Frontlines

Washington Association of Designated Mental Health Professionals

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President's Letter

From the President's desk, direct from the White House, or in my case, the little yellow condo with cherry blossoms outside the window.

I am humbled to be voted into this position and will do my best to continue the good work of Ian Harrell, Gary Carter, and the previous presidents. We have had the good fortune through the leadership of Ian Harrell and Gary Carter to be able to step back from the previously precarious state of the association. Through their vision and hard work we have partnered with the Mental Health Division to present the Safety Forums, the DMHP week long Boot-camps, the day long seminars at the Behavioral Health Conference and our annual Fall Conference and Western State Conferences. This year the Department of Social and Health Services, Health and Recovery Administration, Mental Health Division (that's a mouthful) were able to find funding through the hard work and dedication of the staff, particularly David Kludt, to help support the Association in providing one DMHP Boot-camp to be held in Yakima, the week of August 9-13. They will also be supporting the full day seminar at the Behavioral Health Conference on the topic of Mindfulness and Working with Veterans on Wednesday, June 23. I hope to see you there.

The Fall Conference will again be at Sun Mountain Lodge on October 21 and 22. The main topic will be about Malingering, presented by Dr. Mark Koenen, MD. Save these dates for the chance to refresh, rejuvenate, and invigorate yourself and your work.

Legislatively this has been an exciting year with a number of bills which would have had an impact on our work of involuntary commitment. Some called for the change in the wording of RCW 71.05 from "imminent" to "substantial likelihood" regarding emergent detentions, and another would have required DMHPs to follow the directions of family members or friends regarding the person we are investigating. With your feedback regarding these bills, I was able to share the views of DMHPs with the members of the House and Senate. Fortunately, we saw most of those bills set aside to focus on the passage of HB 3076, which was requested by Governor Gregoire. HB 3076 has 3 primary parts: 1) the search for a validated assessment tool for DMHPs to use in our investigations, 2) the requirement that DMHPs consider the symptoms and behavior of the respondent in light of all available evidence as disclosed by clinical record or credible witness when determining whether a person is gravely disabled or presents as likelihood of serious harm, and 3) within a day of being discharged, hospitals must inform, in writing, the DMHP office of the county to which the person is being released of the discharge and any Conditional Release or Less Restrictive Orders, and the State will keep available a record of all the DMHP offices in the state. This bill still rests on the budget to be funded so it's not a done deal yet.

I would like to encourage all of us to become more involved in the legislative process. Please contact your local Senator and Representative and invite them on a ride-along to see first hand what we are faced with daily in the course of our work. (CONTINUED ON PAGE 13)

Guest Editorial

A letter from Janay Woodward, BSHS

Dear WADMHP Members,

I recently read your newsletter which was posted on our bulletin board here at work, and was disturbed by the bleak and despondent tone of the writing which prompted me to write to all of you.

YES, you make a difference, never doubt that, and *not always to the client you are working with* but to secondary parties such as clinicians, social workers, doctors, police officers, family and community members. Every time you interact with someone you are teaching others and demonstrating empathy and compassion.

A young mother standing nearby watches as you calmly handle a situation. She studies your demeanor and technique and when she goes home she uses what she's learned with her child. She transitions from hitting to parenting and two lives are improved and changed.

A seasoned RN and a nursing student follow your lead in interacting with a mentally ill client that must be restrained in the E.R. The seasoned R.N. softens and the student nurse's fears are diminished. Both take what they've experienced with them as they work with other patients. The student nurse will never again be as frightened of the unknown as he was that night. Perhaps he'll become an advocate for non-discriminatory practices for mentally ill patients. Perhaps what he learned that night will positively change the way he interacts with a mentally ill family member.

Some of you reading this may be saying to yourselves, "She has no clue what we go through." You're right, I've never been a DMHP, but I have had the privilege to learn from three of the best: Eric Skansgaard, Mark Grannemann and Rob Wheeler during our contacts in the emergency room. Each had a different style and observing them and learning from them in the emergency room completely changed and enriched the way I practiced social work. Each took the time to explain and describe the symptoms, causes and treatments of the mental illness a patient was experiencing. Each explained the ITA process, educated me and others in the emergency room on how it worked and when it could be used. Once that education occurred, the core staff members in the E.R. had a good idea if a patient would meet criteria or not and we knew then that we would have to formulate a plan B. I was also able to take what I had learned about personality disorders and educate frontline staff on how best to interact with our "frequent flyers."

These are tough times and they will probably get tougher before we begin to see things easing. I doubt that many of you became DMHPs for the money or the glory. You're in this profession because you have a passion for it and because you're good at it. Your fight for the rights of those who cannot speak for themselves, you fight to keep families together, you fight to balance injustice. You are someone's light even if you don't know it. Frankl said "What is to give light must endure burning." Frankl also said "The one thing you can't take away from me is the way I choose to respond to what you do to me. The last of one's freedoms is to choose one's attitude in any given circumstance."

