhausted. We know now that he was suffering from vicarious traumatization. Over the years, I have heard similar stories of the enormous emotional cost of working with severely traumatized individuals, and still, I've often missed noticing vicarious traumatization, when it was too close to home.

I had a wake-up call some years ago, when I was teaching an undergraduate class at Seattle University. As part of the course, I had invited two colleagues to talk to students about their work. One was a woman, who worked with pre-school children in day treatment. The other was a male social worker, a Viet Nam vet, who worked with adults. After, each of their talks, which were thoughtful and informative, students came to talk with me after class and asked, "Is he O.K.? He seemed really sad and didn't look so good. Was she O.K? She didn't seem O.K." On reflection, I knew neither one was O.K. Both were, in fact, quite depressed and the veteran was still experiencing unresolved post-traumatic stress. How was it that it took, high-spirited under graduates to call it to my attention? I asked another colleague what she thought and she said, "Well I don't think we're a good judge of how we're doing, because we work together and look at each other, and we may be all going down together, and thinking we're just fine." Last week, when I asked her if she remembered that conversation, she did, and she told me that she now believes that she was struggling with vicarious traumatization at that time and that for her the symptom was her difficulty keeping professional boundaries. She said that she had been ashamed of her tendency to talk about cases at home or with friends. But, she now believes that her desire to talk inappropriately was a function of her carrying too much trauma material without adequate support. Now, as a seasoned therapist, she provides herself with regular, high-quality supervision and consultation, and she leaves work at work, and has energy and vitality for her personal life.

For the past decade, my primary professional interest has been "care for the care-givers." How do we support the well-being of those working on the front line, those, like the mental health professionals, who see people in their most desperate moments; those who must keep their heads clear enough to do a thorough assessment in the midst of the energy generated by mental illness, by traumatic events, by angry or frantic family members and by over-worked and under-staffed clinics and emergency rooms?

In 1995, Laurie Ann Pearlman and Karen Saakvatne wrote Trauma and the Therapist. They made a powerful case for their belief that vicarious traumatization is a real and on-going danger to people who "as part of their job, hear and bear witness to trauma survivors' experiences." They say: "Vicarious traumatization is a process not an event. It includes our strong feelings and our defenses against those feelings. Thus, vicarious traumatization is our strong reactions of grief, rage, and outrage, which grow as we repeatedly hear about, and see people's pain and loss, and are forced to recognize human potential for cruelty and indifference, and it is our numbing, our protective shell, and our wish not to know, which follow those reactions. These two alternating states of numbness and over-whelming feelings, parallel the experience of PTSD."

What I have witnessed in this last decade is a growing awareness of this danger on the part of supervisors, employers and clinicians. More clinics, agencies, hospitals, and businesses offer increased staff support. Some offer on-going support groups for their employees; many more offer debriefing groups, after particularly traumatic events, but as a person, who often facilitates such groups and conducts staff debriefings, I have seen another tendency. After a period of sensitivity and commitment to staff support (almost always championed by an administrator or manager, dedicated to the emotional well-being of her staff), time passes, several years perhaps, and then, there is a shuffle in administration or a new supervisor, and gradually, financial restraints increase and commitment to staff support decreases. The budget won't support extra staff to allow workers to attend the groups. Sometimes, other state-required

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trainings are scheduled at the time, previously reserved for staff support, and, little by little, staff support is seen as an unaffordable luxury. If it is retained, it is offered so infrequently that it lacks the intensity and continuity to be of any measurable therapeutic value to workers at risk for vicarious traumatization.

Pearlman and Saakvatne warn us that "one's work setting has a profound effect on his or her vulnerability to vicarious traumatization. Vicarious traumatization is a reality, yet many agencies that deal with traumatized clients operate out of misguided beliefs that feelings are unprofessional and have no place in the work place. This short sighted and unrealistic view increases the risk of vicarious traumatization for professionals within the organization and ultimately for the organization as a whole. It endangers clients and treaters, and it hurts organizations, through employee attrition, absenteeism and professional misconduct."

In a group of this size, I'm guessing that there is a fairly wide range of stress levels. Some of you may feel stimulated, but not stressed by your work; others may feel the first twinges of "compassion fatigue;" some may be flirting with burn-out, and others may be suffering from some aspects of vicarious traumatization. I'm going to ask you to reflect on your own experience, but first I'm going to read a list of the factors, that are known to contribute to vicarious traumatization. They are factors about our clients, about ourselves, and about the context we work in. The factors identified in Trauma and the Therapist, are outlined below:

Our Clients:

- Their multiple problems and limited resources.
- The horror of their abusive histories.
- The poignancy and intensity of their suffering.
- The crisis of a recent traumatic experience.
- The difficulty of their interpersonal style, often developed in response to untrustworthy or exploitative contexts.
- Their idealized or intense negative expectations of the helper.
- Current dangers they may be facing.
- The terror and shame that keep them paralyzed.
- Helplessness and vulnerability of child clients.
- Their self destructive behaviors, self-hatred, despair and chronic suicidal wishes.

