Frontlines

Washington Association of Designated Mental Health Professionals

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President's Letter

It is often interesting to work in publicly funded systems during legislative sessions and this year is not an exception. At the writing of this letter, there are at least 11 separate legislative bills in the public health and human services committees of the Washington State House and Senate. Three of these bills would have direct impact on behavioral health crisis services. This letter will not detail these bills as they have not (or not yet) passed into law. It is important that DMHPs and allied professionals are at least aware of these bills, and if so inclined, take the opportunity to comment to their legislators.

The three bills for crisis services to watch are SB 5533, HB 1456, and HB 1420. One other note on systems changes is the DMIO (Dangerously Mentally Ill Offenders) program has changed its name to CIAP (Community Integration Assistance Program (Please see article on page 11). Watch the DMHP website for updates on any related legislation that passes this year. As always, the DMHP association will provide training related to any state legal or procedural changes at our annual conferences.

The DMHP website has experienced some recent problems including some short periods when it was completely down. These problems have been corrected and the site is up and running again. Please remember that when the law changed CDMHPs to DMHPs, the association also changed our name and website to WADMHP.

The Washington State Mental Health Division is in the second half of the fiscal biennium and the 3rd and 4th installments of the state DMHP boot camps are being planned though WIMIRT (Please see article page 12). The DMHP association worked with the MHD to coordinate and facilitate two "Safety Summits."

The Summits were designed as a first step in identifying statewide needs and best practices related to worker safety. The DMHP association's report summarizing the safety surveys and recommendations presented at the safety summits has been provided to the MHD and the association will post that report when it becomes a public document from the state. The DMHP association will continue to work with the MHD where appropriate on all DMHP related issues.

Also new for DMHPs is the reality of doing GAIN-SS CD assessments. This requirement has what we assume is unintended consequences of attempting to gather subjective information from clients who may be less than inclined to participate or be unable (due to their mental health symptoms) to appropriately participate at the time of a crisis or an ITA investigation. The DMHP association has provided feedback on our belief that this instrument is not useful in the work we are tasked with doing and in fact serves as a distraction. However, as this is current law the association will provide information about the at upcoming trainings. The late winter and early spring are often the busiest times for crisis services and this year is not an exception across the state.

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Plan on attending an exciting Spring Conference

Editor's Notes:

A Japanese company (Toyota) and an American company (General Motors) decided to have a canoe race on the Missouri River. Both teams practiced long and hard to reach their peak performance before the race. On the big day, the Japanese won by a mile.

The Americans, very discouraged and depressed, decided to investigate the reason for the crushing defeat. A management team made up of senior management was formed to investigate and recommend appropriate action

Their conclusion was the Japanese had 8 people rowing and 1 person steering, while the American team had 8 people steering and 1 person rowing.

Believing a deeper study was in order, American management hired a consulting company and paid them a large amount of money for a second opinion. They advised, of course, that too many people were steering the boat, while not enough people were rowing.

Not sure of how to utilize that information, but wanting to prevent another loss to the Japanese, the rowing team's management structure was totally reorganized to 4 steering supervisors, 3 area steering superintendents and 1 assistant superintendent steering manager.

They also implemented a new performance system that would give the 1 person rowing the boat greater incentive to work harder. It was called the "Rowing Team Quality First Program", with meetings, dinners and free pens for the rower. There was discussion of getting new paddles, canoes and other equipment, extra vacation days for practices and bonuses. The next year the Japanese won by two miles.

Humiliated, the American management laid off the rower for poor performance, halted development of a new canoe, sold the paddles, and canceled all capital investments for new equipment. The money saved was distributed to the Senior Executives as bonuses and the next year's racing team was out-sourced to India.

Over the years legislators and bureaucrats have managed to muck up the mental health system so that many individuals become lost due to systemic brouhaha.

Last year the legislature passed legislation mandating that people who are seen by a chemical dependency counselor or a mental health professional be given a test to determine mental health and/or chemical dependency needs. Robby Pellett expressed some of his thoughts for the *Frontlines* about one of the many boondoggles that does not make good clinical sense.

After just a few months of living with the requirement to do the GAIN-SS survey with all the people we evaluate, the GAIN-SS appears to be limited in its usefulness. Many of the individuals I have evaluated have chosen not to complete the GAIN-SS. The responses of many people who have agreed to do the GAIN-SS has ranged from outright lies to simple minimizing. In the context of Crisis Intervention or Involuntary Commitment evaluations there appears to be only a small minority of individuals who are able to participate accurately with the GAIN-SS.

I would like to question the general validity of this instrument. My understanding is this is a 'self administered' tool. My introduction to this tool did not come with an instruction book or training to maintain the 'fidelity' to the protocols of Chestnut Health Systems method for using the GAIN-SS. It has the appearance of a legitimate assessment tool with its IDS, EDS, and SDS Sub-scale Scores. But there is no indication of the value of the scores or their implications.

What are we really hoping to assess here? I believe the legislators wanted to find out if there is a need to provide services for individuals with co-occurring disorders. The illusion that we are conducting a 'scientific survey' is embarrassing and insulting to both the consumers who often feel compelled to misrepresent themselves and the clinicians who have to present the GAIN-SS as a legitimate tool.

Why did they not simply ask the clinicians to give a report based on their client populations? The simple answer appears to be that we are not trusted to provide an actuate representation of the populations we serve currently. So we will be forced to use this much less actuate tool. .

I would also like to question how much we are paying Chestnut Health Systems for the use of their copyrighted too. Is it worth the cost?

As editor of the Frontlines, I want to thank Robby for his contribution. I would hope that members use to the publication to speak out on important issues. The first question on the GAIN-SS is: During the past 12 months have you had significant problems with feeling very trapped, sad, blue, depressed, or hopeless about the future? To this question, when thinking about the future of our profession and the mental health delivery service, I sadly must check: ☒Yes.

