King County

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

September 10, 2012

Motion 13725

Proposed No. 2012-0278.1 **Sponsors** Lambert

A MOTION acknowledging receipt of a report reviewing programs serving inmates requiring psychiatric or other staff-intensive behavioral services, as required by Ordinance 17232, Section 48, Proviso P3.

WHEREAS, the 2012 Budget Ordinance, Ordinance 17232, Section 48, Proviso P3, requires the department of adult and juvenile detention to prepare a report of programs serving inmates requiring psychiatric or other staff-intensive behavioral services, and

WHEREAS, the department of adult and juvenile detention prepared the report in conjunction with council staff and representatives from: jail health services; Harborview Medical Center; facilities management division; and the office of performance, strategy and budget, and

WHEREAS, the report explores: alternative staffing plans to reduce the costs associated with these detention populations; potential capital improvements that could result in reduced costs; the potential use of jail health staff for the provision of the supervision of these populations; and policy changes needed for the county to either not accept these inmate when they are not a public safety risk or allow for the transfer of these inmates, after intake procedures, to a more therapeutic setting;

NOW, THEREFORE, BE IT MOVED by the Council of King County:

Receipt of the report in compliance with Ordinance 17232, Section 48, Proviso P3, which is Attachment A to this motion, is hereby acknowledged.

Motion 13725 was introduced on 8/27/2012 and passed by the Metropolitan King County Council on 9/10/2012, by the following vote:

Yes: 7 - Mr. Phillips, Mr. von Reichbauer, Ms. Hague, Ms. Patterson, Ms. Lambert, Mr. Ferguson and Mr. Dunn
No: 0
Excused: 2 - Mr. Gossett and Mr. McDermott

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

Larry Gossett, Chair

ATTEST:

Anne Noris, Clerk of the Council

Attachments: A. Review of Psychiatric Services

13725

Review of Psychiatric Services

Proviso P3

2012 Adopted Budget

Ordinance 17232

Department of Adult and Juvenile Detention

July 31, 2012

Table of Contents

Executive Summary

The 2012 Adopted Budget, Ordinance 17232, included a proviso directing the Department of Adult and Juvenile Detention (DAJD) to review "programs serving inmates requiring psychiatric or other staff-intensive behavioral services such as suicide watch, that, at a minimum, identifies and evaluates proposed options for: 1) alternative staffing plans to reduce the costs associated these detention populations; 2) potential capital improvements that could result in reduced costs; 3) the potential use of jail health staff for the provision of the supervision of these populations; and 4) policy changes needed for the county to either not accept these inmates when they are not a public safety risk or allow for the transfer of these inmates, after intake procedures, to a more therapeutic setting." This report is the response to the proviso request.

Between 2009 and 2011, the number of inmates in psychiatric housing in the King County Corrections Facility (KCCF) has increased 22 percent from 133 to 162, while the overall population in the County's adult jails has decreased 14 percent. As a result, the number of inmates in psychiatric housing has increased as a proportion of the total population from 6 percent to 8 percent in this period. The inmates in psychiatric housing, particularly those on 15-minute checks or constant watch, are among the most staff- and resource-intensive inmates in the adult facilities. The absolute increase in their numbers, as well as their increase as a proportion of the total population, has placed stress on both DAJD and Jail Health Services (JHS) staff to manage psychiatric housing in a safe, effective, and cost efficient manner.

In preparing the report, DAJD and JHS staff undertook an informal survey of four correctional institutions (Ada County, Idaho; Broward County, Florida; the District of Columbia; and Snohomish County, Washington), the Harborview Medical Center, and Western State Hospital to understand how the different entities staffed their psychiatric population, managed checks, and used video. The results of the survey demonstrated the variability of practice among different locations, but also indicated that current DAJD practices in terms of checks and the use of video is largely consistent with those jurisdictions surveyed.

In early 2011, as it became apparent that the increase in the number of inmates in psychiatric housing was not an anomaly, DAJD evaluated its staffing model for the unit and adjusted its corrections officer-to-inmate ratio from 1:15 to 1:24. The result was to not only stem the growth in overtime costs in the unit, but to decrease them outright. In the first quarter of 2012, DAJD costs to manage the psychiatric housing unit were $99,000 less than they would have been without the staffing change.

DAJD and JHS continue to work together to better understand the nature of the population in psychiatric housing, what is driving the increase in its size, and how the population can most safely and efficiently be managed. To that end, JHS and DAJD are collaborating on the Psychiatric Services Array Project, a project evaluating psychiatric services from booking through an inmate's stay in psychiatric housing. Before the completion of this work, it is premature to suggest changes to staffing.

DAJD met with Facilities Management Division (FMD) and the Office of Performance, Strategy and Budget (PSB) to discuss building group housing in the West Wing of the King County Corrections Facility

(KCCF) and the Maleng Regional Justice Center (MRJC) and using video for observation in isolation cells as potential capital projects that could lead to staff savings. In both cases, the initial assessment was that up-front costs are high and the potential for cost savings is uncertain without a deeper understanding of what drives the number of inmates in psychiatric housing, particularly the number on checks. The report identifies issues that would need to be resolved for a new group housing configuration to move forward. While video could be used to augment physical checks or watch by corrections officers, the report identifies why it is not appropriate to use it as a substitute for those checks. A common conclusion of both examinations of potential capital changes was that they are premature until the County has a better understanding of how best to serve and monitor inmates with mental illness. The psychiatric services project is the best way available to gain that understanding.

While savings could be achieved by using a health care job class to perform checks and constant watch, the savings from such a change would be minimal as a corrections officer would have to be available to handle any emergencies. Additionally, Washington State law prohibits an employer from assigning work that has historically been performed by one bargaining unit to another bargaining unit without bargaining the change.

The jail is not a therapeutic setting for people with mental illness. Both the County and people with mental illness would benefit if fewer were booked into the jail. To evaluate how the County could defer the booking or transfer of people with mental illness, DAJD staff met with the Prosecuting Attorney's Office and Council Central Staff. The report includes an outline of the policy changes the County could make to allow for the deferral or transfer of inmates with mental illness. However, with one exception, there are currently no places in the community to which inmates could be deferred or transferred other than the streets. The one exception is the Crisis Solutions Center (CSC), which is slated to open in July 2012. This 16-bed facility is intended to provide law enforcement with a place to take people who are in a mental health crisis, other than the jail. DAJD will work with CSC staff to help maximize the use of the facility.

Proviso Language

P3 PROVIDED FURTHER THAT:

Of this appropriation, $250,000 shall not be expended or encumbered until the executive transmits a report and a motion that acknowledges receipt of the report and references the proviso's ordinance, section and number and the motion is adopted by the council.