Ourselves, the Helpers:

- Unrealistic expectations for oneself as a professional.
- A personal history of trauma, that may be re-awakened by client material and make one particularly sensitive to certain transferences or expectations from clients.
- Unfounded beliefs about the value of stoicism or non-responsiveness that leave the professional ashamed and silenced about her feelings.
- Personal coping strategies that do not help or carry heavy costs (e.g. addictions, numbness, isolation).
- Current stressful personal life experiences.
- Working in areas in which a helper has insufficient training or inadequate theoretical understanding of the issues.
- Reluctance or barriers to using supervision and consultation, seeking continuing education or taking vacations.
- Being new to the field of trauma work.

Our Context:

- A social context that denies or underrates trauma and its aftereffects.
- A political context that under funds psychological treatment for trauma.
- A cultural context that blames the victim and glorifies violence and victimization as entertainment.
- An organizational context that treats clients disrespectfully.
- An organizational context that fails to provide staff the resources necessary to do the work they believe they can do on behalf of their clients.

"Service organizations must recognize that addressing vicarious traumatization is part of a reasonable standard of practice for any profession that entails direct service to traumatized clients. The cost of not doing so is immeasurable. At a time when much of our work is under scrutiny from several angles, we cannot fail to protect our professions by maintaining high standards of ethics, professionalism, and effective care. Supporting trauma workers also benefits organizations financially as it decreases absenteeism, employee

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TRAUMA AND STRESS CONTINUED FROM PAGE 9

turnover, and unethical practices." Laurie Ann Pearlman and Karen Saakvatne

We know that in many settings we will not get adequate support to prevent vicarious traumatization. My goals for today are that I leave you with a heightened awareness of the personal demands of doing mental health work and that you take with you two tools that are so simple and so effective that you'll actually use them to manage stress and to protect and improve your own physical and emotional health.

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)

Psychotherapy of disorders of the self with trauma

Steve Reed, PhD was the main presenter on the opening day of the conference. The following article, which he wrote for the *Frontlines*, gives a flavor of his interesting notions about personality disorders.

The treatment of personality disorders, or also known as disorders of the self with trauma, (specifically sexual and physical abuse) is a complex and yet relatively under-addressed issue in the clinical literature. Extensive writings have addressed the treatment of personality disorders, such as the writings of Masterson, Kohut, Kernberg, and Gunderson, as well as writings in the field of traumatology, such as van der Kolk and Courtois. However, comparatively there has been little written on treating disorders of the self with trauma in a systematic and integrative fashion. This is surprising when you consider current document findings show a prevalence rate of disorders of the self seen by psychoanalysts to be approximately 46% in private practice and that further research shows that 30% to 50% of borderline patients meet the posttraumatic stress disorder criteria. Needless to say, there is a significant percentage of patients in outpatient practice who have disorders of the self with a compounding factor of trauma. What makes the treatment of these cases so difficult is often it requires the clinician to balance out character work and trauma work.

In understanding the etiology of disorders of the self, Dr. James Masterson has written extensively on the topic of disorders of the self emerging out of disordered attachments with the primary caregiver. What he essentially says is that the caregiver, limited in her ability to provide a secure attachment for a child, impairs the developmental blossoming of the real self of a child. This abandonment of the child's real self produces an abandonment depression. As a child protects against this abandonment depression, they construct defenses that turn into the false defensive self. The Masterson approach has been strongly validated by research in interpersonal neurobiology.

Interpersonal neurobiology has validated the profound impact that disordered attachments have on the "self" of the child. This research also highlights the importance of a secure attachment for the infant in the first years of life. In fact, as early as 10 to 12 months of age, the internalization of the working attachment model can be measured and it continues to consolidate from there, thus making attachments and object relations theory clinically relevant and crucial in understanding how to conceptualize and treat the disorders of the self.

Part of this understanding is seen in the character work of the disorders of the self, in which Masterson has said that the self of the patient upon presenting into therapy is like a sieve initially. The goal of the character work is to build a strong enough container, or ego strength, by plugging up holes in this container of the self in order to be strong enough to contain or metabolize the affects of the abandonment depression and other related abuse. The character work is essentially based upon the triad concept of the disorders of the self. This concept states that self activation leads to the abandonment depression, which in turn leads to defense. This concept is powerfully efficacious in that it encapsulates the totality of treatment.

