MEETING SUMMARY

REGIONAL LAW SAFETY AND JUSTICE COMMITTEE
Thursday, July 30, 2015

7:30 – 9:00 A.M.
Seattle City Hall, Bertha Knight Landes Room
600 4th Ave., Seattle, WA 98104

Theme:

The meeting's theme was Mental Health Legislation and included three panel presentations on different aspects of recent state legislation changes relevant to the intersection between mental health care and criminal justice.

The meeting also included a short presentation from Seattle Police Department Chief Kathleen O'Toole.

Meet the New Seattle Police Chief – Chief Kathleen O'Toole, Seattle Police Department

Chief O'Toole introduced herself to the RLSJC and emphasized her interest in collaboration with members. She has been at the Seattle Police Department for approximately one year. Her vision for the department includes four "pillars":

1. Enhance community trust. Community trust in SPD was shaken in the face of the consent decree and must be rebuilt.
2. Re-build department pride. Chief O'Toole spoke of her high regard for SPD from afar while in Boston. She sent Boston teams to Seattle to learn from the department's practices. She thinks of SPD as a "gem in the rough," but acknowledges there are still challenges within the department. Two favorable reports from federal monitors indicate the "light at the end of the tunnel".
3. Crime and disorder. Part 1 crime is down 13%, but recent random and high profile shooting are concerning. The department uses real-time data to deploy resources efficiently.
4. Running the department as a business. Cops come up through the ranks as good law enforcement officers, but do not necessarily have the management skills for a large organization. Chief O'Toole has hired staff to operate the department more effectively and efficiently.

Chief O'Toole closed by emphasizing her passion for law enforcement. She considers it not a job, but a vocation. She is particularly interested in collaborating with other organizations on prevention and intervention to provide services for people in crisis.

New Mental Health Legislation –Jim Vollendroff, KC Mental Health, Chemical Abuse and Dependency Division; Judge Ken Schubert, KC Superior Court; Dwight Dively, KC Office of Performance, Strategy and Budget

The panel presented information on the impacts of new state mental health legislation.

Jim Vollendroff:

Mr. Vollendroff provided background on Joel's law, which gives family members (defined broadly) the ability for family to appeal the decision of the Designated Mental Health Professional (DMHP) regarding involuntary treatment. The 30 DMHPs respond to commitment requests and determine whether criteria are met. The law went into effect on July 24th and there has been limited interest, but the long-term impacts of the law are unknown. Additional DMHPs are being added in order to meet statutory time frames, which remains a challenge given case volume. Family members can appeal if they disagree with the decision or if a DMHP has not met with the individual within 24 hours.

(See Joel's Law flyer for details)

Judge Schubert:

Judge Schubert provided an overview of the current situation in Involuntary Treatment Court. There has been a 60% increase in caseload, without a similar increase in funding. Judge Schubert knows more DMHPs are needed. An additional challenge this year was the sudden loss of AMR as a transport provider. The court must now rely on video for patients that can't be transported in a van to the court. There is disagreement over the suitability of video proceedings. Defense attorneys would prefer the court was held at the hospital, but previous analysis has shown that option to be cost unsustainable. Video court presents logistical challenges for attorneys, as defense attorneys go to the hospital for video court, but they may not know until the last minute whether the patient can be transported to ITA court.

A recent legislative change in the medical clearance requirement was already applied in King County, but it is easier to apply now that a motion is not required.

Judge Schubert provided a flow chart (available on the RLSJC website) that explains the process for Joel's law. The timelines for DMHPs are limited, and if they cannot respond, the judge must make a ruling without their report. One week into Joel's Law implementation the court has not received any Joel's Law petitions.

QUESTION: Is there a designated person to respond to these petitions?

Mr. Vollendroff: Diane Swanberg is responsible for these petitions as the DMHP coordinator. Mr. Vollendroff explained that King County believes in meaningful family involvement and has always listened to families and worked to educate families about the ITA process. Families can refer multiple times and introduce new evidence that would result in a different decision. Mr. Vollendroff described one concern with the legislation regarding timelines. There is not deadline for submitting the petition. After time has passed and conditions change it would be more appropriate to submit a new request for involuntary treatment than to petition a decision made on previous circumstances. DMHPs are educating families on re-referral.