The report shall be a review of the department of adult and juvenile detention's secure adult detention programs serving inmates requiring psychiatric or other staff-intensive behavioral services such as suicide watch, that, at a minimum, identifies and evaluates proposed options for: 1) alternative staffing plans to reduce the costs associated these detention populations; 2) potential capital improvements that could result in reduced costs; 3) the potential use of jail health staff for the provision of the supervision of these populations; and 4) policy changes needed for the county to either not accept these inmates when they are not a public safety risk or allow for the transfer of these inmates, after intake procedures, to a more therapeutic setting. The report shall identify the options being considered, the costs and any potential savings associated with the option, the resources needed to implement the option and any barriers to implementation. The department should prepare its report in conjunction with council staff and representatives of jail health services, Harborview Medical Center, facilities management division, King County information technology and the office of performance strategy and budget.

The executive must file the report and motion required to be transmitted by this proviso by April 5, 2012, in the form of a paper original and an electronic copy with the clerk of the council, who shall retain the original and provide an electronic copy to all councilmembers, the council chief of staff and to lead staff for the law, justice, health and human services committee and the budget and fiscal management committee, or their successors.

Note: In the 1st Omnibus of 2012, Ordinance 17349, the deadline for this proviso was extended to July 31, 2012.

Background

1. Legal Requirements

Under the Revised Code of Washington (RCW) 70.48.130, local governments operating jails are responsible for providing "...appropriate and cost-effective emergency and necessary medical care." In addition, King County Code 2.16.120 tasks the Department of Adult and Juvenile Detention (DAJD) and Public Health – Seattle & King County to:

> 8. Provide health care to confined or committed adult persons in conjunction with the Seattle-King County department of public health, including medical, dental and psychiatric care;
>
> 9. Provide social services to and for confined or committed adult persons, including, but not limited to, the following: classifying those persons; evaluating mentally ill or developmentally disabled confined or committed persons, including referral to available community programs; reviewing those persons with psychiatric problems; reviewing other special population groups; providing general population group management; and providing outside agency access to those persons including special visitation, library, recreational and educational services;

In addition to the state statute and local code requirements, federal law and regulations, and a significant body of case law, defines the obligation of jail managers to safely house and provide treatment to incarcerated persons, including persons with mental illness. The *Hammer* Settlement Agreement also requires that the King County Corrections Facility (KCCF) be accredited by the National Commission on Correctional Health Care (NCCHC), which provides standards for health services, including psychiatric services. King County has been accredited by NCCHC since 1992.

2. Definition of Terms

A. Inmates with Mental Illness in the General Population

Most inmates with mental illness are not housed in the psychiatric housing unit; rather, they are dispersed in the general population at both the KCCF and the Maleng Regional Justice Center (MRJC). Roughly 20 percent of people booked into the County jails have at least one mental illness diagnosis, while only 8 percent of the average daily population is housed in psychiatric housing. Inmates housed in the general population are considered to be mentally stable, but may require additional support such as therapeutic programming, including pastoral services, Alcoholics Anonymous and Narcotics Anonymous groups, crisis intervention counseling from JHS Qualified Medical Health Professionals, and medication management. Inmates receiving basic mental health services through the general population psychiatric clinic will be seen as clinically indicated, but not less than every eight weeks.

B. Psychiatric Housing

Mentally ill inmates have historically been housed on the 7th floor of KCCF. However, with the increase in inmates needing psychiatric housing, it has expanded, at times, to include beds on the 10th and 11th floors. Inmates housed in psychiatric housing are highly monitored by DAJD corrections officers due to higher staffing levels in the unit as compared to the general population. Admissions to psychiatric housing are made at the recommendation of a Psychiatric Evaluation Specialist (PES) and/or a psychiatric provider. The DAJD Classification Unit, with input from JHS staff, determines the type of psychiatric housing placement required for each inmate based on classification criteria. Housing types include: isolation, group, sheltered, sub-acute, and transitional. Only a JHS medical doctor or Advanced Registered Nurse Practitioner may determine when a discharge or transfer from psychiatric housing can be initiated, unless release from jail is directed by a court.

Inmates booked in to the MRJC who have serious mental health concerns and who will likely require psychiatric housing, are transferred, as soon as possible, to psychiatric receiving in the KCCF. Only those inmates stable enough to reside in general population housing are sent to the MRJC.

C. Psychiatric Receiving

Psychiatric receiving is both a status and a place. Inmates in psychiatric receiving are housed on the 7th floor of KCCF and may be in either group or isolation housing. Because the severity of the prospective mental illness for individuals in psychiatric receiving is unknown, they are all monitored on 15 minute checks by DAJD corrections officers.

When an inmate is sent to psychiatric receiving, a flag is placed in the JHS electronic health records system indicating that an inmate has been referred to psychiatric housing and is awaiting a mental health assessment from a JHS PES to determine what treatment and housing is needed. JHS policy states that patients are to be evaluated, by a PES, within 24 hours of being transferred to psychiatric receiving. The outcome of the screening in psychiatric receiving may be a determination to send the inmate to general population or to hold them in psychiatric housing.

D. Isolation Housing

Isolation housing is for inmates who are not eligible for group housing, either because of their behavior, particularly their risk of self-harm or harm to others, or as warranted by DAJD classification criteria. Once in isolation, an inmate may or may not be subject to 15 minute checks based on his or her assessed potential for self-harm. If an inmate is not on 15 minutes checks, he or she is checked at least once every hour by a corrections officer, as is every inmate in the facility.

E. Group Housing

Group housing in the psychiatric unit is for inmates who are stable, present reduced risk of harm to themselves or others, and are able to tolerate a group housing setting, but require a higher level of psychiatric monitoring than is possible in the general population. Group housing consists of dormitories or "tanks" that can hold up to 15 people. The dormitories contain cots and there is no private space, such as a cell, to which inmates can retreat. The space is monitored by a corrections officer who can see the entire area. Inmates may be on 15 or 60 minute checks while in group housing. Generally, group housing is considered to be more therapeutic than isolation. It is beneficial to expose people with a mental illness to people who are more stable and are able to cope with a group setting. Additionally, inmates can monitor one another for potentially harmful behavior. Only those inmates who are not likely to cause conflict when housed with others are classified into group housing.

F. Sheltered Housing

Sheltered housing is a group housing environment for those inmates who have a psychiatric diagnosis and/or are too vulnerable to be placed in the general population or regular psychiatric group housing.

G. Transitional Housing

Transitional housing is a group housing environment for inmates formerly on behavioral observation or with mental disorder or other psychological vulnerabilities who do not require isolation, can tolerate group housing, but are not yet ready for general population. Transitional housing is meant to be a transition point to the general population or release, but it is optional and many psychiatric inmates do not pass through this housing option.

H. Sub-Acute Housing

Sub-acute housing includes a common day room, as well as cells to which inmates can retreat if they do not want to interact with others and in which they can be confined or racked back by corrections officers as part of managing the unit. Previously this housing type was on the 7th floor, but has been moved to the 10th and 11th floors, which were not designed to house this type of population, due to the increase in the psychiatric housing population.

I. Acute Housing

From the DAJD perspective, acute is a psychiatric status with classification implications. If an inmate is at risk of self harm or harm to others, then he or she has an acute status and is subject to commissary restrictions, is housed in suicide-hardened isolation cells, and requires either 15-minute checks or constant watch.