I encourage all of you, if the opportunity presents itself to channel the frustration, anger and despondence you're feeling into educating others about ITA rights, about mental illness itself, and about techniques that could be useful to the layperson. Get others on your team. Help them to help you and the client. In this time of decreasing resources and budgets – where there may not be beds or enough staff, education is free, will only take some of your time, and will allow you to give with some of the passion you brought into this profession – and perhaps, in the cycle of things, educating the right person may lead to changes in resources and budgets. In the meantime, keep your light burning.

Janay

David Kludt

Greetings from Olympia

April, 2010

Greetings from Olympia,

It has certainly been an interesting, busy, and yes, frustrating time since my last Frontlines article.

The interesting - I began the July 2009 article discussing the then recent joining of the former Mental Health Division and the former Division of Alcohol and Substance Abuse, becoming the Division of Behavioral Health and Recovery within the Health and Recovery Services Administration. The restructuring of DSHS continues as some parts of DBHR, including mental health and chemical dependency programs are moving under the Aging and Disability Services Administration.

The busy - The recent legislative session involved numerous proposed bills relating to RCW 71.05, the role of DMHPs, and forensic mental health. Many of these proposed bills attempted to address issues of public safety, consistency in DMHP evaluations, and the management and movement of individuals committed via RCW 71.09 as Not Guilty by Reason of Insanity (NGRI).

Second Substitute House Bill 3076, sponsored by Representative Dickerson and Kenney is an act relating to evaluations of persons under the involuntary treatment act. This bill will amend certain sections and add new sections to some chapters of RCW 71.05 and 71.09. Highlights of the bill are:

- Washington Institute for Public Policy, DSHS and other applicable entities will undertake a search for a validated mental health assessment tool or combination of tools to be used by DMHPs when undertaking assessments of individuals for detention, commitment, and revocation.
- Requires DMHPs to consider all reasonably available information from credible witnesses and records regarding; prior recommendations for evaluation of civil commitment pursuant to evaluation conducted under chapter 10.77 RCW, historical behavior, including history of one of more violent acts, prior determination of incompetency or insanity under chapter 10.77 RCS and prior commitments under this chapter.
- Expands ability to determine grave disability and likelihood of serious harm by indicating that," symptoms and behavior which standing alone would not justify civil commitment may support a finding of grave disability or likelihood of serious harm when; (a) such symptoms or behavior are closely associated with symptoms or behavior which preceded and led to a past incident of involuntary hospitalization, severe deterioration, or one or more violent acts; (b) these symptoms or behavior represent a marked and concerning change to the baseline behavior of the respondent; and (c) without treatment continued deterioration of the respondent is probable."
- Requires the courts to consider the same historical information and when making a determination of likelihood of serious harm, "give great weight" to any evidence regarding whether the person has, (a) A recent (within 3 years) history of one or more violent acts; or (b) a recent history of one or more commitments under this chapter or its equivalent provisions under the laws of another state which were based on a likelihood of serious harm.
- Requires State hospitals and E&Ts to send notification of discharges, LRs and CRs to the DMHP office that initiated the detention and the DMHP office where the respondent is expected to reside.

I will be working closely with the DMHP Association and other entities as we move forward with the implementation of this bill. The DMHP Association and I will be providing legislative updates, information and discussion at the DMHP conference in Yakima on Wednesday, June 23rd. (CONTINUED ON PAGE 13)

Professional Ethics and Ethical Dilemmas: How Are DMHPs Impacted?

Traci Crowder, Chief of Performance Management, Behavioral Health Resources, Olympia, WA

Ethical issues almost always spark interesting and intense discussions. Sometimes they are cloudy, meaning there isn't always a clear answer when facing an ethical dilemma. While there are laws, protocols, and codes of ethics that provide guidance in how mental health professionals carry out their work, these don't always provide a clear decision.

Learning about ethics has a two-fold purpose. One is to protect the public by maintaining knowledge on current standards of care and developing strategies for resolving moral issues. A second is to protect ourselves by practicing good risk management. The Merriam-Webster dictionary defines ethics as "the discipline dealing with what is good and bad and with moral duty and obligation; a set of moral principles; a guiding philosophy." Ethics are beliefs held by individuals, organizations, and professional that guide them in their practice and these beliefs are outlined in various professional ethics codes. Ethics sometimes involves making decisions that aren't popular or don't feel good. DMHPs inevitably run into ethical dilemmas with more frequency than many other professions in the counseling field. The Merriam-Webster dictionary defines dilemma as "a problem involving a difficult choice; an argument presenting two or more equally conclusive alternatives." Ethical dilemmas arise when two or more principles or laws conflict.

Ethical issues are inherent to DMHP work. Perhaps no single issue in mental health treatment has attracted as much attention and controversy in our society as the use of involuntary treatment with its social, political, philosophical, legal, and clinical perspectives.

According to the Surgeon General's Report, "The question in recent times is less one of whether involuntary hospitalization should take place, but, more, under what circumstances should involuntary hospitalization occur." The ability of a state to civilly commit an individual is derived from two legal theories: parens patriae and police power.

