
Bree Collaborative | Risk of Violence to Others Workgroup

January 6th, 2020 | 2:30-4:00

Foundation for Health Care Quality

Members Present

Kim Moore, MD, Associate Chief Medical Officer, CHI Franciscan (Chair)
Anne Allen, Harborview Medical Center & NASW
Laura Groshong, LICSW Private Practitioner Washington State Society for Clinical Social Work
Amanda Ibaraki Stine,* LMFTA, Member Washington Association for Marriage and Family Therapists
Mary Ellen O’Keefe,* ARNP, MN, MBA, Clinical Nurse Specialist – Adult Psychiatric/Mental Health Nursing; President, Association of Advanced Psychiatric Nurse Practitioners

Jennifer Piel,* MD, JD, Psychiatrist, Department of Psychiatry, University of Washington
Samantha Slaughter, PsyD, Member, Director of Professional Affairs for WA State Psychological Association
Jeffrey Sung, MD, Member, Washington State Psychiatric Association
Jaclyn Greenberg, JD, LLM, Policy Director, Legal Affairs, Washington State Hospital Association
Kelli Nomura,* MBA, Behavioral Health Administrator, King County

Staff and Members of the Public

Craig Apperson,* MS, LMHC, CCCJS, BAPC
Jason Fodeman, MD, MBA, Labor & Industries
Katerina LaMarche, Washington State Medical Association

Joan Miller,* JD, Sr. Policy Analyst, Washington Council for Behavioral Health
Alex Kushner, Bree Collaborative
Ginny Weir, MPH, Bree Collaborative

* By phone/web conference

CHAIR REPORT AND APPROVAL OF MINUTES

Kim Moore, MD, Associate Chief Medical Director, CHI Franciscan (Chair) and Ginny Weir, MPH, Bree Collaborative, opened the meeting and those present introduced themselves.

Motion: Approve 10/10/19

Outcome: Passed with unanimous support

REVIEW OF PUBLIC COMMENTS

Ms. Weir walked the group through each of the different public comment categories.

- The group viewed comments made in response to Question 2 and had no changes to make.
- The group viewed comments made to Question 3 and discussed:
 - Whether or not to address a comment made about methamphetamine potentially masking psychosis. The group agreed that there are many substances which can do this, so there is no need to single out one in particular.
 - A comment relating to intimate partner violence; the group agreed that the phrase “including intimate partner violence” should be added to the end of both the “History of criminal acts” and “History of being the victim of abuse” bullets found in the “Assessment of Violence Risk” table.
 - A comment regarding the use of the Adolescent Psychopathology Scale Short Form for adolescent intake. The group decided that this screen would not be specific enough to be validated for risk of violence.

- The group viewed comments made in response to questions 4 and 5 and had nothing to change in the document.
 - The group viewed a comment saying that a path to a 72 hour hold needs to be developed for someone in psychosis; however, such a pathway already exists, so no change was made.
- The group viewed comments made in response to question 6 and discussed a comment asking for clarification of whether or not a warning to third parties is required upon a patient being involuntarily committed.
 - The group agrees that there is a huge amount of ambiguity around when duty is discharged and when to warn third parties. The group added “Note: The steps below are provided as guidance and are not meant as a checklist or as a decision tree” to the beginning of the “Protection of Third Parties” table to help emphasize that practitioner discretion is still required.
 - The group decided that they could not say definitively that referral to a Designated Crisis Responder (DCR) would always equate to a practitioner legally discharging their duty. Upon legal fact finding, it is hypothetically possible that DCR referral would be deemed insufficient without either a warning or further steps taken. In clinical terms, the decision is always up to the practitioner’s judgement.
 - The bullet on issuing a warning to third parties is changed to “At any time, if the provider decides that issuing a warning is needed...”. This is meant to demonstrate that a warning to third parties and a referral to DCR are independent actions and that DCR referral does not necessarily require or prevent an immediate warning.
- Another comment in question 6 asks for an explanation of what counts as reasonable contact to potentially endangered third parties. The group agrees that this is context specific and the group cannot make recommendations.
- The group discussed a comment in question 7 asking what family members should do if they identify a risk of violence coming from a family member.
 - DCRs always contact family members of a patient who is identified for risk; as such, there is no need for the workgroup to include recommendations on that subject.
- The group discussed a comment in question 8 asking for clarification on the language “Display preventive messaging around safe storage of firearms”.
 - The word “safe” is often interpreted by readers as meaning “readily available in case of home intrusion” rather than as “being kept in locked storage”. Group decides to change “safe storage” to “secure storage” to clarify the necessity of locking.
- A comment in question 9 asks whether or not to include language discussing the obligation of employers to provide appropriate support when terminating an employee.
 - The group agreed that this is outside the scope of the workgroup.
- The group discussed an email comment submitted by Jaclyn Greenberg of WSHA regarding the “Washington State Legislature” subsection of the “Recommendations for Other Stakeholders” section of the report.
 - Specific language stating exactly what the workgroup wants from the legislature needs to be included. The group agrees to use the language provided by Jaclyn Greenberg, with modifications where appropriate. Her language clarifies exactly which practitioners are subject to the duty to protect, what conditions explicitly trigger the duty to protect, an ascertainable class of person to whom the duty is owed, and clarification of when duty is discharged.
 - In Jaclyn’s language designating the exhaustive list of clinicians who are subject to the duty to protect, “social worker” is changed to “licensed independent clinical social worker” because these are the only social workers who are licensed mental health workers.
 - The group discusses where and how Jaclyn’s language should be included in the report and if modifications are needed.

- The first bullet, that begins with “The range of clinicians...,” is changed to “The group of mental health professionals subject to the duty to protect as...” and then the list of mental health professionals provided in Jaclyn’s comment, with the change noted above, and with “chemical dependency professional” removed since they are not trained as mental health professionals.
 - “Clarify the scope of the duty to protect by specifying:” is changed to “Define one standard to address the duty to protect third parties across all treatment settings:”.
 - The second bullet in this section is changed to “The duty to protect only arises when the patient has communicated an actual threat of physical violence that poses a serious and imminent threat to the health or safety of a reasonably identifiable person or persons”.
 - “Persons to whom the duty to protect is owed” is deleted because it is now covered by the second bullet.
 - The final bullet, “Options for discharging the duty to protect” will be modified by Ginny to include the option of either fulfilling the duty to warn “or to take reasonable precautions to provide protection”. This brings the wording into accordance with already existing law.
- The group reviewed and approved a change that Ginny made in the “Counseling” sub-section to clarify that reduction in violent acts was not studied in regards to “Assertive Community Treatment”
 - The group reviewed and approved an email comment to change the last bullet of the Violence Risk Management table to, “At each decision point, document actions taken in the health record, other options considered, and the clinical rationale for the actions taken”.
 - The group decided to change the last sentence in the fifth paragraph of the “Community Protection” section so that it clarifies that the law is unclear regarding its applicability to “clinicians who see patients who may be dangerous, but do not meet criteria for involuntary commitment in an emergency department...”. “No special relationship” is changed to “no ongoing relationship” to avoid using legal terminology in a clinical recommendation.

Action Item: Returning to the “Washington State Legislature” sub-section, four group members agreed to develop language, and possibly a chart, that explains the conflicts between current law and the Volk ruling and to deliver that content to Ginny before the end of the week.

CLOSING COMMENTS

Dr. Moore and Ms. Weir thanked all for attending. The meeting adjourned.