Scott Kuhle, Editor

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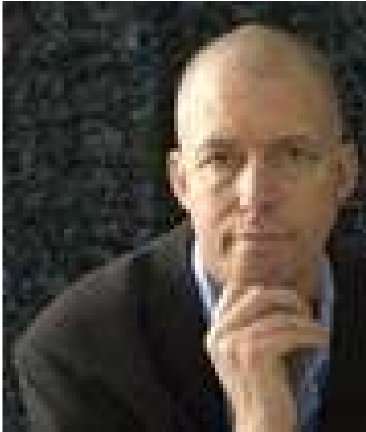
PRESIDENT EMERITUS

Gary Carter

2nd Vice-President and Secretary

Two Executive Board positions filled

Two positions on the WADMHP Executive Board were filled at the fall conference in Pasco. Robby Pellett was elected 1st Vice President, and Teresa Schotzko will serve as Secretary. Both positions are two year terms. They fill out the association's board with Ian Harrel, President, Jami Larson, 2nd Vice President, and Gary Carter, Treasurer.



Robby Pellett

Robby Pellett from Pierce County Human Services will serve as 1st Vice President. The primary responsibilities of the 1st Vice President are to plan the fall conference and assume the role of the president in his/her absence.

Robby grew up on the West Coast, mainly in rural logging communities. There were strong conservative interests such as the John Birch Society. He was active in High School in breaking down stereotypes and challenging the dress codes of that time. Later in University Robby studied performance arts, eventually going to San Francisco and studying dance therapy with Anna Halprin's Dancer's Workshop.

Eventually Robby returned to the logging communities of Oregon to work for the National Forest Services as a crew boss doing trail maintenance and forest fire fighting. He went from the Forest Service to working for a Tree Planting Collective in Northern Montana for 2 years. Then he returned to school and studied at Naropa Institute receiving a certificate in Dance. He became involved with performance as therapy with the Cancermont program in Denver, a program for terminally ill cancer patients addressing the issues of quality of life.

Later Robby studied Body-Centered Psychotherapy in Mill Valley and worked in private practice in Boulder for the next 5 years. After this he moved to Japan and studied the arts of Tea and Flowers as well as Zen Buddhism. Eventually he received a teaching license in the Way of Tea, a certificate in the Way of Flowers, and 4 black belts in various martial arts. Being ordained in the Soto Zen school of Buddhism, Robby has been an active priest since 1994.

Robby returned to Seattle and received a Master of Arts in Psychology at Antioch University. He has worked as a Child and Family therapist, a contract therapist for the Family Reconciliation Services and a Child Crisis Therapist.

In August of 1999 Robby was hired by Pierce County Human Services as a County Designated Mental Health Professional. Two years later, he assisted in forming a collective bargaining unit with our CDMHP team here in Pierce County and we became represented by the Teamster's local 117. He has been active in labor negotiations with the County ever since.

Robby was a participant in the first CDMHP training offered by the Washington Institute and says, "I am committed to seeing our profession continue to grow on both an individual level as well as on an association level."

"I would like to see all DMHP's receive a standard 40 hour training regarding the law and procedures of our profession. I would like to see all DMHP's be sworn in the Superior Court of our county as DMHP's so our responsibility is to the citizens of the county first and foremost. And I would like to continue to strengthen our decision making process and protect it from third party pressure, be it our bosses, agencies, or the state."

Secretary

Teresa Schotzko, a DMHP and therapist at Palouse River Counseling in Pullman, will fill the duties of secretary for the association. The primary responsibility of the Secretary is to keep the associations records and to record the minutes of the business of the executive board. All of the officers are expected to attend the four annual executive board meetings, and participate in the monthly teleconference calls. Each of these positions is a term of two years. Officers must be a DMHP.

Teresa Schotzko

David Kludt

Greetings from Olympia

As the New Year came upon me, as I often do, I took a little time to reflect back on 2006 both personally and professionally. I will spare all of you the personal (pretty good year all in all), but thought I might share with you some highlights regarding our work together and in support of Designated Mental Health Professionals (DMHP)

The Mental Health Division was once again pleased to have contracted with the DMHP Association to help support the three (3) annual conferences that the Association presents each year. Each of the conferences in 2006 were well received by those attending and covered important subjects such as; co-occurring MH/CD (Dr. David Shackley), worker safety (Deputy Jesus Villahermosa), and sleep disorders (Dr. Tim Truschel).

The Division was also able to re-introduce the DMHP Boot Camp trainings. The Division contracted with Washington Institute Mental Illness Research and Treatment (WIMIRT) for this project, which in turn contracted with Gary Rose to coordinate and present these week long trainings. These trainings were very well received, and the Division is pleased that Boot Camp Training for 2007 is in the works.

As many of you know, Ian Harrell, I, and a number of others spent a significant amount of time beginning in June of 2006 in the arena of workers safety. The Division contracted with the DMHP Association to present two "Safety Summits" in September. The summits went very well. Through them and the approximately 150 safety questionnaires that we received we learned a tremendous amount about our system, our strengths and where we need to focus on-going efforts.

2007 will certainly bring more challenges and also more opportunities. Some of the projects that the Division will be working on in the coming months are:

- Involuntary treatment statutes. For more information on this please see the MHD Intranet Site.
- Continue to work with Washington State Tribes regarding tribal DMHP's and crisis services.
- Continue to work with WIMIRT and Gary Rose in planning for Boot Camp Trainings. For more information, see the Boot Camp article in this edition of Frontlines
- Continue to contract with the DMHP Association for three annual conferences.
- Mental Health Workers Safety: The Division is committed to continue to address this important issue.

We are actively working with other stakeholders in both analyzing and assisting in the crafting of the proposed Marty Smith Bill. Whether this legislation becomes law or not, you can anticipate a significant amount of future activity related to workers safety. The DMHP Association's final report from the safety summits will be made public in the very near future. Keep an eye on both the DMHP Association and MHD Web sites for this report. We will also be sending it directly to all RSN offices for distribution to provider agencies.

The Division and I look forward to working with all of you on these and other important projects in 2007. Be safe and continue doing the good work!

David Kludt
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Complicating matters more is the lack of inpatient beds and the regionalization of inpatient beds. As we all know, there has been a severe shortage of inpatient beds starting in March of 2001. As a result of dwindling resources many area hospitals and E&Ts have begun to refuse out of county ITAs. Some counties have started requiring in person DMHP court testimony for out of county ITAs (as opposed to telephonic). Other counties have ordered their clerks to not allow filing numbers for out of county ITAs. These methods result in less access across the state and are having dramatic impact on the ability to move ITAed clients out of emergency departments. This issue impacts rural and urban areas somewhat equally. In the rural areas, ITA'ed clients sit in hospitals that have no psychiatrist to assist with the medications and with no appropriate rooms to hold them in so they often take up needed resources within the emergency departments that are already stretched thin. In the urban areas the EDs are impacted more frequently as larger population areas have more individuals that are in need of ITA services. Although hospitals have federal EMTALA regulations that require them to care for these individuals until the medical/ psychiatric care they require is available, this does not change the fact that ITAed clients are still waiting at times throughout their entire 72 hour commitment and then released from the emergency departments and that this is not

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the intended or best treatment for individuals who require ITA services. This issue also has caused strained working relationships with many local hospitals and crisis teams, with hospital administrators and medical providers at times emotively demonstrating their frustrations toward DMHPs as if we have some access to beds that we are deciding not to share with them.