QUESTION: Are you monitoring the number of affirmative decisions to see if DMHPs are more frequently ruling to detain based on concerns about family petitions under Joel's Law?
Mr. Vollendroff: All the information is tracked, so they will be monitoring that.

QUESTION: When does representation kick in for the client? When are prosecutors assigned?
Judge Schubert: Once there's an order from a judge, the case proceeds as if the referral was from the DMHP. There's nothing to require the hospital to detain someone based on the judge's decision. The person isn't informed that there is a petition filed. One of the challenges with video is it prevents the face to face meeting with family and patient that often resolves issues. Judge Schubert explained another concern around the severe space constraints in ITA court. He is optimistic that recent County Council and Facilities efforts to address this will be successful.

Dwight Dively:

Mr. Dively provided the budget perspective on the intersection of mental health and criminal justice. (See the Fiscal Issues with Mental Health Funding handout.) He explained that Washington State is 49th of 50 states in funding for mental health. As a result, there are some very bad outcomes. Both state and federal courts have ordered that the state needs to respond with additional funding.

Overall the news was good from the recent legislative session. It was the best outcome for mental health in the last decade or so, but there is still a long way to go. State funding was increased, but at the last minute there was a $9 million dollar cut to King County without discussion.

Mr. Dively explained the three different categories of County funding for mental health (please see the "Fiscal Issues with Mental Health Funding" handout on the RLSJC website):

1. State funding – state general fund, Medicaid, grants, etc. - comes to KC : better than it has been in many years
2. Mental Illness/Drug Dependency (MIDD) - The state allows the cities or counties to impose this tax. Interestingly, Pierce County has not imposed it. This tax can be imposed

by the County Council and does not need to go to voters. In King County it expires at the end of 2016. It is highly likely the council will renew MIDD, but there is a process starting now to re-visit the specific programs that are funded. The tax has to be imposed before the budget process (next summer).

It has been permissible to "supplant" General Fund programs with MIDD money. This was allowed during the recession, but the state required the costs to be shifted back to the General Fund over time or eliminated. In 2015, 20% of MIDD can be supplantation but this will be completely phased out by 2017. Court therapeutic programs are exempt, but other County programs will have to be shifted.

3. County General Fund – the General Fund has historically been used for mental health. However, in King County there are so many competing demands that we aren't investing in mental health. Counties in Washington State are uniquely disadvantaged in budget. There's almost nothing the County can do to raise revenue, so cuts to services will be required to meet the budget deficit in 2017/2018 (currently 2.5%).

Mr. Dively commended Mr. Vollendroff and his staff for a phenomenal job managing a very complicated budget.

Alternatives to Boarding Task Force – Jim Vollendroff, KC MHCADS

Mr. Vollendroff explained the background and current situation with boarding. When he began in his current position he made a public statement against the practice of psychiatric boarding and King County has been actively working on the issue since before the Supreme Court ruling prohibiting it. Boarding occurs when a DMHP makes the determination that someone needs to be committed, but there is not a psychiatric bed available, so the individual waits in a hospital. The State Supreme Court found the practice to be unconstitutional. Psychiatric boarding is a national problem and is not limited to the County or the state. It is not a new problem and has been discussed since at least 2002.

There are a variety of causes for boarding. Washington State ranks near the bottom for availability of psychiatric beds and the numbers have decreased in the past several years. State hospitals reduced the number of beds and local beds also decreased. Some of the new funding approved this year will go to increase the number of beds at Western and Eastern State hospitals. The ITA law has been amended 10 times – each time making it easier to detain someone.

A goal of the Alternatives to Boarding Task Force was to look at alternatives to get ahead of the Court decision by finding additional bed space. Some of these efforts are:

- Working with local organizations – Harborview, Navos, Fairfax and Cascade - to bring on additional beds.
- Worked with the State to bring on additional facilities and secured land for new evaluation and treatment center, which will provide new beds in mid-2016.

- Telecare will bring on 16 beds at a future site.
- Working with multi-care to bring on beds in South King County, specifically for the geriatric population.
- Swedish will offer new beds for co-morbid medical issues.
- The team is also looking for alternatives, as in adding a mobile crisis team to intervene earlier, diverting people from in-patient systems by helping them earlier, and expanding the ability to offer next day appointments.