J. 15-Minute Checks

If an inmate has been assessed as potentially suicidal, he or she is placed on 15-minute checks. When on 15-minute checks, a DAJD corrections officer will observe the inmate at staggered intervals not to exceed every 15 minutes. The check includes visually observing the inmate to ensure that he or she is still breathing and is not engaged in harmful behavior. Inmates on 15-minute checks are considered to have acute psychiatric needs.

K. Constant Watch

An inmate is placed on constant watch because he or she is actively suicidal or is potentially suicidal and has been placed in isolation. An inmate on constant watch is under personal, visual observation by a dedicated DAJD corrections officer at all times. This means that one corrections officer is watching one inmate and has no other duties or responsibilities.

L. Classification

An inmate's classification determines where in the facility inmates may be housed. The DAJD Classification Unit uses an established set of criteria that includes sex, current charge, criminal history, mental health and medical needs, and previous behavior in the facility to determine if an inmate should be in minimum, medium, or high security housing. In psychiatric housing, classification staff assigns inmates to the various types of housing available: group, isolation, sheltered, sub-acute, or transitional. They will review the classification of an inmate monthly or when needed, should inmate behavior change.

3. How Inmates Reach Psychiatric Housing

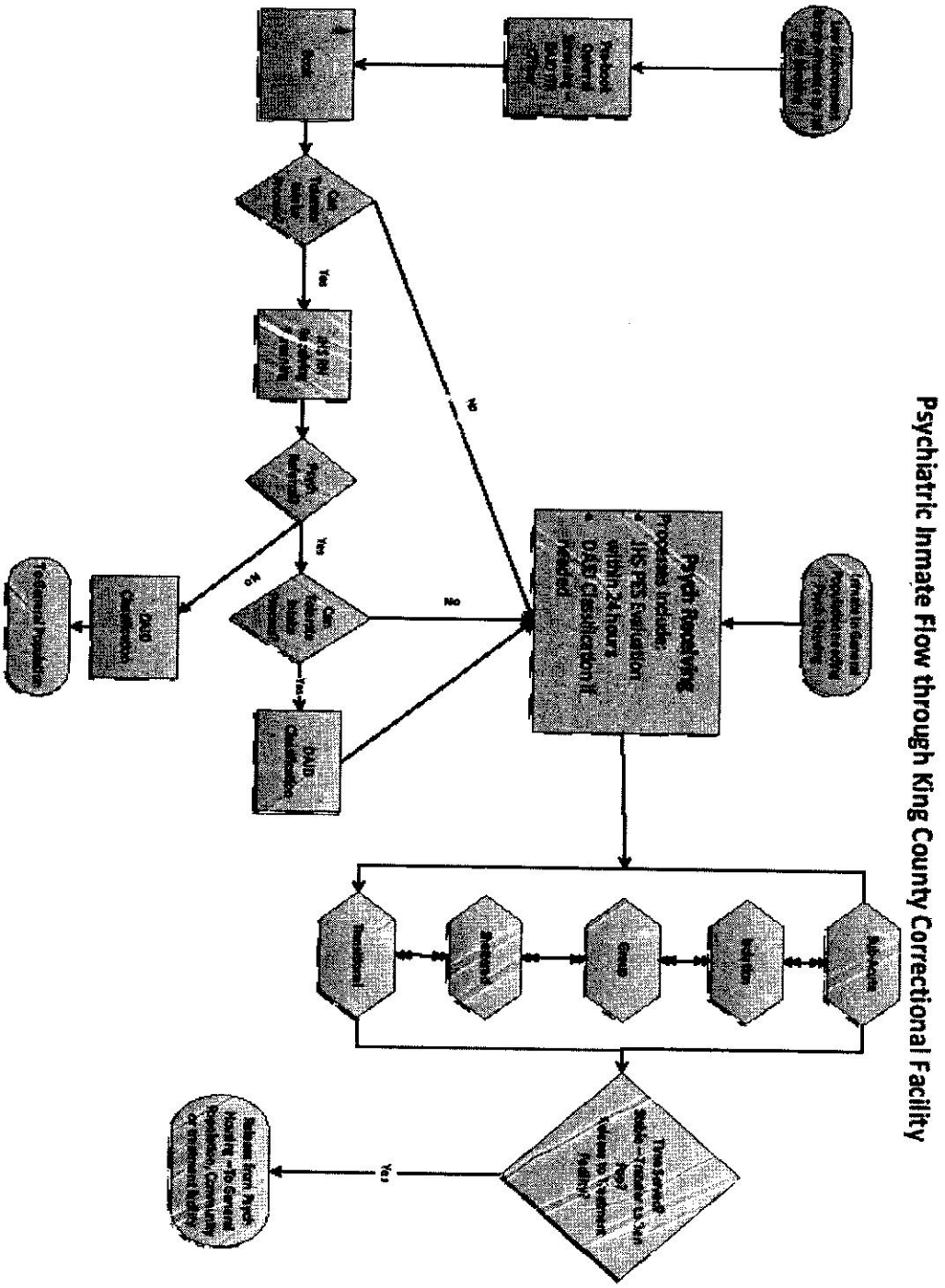
There are three paths by which an inmate may be referred to psychiatric housing.

A. Inmates can be referred to psychiatric receiving at any point during the intake process after being booked into custody. If someone refuses to answer the questions from either the "Deferral Screening" administered by DAJD corrections officers or the "Receiving Screening" form administered by a Registered Nurse, he or she is automatically referred to psychiatric receiving as a safety precaution. An inmate will be referred to psychiatric receiving if he or she (1) is uncooperative or unable to answer the mental health screening questions; (2) is actively suicidal; (3) has attempted suicide in the last 12 months; (4) has attempted suicide in jail; or (5) displays bizarre or inappropriate behavior at screening.

B. Within 14 days of booking, all inmates in the general population receive a Health Assessment, which includes a mental health screening, conducted by registered nurses who have received instruction and training in identifying and interacting with people with mental health conditions. If the Health Assessment reveals a mental health condition that requires immediate evaluation, such as suicidal or homicidal ideation or agitated/aggressive behavior, then he or she is referred to psychiatric receiving. Those inmates with mental health concerns, but who are not suicidal, homicidal, or exhibiting agitated/aggressive behavior will have their medical record referred to the JHS psychiatric providers for review and follow up.

C. If DAJD or JHS staff identify an inmate is at risk of self-harm at any time during his or her incarceration, he or she may be transferred to psychiatric receiving for further evaluation.

The flowchart below maps out how a person is referred to psychiatric receiving and then housed in psychiatric housing.



Psychiatric Inmate Flow through King County Correctional Facility

4. *Housing Decisions*

The decision of what type of housing is appropriate for each inmate must accommodate both the DAJD Classification Unit's security risk assessment and the JHS's assessment of psychiatric status. Generally, when there is a difference in recommendations between JHS and DAJD, the more restrictive option will be selected.

The table below illustrates the interplay between mental illness seriousness and classification criteria in psychiatric housing that determines the level of restriction and type of housing for each inmate in psychiatric housing. Inmates with mental illness who are stable, due to medication or other reason, are housed in the general population.