This problem will not be remedied by DMHPs as we are in the middle of this broken system and I imagine I can speak for every DMHP in the state when I say that we would all prefer to return to 2000 when over 98% of the people we provided ITA services to were placed within 3 hours or less and that if no other place had room or would accept them then the state hospitals would accept all adults and geriatric clients. ESH still accepts 72 hour ITAs and WSH accepts no 72 hour holds that originate from the communities and has not for at least 3 years (at one point some agencies were actually paying bonuses to DMHPs that could get people on 72 hour holds into WSH). Availability of voluntary inpatient beds has decreased as well. The state has reopened three units at WSH attempt to address the issue but this compounded problem unfortunately needs a variety of fixes to return Washington State to a place that all people ITA'ed have an inpatient bed in a psychiatric unit in order to receive the treatment they need. This problem is now over six years old and even with the current new state measures in place the problem continues to get worse or at the very least not improve.

The answers to this problem will have to come in the form of leadership and financial support from the state legislators as the system continues to limp along in what is now regular (even though unacceptable) practice of treating civilly committed individuals in emergency departments and medical units of hospitals.

Kindness is more important than wisdom, and the recog-nition of this is the beginning of wisdom. -Theodore Rubin, psychiatrist and writer (1923-)

Two 40 hour sessions

70 DMHPs attend excellent training

Two week-long training sessions for DMHPs were given in September, 2006, one in Tacoma and one in Spokane. The Mental Health Division, using Federal Block Grant funds, sponsored the free training, which was provided by Washington Institute for Mental Illness Research and Training. WIMIRT contracted with Gary Rose to coordinate the two events.

The topics included:

Presentations by Experienced DMHPs:

DMHP: The Process of Investigation and Detention
Writing a Good Petition
Who Gets Detained? (ITA Data)
What Makes a Good DMHP?

Legal Topics:

Assistant Attorneys General
Prosecuting Attorney
Defense Attorney
Court Commissioner (Spokane only)

System Partners:

MHD
History of the DMHP Protocols
Tribal Relationships
Community Integration Assistance Program (formerly DMIO)
Use of reasonably available history
Data Collection
ITA and MH system changes
Developmental Disabilities
Aging Services
Alcohol & Substance Abuse
Children's Services
Consumer & Family Member Panel
Eastern and Western State Hospitals

The Tacoma training included 39 people, who attended a total of 140 training days. The Spokane training included 31 people, who attended a total of 121 training days. Participants included new and experienced DMHPs. Participants were DMHPs working in 31 counties: Adams, Asotin, Benton, Chelan, Clallam, Clark, Columbia, Cowlitz, Douglas, Ferry, Franklin, Grant, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Okanogan, Pacific, San Juan, Skagit, Skamania, Snohomish, Spokane, Stevens, Thurston, Walla Walla, Whatcom, and Whitman.

All participants received a notebook with the current DMHP Protocols, RCW 71.05, RCW 71.34, WAC 388-865 Section Five, and a list of all certified Inpatient Hospital and Evaluation and Treatment Facilities. In addition, each participant received the presenters' handouts for each day the participant attended.

WIMIRT awarded CEUs to the Licensed Independent Clinical Social Workers, Licensed Mental Health Counselors, and Licensed Marriage and Family Therapists. Certificates of Attendance were provided to all other participants.

On evaluation, the participants gave the training high marks.

"The great and invigorating influences in American life have been the unorthodox: the people who challenge an existing institution or way of life, or say and do things that make people think." -- William O. Douglas (1898-1980), U. S. Supreme Court Justice

2007 Spring Conference – Sun Mountain

Planning is well under way for an exciting conference to be held at Sun Mountain, Washington, on April 12th and 13th. Jami Larson, the Program Manager of Crisis Services at Cascade Mental Health Care in Lewis County, has organized a two day agenda of presentations that are relevant for DMHPs and other mental health professionals.

The purpose of the two annual conferences is to provide specialized training for DMHPs on topics that directly affect their crisis intervention and detention evaluation.

The Thursday presenter for the fall conference is Kurt Stroshal, a PhD clinical psychologist practicing in the Yakima area. Dr. Strosahl is a leading expert in the field of suicide and mental health. He co-authored a book, *The Suicidal Patient: Priciples of Assessment, Treatment, and Case Management*, with Dr, John Chiles. The book presents an easy –to-use, innovative clinical model, with specific stages of treatment and associated and outpatient settings.

Dr. Strosahl's presentation will offer tailored techniques and assessments for handling special populations. He will talk about moral/ethical and legal dilemmas that often complicate treatment.

On Friday morning, Dr. Rich Caggiano, Medical Director at Pullman Regional Hospital, will present information about the federal Emergency Medical Treatment and Active Labor Act (EMTALA). Dr. Caggiano will provide Legal information including the statute, case reports, regulations, articles on EMTALA, also known as the patient anti-dumping law.

Dr. Caggiano is a Fellow of the American College of Emergency Physicians, or FACEP. To become a Fellow, a physician must be an active, life, honorary, or international member of ACEP for three consecutive years and primarily practice as an emergency physician.

CEUs will be given for each of the two sessions. The custom is that the CEU certificates are handed out at the end of the conference, or the first day for those attending only the first day.

Both of the presenter's topics are appropriate for both new and veteran DMHPs, other crisis workers, and first responders.

Registration fee is $160 for both days, $95 for Thursday, and $95 for Friday. The membership due for the Washington Association of Designated Mental Health Professionals is included in the price of the conference. The fee also includes a subscription to the *Frontlines* newsletter.

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

The room rate is $77.50 per evening for double occupancy. To make your room reservations, call Sun Mountain Lodge at 1-800-572-0493.