Parens patriae means "parent of the country" and obligates the country to protect those who are unable to protect themselves. The emphasis in this theory is the individual's needs. Police power is a concept which gives the state the authority to act on behalf of its citizens in order to protect the public. The emphasis in this theory is dangerousness. Involuntary hospitalization comes down to two elements: the presence of a mental disorder and the likelihood of danger to self, others, or property as a result of the mental disorder. DMHPs remove someone's freedom in order to protect the individual or the public from harm. Because power is intrinsic to this work, DMHPs are sometimes accused of being overzealous with this power or not doing enough in the minds of family or other professionals. They receive pressure from a multitude of sources to either detain or not detain. Involuntary commitment is a meeting place for several ethical principles including some that conflict with each other like utilitarianism, beneficence, informed consent, coercion. Some of the conflicting principles that are built in to DMHP work include: client autonomy versus client's best interest, effective treatment versus loss of freedom, client autonomy versus public safety, most effective treatment versus least intrusive treatment, and confidentiality versus duty to warn. Those against involuntary hospitalization support the principles of autonomy and libertarianism and attest that individuals have a right to exist independently without control by others. People supporting involuntary commitment uphold the utilitarian principle that temporary deprivation of liberty is justified by the eventual good of returned health.

Dual relationships and multiple roles can also pose an ethical challenge for DMHPs. For example, a DMHP may be requested to evaluate someone that he/she knows in another capacity, such as a personal physician, or a member of a social group. Suppose you were ill and went to an urgent care clinic and discovered that the doctor on duty is someone you've detained in the past. Or your child begins dating an individual that you've interacted with

as a DMHP and you know things about this person that concern you. An individual that you've detained may join a group of which you are a member such as a book club or an exercise class and this may be uncomfortable. It is more challenging to avoid dual relationships in smaller communities and nearly impossible in rural areas so precautions should be taken in outlining expectations and maintaining boundaries. In some agencies, DMHPs also carry caseloads as therapists or case managers and they may be requested to evaluate someone on their caseload when they are the only available DMHP. We know it might not be ethical to detain your own client as this situation can seriously alter the therapeutic relationship and case law says don't do it; however, in some rural areas, there isn't always another choice of DMHP. Ongoing consultation and supervision are important in these situations. Some of the other ethical issues that DMHPs face include a psychiatric bed shortage, which results in individuals being held in emergency departments for lengthy periods or sent out of town away from natural supports and pressures from funders or agencies to detain or not detain.

Individual values and prejudices can play a role in decision-making when there is no concrete right or wrong answer mandated by a law or policy so it is important to be aware of these influences in order to maintain ethical practices. Consider the following case studies and determine what course of action you would take as a DMHP:

- The daughter of a 58-year-old man requests that he be evaluated by a DMHP. The man has inoperable, terminal cancer and applies for and receives medications to assist him in dying. His daughter is devoted but very religious and opposes assisted suicide. She believes he is suffering from depression and wouldn't consider this option if he wasn't depressed. Do you detain this individual? Do you take a different course of action if you voted for or against the Death with Dignity Act?

- You are contacted by police after a 14-year-old female poured gasoline all around her bedroom and threw a lit match onto the floor, burning the house that her mother rented to the ground. This followed a fight with her mother. Her 9-year-old brother was downstairs at the time. Mother had left the home prior to the fire. The explosion blew her out of the 2nd story bedroom window. She sustained no injuries except minor burns to her arms. The brother escaped the fire unharmed. The 14-year-old has a history of self-harm behaviors and cluster B personality disorder traits. Police will not arrest her, stating that this was a suicide attempt and is a mental health issue and they left the emergency department. You interview her and determine that she is not suicidal or psychotic. What do you do?

- You are contacted by the obstetrician of a 24-year-old, pregnant, female. Prior to her pregnancy she met criteria for binge eating disorder, but since pregnancy she is restricting and purging her meals as well as abusing over the counter diet pills and laxatives. She has lost significant weight during her pregnancy. At the onset of her pregnancy, she weighed 157 pounds and she has lost 20 pounds during the 1st 28 weeks of pregnancy. She is refusing treatment for an eating disorder. Her doctor wants her evaluated for involuntary commitment. Do you believe she might be a danger to self? Do you consider the unborn baby?

- You are asked to evaluate a 58-year-old male whom you have evaluated and detained many times in the past. He has schizophrenia, is delusional, has not had much success with medications, and has been in and out of hospitals and jails. He is always threatening, loud, and combative. He has been kicked out of his house and has been issued a restraining order. He went to the office of the judge who issued the restraining order and demanded to talk to him. The front desk staff denied the request and asked him to calm down. He didn't and made a threat to kill the judge. Front desk staff contacted security. He stated, "I said something wrong," immediately ran down the stairs and left the building. Were his actions due to a mental disorder? Police believe he should be involuntarily committed. Should he?

- You are requested to go to the emergency department to evaluate a 78-year-old female who was directed to go to the ED after a visit with her primary care physician. Her PCP was concerned with the effects of malnutrition. ED staff tell you that she has major depression and has quit eating so that she will die. Her husband is with her and he says that she is dying and they tried to get hospice to see her at home but they denied her because she (**Continued Page 11**)

Spring Conference

The DMHP spring conference this year will be offered in Yakima, on June 23, 2010.