Table 1:

Classification Risk	Mental Illness Seriousness: Low	Medium	High
Minimum /Medium	**Group Housing** w/o 15 Minute Checks (includes Sheltered & Transitional)	**Group Housing** w/ 15 Minute Checks & **Sheltered** w/ 30-Minute	**Sub-Acute** w/ 60-Minute Checks	**Isolation** w/ 15 Minute Checks or Constant Watch
High	**Isolation** w/o 15 Minute Checks	**Isolation** w/ 15-Minute Checks	**Isolation** w/ 15-Minute Checks	**Isolation or Infirmary** w/ 15 Minute Checks or Constant

4. *Recent Population Trends*

Historically, there have always been inmates with mental illness in the County's jails. While the overall population in the adult facilities has fallen in recent years, the number of inmates with mental illness in the jail has been relatively stable and the number in psychiatric housing has increased. Because inmates in psychiatric housing require a disproportionate amount of JHS and DAJD staff resources, costs associated with running KCCF have not decreased to the same extent as the overall population.

In absolute terms, the number of inmates with at least one mental illness diagnosis has been reasonably stable between 2009 and 2011; however, because the overall jail population has been declining, the

percentage of inmates with at least one mental illness diagnosis has increased from 18 percent in 2009 to 21 percent in 2011.[1]

Table 2

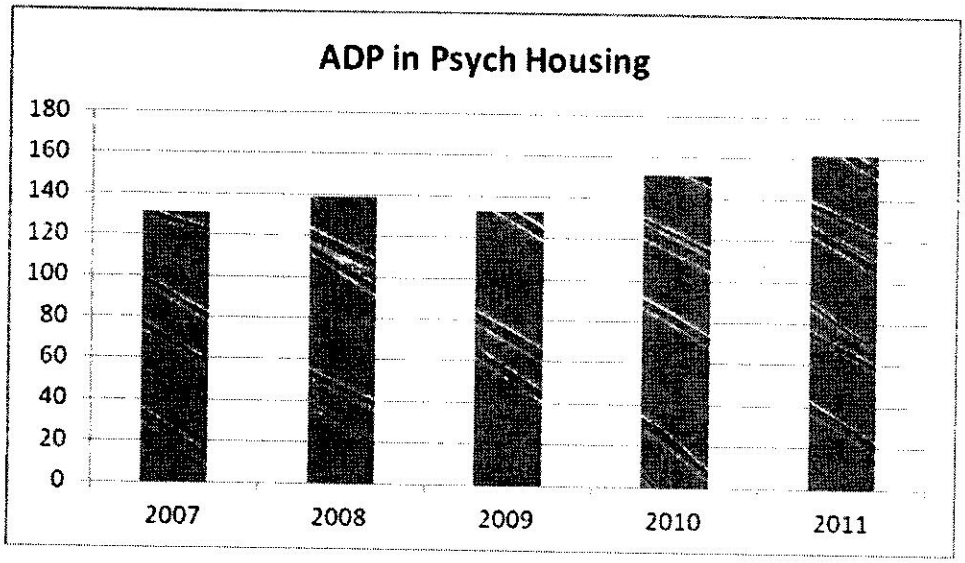
	2009	2010	2011
# of Patients w/ at least 1 Mental Illness Diagnosis	7,859	8,365	7,835
Total Bookings	44,797	43,018	38,089
Mental Illness Diagnosis as % of Bookings	18%	19%	21%

Of those inmates with a mental illness diagnosis, the vast majority are stable enough to be housed in the general population. Those with severe mental illness or who are likely to harm themselves or others need specialized housing, treatment, and observation and these inmates are referred to psychiatric housing.

In 2007, the average daily population (ADP) in psychiatric housing was 131; in 2011, it was 162, or a 24 percent increase. The increase is shown in Table 3 below.

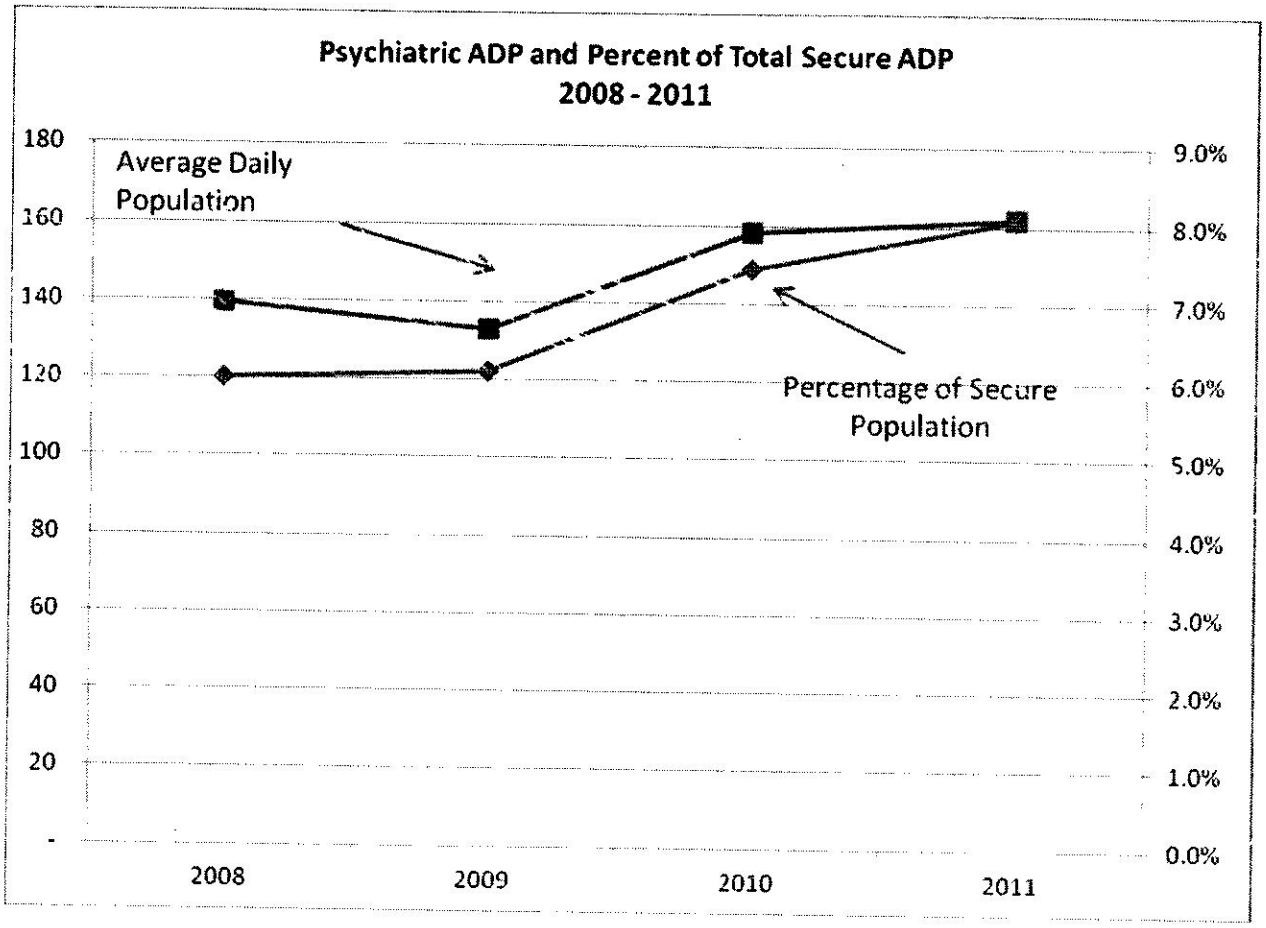
[1] Data for the number of inmates or patients with at least one mental illness diagnosis are drawn from the JHS Electronic Health Records system (PEARL), which tracks the number of inmates who are screened by a Registered Nurse in the intake process and therefore are considered patients of JHS. Although not identical to booking data, these data can be used to closely estimate the number of people with at least one mental illness diagnosis as a portion of total bookings. In limited instances a person can be booked into the jail without staying long enough to receive a health screening by a Registered Nurse and thus being entered in PEARL. For instance, some may be booked as a paper exercise for the Court and others may be released before being screened by a Registered Nurse. However, these instances do not occur often.