The hotel registration includes breakfast on both days of the conference for participants who are registered at Sun Mountain Lodge. Lunch on Thursday is included as part of the conference registration fee.

Cancellations are subject to a $15.00 handling charge. No refunds will be provided after April 7, 2007.

Executive Board Meeting

The Executive Board will hold their quarterly meeting on Wednesday, April 11th in the hospitality suite at Sun Mountain Lodge. David Kludt, the Mental Health Division's liaison with the association, will attend part of the meeting. The executive board meeting is open to all members.

Hospitality Evenings

The Okanogan County MHPs will host a hospitality gathering in the reception room on both evenings of the conference. The traditional evening hospitality gathering will begin Wednesday at 7:00 and Thursday at 7:00 in the reception suite at the lodge.

For further conference information, please contact Jami Larson at 360-748-6696. For registration questions, please contact Kincaid Davidson at 360-676-5162. For updated information, check the WADMHP website: www.wacdmhp.org

The Association's Website up and running

The problems that the website has been having the past few months have been taken care of, and it is again up and running. The website offers member another way of keeping updated about information regarding legislation, the laws, conferences, and upcoming workshops. There is a page for job listings in the state.

Check out www.wadmhp.org

A moment of tragedy

A Life of Beauty and Love Revealed

On October 6, 2006, Palouse River Counseling received the news that mental health professionals dread to hear about a client: Andrew Hanes was found hanging from a tree.

Andrew had returned to Pullman in August because he was interested in resuming his studies at WSU – he only had a couple of classes to take in order to earn his BA. He had found an apartment and began to renew activities in the town that he had enjoyed for a number of years during his undergraduate years. It wasn't long before Andrew's symptoms brought him attention in the community and eventually to mental health professionals.

After a brief hospitalization, Andrew returned to Pullman and began treatment. It was apparent that he was still in a lot of pain.

We professionals often see only the side of our clients that has been ravaged by the mental illness. While witnessing the brokenness of the person with the mental disorder, we don't often have an opportunity to experience the side of the client that relatives and friends have experienced through the years. We don't see the potential that the client once had. We don't see the goodness and beauty that the family and friends have been privy to over the years.

The following letters provide a glimpse into the son, brother, and friend that Andrew, like most clients, were before the onset of their symptoms They also reveal the pain, suffering, and love that is experienced by those who have know the client in a different time, under different circumstances.

Note from Andrew's mother to *Frontlines'* editor:

Thank you for sending me a copy of the *Frontlines*. The journey and the mystery of mental health leaves so many wounds, losses, and questions … so many questions that will never be answered … so much to endure as we struggle not to be defined by the pain. The pain wants to own us and sadly, it will win if/when a person does not have the strength to fight, or the faith and support, or the knowledge and the time, or the resources, or the luck, OR? That's the mysterious part. What does it take? We all do the best with what we have and what we know at the moment in time.

I believe that that's why it is so important to keep learning – keep searching for answers and resources … then at least when those decisions are made we at least find comfort from knowing we tried so hard. Death is part of life … regrets, guilt, the what ifs, anger, the pain, and the love are all part of what fuels us to seek those answers that have the chance to solve at least part of the mystery.

The system is broken and so are many hearts as a result of the brokenness. But as long as people like you and those involved in the missions, publications like *Frontlines* and NAMI, seek to become armed with education and resources, as long as that continues, positive changes will be made, and fewer people will suffer. Step by step – inch by inch – one person … one more person than yesterday may just get the help they need to overcome because people like you were fighting to boldly fight a system that fails to properly front load and focus on prevention.

Donations keep coming in. I am mailing over $1000 to NAMI tomorrow … just a drop in the bucket of needs, but added up it also equals lots of people who have given $10, $20, $100 to support a cause they are trying to understand and learn about in ways that will result in some other kind of support from the same cause somewhere in the future.

I have enclosed all but Willy's message read at Drew's service. He has not sent his copy to me yet. He will. He and Drew were best friends and to speak at the funeral was very hard for him. He had been involved in working through his grief of losing his relationship as it used to be, for a couple of years. He even worked for Richland Mental Health for a year to help himself deal and learn … he had to detach and become involved in business … something so much in the opposite direction. He is struggling … so are Erik and Shanda … they both found comfort in the fact you attended the services. They are further comforted by your desire to publish Drew's story. It means a lot to them and from the heart of this mother I know you know what that does for me. Thank you!

"God grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference." - Reinhold Niebuhr " - the courage to change the things I can…" That is what I see publications like *Frontline* having the influence to do. To love, educate, and influence - To live, to laugh, to love, to leave a legacy …

Scott, Thank you for being able to see people through the eyes of their courage – even when their brokenness steals their smile and the twinkle in their dancing eyes. Let the hope in each person's heart outlive the pain they cannot hide or control.

Brenda Mehlenbacher
165 Corny Hollow Rd.
Burbank, WA 99323

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From Erik, Drew's brother.

I remember Drew in the days he wasn't troubled with illness as most of us do. I was the big brother and I know he looked up to me, but something he didn't know is that I always looked up to him as much or even more. "Behind these dying eyes lies an ocean." was a quote he often wrote at the end of the many journal entries he wrote in his last years. To m e it was a quote that captured his essence.

On the outside Drew was just an ordinary kid, but those of us who knew him had glimpses of his brilliance. He had an incredible ability to make people laugh. I just want us all to take a second and remember a time he did or said something that made us laugh. I could go on and on telling stories about Drew, but it wouldn't do justice to the moment so I just want everyone to take a good look at the big picture in the frame and remember him that way.

The last three years he lived in the clouds and in hell. In his own words he wrote, "It's like I got all my life's happiness at once and then all my life's sadness too." This is basically how he lived his life in the past few years. God only knows how hard it was for him, but for friends and family it was really hard too. I don't want to focus on that though. Not today. I want to leave a positive impression of Drew and in his own words because he did it best.

His ability to color words with clarity was almost unmatched in my opinion. He wrote, "I want something positive to come out of all of this. Create something for humanity that captures the beauty of a flower." How beautiful are flowers?

He also wrote that through his struggles with mental illness he wanted to bring compassion and understanding to the world of psychiatric medicine. He wanted patients LIKE HIM to have someone on their side, who had been there and LORD, have I been there." Drew, or Andrew as he liked to be called. My brother boo.