For further conference information, contact Jami Larson at (360) 754-1338. For registration questions, please contact Kincaid Davidson at (360) 676-5162. For updated information, check the WADMHP website: www.wadmhp.org

REGISTRATION FORM

Washington Association of Designated Mental Health Professionals

2010 Spring Conference

June 23, 2010
The Yakima Convention Center

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Employer: _____ County: _____

Position Title: _____

☐ WADMHP member ☐ Non member
Registration fee: $70
☐ A check payable to WADMHP is enclosed for: _____
Please note: Check or cash only

Signature: _____ WADMHP Identification Number: 91-1997711

Mail registration form to:

WADMHP, PO Box 5371, Bellingham, WA 98227

Hotels near the Yakima Convention Center as follows. When making a reservation, please be sure to mention you are with the Washington Behavioral Healthcare Conference in order to receive conference rates. After May 14, you will need to ask for the Government rate to receive conference rates. All hotels are within walking distance of the conference.

Red Lion Hotel Yakima Center
802 East Yakima Avenue
Yakima, WA 98901
$87+tax single; $97+tax double
(509) 248-5900

Holiday Inn
607 East Yakima Avenue
Yakima, WA 98901
(509) 249-1000
$102+tax

Holiday Inn Express
1001 East A Street
Yakima, WA 98901
(509) 249-1000
$102+tax

Howard Johnson Plaza Hotel
9 North 9th Street
Yakima, WA 98901-2522
(509) 452-6511
$79.95+tax single; $89.95+tax double

Cedars Inn
1010 East A Street
Yakima, WA 98901
(509) 452-8101
$72.20+tax single; $77.80+tax double

2010 Spring Conference

The Yakima Convention Center
Yakima, WA

Mindfulness Based Stress Reduction for PTSD

07:30 Registration and Breakfast
08:45 – Opening remarks
09:00-10:30 Legislative Updates
10:30-10:45 – Break
10:45-12:00 – David J. Kearney, M.D.
12:00-1:00 – Lunch
1:00-2:30 – Presentation continued
2:30-2:45 – Break
2:45-4:15 – Presentation Continued

CEUs available.

About the Speaker:

David J. Kearney, MD is an Associate Professor in the Department of Medicine at the University of Washington, Gastroenterology Division, and the Gastroenterology Fellowship Program Director at the University of Washington School of Medicine. He is a full-time staff physician at the VA Puget Sound Health Care System, a major teaching hospital for the University of Washington. He is also Director of the Mindfulness-Based Stress Reduction (MBSR) program at VA Puget Sound Health Care System, and has been teaching and organizing MBSR on a regular basis for three years. Nationally, he has been a member of the Functional Brain-Gut research group since 2005. He has a specific interest in mind-body aspects of medicine, and was involved in 2006-2007 in the University of Washington's 'Faculty Integrative Health Program', a NIH-funded intramural program designed to educate UW faculty about integrative medicine techniques; he also participated in the 2007 Mind and Life Summer Research Institute, a course designed to teach investigators the methodology to study the meditative disciplines. He also spent 2007 as a visiting scholar at the Osher Center for Integrative Medicine at the University of California-San Francisco, during which time he gained more expertise in the application of meditation in the practice of medicine. Currently, he has two ongoing studies which assess the effect of mindfulness meditation and lovingkindness meditation on PTSD symptoms and physical symptoms.

Involuntary Commitment & The Right to Remain Silent

By Robby Pellett DMHP

Over the past 11 years I have heard various Designated Mental Health Professionals voice frustration about reading the subject of an investigation their rights. In most Counties in the Washington State, Designated Mental Health Professionals (DMHP) are generally working as Crisis Interventionists and/or case managers or therapists while on duty as a Designated Mental Health Professional. Having two or more roles at the same time leads to confusion regarding when to inform a person of their rights. I have also heard many Designated Mental Health Professionals refer to the rights as the Miranda Rights. These frustrations regarding a person's rights and the involuntary commitment process have led to this research.

The basis of the involuntary commitment law rests on two state powers - police power and parens patriae. Police power is the power of the state expressed generally by the police force to confine an individual in order to protect society from the dangers of antisocial acts or communicable disease. With regards to communicable disease there are laws in Washington State regarding the detention of people with tuberculosis as well as AIDS. Parens patriae is Latin for "Parent of the Country" and is the doctrine that grants the inherent power and authority of a state to protect persons who are legally unable to act on their own behalf. This doctrine has its origins in English common law when the king exercised this power as the father of the country.

When creating the involuntary commitment laws, Washington state legislators included the right to remain silent and the right to speak with an attorney in RCW 71.05.360 (5)(b, c). In 1999, the legislators also enacted a law RCW 71.05.214 to create the Protocols for Designated Mental Health Professionals. In the Protocols under the Investigative Process Section 200 the issue of rights is addressed. It directs the DMHP to advise the person of their legal rights before beginning an interview to evaluate the person for possible involuntary detention. These Protocols have now become a part of the contractual language of the Regional Support Networks contracts with the state. This means that the Regional Support Networks must ensure that the Designated Mental Health Professionals who work in the counties within the Regional Support Network's area are working according to the Protocols. The Regional Support Networks are liable for contractual penalties if the DMHPs are not working according to the Protocols.