King County has added 350,000 people to its population, without significant additions in capacity or resources to address the volume. The legislature has provided some timeline relief by allowing patients to get medically stabilized prior to the evaluation timeline being triggered for involuntary mental health treatment decisions.

The Task Force is looking at multiple related issues and needs:
- Alternatives, such as assisted outpatient treatment
- Alternatives and resources for people with dementia, developmental disabilities and geriatric issues, where involuntary psychiatric treatment services may not address the patient's needs. Where is the appropriate place for treatment?
- Workforce development – facilities cannot hire qualified employees quickly enough to provide needed services
- Integration of mental health and behavioral health services, which was required by the previous legislative session and will be combined in state contracts in April 2016
- Funding solutions for individuals who are not Medicaid eligible, and for services that are not Medicaid reimbursable. Legal and capital costs come out of the budget for treatment, displacing funding for services.

QUESTION: How has availability of resources for substance abuse affected these clients given co-occurring disorders?

Mr. Vollendroff: King County had a long term contract for detox beds and the contract was terminated at short notice. We were able to secure some beds, but not enough and not at a sustainable rate. RCW 17.13 called for the integration of mental health and substance abuse ITA. I've heard DMHPs take calls and I can tell you that the calls were substance abuse related. We could divert people. We'll be re-introducing legislations to integrate these systems.

QUESTION: Why are beds restricted to 16?
Mr. Vollendroff: Federal rule prevents us from getting reimbursement from larger facilities that have more than 16 beds – this goes back to deinstitutionalization in the 50's. There are some ways that we can use larger facilities in some cases, such as Navos and Fairfax. It is less expensive to use those facilities than state hospitals, but this is on a waiver basis and could change. We are working on federal legislation.

QUESTION: What has been impacted by the rule change on single bed certification?

Mr. Vollendroff: The Supreme Court decision says we cannot board people. DSHS allowed us to get single bed certification for a non-evaluation facility if the hospital could attest that they can provide appropriate care. That is a capacity issue. Patients are there because we don't have enough beds, but in the best case scenario they would be in a specialized facility.

(Please see meeting handouts on the RLSJC meeting website.)

Intersection between RCW 10.77 (Criminal Competency Procedures) and RCW 71.05 (Mental Illness/Involuntary Treatment) – Sergeant Eric Pisconski, SPD; Andrea Chin, Seattle City Attorney's Office; Melody Overton, SMC Mental Health Court, KC Public Defense; Diane Swanberg, KC Crisis and Commitment Program Manager; Laura Collins, Psychiatry Administrator, Harborview Medical Center.

(Please see PowerPoint presentation document, also posted on the RLSJC website.)

Sgt. Pisconski:

Sgt. Pisconski discussed how SPD officers decide where to take a person in crisis. Law enforcement officers are usually the first people on the scene to deal with a situation. SPD trains officers on crisis intervention and gives officers access to resources. All officers are required to take a one-day training to recognize crisis and mental health issues, and about 500 officers have been through the 40-hour, Memphis-model training. All officers are given a pocket card that provides general information on symptoms and disorders to help them determine if someone meets criteria. With this training, officers are armed with the ability to assess an individual for diversion or an ITA process, and make their determination based on interviews, observation and whether the individual meets criteria. The Mobile Crisis Team (MCT) and the Crisis Solution Center are additional resources to call for information and/or referrals.

The Crisis Diversion Facility is an option for individuals who have committed low-level crimes, to provide services as an alternative to jail. If jail is determined to be the right decision, officers have the option to route people though mental health court. The LEAD program is another option that has been very successful.

Sgt. Pisconski heads SPD's Crisis Response Unit, which follows up on mental health cases handled by SPD. Documentation is required for any situation of crisis and is routed to Sgt. Pisconski's office. This crisis response team consists of 4 dedicated officers and a mental health professional. Reports come to the unit for possible follow up, even if individual was not taken to a facility. The Crisis Response Unit will often develop and communicate a tailored response plan, regarding high utilizers of 911 services, to inform and provide guidance to officers.