My love lives on for you. The laughs and the good times we had together live on in my ocean behind these dying eyes and in all the oceans behind every family member and friend who really knew you. I love you bro and always will. Say hello to Dad, Grandpa, Grandma and Josh for me. And I hope you open up the gates for me. I love you.

From Shanda, Drew's sister

Back when Drew and I were young he would always throw toasters at me. That's right, toasters, my brother Eric would always have to protect me. One time Erik and Drew even convinced my mom to ground me … she told us to not use the phone under any circumstances … so what did my brothers do? They put the phone in my hand and called my mom over because their little sister was using the phone. I think I was grounded for a week. No matter though, Drew always made me feel like HIS sister.

He was a bit of a handful in high school. I was a year younger than Drew in school and when the teachers got to me they would always say, "You are Drew's little sister? Drew Hane?"

After high school Drew moved to Spokane. He lived there for a couple of years and I convinced him he needed to move to Pullman and be a "true" Cougar. I lived with Drew the last semester of college. It was like we were young again. I got to clean the bathroom, he would eat my food, and he would wake me up at night when he came home. Yep, just like when we were young.

Erik and I liked to imitate Drew every chance we got. We would often make up crazy sentences that didn't make any sense like, "I am going to turn you into a chair and roll you down the hill" or, "it was about three or four days ago I decided I was going to blip you in the blap" – what? People looked at us with a confused look, but we siblings knew it was funny. Drew also had a face he made. Erik and I would often make this face at one another – even when Drew wasn't around – because it reminded us of our brother.

I remember one of the last phone calls I had with Drew. He asked me if I watched the Cougar game that Saturday. I told him that I had missed it. Drew said, "Who's the true Cougar now?" Well, I watched the game Saturday Drew – and guess what – they won.

I want everyone to remember Drew at that point in your life when you were the closest to him – for some of you it is now and for some it was back in the day when he gave you that nickname that has stuck with you even to this day. For me, it was my whole life. Bu – I love you – I wouldn't have traded you for any other brother in the world.

PLEASE SEE **A LIFE OF LOVE** ON PAGE 9

A LIFE OF LOVE CONTINUED FROM PAGE 8

From Ray, who is in the Army – a friend who did not allow the fear or pain to abandon Drew.

No matter how far away we ever were from each other we always remained the most closest of friends. Only once in a lifetime does a friend come along that can make you smile or laugh when you are down no matter the situation, you were that friend.

I can remember back to our freshman year in high school when our friendship really began to build. You and I were sitting in Mr. DeBord's class. I asked you if you wanted to come over to my house and do nothing but drink coffee and play nintendo all night. We did just that. This was the beginning of a friendship that would last forever. No one could forget that same year when you and I showed up to our baseball game with bald heads, you and I constantly reminded each other of Coach Washburn's facial expression as we took our hats off, he made us keep them on of course. Every day after school you, Derek, and I would head over to your house and play on the "Emerald Square" and see who had the wiffle ball skills for the day. We would call your sister Pissant and have a good laugh about it. I even remember when you and I tried our luck in sculpy with Erik and Zane. They were just too good and made us look like amateurs, but we still tried.

Only one of my friends did I make it a point to see every time I came home on leave since I joined the military 9 years ago. Drew, you were that friend. Some were good times and some were sad, but it was always the highlight of my leave. We had the most peaceful cabin trips doing nothing but relaxing and talking about the past. The first time you saw my son, I am sure that your Mom or I will never forget the look on your face that day.

Drew, you were the most intelligent person that I have ever known and probably will be for as long as I live. You were the only person that I actually liked to talk politics with, so what am I now an elephant or a donkey? Who is going to answer these questions when I have them?

More people than you could imagine are going to miss you Drew, and the accomplishments you would have given to this world will never be known though they would have been milestones reached. I love you Drew and I will never forget you.

From Derek – A high school friend.

Boston - It's ironic that I'm stuck here in Boston, Drew's favorite city. He and I talked about this town a lot. We talked about visiting, going to a game at Fenway Park, remembering the times Dewey Evans played here. Shoot, he even said he wouldn't mind living here some day.

I don't know if he ever got here to visit but it's all you imagined, Drew. It's a great city and it would have been proud to have you, even just for a weekend.

I read the paper piece about Drew and it mentioned his nickname, "Bu". That was his nickname but it didn't start out as that. There was an evolution there and I'll let you know, that is, as I remember it. It came about during summer baseball one year.

Doug Ricard, who was one of the coaches, called him "Bull." He called him bull because that's what he ran like. When he was on his way to first base or second base, there were no brakes with that kid! He just ran straight ahead, hard and fast like a bull. He was our bull for the rest of that season and eventually the nickname was eroded down to just "BU".

It was inevitable that when he spoke, you were laughing. That's all there was to it. Drew and I went to the Apple Cup in 1993, the cougs blasted the huskies and further entrenched our love for Pullman.

Fast forward about 10 years and we were both going to school there and living together. We always knew we would … that's where I introduced BU to Taco Pizza from Pizza Hut. He was very skeptical when I wanted to order it … then he fell in love with one bite. It's really quite good … you should all try it sometime. He adored it. Drew and I played home run derby together just about every day after school, only with Drew you couldn't just play the game. After playing we'd go inside after every game and we'd have to record our stats … then he'd make formulas and percentages and rework the numbers and plug in all the games we played and such … he was always thinking.

Brenda, thank you for not beating us the night Drew and I spent about 12 hours re-typing all the correct names of all the baseball players in our Ken Griffey Jr video game … only to sneak up those creaky stairs about 2:30 in the morning because we thought we needed to make coffee … only we decided the coffee maker would be too loud so we tried to experiment with the iced tea pot …

You just cocked your head to the side and gave us the trademark, "Oh Drew!" On the outside your were steaming … but on the inside I know now that you had to be smiling! That was Drew, you just couldn't be mad at him.

Gosh, I could go on forever, I've got a million more things to say. This part is for you Shan. Shanda please know that I wish the best for you and Eric and Brenda and Allan during this time. You've got thousands of prayers heading your direction. Just be Strong.

We'll always have our memories and if we're brave enough some day we'll all meet up with our brother again … in the bleachers at Fenway Park … watching Dewey Evans … or possibly Martin Stadium cheering on the Cougars to victory! I'll miss my friend … God please take care of him, he's very special and if you start a debate with him, look out … you've got your hands full now!