Table 3



At the same time, the overall population in secure detention has dropped significantly. In 2007, the ADP in secure detention in both adult facilities was 2,459. In 2011, it was 1,998, or a 19 percent decline. The combination of the increase in psychiatric housing and the decline in the overall population has resulted in the psychiatric population representing an increasing percentage of the total population in the last three years, as shown in Table 4. This shift has had noticeable impact on workload in KCCF and has been a key driver of overtime expenses in this period.

Table 4



5. Jurisdictions Booking the Most Inmates in Psychiatric Housing

The County has responsibility for housing all individuals arrested for felonies. In addition, many jurisdictions will book arrestees on investigation holds while the specific charge is identified. As of July 2012, 20 cities have signed the extension Jail Services Agreement to have the County house their misdemeanants. Table 5 shows the law enforcement agency that booked individuals in psychiatric housing, as well as their most serious offense charge for 2008 to 2011.

Table 5

Bookings with a Stay in Psychiatric Housing by Originating Agency and Charge Type Of the Most Serious Offense – 2008-2011

Agency	2008 Total	2008 Felony 08	2008 Inv* 08	2008 Misd** 08	2009 Total	2009 Felony 09	2009 Inv* 09	2009 Misd** 09
Annual Total	**4,304**	1,498	617	2,189	**4,869**	1,440	690	2,739
Seattle Police Dept	**1,631**	326	313	992	**1,938**	277	381	1,280
WA - City/County (Out of County Holds)	**1,054**	848	0	206	**1,007**	780	0	227
King County Sheriff	**452**	93	96	263	**572**	119	94	359
WA State Patrol	**125**	6	9	110	**199**	3	25	171
Tukwila Police Dept	**82**	13	15	54	**104**	18	13	73
Federal Way Police	**109**	24	30	55	**125**	23	26	76
Burien Police Dept	**87**	19	11	57	**90**	13	15	62
Auburn Police Dept	**49**	22	14	13	**60**	30	22	8
Bellevue Police Dept	**108**	20	22	66	**90**	17	23	50
Seatac Police Dept	**57**	8	13	36	**69**	8	7	54
Renton Police Dept	**54**	19	16	19	**61**	20	16	25
Kent Police Dept	**29**	27	0	2	**36**	25	2	9
All Others	**467**	**73**	**78**	**316**	**518**	**107**	**66**	**345**

Agency	2010 Total	2010 Felony 10	2010 Inv* 10	2010 Misd** 10	2011 Total	2011 Felony 11	2011 Inv* 11	2011 Misd** 11
Annual Total	**5,175**	1,457	727	2,991	**4,963**	1,532	738	2,693
Seattle Police	**2,173**	296	400	1,477	**2,196**	367	388	1,441
WA - City/County (Out of County Holds)	**937**	778	0	159	**922**	741	0	181
King County Sheriff	**587**	103	104	380	**493**	105	113	275
WA State Patrol	**191**	9	13	169	**235**	8	21	206
Tukwila Police Dept	**145**	26	19	100	**168**	30	21	117
Federal Way Police	**152**	37	27	88	**145**	31	26	88
Burien Police Dept	**113**	23	17	73	**108**	19	24	65
Auburn Police Dept	**35**	19	14	2	**71**	29	19	23
Bellevue Police Dept	**75**	12	16	47	**67**	19	23	25
Seatac Police Dept	**91**	6	12	73	**65**	7	16	42
Renton Police Dept	**71**	28	15	28	**51**	23	11	17
Kent Police Dept	**43**	36	3	4	**48**	41	1	6

All Others	562	84	87	391	394	112	75	207

* Felony Investigation ** Misdemeanors

DAJD's examination of inmates housed in psychiatric housing included an analysis (based on the originating agency) of the most serious offense (MSO). Because an inmate may be in custody based on multiple offenses from multiple jurisdictions, the MSO may not be related to the entirety of the inmate's stay in custody. Between 2008 and 2011, the Seattle Police Department (SPD) had the plurality of bookings, with SPD responsible for 44 percent of all bookings in 2011.

Seattle has seen a significant growth in the number of inmates with psychiatric housing days, especially misdemeanant inmates. In 2008, 1,631 inmates with SPD charges spent time in a psychiatric status. By 2011, that had grown to 2,196. Misdemeanants increased from 992 to 1,441. In comparison to all inmates with a psychiatric stay, SPD increased from 38 percent of all bookings to 44 percent.

The second most common source for inmates with psychiatric housing is "Out of County" holds or persons whose most serious offense is from an agency outside of King County such as another county or city not in King County. These individuals were booked on a lesser, local charge. While some of these inmates are being held only as long as is needed to transfer them to their respective jurisdictions, many of these inmates have local, less serious matters that are being resolved prior to the inmate moving on to the next jurisdiction. Further examination of this group is underway.

Alternative Staffing

Proviso Language: 1) alternative staffing plans to reduce the costs associated these detention populations