Essentially this triad helps to focus therapy on activating the real self of the patient (for example, areas of separation, individuation, and attachment), while processing and regulating the core affects (abandonment depression) that have prevented the blossoming of the real self and then focus on defense analysis as it dismantles the false defensive self. These three components of the triad form the three primary cornerstones of the character work. There are different triads for each of the disorders of the

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"Mental health problems do not affect three or four of every five persons but one out of one."
Dr. William Menninger (1957

DISORDERS OF SELF CONTINUED FROM PAGE 10

self. Generically speaking, these triads are: The borderline triad: competence leads to abandonment leads to regression. The narcissistic triad: imperfection leads to painful vulnerability leads to grandiosity. The schizoid triad: connection leads to danger and leaves a safe distance. Thus as the triad informs a therapist of what to focus upon and listen to, as well as show what the core dynamics are, it then allows a therapist to empathically attune to the patient's experience (conscious and unconsciously). This then helps to discern the difference between the real self and false self of the patient. Often, however, the patient nor the therapist knows the difference between the patient's real and false self, but as therapy helps the patient dismantle the defenses of the false self and attune more to the real self, a therapeutic alliance is made possible.

In addition, the triad of disorders of the self has several therapeutic benefits. One being that it strengthens the patient's sense of self, enabling the person to move towards higher levels of self activation and functioning. Secondly, it also potentially allows, I believe, for the therapist to zero in on the core dynamics and primary affects quickly and effectively. By knowing the specific triad of the patient, the therapist can identify the underlying object relation units (pathological interpsychic attachment templates), which are the source of the core affects of the abandonment depression. Winnicott advocates knowing one's theory so well as it is "in one's bones" in order to enable or intellect, to go on cruise control, so we are better able to immerse ourselves deeply into the phenomenology of the patient's experience. This emersion or empathic attunement is largely an unconscious phenomenon mediated by the right hemisphere. Case in point, research has shown that the right brain can appraise facially expressed emotional cues in less than 30 milliseconds, far below the perceptible conscious level of what we are actually aware of. As the character work consolidates and progresses, often it allows the trauma to emerge behind the dissociative wall spontaneously.

The trauma work is essentially a deeper level of the Masterson concept of the working-through phase. At the core of the working through, is the letting go of the wish for reunion or the need for love and connection to the parent. This is particularly true when the parent is the abuser (an attachment paradox: one's protector is the predator, creating a disorganized attachment. The difficulty of giving up or grieving the wish for reunion is related to the degree of trauma and the attenuating degrees of annihilation anxiety and sadism. The annihilation anxiety is exacerbated when there is a threat of physical death (for example, being choked, beaten into unconsciousness, violently attacked). Furthermore, when dissociation is involved, it often turns traumatic memories into tormenting flashbacks or disruptions in mental consciousness; for example, dissociative states.

Therefore, the treatment stance for trauma work is different from that of the character work. In character work the treatment stance is one of therapeutic neutrality, as it assumes the patient is able to manage their affects, giving a vote of confidence to the patient, whereas in trauma work the treatment stance is more actively supportive in that it acknowledges that the trauma has overwhelming affects and the patient is not able to manage it on their own. Thus the interplay between character work and trauma work is often a progressive complicated therapeutic issue that challenges us therapists in being able to deal with our more traumatized clients in a safe, progressive framework. The workshop that will be presented in September will further illustrate and practically expand upon doing psychotherapy of the disorders of the self with trauma.

Dr. Reed is on the faculty of the Masterson Institute for Psychoanalytic Psychotherapy. He has a private practice in Belleville, WA.

SB 5763 provides money for mental health jail-transition

The Washington Legislature passed SB 5763 this past legislative session providing funding for transition services for mentally ill offenders while confined in a county or city jail. These services are intended to facilitate transition to programs that offer mental health services upon mentally ill offenders' release from confinement. This includes efforts to expedite applications for new or re-instated Medicaid benefits.

Utilizing funding provided by the Legislature to

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TOPICS FOR CONFERENCES

One of the main concerns of the Executive Committee and those planning WACDMHP conferences and workshops is to present topics that are timely and relevant to the DMHP profession.

The conference planners would like your suggestion for topics. Please contact either:

Sharon Nations at 206-296-5296
or
Ian Harrel at 360-528-2590

WPAS Wins Victory in *Pierce County v. State of Washington*

by David Lord
October 18, 2005

Last month, the Washington Protection and Advocacy System (WPAS) and Pierce County Regional Support Network (RSN) won a stunning victory for Washington State mental health consumers in *Pierce County v. State of Washington*. This lawsuit was originally brought by Pierce County RSN and WPAS joined the court case as a plaintiff almost two years ago. Ira Burnim, the legal director of the Bazelon Center for Mental Health Law, was also an attorney on the case.