Shakespeare said once: "Goodnight sweet prince, and may flights of angels sing thee to thy rest."

Couldn't be more fitting …

With great love,
Derek Jeffery, Amanda Fay, and Jaxson Paul Schoenrock

WADMHP

2007 Spring Conference

Sun Mountain Lodge

Day One: April 12th

Working with Individuals who are, or may be, suicidal

Presenter: Kirk Strosahl, PhD

Dr. Kirk Strosahl will present on the assessment and treatment of suicidal patients.

Morning Session:

7:45 Registration and Breakfast
8:30-8:45 - Legislative Updates
8:45-10:15 - Presentation – Kirk Strosahl, PhD
10:15-10:30 - Break
10:30-12:00 - Presentation continued
12:00-1:00 - Lunch

Afternoon Session

1:00-3:00 - Presentation continued
3:00-3:15 - Break
3:15- 5:00 - Presentation continued
7:00 – Evening Hospitality

Day Two: April 13th

Treating the Mentally Ill Person in the Emergency Department

Presenter: Rich Caggiano, MD

Dr. Caggiano will focus on EMTALA regulations as they pertain to persons with mental illness

7:45 - Breakfast
8:30- 12:00 – Presentation – Rich Caggiano, MD
(10:15-10:30 – Break)

CEUs will be given for each of the two sessions.

DANGEROUS MENTALLY ILL OFFENDER PROGRAM (DMIO)

Community Integration Assistance Program

Michael J. McGuire, Ph.D

The legislation for the DMIO program was initiated as the result of an unprovoked fatal assault of retired firefighter Stanley Stevenson by a mentally ill man in Seattle in 1997. The Dangerous Mentally Ill Offender Program (RCW 72.09.370) was established in March 2000 in response to a 1999 Substitute Senate Bill by the Washington Legislature (SSB 5011).

In 2006 the Mental Health Division renamed the DMIO program “Community Integration Assistance Program” (CIAP). However, by statute the official program name remains DMIO.

The statute required improving the process of communicating among state and county agencies, and identifying and providing additional mental health treatment and other community support services for mentally ill offenders who pose a threat to public safety being released from the Department of Corrections (DOC) institutions. This legislation defines a "Dangerous Mentally Ill Offender" as an offender who is (a) reasonably believed to be dangerous to self or others and (b) have a mental disorder.

Typically, the criteria for DMIO designation include a major psychotic disorder, affective/mood disorders (not substance abuse disorders) and/ or developmental disabilities (mental retardation).

The Washington Association of Designated Mental Health Professionals (WADMHP) and the Designated Mental Health Professional (DMHP) have a significant role with the DMIO. The WADMHP has a voting seat on DMIO multi-systems review committee. As a committee member this representative is able to provide valuable clinical and behavioral insight into the decision making process of designating an offender as dangerous and mentally ill.

On occasion the committee may recommend that the offender be evaluated for civil commitment prior to release from the institution. The statute allows for a ten (10) day early release. The DMHP will typically evaluate for commitment during that time period. If the DMIO is not detained the institution may choose to ask for a second evaluation on the day of release.

Created by legislation, a statewide multi-system review committee, referred to as the DMIO Committee, identifies offenders that qualify for the program. The committee is co-chaired by the Department of Corrections (DOC) and the Mental Health Division (RCW 71.24.470). Additional members are from Community Mental Health, the Division of Alcohol and Substance Abuse, the Division of Developmental Disabilities, law enforcement agencies, the Regional Support Network (RSN), DOC Mental Health Program, the DOC Special Needs Unit, a Designated Mental Health Professional representative, and, as necessary, a representative of the Indeterminate Sentence Review Board (ISRB).

Once a DMIO candidate is identified the development of a plan for delivery of support services and treatment is implemented for the offender prior to and upon release. A mental health provider is contacted and the pre-release transition process begins.

About six months prior to release, a mental health caseworker begins working with the individual; pre-release meetings are scheduled at 90-day, 60-day, and 30-day intervals before release with a Multi-System Care Plan (MSCP) team.

The “wrap-around” team consists of a Risk Management Specialist, a representative from the Department of Social and Health Services, a member of the Regional Support Network, a member of the DMIO Program, a Community Corrections Officer, a Classification Counselor, a Community Mental Health worker, and a representative from the Division of Alcohol and Substance Abuse; others members are utilized to meet the individual needs of the offender.

The MSCP team develops a transition plan with the individual in order to ensure that mental health and other services, such as housing and transportation, are available and accessible upon release.

The DMIO Committee began to review cases in April 2000. Although more than 7,000 offenders have been considered for the DMIO program, to date the DMIO Committee has reviewed 2,131 candidates who appear to meet program criteria and has designated 451 offenders as DMIO who do meet criteria.

The effectiveness of the DMIO program is well established through empirical research conducted by the Washington State Institute for Public Policy (WSIPP) that provides a non-partisan research at legislative direction on issues of importance to Washington State. The most recent publication in January 2007, *The Dangerous Mentally Ill Offender*

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INTEGRATION ASSISTANCE CONTINUED FROM PAGE 11

Program: Cost Effectiveness 2.5 Years After Participants' Prison Release (http://www.wsipp.wa.gov/pub.asp?docid=07-01-1902), has found that recidivism is reduced by 45% and that new offenses are reduced by 38% by DMIO participants. Additionally, the data indicates that the program is cost effective and provides an important contribution to community safety.

The DMIO program staff are:

- Monica Holloway, Administrative Secretary (360) 725-8694 E-mail: mfholloway@doc1.wa.gov
- Derrick Keys, M.A., Risk Management Specialist (360) 725-8710 E-mail: ddkeys1@doc1.wa.gov
- Michael J. McGuire, Ph.D., Program Manager (360) 725-8713 E-mail: mjmcguire@doc1.wa.gov

Department of Corrections
Dangerous Mentally Ill Offender (DMIO)
Health Services Unit
Post Office Box 41123
Tumwater, Washington 98504-1123

Silent gratitude isn't much use to anyone. -Gladys Browyn Stern, writer (1890-1973)

2007 Fall Conference planning underway

Robby Pellett, Second Vice-president, said that the Fall Conference is tentatively scheduled for the Oct 25 and 26.

The focus will be on performing risk assessment of harm to others in the field. The proposed speakers will be the Mental Health Liason from the Secret Service.