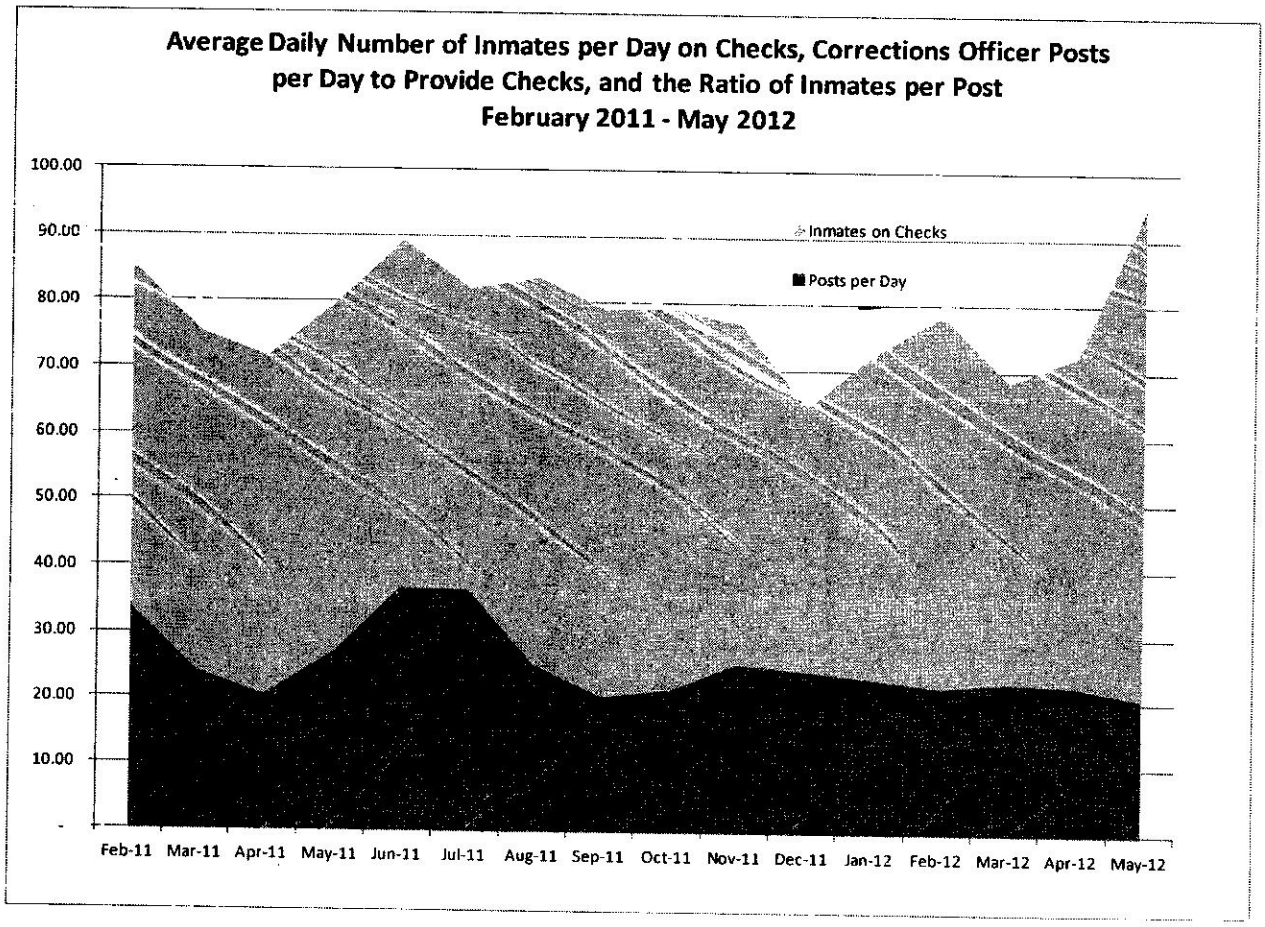
1. *Responses to Population Increase*

The increase in psychiatric housing is disproportionately driving costs in the jail because this population requires a higher staff to inmate ratio due to the number of 15-minute checks and constant watches. The increase in the number of inmates on 15-minute checks and constant watch has caused DAJD overtime usage to skyrocket. As it became apparent that the increase in psychiatric housing, which began in mid-2010, was not an anomaly and would be sustained, DAJD began evaluating its staffing model in an effort to control overtime costs.

Historically, DAJD assigned one corrections officer for every 15 inmates on 15-minute checks, in addition to the regular unit officer. With the increase in population and overtime costs in 2011, DAJD re-evaluated its staffing model for psychiatric housing. As a result of this analysis, DAJD concluded that basing staffing coverage on housing location rather than on the number of inmates on checks was a superior model because it better aligned officer tasks and the number of inmates needing checks. This change reduced the officer-to-inmate coverage ration from 1:15 to 1:24 and decreased the number of posts needed to conduct the 15-minute checks.

As Table 6 illustrates, starting in August 2011, the usage of posts in psychiatric housing leveled out and has decreased slightly in recent months. Whereas before the staffing change, the number of posts fluctuated largely with the population, now the number of posts is relatively stable and the department is better able to absorb population increases without having to add posts and associated overtime costs.

Table 6



The change in staffing has enabled DAJD to avoid significant unbudgeted overtime costs since its inception. To measure the impact of the change, DAJD calculated the overtime costs that would have been incurred had the staffing model not been changed. In the first quarter of 2012, DAJD would have paid an additional $99,000 in overtime had it not made the staffing change. This annualizes to an estimated cost avoidance of $396,000 for 2012.[2]

2. Interdepartmental Prevention of Self-Harm Committee

In addition to evaluating the DAJD psychiatric housing model, JHS and DAJD leadership convened the Interdepartmental Prevention of Self-Harm Committee (IPSHC) to evaluate how the population and level of acuity in psychiatric housing was changing, especially for inmates on 15-minute checks. The goals of the collaborative group included:

A. Maximize safety of inmates (protection from self harm);

[2] Overtime savings were calculated using a pay rate of $53 per hour.

B. Improve therapeutic capacity of program (housing and services); and
C. Timely movement of inmates to clinically appropriate, least restrictive, most therapeutic housing and observation levels.

The work of the group focused on the following:

A. Researching the causes of the drivers of the increase in psychiatric inmates;
B. Identifying and implementing changes to the psychiatric program/suicide prevention program, emphasizing those changes that can have the greatest and most immediate impact;
C. Identifying and recommending additional resources needed;
D. Providing ongoing oversight to the psychiatric program and suicide prevention program as appropriate to meet and maintain goals; and
E. Developing and using data to inform the most effective actions and to maintain ongoing oversight of the program.

Outcomes from the IPSHC effort included the collection of more data that enhanced the County's ability to identify and track cost drivers related to the psychiatric population and the number of people on checks or constant watch. These data also helped to define the characteristics of the population in terms of the proportion of felony vs. misdemeanor charges, as well as length of stay data for inmates in psychiatric housing.

The work of IPSHC resulted in positive changes in the facility and in staff training, as well as the compilation of a great deal of data regarding the growing psychiatric population and improved communications between the agencies. However, IPSHC participants concluded that the scope of the group was not sufficient to meet the challenges of better understanding and managing the psychiatric population. What was needed was a full and common understanding of the entire process related to psychiatric services and housing in the jail. Thus, IPSHC was disbanded and JHS and DAJD leadership instead have launched a Lean process to take a targeted and deeper look at the entire array of psychiatric services in the jail.

3. Psychiatric Services Array – Lean Process

Layered on top of the increase in the psychiatric housing population was the presence of the Department of Justice (DOJ) monitors as part of the settlement agreement between King County and the DOJ. The County was under the settlement agreement from January 2009 to January 2012. In response to the DOJ monitors' suggestions, both DAJD and JHS changed some practices related to psychiatric care and observation. Many of the changes had a positive impact on the health and safety of inmates and staff in the facility, but they were implemented in a somewhat piecemeal fashion without a comprehensive analysis of the full needs of the psychiatric population. Now that the DOJ settlement agreement is complete, both agencies are able to step back and take a holistic look at psychiatric services and housing and refocus on meeting all the needs of the high risk, and resource intensive, psychiatric population in an effective and efficient manner.