The case is not yet completed and a trial is scheduled for November. However, the judge has already made two significant rulings and a major part of the case settled. As a result, people who use State mental health services have won three important victories:

- The State must provide appropriate treatment for long-term hospital patients.
- Western State Hospital has a new discharge policy that will be monitored by WPAS.
- The State can no longer automatically take money away from community service providers when too many patients are admitted to Western State Hospital.

Treatment for Long Term Hospital Patients

On September 9, 2005, Thurston County Superior Court Judge Paula Casey ruled that the State is responsible for taking "custody" of patients with 90 or 180 day civil commitments. This means that the State can no longer refuse to treat these patients when Western State Hospital (WSH) is full.

The State left many patients with 90-day and 180-day commitments at community hospitals, emergency rooms, and sometimes even jails. As a result, these patients were stuck in "evaluation and treatment" and other facilities. These facilities are not designed or licensed to provide long-term psychiatric hospital care. Patients who have longer commitments don't receive adequate treatment in these short-term facilities.

As a result of the Judge's ruling, the State must take "custody" and it seems likely that the State will have to open a new ward at WSH. However, an increase in hospital beds should only be a short term strategy to address the Judge's ruling. In the long term, more effective community supports should be put into place.

"Life itself remains a very effective therapist." -Dr. Karen Horney (1957)

WPAS to Monitor State Hospitals Discharges

As a result of a partial settlement of the lawsuit, Western State Hospital has a new discharge policy. The new policy requires that patients be psychiatrically stable at the time they are discharged, and they cannot be discharged to a place that is likely to cause their mental illness to become worse. The implementation of this policy will be monitored by WPAS. The State agreed to the policy after WPAS and the Pierce County RSN showed that numerous hospital patients had been inappropriately discharged from the State psychiatric hospital. Patients were sent to the streets, homeless shelters and other unsafe situations.

WPAS began its investigation over two years ago after receiving reports of people being discharged to the streets. "The investigation was hard work – and you couldn't do it from the office," explains Debbie Dorfman, WPAS Legal Director. "Legal team members interviewed homeless people in shelters, streets, and jails. We found out how bad the 'patient dumping' was at Western by talking to the people who experienced it. For example, some people had to walk to shelters in downtown Tacoma from WSH." There was no discharge policy at Western State Hospital.

The investigation took months to complete. WPAS staff visited shelters, soup kitchens, boarding homes, clinics, and community providers. Many people were interviewed and the records of many patients were examined.

WPAS investigator Craig Awmiller was swamped in paper. "The documents! There were thousands of them. We pored over files for months. We reviewed records at Western, at community agencies, and records from the State," Awmiller said. "Then, we had to get examples of discharges to the experts. They determined whether or not the discharges were up to professional standards."

The WPAS team found many instances of poor and unsafe discharges. An examination of Western State Hospital patient discharge records by a national expert, Dr. Ivor Groves, found that 46 percent of those discharges did not meet professional standards. Another expert, Dr. John R. Elpers, UCLA Professor of Psychiatry, stated that "in regard to discharge planning, [Western State Hospital] treatment teams are indeed doing the same unsuccessful thing over and over again . . . that places their patients at risk of suffering immediate and irreparable harm."

Community Services Cannot be Punished when Patients are Admitted to Western State Hospital

Judge Casey also ruled that the State cannot

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charge the Pierce County Regional Support Network "liquidated damages" for admissions to Western State Hospital. These charges reduced the money the RSN has available to provide community services by over $1 million per year.

For several years, the State has set a limit on how many patients can be admitted to the state psychiatric hospitals from each Regional Support Network (RSN). When there are more admissions than this limit, the State automatically charges a penalty against the community providers. The theory is that the community providers will do anything to avoid having their clients admitted to the State hospital, because they will have to pay a huge penalty if there are too many admissions.

WPAS supports the goal of serving people with psychiatric disabilities in the community. However, as Awmiller puts it, "the State's method for reducing hospitalization makes no sense. They are actually taking away the money from community providers when they don't succeed in avoiding hospitalizations. That's backwards. Community providers need more resources, not less, to keep their clients out of Western."

Instead of punishing failure, the State should mandate that community providers use services that have been shown to be effective in preventing hospitalization. However, these services don't come free. Siphoning money out of the community through liquidated damages only makes the problems worse.

The money taken away from the community as liquidated damages should be used to pay for individualized, wrap-around services. Instead of requiring a client in crisis to go to a community mental health center or other agency, services and supports travel to the client. WPAS will advocate for the development of these sorts of community services.