There will also be a presentation on the recent case law and a legislative report on upcoming changes to the ITA law.

The topic for the second day of the conference has not been determined. Robby said that he would welcome suggestions. He may be contacted at: either robbypellett@hotmail or Pierce County Human Services, (253) 798-2709.

Robby said that he is still has not found a venue to host us but I am working on it.

Pencil in, better yet, use an indelible pen, to mark October 25th and 26th on your 2007 planner for an exciting and educational conference

More DMHP training planned

Sessions to be offered this summer

Two trainings for DMHPs will be offered this year. The first one will be conducted in Spokane from May 14 through the 18th. The second training will be the week of August 6th through the 10th. The city and location has not be determined.

The trainings are funded by the Mental Health Division, and are modeled after the residential and case management “boot camps”. There will be no cost for the training to either individuals who attend, or to agencies that send DMHPs for the training.

The goal of the training is to standardize the implementation of RCW 71.05 and 71.34, and to encourage best practices. Basic training will cover the DMHP Protocols. The advanced training curriculum, which is still being developed, will include information for the more experienced DMHP, such as case law, guardianship and power of attorney. The curriculum will be similar to the curriculum of the sessions last year.

The 5 days of training will be divided between basic (the first 3 days) and advanced (the last 2 days). Registrants may attend either session, or both. Attending advanced training does not require attending basic training first.

Teaching staff will include attorneys (prosecuting and defense); experienced DMHPs; psychologist(s); and system partners. Teaching staff are being selected both for their knowledge and for their ability to teach.

Priority for attendance will be: 1) Current DMHPs; 2) CMHA staff members who want to become DMHPs; and 3) Other CMHA staff, system partners and others.

The training on the eastside of the state will be in the Spokane area during the week of May 14 -18, 2007. The training on the west side of the state will be held August 6-10, 2007 in the Tacoma area. Both training sessions are open to DMHPs from either side of the state.

Registration is free. Hotel rooms for 25 people at each event (double occupancy) will be provided for those attendees who have the greatest travel

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DMHP TRAINING CONTINUED FROM PAGE 12

distances. Meals and transportation are not included.

CEUs for Washington State licensure will be available for Mental Health Counselors, Independent Clinical Social Workers, and Marriage and Family Therapists at no cost.

Information about the Eastside training will be available in March. Please contact Gary Rose at gary.rose@adelphia.net or 360 200-5230 to request a registration form, or for additional information,

A Guide for Taking Care of Family Member

After treatment in the emergency department

Suicidal thoughts and actions generate conflicting feelings in family members who love the person who thinks about taking his or her own life. That is why the following guide was developed for patients who have presented in emergency departments. It provides some important points on how to take care of both the person at risk of self harm and family member following a suicide attempt, and it provides resources to help individuals move forward.

What Happens in the Emergency Department?

The goal of an emergency department visit is to get the best outcome for the person at a time of crisis—stabilizing the patient medically and emotionally, resolving the crisis, and making recommendations and referrals for follow up care or treatment. There are several steps in the process, and they all take time.

When someone is admitted to an emergency department for a suicide attempt, a doctor will evaluate the person's physical and mental health. Emergency department staff should look for underlying physical problems that may have contributed to the suicidal behavior, such as side effects from medications, untreated medical conditions, or the presence of street drugs that can cause emotional distress. While emergency department staffs prefer to assess people who are sober, they should not dismiss things people say or do when intoxicated, especially comments about how they might harm themselves or others.

Assessment

After emergency department staffs evaluate your family member's physical health, a mental health assessment should be performed, and the physician doing the exam should put the patient's suicidal behavior into context for the relatives. The assessment will generally focus on three areas:

1. What psychiatric or medical conditions are present? Are they being or have they been treated? Are the suicidal thoughts and behavior a result of a recent change, or are they a longstanding condition?

2. What did the person do to harm himself or herself? Have there been previous attempts? Why did the person act, and why now? What current stressors, including financial or relationship losses, may have contributed to this decision? Does the person regret surviving the suicide attempt? Is the person angry with someone? Is the person trying to reunite with someone who has died? What is the person's perspective on death?

3. What support systems are there? Who is providing treatment? What treatment programs are a good match for the person? What does the individual and the family feel comfortable with?

Finally, a doctor may assess in more detail the actual suicide attempt that brought your relative into the emergency department. Information that the treatment team should look for includes the presence of a suicide note, the seriousness of the attempt, or a history of previous suicide attempts.

The relative of the suicidal patient needs to inform the emergency department personnel if the suicidal patient has:

- Access to a gun, lethal doses of medications, or other means of suicide.
- Stopped taking prescribed medicines.
- Stopped seeing a mental health provider or physician.
- Written a suicide note or will.
- Given possessions away.
- Been in or is currently in an abusive relationship.
- An upcoming anniversary of a loss.
- Started abusing alcohol or drugs.
- Recovered well from a previous suicidal crisis following a certain type of intervention.

What the Emergency Department Needs to Know:
How the family can help

Confidentiality and Information Sharing

Family members are a source of history and are often key to the discharge plan.

It is important that family and friends provide as much information as possible to the emergency department staff. Even if confidentiality laws prevent the medical staff from giving family members information about the patient, family members and friends can always give the medical staff information. Find out who is doing the evaluation and talk with that person.

Family and friends can sometimes offer information that is helpful in the decisions made for the suicidal patient. It helps the medical staff when family or friends, who have to accompany a suicidal person to the emergency department after an attempt, to remember to bring all medications, suspected causes of overdose, and any names and phone numbers of providers who may have information.

Emergency department personnel should try to contact the medical professionals who know the situation best before making decisions. Other important information about your patient's history to share with the emergency department staff includes:

- A family history of actual suicide—mental health professionals are taught to pay attention to this because there is an increased risk in families with a history of suicide.
- Details about the suicidal patient's treatment team—a recent change in medication, the therapist is on

PLEASE SEE **TAKING CARE** ON PAGE 14

TAKING CARE CONTINUED FROM PAGE 13

vacation, etc. This information is relevant for emergency department staff because if they do not think that hospitalization is best, they need to discharge the patient to a professional's care.

- If the person has an advance directive, review this with the emergency department treatment team. If the person accompanying the patient to the ED has a guardianship, let the medical staff know that as well. It may be helpful to get permission from the staff and the patient to sit in on the evaluation in the emergency department in order to listen and add information as needed. This can balance the emergency department staff's knowledge about the patient with another perspective. The best emergency department decisions are made with all the relevant information.