Statistics – SPD implemented a crisis reporting template and database that went live May 15. Since then, there have been over 2000 contacts reports. Of those, 600 resulted in emergency mental health detentions and 224 voluntary commitments. 40% of the time, officers make the decision for services vs. detention.

Further statistics: Of the roughly 2,000 Crisis templates completed from May 15 – July 27:
600 – Emergent Detentions
224 – Voluntary evaluations
140 – Weapon involved
353 – Declined services
162 – MCT contacted
63 – Case manager contacted
41 – Referred to DMHP
46 – Individuals taken to Crisis Diversion Facility in lieu of jail
144 – Arrests (only 7%)
4 – Instances of a sustained injury (1 Taser application / 3 'other' – abrasion, soreness or bruising – while being taken to the ground) by officer's use of force during the encounter (0.2%)

Panel

Ms. Collins and Ms. Swanberg provided a quick overview of the ITA process and criteria. In non-violent misdemeanor cases the designated mental health professional (DMHP) is charged with making the determination of whether persons can care for themselves and live safely in the community or should be detained and a petition filed with the court for involuntary commitment proceedings. The DMHP looks for least restrictive option, including diverting to the crisis solutions center when appropriate. The DMHP has the authority to make a decision to detain the individual for 72 hours. A judge then determines whether the person should be held for successive periods of 14, 90 or 180 days. When the individual is incarcerated, the DMHP interviews the individual in the jail. In violent misdemeanor cases, the determination of whether a person should be detained for involuntary commitment proceedings is made by the State or an evaluation and treatment facility.

The threshold for civil commitment is that an individual has a mental disorder and, as a result, is gravely disabled or presents the likelihood of harm to themselves/others/property, and in need of involuntary treatment. A mental disorder is defined broadly to include dementia, developmental delay, drug induced psychosis, and traumatic brain injury.

The criminal standard for competency was defined by the Supreme Court in 1960. For someone to face criminal charges, they must be able to understand court proceedings and the charges against them, and be able to assist in their defense. Competency issues can be raised by any involved party – attorneys or judges – at any time.

There are two different ways in which a misdemeanor criminal case can "flip" to become a civil commitment case, depending on whether the case is non-serious or serious (violent.) In either case, the Court dismisses the criminal charges and refers the individual for evaluation. In non-violent misdemeanor cases the designated mental health professional (DMHP) is charged with making the determination of whether persons can care for

themselves and live safely in the community or should be detained and a petition filed with the court for involuntary commitment proceedings. The DMHP looks for least restrictive option, including diverting to the crisis solutions center when appropriate. The DMHP has the authority to make a decision to detain the individual for 72 hours. A judge then determines whether the person should be held for successive periods of 14, 90 or 180 days. When the individual is incarcerated, the DMHP interviews the individual in the jail. In violent misdemeanor cases, the determination of whether a person should be detained for involuntary commitment proceedings is made by the State or an evaluation and treatment facility.
. (See PowerPoint presentation outline for more detail.)

Historically, individuals who have been referred from the serious (violent) case scenario have been sent to Western State Hospital. However, due to capacity and staffing issues over the past two years, Western has declined most cases. To address these capacity issues, a pilot Triage Project was initiated at Harborview Medical Center (HMC), where HMC professionals evaluate individuals in jail to determine whether they meet the criteria for commitment. If so, they were referred for evaluation to Western or to local E&Ts, when Western was unable to provide the evaluation. If the criteria for commitment is not met, HMC petitions a judge to release the person from jail to a safe outpatient plan. Most of the referrals are evaluated and placed locally.

FINDINGS:
- 57% already had outpatient services
- 7% already on less restrictive orders
- 40% petitioned Court for release
- Average length of stay is 2-4 weeks
- Only 2% on 90 day order
- 15% were repeat referrals.

The 10.77 Workgroup continues to look for different diversion opportunities. While there are resources and services available in the system, there is the need to connect individuals early on. In addition, after the initial disappointment in Western's lack of capacity to provide evaluations, the Workgroup saw the benefits to providing services and placing individuals locally, including shorter lengths of stay and cost efficiencies related to transportation and evaluation.

Opportunities and next steps for the Workgroup include legislation and resources for assisted outpatient treatment, resources to expand assertive outreach for established programs and increased diversion.