Potential Impact of the Settlement and Orders

The partial settlement and Judge Casey's orders in this case have major implications.

1. First, the court's requirement that the State take responsibility for long-term patients will increase the size of Western State Hospital in the short term – but patients will no longer be kept in community facilities, including jails, that aren't able to meet their needs.
2. Second, WPAS will closely monitor the discharges from WSH and will challenge the State when discharges don't meet the policy's standards.
3. Finally, the end of liquidated damages could result in the restoration of millions of dollars to community programs.

The Pierce lawsuit shows that reducing the size of the State hospitals is not a worthy goal if the result is patients dumped onto the streets or denied hospital care when they need it. Downsizing must be done appropriately and safely. The lawsuit also affirms that well-funded, quality community services are a solution for many of the serious problems of the State's mental health system.

This article has been reprinted with permission from the Protection and Advocacy System (WPAS).

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

Pierce County lawsuit update by CEO

The following is a summary written by Fran Lewis, CEO of Pierce County Human Services in Tacoma, to her staff, providers, and RSNs; that describes the outcome of the lawsuit between Pierce County and the State of Washington, compliments of Fran Lewis. It is not yet clear how these rulings will play out in other regions of the state, but we do know that things are likely to change as a result of this legal process.

At last the trial of Pierce County vs. the State of Washington has concluded. After eight days in trial, the judge ruled on the Wednesday before Thanksgiving. Until we receive her written rulings, here is a brief (non-legalese) summary:

1. Long Term Patients - Judge Casey had ruled in September that the State must take responsibility for patients committed to Western State Hospital for 90 or 180 days from Puget Sound Behavioral Health and failure to admit by WSH was a failure to meet their obligation. If WSH does not take the patients, then the State is responsible for payment for their care at PSBH. The judge ruled last week that Pierce County RSN will be paid retroactively and into the future for their care if they remain at PSBH, at the RCC rate in effect at the date of treatment, and interest should accrue from the billing date of the retroactive billings.

2. Liquidated Damages - Again Judge Casey ruled in Summary Judgement in September that the State has no authority to levy such damages. Last week her decision on recovery of these damages was that there should be a "special remedy" which she proposed. She felt that since the RSN withheld the amount from the providers that the state withheld from the RSNs for the liquidated damages, the RSN

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Dreams have only one owner at a time. That's why dreamers are lonely. –Erma Bombeck, author (1927-1996)

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was not hurt; likewise since the providers did not provide the services the withheld money might have paid for, they were not hurt; but she didn't want the state to benefit, so she ordered the liquidated damages be paid to the RSN with interest and put in a special fund to be used for "more and new services". The RSN will be required to develop a plan for the use of the funds (uncertain if the plan goes to the judge and/or MHD but the court will be monitoring). I felt like she had remembered our agreement with the State last February and this order will allow us to fulfill some of our plans for new services.

Obviously we were very pleased with both of these rulings, along with the prior ruling on discharges that will be monitored by Washington Protection and Advocacy Services.

3. Contract issues - The final issue was more complicated and we knew it would be difficult to gain the judge's understanding and also that the State would strongly oppose our case. I believe the judge does understand and she did a great job of "dividing the baby" and so with some procedural changes, things remain pretty much the same on this issue. I will wait for the written rulings before I even try to explain this one!!

When we get the written decision(s) I will clarify any confusion my brief summary may cause.

I need to express my appreciation to the attorneys and staff at Bennett, Bigelow and Leedom. After working with them for 3 ½ years it is hard to believe that we have reached closure. They were just terrific! Of course we are fully aware that there could be an appeal.

We also thank WPAS for joining as co-plaintiffs and the work that Debbie Dorfman and the rest of the staff contributed to the cause.

Pierce County is most indebted to the RSN staff for the life consuming tasks of discovery, depositions, preparing for the trial and the hundreds of hours of time put into the effort. Dave Stewart and David Dula have given long hours, weekends, and most waking moments to THE lawsuit. It took over our lives. Fiscal staff, IS staff, Diana Fitschen, Providers, Pete Philley and so many more have also given huge amounts of time and effort. My heartfelt thanks to each of you. And now it is over.

The real victory is what we have gained for our consumers. I am proud that we had the courage to take on this fight. As in other instances, Pierce County RSN has led the way and although these rulings were only for Pierce County, I believe other RSNs will benefit in time as well.