Since the creation of the modern involuntary commitment laws, the United States Supreme Court has found that involuntary hospitalization for mental health is a massive curtailment of liberty in the case Humphrey v Cady, 405 U. S. 504 (1972). Here in Washington the State Supreme Court noted that involuntary commitment for mental disorder is a significant deprivation of liberty in the case In re Detention of Thomas Labelle and In re Detention of Harris.

With the recognition that involuntary commitment is a massive curtailment of liberty and the inclusion of the right to remain silent in the statues we could consider the ruling of Miranda v Arizona as a guideline for informing the subject of an evaluation of their rights.

The history of the Miranda rights may be said to have begun in the middle ages. The maxim nemo tenetur seipsum accusare (No one is bound to accuse himself) had its origin in a protest against the inquisitorial and unjust methods of interrogating accused persons, which was the common practice in the royal Star Courts in England. With the expulsion of the Stuarts from the British throne in 1688, and the creation of additional barriers for the protection of the people against the exercise of arbitrary power, the right to remain silent became a part of common law in England. Since then the confessions of a prisoner, when voluntarily and freely made, have always ranked high on the scale of incriminating evidence.

Here in the United States, the right to remain silent was established with the addition of the Bill of Rights to the Constitution on December 15, 1791. It has been said that the original Bill of Rights were added to the United States Constitution due to concerns that the Constitution did not adequately protect the people's liberty as the Constitution guarantees the right to life, liberty, and the pursuit of happiness. The following amendments were the foundation to the Miranda decision.

Fifth Amendment = No person shall be held to answer for any capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb*; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law*; nor shall private property be taken for public use, without just compensation.

Sixth Amendment= In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury of the State and district where in the crime shall have been committed, which district shall have been previously ascertained by law, and *to be informed of the nature and cause of the accusation*; to be confronted with the witnesses against him; to have compulsory process for obtaining witnesses in his favor, *and to have the Assistance of Counsel for his defense.*

Fourteenth amendment = *No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.*

The US Supreme Court case of Miranda v. Arizona was decided on June 13, 1966 and included arguments for Vignera v. New York, Westover v. United States, and California v. Stewart as well. Briefly in all the cases, the defendants, while in police custody, were questioned by police officers or prosecuting attorneys in a room cut off from the outside world. None of the defendants was given a full and effective warning of their rights at the outset of the interrogation process. The FBI has been using a modified rights notification for a few decades by this time. In all four cases the questioning elicited oral admissions, and in three of them signed statements as well, which were admitted as evidence at their trials. All defendants were convicted based on those statements.

The Court found that all the defendants had been denied their constitutional rights and the lower court decisions were reversed. Specifically in Ernesto Miranda's case he was charged with kidnapping and rape. He was retried with evidence from a different source and was found guilty and sentenced to 20 to 30 years, but was paroled in 11 years. He died 4 years after his release from prison in a knife fight.

Based on the US Supreme Court ruling in this case, it has become the established practice to give individuals taken into custody for criminal charges, their Miranda warning. But since 1966 there have been various challenges to the Miranda decision including a law enacted by the US Congress in 1968, the 18 United States Code 3501 as part of the Omnibus Crime Control and Safe Streets Act. This law was enacted to remove the Miranda ruling and reinstate the older voluntariness test as the bases for admission of evidence gained through police interrogation. However, as indicated below the U.S. Supreme Court continued to cite the Miranda case as a basis for admission of evidence gained by questioning of a person in custody and helps to define custody.
In Thompson v. Keohane U.S. (1995) Carl Thompson was called down to the police station to purportedly identify the remains of his wife. But, in fact, he was held in interrogation for several hours of intense questioning resulting in his giving a confession after which the police gave Thompson a ride to a friend's house only to arrest him for murder a few hours later. The tape recorded confession was used in his trial in spite of his motion to suppress his statements to the police as the court found that Thompson was not 'in custody' at the time of the confession. The US Supreme Court found in Thompson's favor and vacated the Ninth Circuit Court's ruling, finding that Thompson was 'in custody' and was denied his constitutional rights since he received no Miranda warning.

In U.S. v. Craighead (2008) a U.S. Air Force enlisted man, Craighead, was under investigation of possession of child pornography and a search warrant was used to search his home. During the search Craighead was
(Continued on page 10)

(**SILENT, continued from page 9**) questioned by the FBI without Miranda warning as he was in his home and not "in custody". The Court found in favor of Craighead citing that interrogations that occur inside the home are custodial if the circumstances turn it into one of a police dominated atmosphere and therefore require Miranda warnings. There were 8 officers from various jurisdictions, armed, in flak jackets, and with firearms un-holstered. Craighead was taken to a storage closet and questioned as officers stood before the door.

While we can look at the fact pattern of the Miranda ruling and use it to provide some direction to our own situation, it is critically important to understand that the Miranda ruling is limited to criminal prosecution only. There has been no rulings regarding the right to not incriminate oneself in a civil commitment hearing, for mental illness. But there have been rulings regarding rights and the civil commitment of a sexual predator. These may be viewed in support of our situation as in the case In re Lombard which was heard in the Wisconsin State Supreme Court.