Advance directives are legal documents that allow someone to give directions for future medical care or designate another person to make medical decisions if one is unable to competently make such decisions. More information can be obtained by contacting the National Disability Rights Network (NDRN) at 202-408-9514 or www.ndrn.org.

Next Steps after the Emergency Department

After the patient's physical and mental health are thoroughly examined, the emergency department personnel will decide if the patient needs to be hospitalized—either voluntarily or by a commitment. If hospitalization is necessary, family members can begin to work with the receiving hospital to offer information and support and to develop a plan for the next steps in your relative's care. If involuntary hospitalization is necessary, the hospital staff should explain this legal procedure to the relatives so that they have a clear understanding of what will take place over the next 3–10 days, while the court decides on the next steps for treatment.

If suicidal patient has a hearing impairment or does not speak English, he or she may have to wait for someone who knows American Sign Language or an interpreter. It is generally not a good idea to use a family member to interpret in a medical situation. If the emergency department's treatment team, the patient, and family member do not think that hospitalization is necessary, then family or the friend in the emergency department should all be a part of developing a follow up treatment plan.

In developing a plan, it is important to ask family members to consider the following questions. *(It is important to encourage them to be honest and direct with questions and concerns):*

- Ask the treatment team (*This includes the doctor, mental health professional, therapist, nurse, social worker, etc.):*
- Do those who are going to have some responsibility with the suicidal patient feel safe to leave the hospital, and comfortable with the discharge plan?
- Do the professionals think that the suicidal family member is ready to leave the hospital?
- How is your relationship with your doctor, and when is your next appointment?
- Why did you make the decision(s) that you did about my family member's care or treatment?
- What has changed since the suicidal feelings or actions began?
- Is there a follow up appointment scheduled? Would it help to move an existing appointment to an earlier date, if it can be moved?
- What else can family and friends do to help the patient after he/she leave the emergency department?
- What is a family member's or friend's role in the safety plan?
- Will the suicidal patient agree to talk with family or friends if the suicidal feelings return? If not, is there someone else the patient is willing to talk to?
- What should family look for and when should they seek more help, such as returning to the emergency department or contacting other local resources and providers?

Remember: It is critical for the patient to schedule a follow up appointment as soon as possible after discharge from the emergency department.

What family members need to know

Make safety a priority for your relative recovering from

PLEASE SEE PRESIDENT'S LETTER ON PAGE 15

"Imagination will often carry us to worlds that never were. But without it, we go nowhere." ~Carl Sagan

Trainings for DMHPs in 2007

Free 40 hour training session

Great for new DMHPs – Helpful for experienced DMHPs!

Spokane
May 14 -18

August 6-10 (Location to be announced)

Contact Gary Rose at gary.rose@adelphia.net or 360 200-5230
for registration form or additional information

RESERVE THE DATES!

Taking Care CONTINUED FROM PAGE 14

a suicide attempt. Research has shown that a person who has attempted to end his or her life has a much higher risk of later dying by suicide.

Safety is ultimately an individual's responsibility, but often a person who feels suicidal has a difficult time making good choices. As a family member, you can help your loved one make a better choice while reducing the risk.

Reduce the Risk at Home—To help reduce the risk of self-harm or suicide at home, here are some things to consider:

- Guns are high risk and the leading means of death for suicidal people— they should be taken out of the home and secured.
- Overdoses are common and can be lethal—if it is necessary to keep pain relievers such as aspirin, Advil, and Tylenol in the home, only keep small quantities or consider keeping medications in a locked container. Remove unused or expired medicine from the home.
- Alcohol use or abuse can decrease inhibitions and cause people to act more freely on their feelings. As with pain relievers, keep only small quantities of alcohol in the home, or none at all.

Create a Safety Plan—Following a suicide attempt, a safety plan should be created to help prevent another attempt. The plan should be a joint effort between your relative and his or her doctor, therapist, or the emergency department staff, and you. As a family member, you should know your relative's safety plan and understand your role in it, including:

- Knowing your family member's "triggers," such as an anniversary of a loss, alcohol, or stress from relationships.
- Building supports for your family member with mental health professionals, family, friends, and community resources.
- Working with your family member's strengths to promote his or her safety.
- Promoting communication and honesty in your relationship with your family member.

Remember that safety cannot be guaranteed by anyone—the goal is to reduce the risks and build supports for everyone in the family. However, it is important for you to believe that the safety plan can help keep your relative safe. If you do not feel that it can, let the emergency department staff know before you leave.

Maintain Hope and Self-Care—Families commonly provide a safety net and a vision of hope for their suicidal relative, and that can be emotionally exhausting. Never try to handle this situation alone—get support from friends, relatives, and organizations such as the National Alliance on Mental Illness (NAMI), and get professional input whenever possible.

Moving Forward

Emergency department care is by nature short-term and crisis oriented, but some longer-term interventions have been shown to help reduce suicidal behavior and thoughts. You and your relative can talk to the doctor about various treatments for mental illnesses that may help to reduce the risk of suicide for people diagnosed with illnesses such as schizophrenia, bipolar disorder, or depression. Often, these illnesses require multiple types of interventions, and your relative may benefit from a second opinion from a specialist.

If your relative abuses alcohol or other drugs, it is also important to seek help for this problem along with the suicidal behavior.

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

REGISTRATION FORM

Washington Association of Designated Mental Health Professionals

2007 Spring Conference

April 12th & 13th, 2007
Sun Mountain Lodge, Winthrop, Washington
Reservations: 1-800-572-0493

Name: ____________________

Address: ____________________

City: ____________________ State: __________ Zip: __________

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

Employer: ____________________ County: __________

Position Title: ____________________

☐ WADMHP member ☐ Non member

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

☐ A check payable to WADMHP is enclosed for: __________

Charge to my: ☐Visa ☐MasterCard

Account Name: __________ Account #: __________Expiration date: __________

Signature: ____________________ WADMHP Identification Number: 91-1997711

Mail registration form to:

WADMHP PO Box 5371, Bellingham, WA 98227

WADMHP

Annual 2007 Spring Conference

Assessing for possible suicide

&

Managing the mentally ill person in the Emergency Department

April 12th & 13th

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Winthrop, WA

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