Fran Lewis

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It is easy - terribly easy - to shake a man's faith in himself. To take advantage of that to break a man's spirit is devil's work. -George Bernard Shaw

Memo from CEO of Western State Hospital

To: All Staff Western State Hospital
From: Andrew J. Phillips, Ed.D
Chief Executive Officer

Subject: Western State Hospital Expansion

You may have read in the news or heard elsewhere that there has been a recent court decision in what we refer to as "The Pierce County Lawsuit." This decision will have an impact on Western State Hospital and the way we do business. Historically, in an effort to control overcrowding on the wards, the hospital has been able to defer some admissions to other hospitals until bed space becomes available. Also, we have had the option of charging Regional Support Networks (RSNs) liquidated damage dollars if they over-used the bed space that was allotted to them in their contracts. The recent court decision took away both of those options in Pierce County.

First, the recent court decision will cause our admission process to change significantly. Effective December 9, 2005 WSH will admit Pierce County patients who have a 90 or 180-day civil court order within 24 hours of receiving the admission request. These are the very patients that in the past we have been able to defer to community hospitals until bed space opens here or they were placed in community programs. The effect of this will be a substantial increase of Pierce County admissions to WSH.

Secondly, it will now be more difficult to impose liquidated damages on Pierce County when/if the county over-utilizes the bed space allotted in their contract. This decision will likely slow discharges. It is possible that these two court rulings will set a precedence (sic) for other counties to follow.

Anticipating an increase in admissions and a delay in discharges has lead (sic) us to request emergency funds to open at least one additional ward. The new ward will open just prior to December 9th, the effective date of the judge's order. The long-term effect of these court decisions remains to be seen; however, the Mental Health Division and hospital administrators will be keeping a close watch on the impact, and will continue to analyze the need for further planning to ensure overcrowding does not occur.

We are pleased to be a part of state-wide workgroups that are focused on evaluating the needs of the mental health system in Washington. It appears that there will be much effort put forth over the next few years to enhance community services to a degree that once again our patients may have more and better options for placement in their home communities. As we all know, the best recovery successes are likely to occur with adequate and appropriate supports in place in the community. We will

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The soul would have no rainbow had the eyes no tears. - John Vance Cheney, poet (1848-1922)

WSH MEMO ON EXPANSION CONTINUED FROM PAGE 11
continue our efforts to assist in that regard.

I want every Western State Hospital employee to know that the work you do is important and should never be minimized. You work with difficult challenges daily, and your work is highly regarded throughout the state and across the country. I take great pride in knowing that we have very caring dedicated employees here, who have only the best interest of our patients in mind. We must look at this recent development as an opportunity for our state to learn and develop. We are hopeful that with community service enhancements, the up-sizing of WSH will be a temporary step towards an overall better mental health system in the State of Washington. I will keep you informed as things progress.

Printed with permission from WSH.

A quiet conscience sleeps in thunder. -English proverb

JAIL TRANSITION PROGRAM CONTINUED FROM PAGE 11
DSHS – Mental Health Division, counties can explore implementing a best practice approach to community re-entry from jails. Some agencies are using the APIC (Assess, Plan, Identify, Coordinate) Model developed by Fred Osher, Henry J Steadman., and Heather Barr. The model is described in *A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-Occurring Disorders: The APIC Model*. This model is a product of the National GAINS Center operated by SAMHSA. The model recognizes that almost all jail inmates will leave correctional settings and return to the community. Inadequate transition planning puts people who enter jail in a state of crisis back on the streets in the middle of the same crisis.

The outcomes of inadequate transition planning include the compromise of public safety, an increased incidence of psychiatric symptoms, relapse to substance abuse, hospitalization, suicide, homelessness, and re-arrest. The APIC Model is a set of critical elements that, if implemented, are likely to improve outcomes for persons who are released from jail.

The APIC Model	
***A**ssess*	Assess the inmate's clinical and social needs, and public safety risks.
***P**lan*	Plan for the treatment and services required to meet the inmate's needs.
***I**dentify*	Identify required community and correctional programs responsible for post-release services.
***C**oordinate*	Coordinate the transition plan and avoid gaps in care with community-based services.

The APIC Model builds from a base of interagency coordination that crosses the justice, mental health and substance abuse systems. Therefore, agencies need to determine if they want coordinating agreements between these systems to be formal and include processes for referral and transition planning.

The agreements between the mental health provider and jail can include detailed referral procedures as well as a methodology to compare jail booking information with mental health service data to facilitate the identification of persons potentially requiring mental health services.

The APIC Model consists of four major conceptual elements, assess, plan, identify, and coordinate.

Assessment of clinical and social needs

Assess the inmate's clinical and social needs, and public safety risks. This will be accomplished by deploying staff to identify and accept referrals for intake of individuals who are not enrolled in community mental health services but who meet priority populations as defined in 71.24. Varying staffing levels will be deployed to each facility based on demand. Regularly scheduled hours in each facility will be supplemented with urgent services as necessary. The assigned staff will conduct mental health intake assessments for these individuals.