In re Lombard, 684 N.W.2d 103 (Wisc. 2004) Lombard was convicted in 1981 of first-degree sexual assault and five counts of second-degree sexual assault. Several days prior to his January 2000 mandatory release date, the State petitioned to have him committed under Wis. Stat. ch.980 as a sexually violent person. The trial court entered judgment on the jury's verdict and committed Lombard to the Department of Health and Family Services for control, care and treatment in a secure mental health facility until such time as he is no longer a sexually violent person.

Lombard filed an appeal in part due to his concern that there was a violation of his Fifth Amendment rights stemming from the State's use at trial of statements he made during a pre-petition psychological evaluation. He asserts that the examiner did not advise him of his right to remain silent as required under Miranda v. Arizona, and thus he did not knowingly and voluntarily waive his right to silence when he gave information to the psychologist about his past offenses. The psychologist in turn used these statements to conclude that Lombard was substantially likely to reoffend and testified so before the jury. The Court did find that Lombard's statements could not be used to incriminate him in pending or subsequent criminal prosecution. But as to the issue of a Sexually Violent Person civil commitment proceedings, the court findings were that under the Wisconsin State Sexually Violent Person involuntary commitment law a respondent has a constitutional right against self incrimination which prohibits the State from commenting at a commitment trial on the respondent's refusal to be interviewed. But it was noted by the Court that a person who is being evaluated for potential filing of Sexually Violent Person involuntary commitment petition, is not entitled to a Miranda warning.

It is also interesting to note that at the time of the Miranda ruling, police departments across the country complained that if they had to give every person taken into custody their rights no one would talk with them and they would not be able to do their job of catching criminals. It is a strange coincidence that the concern of many DMHPs that if they have to inform a person of their rights that the person will not talk with them. In 1985 the authors RD Miller, GJ Maier and M Kaye published their research regarding informing psychiatric patients in hospitals who were being evaluated for civil commitment of their Fifth Amendment rights. They found that being informed of their rights had little impact on the patient's cooperation with the evaluation or treatment. Their article was titled *Miranda Comes to the Hospital: The right to remain silent in civil commitment*, and was published in the American Journal of Psychiatry 1985; 142:1074-1077.

Based on the cases cited above, Washington State law, and the DMHP Protocols, I would like to suggest that anytime a therapist, case manager, or crisis interventionist, who is also on duty as a DMHP is called to intervene with and/or evaluate a person being held at an Emergency Room/Department, jail, mental health center, hospital, or by police in the community, that before talking with the person, that they be informed of their rights. If a person who is on duty as a DMHP goes out to see a person in community and has police present, such as for safety, I would suggest that the person be informed of their rights prior to talking with them. And based on best practice and our duty to protect the rights and liberty of all people we see, I would suggest that anytime we are on duty as a DMHP we inform anyone we see, as to our authority, and their rights. For unlike police officers who wear uniforms and badges, it is on the DMHP to ensure that the person we are seeing is aware of who they are talking to and the possible consequences.

(ETHICS, continued from page 5)

- doesn't have a terminal illness. The husband tells you that the client has struggled with depression for 50 years with no effective treatment, she is ready to die, and she does not want to be in a hospital. The client says she is not suicidal but she is tired of living and it would be ok with her if she died. She states she does not want to be in a hospital. Does she meet criteria for detention? Do you pursue detention?

There is potential for misuse of the involuntary commitment law just in trying to determine if someone's behavior is due to a mental disorder as this poses significant challenges at times. For example, an individual hospitalized on a medical unit for a physical health issue became combative and assaulted staff. The hospital would not press charges because the individual had a mental health diagnosis and they wanted him detained. It may be difficult to determine if his assault of others was due to a mental disorder or was a result of anger. A similar example is a case of an individual who lost his job, went home and got a gun, returned to work and shot his supervisor. This individual has a diagnosis of depression and is on a low dose antidepressant. Can his dangerousness be due to a mental disorder or is it a result of being angry about losing his job? These are some of the difficult challenges DMHPs face as a course of business.

What is helpful in managing these ethical dilemmas? In order to practice ethically, good risk management behaviors are essential. Posing the greatest risk are rights violations relating to privacy and boundaries, incompetent treatment of clients, and failing to protect others from clients. First and foremost, be familiar with the laws and protocols relating to the work you do. For DMHPs this includes:

- WAC 388-865 Community Mental Health and Involuntary Treatment Act
- RCW 71.05 Adult Involuntary Treatment Act
- RCW 71.34 Mental Health Services for Minors
- RCW 10.77 Criminally Insane
- RCW 70.96A Treatment for Alcoholism and Drug Addiction
- DMHP Protocols updated in 2008
- RCW 18.130.180 Department of Health Unprofessional Conduct (relates to all mental health professions)

Other good risk management techniques are:

- Be familiar with codes of ethics relating to your profession
- Obtain informed consent when possible
- Stick with established standards of care
- Practice within your scope of competency
- Establish and maintain clear professional boundaries with clients
- Watch physical contact with clients
- Watch accepting gifts from clients
- Know confidentiality laws
- Maintain adequate documentation and make sure it is secure
- Obtain regular supervision and consultation around difficult cases
- Develop a strategy for managing ethical dilemmas. One model contains the following steps:
    1. Identify the ethical problem
    2. Identify people with an interest
    3. Identify relevant laws and principles
    4. Generate possible courses of action
    5. Consider potential consequences for each course of action
    6. Select best course of action