To structure this work JHS and DAJD are undertaking a new project: Psychiatric Services Array, using a Lean approach. The effort will focus on aligning staff resources and work processes with best known clinical practices to improve patient outcomes and optimize the number of patients on checks while ensuring that they are provided with the least restrictive security environment that is appropriate. This process will involve the close collaboration of both agencies given the intertwined nature of their day-to-day work. A multi-disciplinary work group has been formed to:

- Prepare a series of "snapshots" summarizing existing data about the psychiatric population, including housing and services to establish baseline data to describe the current state;
- Define clinical levels of care and consistency therein;
- Choose an acuity level scale, which will help standardize treatment, treatment timelines, and housing;
- Define DAJD and JHS staff needed to provide service; and
- Develop quality metrics.

The anticipated outcomes of this effort are a common understanding of the psychiatric services provided, housing operations, and an assessment of current staffing models, as well as standardization of work, greater understanding of the population, greater definition of staff roles, better management of the work load, and reporting on measures that have Equity and Social Justice implications.

The Psychiatric Services Array Project was launched in March 2012 and is anticipated to be completed sometime in 2013. Until this process is complete, it is premature to make further staffing changes to either JHS or DAJD's psychiatric units.

Potential Capital Improvements

Proviso Language: 2) potential capital improvements that could result in reduced costs

The proviso process focused on two potential concepts that would involve capital improvements: Group housing in the West Wing of KCCF and at the MRJC, and the use of cameras to monitor inmates in psychiatric housing.

1. *Group Housing Concept*

DAJD and JHS staff, along with representatives from the Facilities Management Division (FMD) and the Office of Performance, Strategy and Budget (PSB), engaged in preliminary discussions about the concepts of utilizing the West Wing of KCCF and the MRJC for group housing of psychiatric inmates. These concepts have been discussed generally by many people interested in jail operations in the past. For the purposes of the proviso, staff discussed the pros and cons of these two options as compared to the current configuration and identified key issues that would have to be resolved before either concept could be evaluated further.

The concept of group housing has general appeal because it is more therapeutic than isolation housing. Inmates who are struggling to manage their mental illness may find it easier to learn to cope when they are exposed to people who are coping better. Both the MRJC and the West Wing of KCCF have more natural light than the 7th floor of KCCF and officers are better able to observe and interact with inmates in group settings, both of which make for a more positive living environment. Particularly if the space is configured for direct observation, JHS psychiatric staff could be present in the unit to interact directly and consistently with inmates and help manage behaviors stemming from mental illness. And, adding new group housing space may make it possible to identify group housing space for women, which is currently unavailable.

Issues for Resolution

Despite the potential benefits of expanding group housing to new space, the concept raises serious financial, safety, and operational issues that would need to be evaluated and mitigated before any action could be taken.

A. Types of Inmates and Staffing

Currently, demand for group housing exceeds space available; however, it is not clear that there are enough eligible inmates to fill expanded group housing space on the order contemplated in these concepts. The key question is what type of inmates, in terms of both psychiatric diagnosis and classification, might be housed in new group space. Transferring the inmates currently in group housing on the 7th floor would free up space in the KCCF tower, but would not necessarily lead to significant staff savings. Moving inmates currently in isolation and on 15-minute checks to a group environment could lead to staff savings. However, the number of inmates in isolation

and on checks who might be eligible from both a JHS and DAJD Classification perspective is unknown and could be limited. Without resolving the question of what types of inmates and how many inmates might be placed in a new group housing environment, it is difficult to estimate the impact on staffing.

B. Capital Investment

Operating group housing at either the West Wing or the MRJC would require extensive capital upgrades. The West Wing was designed for, and has always housed, minimum security inmates and has not been fully hardened. Security features, such as windows, would have to be upgraded. The beds in the dormitories would likely have to be replaced and changes may be needed to improve sight lines for corrections officers. The MRJC is designed with two levels within each living unit and 64 individual cells surrounding a common area. Depending on the population that would be housed at the MRJC, capital improvements may be needed to restrict access to or make safe the second level of the living units at the MRJC. Additionally, the toilets and bunks in the cells may need to be changed to make them suicide proof and some space would have to be configured as isolation space to manage inmate outbursts. These up-front costs would have to be weighed against potential ongoing savings.

C. Flexibility vs. Efficiency

From a treatment perspective, having some excess capacity can be beneficial because it means that people can be slotted into the most appropriate housing type rather than the next available housing type. This flexibility is offset by the inefficiency of having too much unutilized space. Fully utilizing the space may require expanding the number and types of inmates housed in psychiatric housing.

D. Capacity Trade Off

Changing the physical configuration of the West Wing or an MRJC unit would mean that the space is taken offline for the general population. Such a change would need to be evaluated within the context of the County's entire adult detention system to ensure that DAJD had sufficient space to accommodate the different housing needs of the population.

E. Conflict Tolerance

One way to maximize the use of group housing would be to evaluate the tolerance for conflict in group housing. Currently, if conflict occurs in group housing, the inmate acting out is sent directly to isolation housing. If trained DAJD or JHS staff members were available in the unit, he or she might be able to de-escalate the conflict, so that it did not reach the level that would require a move to isolation.

Further evaluation of staffing models and desired outcomes would be needed to determine if staffing reductions could result from creating new group housing space. This analysis would logically follow the work of the Psychiatric Services Array Project's efforts to better understand the psychiatric population and how best to treat and house them.

2. *Video to Monitor Inmates in Psychiatric Housing*

Based on the informal survey conducted by DAJD, the use of video in psychiatric housing units is common practice. However, the exact use of the technology varies among the four jurisdictions surveyed. Only one (Broward County) uses video in isolation cells in lieu of physical constant observation, although physical 15-minute checks continue to be conducted. The remainder (Ada County, District of Columbia, and Snohomish County) all use video to augment physical checks. Those that used video to augment physical checks reported that the risks associated with relying solely on cameras for checks was greater than they were willing to take on.

Table 7

	Location of Cameras	Use of Cameras
Ada	In All Acute Cells & Dorms	Augment Deputy Observation
Broward	In Infirmary & In Single Cells	Augment Staff Observation in Infirmary & for Continuous Observation in Single Cells
District of Columbia	In Psychiatric Infirmary	Augment Staff Observation
Snohomish	In Mental Health Unit & Booking for Suicide Watch	Augment Deputy Observation

For the proviso response process, DAJD, FMD and PSB staff met to discuss how cameras are used in the adult facilities today and to evaluate extending their use to monitor inmates in isolation housing.

Today, there are approximately 425 cameras in KCCF and 175 in MRJC, of which 75 and 39, respectively, are recording. The cameras provide views of common areas, such as dayrooms, hallways and elevators, but not individual cells. With the images from the cameras, corrections officers in Central Control and Floor Control are able to watch movement throughout the facility and identify any problematic behavior or emergencies. However, there is a limit to how many views an officer can monitor and not all action in the facility is monitored.