Planning for current needs

Plan for the treatment and services required to address the inmate's needs. Assigned staff will coordinate with other stakeholders and systems to provide transition planning to identify and remove barriers to successful re-entry prior to the inmate's release from jail.

Identification of future needs

Identify required community and correctional programs responsible for post-release services. The assigned staff will develop relationships with key community and correctional systems to develop seamless transition points. A critical example of this type of activity is the development of formal agreements with local CSO to facilitate expedited application for or reinstatement of medical assistance for inmates. The assigned staff will assist individuals with mental illness in completing and submitting applications for medical assistance to the local CSO prior to release from jail. In addition, staff will work with inmates to plan for services such as post-release housing, co-occurring disorders treatment and on-going mental health services.

Coordination of services

Coordinate the transition plan to ensure implementation and to avoid gaps in care with community-based services. The assigned staff will provide care coordination and service brokering to insure that the transition plan is implemented. This may include intensive post-release outreach to ensure individuals follow up with CSO and appointments for mental health and other services and monitoring of transition plan implementation.

Additional activities can be continued or implemented to assure integration with existing jail programming and improved psychiatric assessment. Psychiatric assessment services may be made available in the County jail as funds are available.

Worth begets in base minds, envy; in great souls, emulation. –Henry Fielding, author (1707-1754)

New officers elected for two positions One retained as Treasurer

Ian Harrel was elected President of the Washington Association of Designated Mental Health Professionals. Ian recently accepted a new position with Behavioral Health Resources with Thurston Mason County as emergency services program manager.

Three positions on the WADMHP Executive Board were filled at the fall conference in Federal Way. Ian Harrel, formerly 1st Vice President, was elected President. Ian supervises the crisis team-, including the DMHPs and supervises a 10 bed mental health stabilization unit with Behavioral Health Resources in Olympia. He will be managing the soon to be opened crisis Mental health triage center. The position of 1st Vice President was filled by Scott Kuhle. Vicki Bringman, current treasurer, was re-elected as treasurer. The terms begin January 1st.

The officers, who must be a DMHP, attend the four annual executive board meetings, and participate in the monthly teleconference calls. Each of these positions is a term of two years.

Gary Carter, retiring President, will serve for two years on the Executive Board as President Emeritus. Gary also served the association four years as treasure.

Mental Health Division liaison shares thoughts with association members

Greetings from Olympia,

As the Mental Health Division (MHD) liaison to the Designated Mental Health Professional (DMHP) Association, I have been asked by the association if I would be willing to be a regular contributor to *Frontlines*. I think our vision for this is that it will be an opportunity to share important news from the division as it relates to crisis services. As we

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DAVID KLUDT CONTINUED FROM PAGE 16
prepare for the up-coming legislative session, and the completion of the RFQ process, I am sure there will be plenty to write about. I am very pleased to do this and certainly hope my contributions will be worthwhile.

The Mental Health Division along with so many others was truly shocked and saddened at the tragic death of Marty Smith a Designated Mental Health Professional from Kitsap Mental Health Services. Mr. Smith was apparently killed while doing a crisis outreach. Our thoughts and prayers go out to Mr. Smiths' family, the employees of Kitsap Mental Health, and to all of our community mental health providers who daily, in their efforts to serve our consumers must make difficult decisions in how and where to serve them. In each agency these decisions are guided by protocols and policies that are put in place to make every effort that we as first responders are able to do our jobs in as safe a manner as possible.

In 1978, I began my career in community mental health as a DMHP at Kitsap Mental Health. I vividly re-call one of my very first cases, in which I was called to respond to an individual reportedly suicidal. I assessed the situation, and followed the agency policies including the option of taking another staff member, which I did. During the course of our evaluation at this individual's home he suddenly pulled a machete from underneath of the mattress that he was sitting on and came after us. We were very fortunate to escape unharmed. Policies were followed and yet a decision still needed to be made regarding, asking for law enforcement to accompany or transport the individual to a safe and secure setting It is these and many other difficult decisions that all of us are struggling with and looking at our policies and procedures.

I would like to take this opportunity to ask for your assistance. In early 2006 I would like to convene a group to address issues related to staff safety. At this time I am interested in hearing back from those of you who feel this might be helpful and might be willing to work with me to make it happen. Please contact me during the month of January with your interest and ideas.

As we enjoy this wonderful time of year with our families, friends, and co-workers please take a moment to remember Mr. Marty Smith and his family.