For DMHPs, the question is not whether you will be involved in an ethical dilemma, but how often you will encounter them. These quandaries have real implications in people's lives on a daily basis throughout the state. Perhaps one of the greatest and most frequent challenges for DMHPs is whether to use the authority granted by the state, county, and superior court to hospitalize someone before they, in the opinion of the DMHP, meet the state criteria for involuntary commitment. DMHPs must work within the context of the laws in making the decision to detain and to not detain. An individual has civil rights, which include the right not to undergo medical procedures and take medications yet DMHPs are regularly asked to use (some would say misuse) their authority to force a person with diabetes to take their medication, a renal patient to undergo dialysis, a cancer patient to undergo radiation or chemo. DMHPs must always have the clinical and legal hurdles crossed prior to making determinations in cases. If a DMHP is on a shaky foundation in the decision, seeking appropriate supervision is crucial. Then, after all of these steps are completed the DMHP, as with anyone in an ethical dilemma, must make the best decision that they believe is closest to right with all of the factors considered.

When the Crisis Hits Home –

By Jami Larson DMHP

Crisis work, as we all know, is inherently stressful and challenging. We see people most often at their sickest and frequently on the worst days of their lives. The need continues to increase while resources are ever-dwindling. What happens when tragedy and the grief, loss, and myriad of emotions along with it, strikes personally?

I am aware of two crisis workers, one a co-worker, who committed suicide within a six month period of time. At the time of this writing it will be about six months since my colleague died by his own hand. In that time I have had the opportunity, shall we say, to reflect and do some serious and vital soul searching. Many questions have arisen, many of which we all have faced at some point in life, likely more than once.

What do we do when there is such tragedy? How do we cope and continue to do this work? What sustains us? How do we support one another? How do we take care of ourselves and each other? Do we choose self-care or self-destruction? How do we continue in this work? What do we do if we ourselves spiral down, maybe have our own suicidal thoughts? Do we have unnecessary fear or shame in acknowledging such feelings and/or the need for help? Can we continue in this profession, or is it time for a change?

My hope is that as fellow humans we seek help, support, and healing when and as needed—whatever that means for each of us. May the compassion and empathy we have for the clients we serve also be there individually and for each other.

WADMHP Association Position Vacant

It is with sadness that we report that Peter Merrill has resigned from his position as 2nd Vice President due to a personal tragedy. This position is open, and we invite anybody who is interested to contact any member of the executive for more information.

The Loss of a Friend

The Washington Association of Designated Mental Health Professionals lost a good friend December 17, 2009, with the death of Carolyn Williamson.

Carolyn passed the Washington State Bar in 1983 and practiced law in the Pierce County Prosecutor's office for 24 years. In the 1990's Carolyn become an advocate for mental health issues and served on the boards of local and state affiliates of the Community Action of the Mentally Ill Offender and the National Alliance for the Mentally Ill.

Carolyn was passionate about seeking justice for those who could not help themselves. For the last 12 years of her career she served as the Deputy Prosecuting Attorney in charge of handling civil commitment hearings for Pierce County and Western State Hospital. She represented the petitions of DMHPs from across the state for patients sent to Western State Hospital on a 72 hour hold for many years. She was also involved in a number of cases which were brought to the State Supreme Court and that became a part of case law for involuntary commitment.

Carolyn was active with the Washington Association of Designated Mental Health Professionals writing articles for the Frontlines newsletter, and presenting at a number of our conferences on the law of civil commitment. She was a strong advocate for the independence of the decision making by the DMHP but she also was demanding of the DMHP to articulate that decision in the legal forum of the courtroom through the DMHPs testimony. Carolyn assisted DMHPs from across the state in preparing to give testimony. Carolyn will be remembered for her generosity and passion for DMHPs and the involuntary commitment process.

(**CONTINUED FROM PAGE 1 – President**) It was clear from the hearings this year, the vast majority of the legislators had no idea of the reality of our work. And, as Representative Green suggested last year at the Fall Conference, that we become our local legislator's expert on DMHPs, involuntary commitment, and the local mental health system.

Unfortunately due to a family tragedy Peter Merrill has resigned from the Association Board. If you or someone with whom you work has any interest in serving on the Board, please contact one of the Board members with your interest. Thanks.

And finally, I ran across an interesting document that I encourage all of us to read regarding the ideas the Mental Health Division is reading and considering. It is entitled, "Improving Care: Options for Redesign of Washington's Mental Health System." Here is the address: http://hrsa.dshs.wa.gov/news/legbrief/wastatefinalrev.pdf We have all become accustomed to change in the world of publicly funded community mental health, but it's good to have some idea of the directions being considered.

If I can be of any assistance to you or you have a question or suggestion, please give me a call at 206-369-5893. Stay safe!

(CONTINUED FROM PAGE 3 – David Kludt) The frustrating – We as social service providers continue to be asked to do more with less. We watch with tremendous empathy as co-workers are laid off. We watch the services and safety nets for our consumers slowly disappearing. It is too simple to just say, these are tough times! I truly hope when I write my next Frontlines article that the tough times will be starting to fade.