Be safe and have a wonderful holiday season!
David Kludt, Program Administrator

David may be contacted at the Mental Health Division (360) 902-0786 or by e-mail at: kludtdj@dshs.wa.gov

WADMHP loses Gary Rose as liaison to the Regional Support Administration

Gary Rose resigned as director of Timberlands Regional Support Network effective October 30, 2005. The RSN covers Lewis, Pacific, and Wahkiakum counties. Gary served as the liaison between the RSN Administrators and WADMHP.

When the executive board determined that it was important to have the association's issues represented at the RSN Administrators level, it was natural that they would request that Gary fill that role because He had been a CDMHP and continued his interest by attending WADMHP conferences and workshops.

Gary had served a term as president of the association. Not only did Gary bring the needs of the association to the RSN Administrators, but he was an advocate for DMHPs. At conferences Gary added his voice to discussions, and could be depended upon for stimulating conversation at the social gatherings and in the hot tub.

The WADMHP board and members wish to thank Gary for his dedicated service to both the association and persons with mental illness.

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

The Washington Association of Designated Mental Health Professionals and Western State Hospital Conference

"Differentiating Symptoms of drug abuse versus mental illness"

Featuring

Dr. David Scratchley

Dr. David Scratchley serves as Director of Clinical Education at Lakeside-Milam Recovery Centers. Additionally, he holds the position of Director of Operations at Children's Hospital for Cystic Fibrosis research. He is a spokesman for a nationally recognized educational video series, including a new video on how children can cope with bullies called "*Gum in my Hair*."

In 2003, Dr. Scratchley received the prestigious John Horngren award for excellence in treatment in Washington State presented by the adolescent chemical dependency treatment providers. Dr. Scratchley serves on the board of the Matt Talbot Center. He has been acknowledged by 248 judges, including the Washington Supreme Court, for providing excellence in education regarding treatment and the brain.

Dr. Scratchley is the co-author of a widely used textbook on addiction. He is a well-known forensic expert witness on the relationship between addictive drugs and violent behavior. Dr. Scratchley was educator of the year in 1995 in the field of addiction studies for Washington State. His positions have included: Clinical Director for Seattle Children's Home and faculty member at Seattle University from 1988-2002.

Dr. Scratchley holds a Ph.D. in neuroscience and psychology, including five years of post-doctoral training in clinical psychology.

Friday, February 24, 2006

8:00 -8:30	Registration
8:30-8:45	Introductory remarks: WSH CEO; and Ian Harrel, WADMHP President
8:45-9:00	Remembering Marty Smith, DMHP
9:00-10:30	"Differentiating symptoms of drug abuse versus mental illness" - Dr. David Scratchley
10:30-10:45	Break
10:45-12:15	Continuation of "Differentiating symptoms" - Dr. David Scratchley.
12:15-1:15	Lunch.
1:15-2:15	Continuation of "Differentiating symptoms" - Dr. David Scratchley
2:15-3:15	Final presentation of "Differentiating symptoms" - Dr. David Scratchley
3:15-3:30	Break
3:30-4:30	Civilly Committing Chemically Dependent Clients - Rebecca Bird, D.C.D.S.

- The conference fee for members is $45.00 and for non-members is $65.00. This includes lunch, refreshments, and snacks.
- **Special:** If you register as a non-member ($65 fee), you can receive one-year WADMHP membership and newsletter without additional charge. Enclose a check or money order payable to *WADMHP.* No purchase orders please.
- Lunch is included in the registration fee. Registrations are limited to the first 125, so register now.
- **NO** day of conference registrations will be accepted. Registrations postmarked after February 20, 2006 subject to space availability.

Directions to WSH from I-5

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

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

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

For further information contact Ann Taggart at (253) 879-7965 or James Jones at (253) 798-2709.

REGISTRATION FORM

Western State Hospital
2003 Spring Workshop
February 28, 2003

Name: ______________________________

Address: ______________________________

City: ____________________ State: __________ Zip: __________

Home phone: (________) ____________________ Work phone: (________) ____________________

Employer: ____________________ County: __________

☐ WADMHP member ☐ Non member

Would you like to become a WADMHP member at this time? Y___ N__

Are you a WSH employee? Y___ N___ If so, we will bill WSH for your registration.

Are you currently a DMHP? Y___ N___

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

Enclose a check or money order payable to **WADMHP.** No purchase orders please.

Signature: ____________________ WADMHP Identification Number: 923161171

Detach and mail this form with payment to:

Staff Development
16-223Western State Hospital
9601 Steilacoom Blvd. S.W.
Tacoma, WA 98498-7213

The Washington Association of Designated Mental Health Professionals
and
Western State Hospital Conference

February 24, 2006

"Differentiating Symptoms - drug abuse versus mental illness"

Western State Hospital
9601 Steilacoom Blvd. S.W.
Tacoma, WA

Washington Association of Designated Mental Health Professionals
PO Box 5371
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