Oh yes – Greetings from Olympia/Spokane – I have recently relocated (same job) to beautiful Spokane. Below is my new contact information if you ever need to reach me.
Mailing address - 1925 E. Francis Ave - Spokane 99208
Office phone (509) 227-2617
Office fax (509) 482-3603
Blackberry (509) 413-9368

As always be safe!
David Kludt
DBHR/Program Administrator

Frontlines *invites comments, feedback, and submissions. Our newsletter is only as good as the people who are willing to contribute –* ***yes, crisis worker, dashing out the door with that phone surgically implanted on your hip – this means you.***

Please consider sending relevant submissions of any of the following to kschafer@co.stevens.wa.us. You can also reach me by phone at (509) 685-0610 with questions or concerns.

- *Opinion pieces or thoughtful discussion of topics concerning DMHPs*
- *Original artwork or cartoons*
- *Original poetry*
- *Reviews of useful or interesting books*
- *Suggestions of other people who could write interesting articles*

ITA Investigation Statistics, by County,* for 2008

DMHP Investigation County	Detention to MH Facility (72 hours)	Revocation	Grand Total (All DMHP Investigations)	Estimated Population for 2008 Source: Office of Financial
Adams	14	2	34	17,600
Asotin	13	0	59	21,300
Benton	250	45	1976	162,900
Chelan	91	16	515	71,200
Clallam	45	37	120	68,500
Clark	208	7	934	415,000
Columbia	9	1	47	4,100
Cowlitz	156	26	314	97,800
Douglas	0	--	0	36,300
Ferry	5	--	13	7,550
Franklin	47	12	425	67,400
Garfield	0	--	9	2,350
Grant	1	4	19	82,500
Grays Harbor	37	2	43	70,800
Island	80	6	180	78,400
Jefferson	30	0	30	78,400
King	1939	305	6111	1,861,300
Kitsap	379	44	1100	244,800
Kittitas	51	1	52	38,300
Klickitat	18	3	21	19,900
Lewis	52	3	528	74,100
Lincoln	--	--	--	10,300
Mason	24	4	124	54,600
Okanogan	--	5	5	39,800
Pacific	22	2	107	21,600
Pend Oreille	--	--	42	12,600
Pierce	1276	74	1691	790,500
San Juan	18	1	37	15,900
Skagit	556	42	945	115,300
Skamania	3	--	64	10,700
Snohomish	838	89	1480	686,300
Spokane	695	198	1124	451,200
Stevens	--	--	--	43,000
Thurston	175	11	841	238,000
Wahkiakum	0	--	2	4,000
Walla Walla	53	7	402	58,300
Whatcom	702	83	1022	188,300
Whitman	6	--	20	42,700
Yakima	358	55	492	234,200
Grand Total	8,151	1,085	20,928	6,537,800

* Detentions include Secure Detox Facilities. An ' – ' indicates information is unavailable for this county.

ITA Investigation Statistics, by County,* for 2009+

DMHP Investigation County	Detention to MH Facility (72 hours)	Revocation	Grand Total (All DMHP Investigations)	Estimated Population for 2008 Source: Office of Financial
Adams	1	0	5	17,600
Asotin	9	1	48	21,300
Benton	233	30	1617	162,900
Chelan	84	17	387	71,200
Clallam	58	19	191	68,500
Clark	215	5	986	415,000
Columbia	4	0	41	4,100
Cowlitz	170	11	371	97,800
Douglas	1	--	2	36,300
Ferry	--	--	2	7,550
Franklin	60	7	633	67,400
Garfield	2	--	5	2,350
Grant	0	0	0	82,500
Grays Harbor	58	4	73	70,800
Island	53	11	187	78,400
Jefferson	29	--	42	78,400
King	2003	245	5968	1,861,300
Kitsap	301	61	873	244,800
Kittitas	35	2	38	38,300
Klickitat	9	0	9	19,900
Lewis	41	1	468	74,100
Lincoln	--	--	--	10,300
Mason	30	3	130	54,600
Okanogan	--	0	0	39,800
Pacific	7	1	31	21,600
Pend Oreille	--	--	2	12,600
Pierce	492	28	707	790,500
San Juan	16	0	36	15,900
Skagit	305	28	809	115,300
Skamania	0	--	63	10,700
Snohomish	623	73	1518	686,300
Spokane	701	190	1081	451,200
Stevens	--	--	--	43,000
Thurston	185	16	854	238,000
Wahkiakum	1	--	1	4,000
Walla Walla	57	6	86	58,300
Whatcom	457	60	900	188,300
Whitman	4	--	13	42,700
Yakima	346	40	388	234,200
Grand Total	6590	859	18565	6,537,800

* Detentions include Secure Detox Facilities. An ' – ' indicates information is unavailable for this county.

+ Timeliness of reporting by RSNs may influence 2009 data

WADMHP

2010 Spring Conference

Mindfulness Based Stress Reduction for PTSD

Legislative Update

June 23rd

Yakima Convention Center
Yakima, WA

Washington DMHP Association
PO Box 5371
Bellingham, WA 98227