On the 7th floor, there are currently a total of 21 cameras. Those cameras on 7 North and East monitor the circulation paths on the floor and the dayrooms. They are not installed in individual cells.

If cameras were added to isolation cells, two cameras would have to be installed per cell to ensure that the entire cell was visible and there were no blind spots where an inmate could not be viewed. Based on previous bids and actual experience, it is estimated that each camera would cost $6,000, including conduit cable, network video recorders, encoders, sales tax, escort costs, hazardous material costs, project management costs and a 10 percent contingency. However, this estimate may be low as past experience has only been in common areas and the facility challenges of installing the equipment in isolation cells is not known. Using the $6,000 estimate, it would cost at least $576,000 to install two

cameras in each of the 48 cells on 7 North and at least $576,000 to install two cameras in each of the 48 cells on 7 East. Based on these estimates, adding cameras to all the isolation cells on the 7th floor would likely cost over $1 million. This estimate does not include the ongoing costs of maintaining and replacing the cameras. The addition of this many new cameras could trigger the need for an additional position to manage and maintain the equipment on an ongoing basis.

If the County were to install in cameras in all the isolation cells, there would need to be a significant savings in staff costs to justify the investment. Such a savings may be possible, if the cameras were used as a substitute for 15-minute checks. (Because constant watch is constant, it requires a single corrections officer dedicated to the tasks whether he or she does it in person or via video.) However, given the risks associated with relying on video observation for people at risk of self harm, such an approach is not advisable.

The purpose of checks is to prevent suicides and incidents of self-harm and they are employed because the inmate has indicated in some fashion that he or she is at risk for suicide or self harm. The key component of physical checks is the visual inspection of the inmate to ensure that he or she is breathing and therefore still alive. If the inmate is sleeping under a blanket or curled up, it may be difficult or impossible to determine if someone is breathing via a video image. Additionally, if the officer assigned to watch the monitors has other duties or is in an environment with distractions, he or she may not be as effective at monitoring inmate status as someone walking the floor and physically checking on inmates. Relying on video alone to conduct checks undermines the purpose of the checks.

The use of video in lieu of physical checks carries risks that have been articulated by the Department of Mental Health and Substance Abuse of the World Health Organization:

> With increasing technology, camera observation has become a popular alternative to the direct observation by correctional staff in some locales. However, camera blind spots coupled with busy camera operators lead to problems. Tragically, there are numerous examples of suicides that occur in full view of camera equipment. Moreover, most inmates dislike constant observation without emotional support and respect. Therefore, camera surveillance should never be utilized as a substitute for the officer's observation of the suicidal inmate and, if used, should only supplement the direct observation of staff.[3]

Given the safety risk for the inmates, DAJD does not support using cameras as a substitute for physical checks. Cameras can, however, be a useful tool to augment checks. It is not clear at this time if the benefit of using cameras to augment physical checks is sufficient to warrant the capital investment.

[3] Department of Mental Health and Substance Abuse of the World Health Organization, "Preventing Suicide in Jails and Prisons," 2007, page 17.

Potential Use of Jail Health Services Staff for Observation

Proviso Language: 3) the potential use of jail health staff for the provision of the supervision of these populations

1. DAJD and JHS Staff Responsibilities in Psychiatric Housing

DAJD and JHS staff have distinct responsibilities within psychiatric housing. DAJD corrections officers are responsible for the physical security and safety of the inmates and of staff in the unit. DAJD corrections officers perform all 15- and 60-minute checks, as well as constant watches. Through past practice, checks and constant watch are clearly defined parts of their job responsibilities. JHS staff are responsible for providing medical and psychiatric care to inmates in psychiatric housing. They evaluate and treat mental illness and make recommendations on housing. DAJD classification, using established criteria, as well as the input of JHS staff, determine the type of housing for inmates in psychiatric housing.

The matrix in Table 8 shows the responsibilities of DAJD and JHS staff in the various housing types in psychiatric housing.

Table 8

Psychiatric Housing Management in the King County Corrections Facility

	Receiving	Group Housing	Sub-Acute Housing	Sheltered Housing	Transitional Housing	Isolation
	Inmates awaiting evaluation by a PES are flagged as being in receiving. May be housed in isolation or group.	For inmates on observation or in need of a higher level of monitoring than offered in the general population and able to tolerate group housing situation, but require a higher level of psych monitoring than in general population.	Housing with single cells ***and*** group day room access for inmates who can tolerate limited or intermittent interaction with others, but can retreat to cells when needed.	For inmates who are chronically mentally ill or otherwise impaired, who are too vulnerable to be in the general population, and can tolerate group housing.	Optional housing for inmates formerly on behavioral observation or with mental disorder or other psychological vulnerability who do not require isolation, can tolerate group housing, and are transitioning to general population.	Single-bunked, isolation cells for inmates who cannot tolerate group housing, either because of their beahvior, particularly risk of self-harm or harm to others, or as warranted by DAJD classification criteria
DAJD Corrections Officer Observation	15-minute checks	60-minute security checks	60-Minute security checks	60-minute security checks	30-minute checks	Depending on need, constant watch, 15-minute checks, or 60-minute security checks
JHS Psych Evaluation Specialist	Sees new referrals within 24 hours to make diagnosis/acuity decision	Weekly follow-up evaluation or daily suicide risk assessment as needed	Biweekly follow-up evaluation, or more frequently as needed	Biweekly follow-up evaluation, or more frequently as needed	Biweekly follow-up evaluation, or more frequently as needed	Weekly follow-up evaluation, or more frequently as needed
JHS Psychiatric Provider	Evaluates new psych referrals within 2 days - 1 day after PES evaluation	Monthly evaluations, or more frequently as needed	Monthly evaluations, or more frequently as needed	Monthly evaluations, or more frequently as needed	Monthly evaluations, or more frequently as needed	Monthly evaluations, or more frequently as needed
DAJD Classification	Determines housing type based on classification criteria; conducts monthly review and hearings for rules violations	Determines housing type based on classification criteria; conducts monthly review and hearings for rules violations	Determines housing type based on classification criteria; conducts monthly review and hearings for rules violations	Determines housing type based on classification criteria; conducts monthly review and hearings for rules violations	Determines housing type based on classification criteria; conducts monthly review and hearings for rules violations	Determines housing type based on classification criteria; conducts monthly review and hearings for rules violations

2. *How Other Jails Staff Checks*

The four jurisdictions surveyed by DAJD used either deputies or medical staff to conduct 15-minute checks, or their equivalent. The two using medical staff, Broward County and the District of Columbia, both contract for jail health services, whereas Ada and Snohomish counties, like King County, provide health services with county employees.

Table 9

	Staff Performing 15-Minute Checks
Ada	Deputies
Broward	Deputies in housing units & infirmary (Medical Technicians/Clerks do constant observation by video in addition to the Deputy's 15 minute physical checks in infirmary single cells)
District of Columbia	Registered Nurses, Licensed Practical Nurses, or Medical Assistants
Snohomish	Deputies

3. *Harborview Medical Center & Western State Hospital*

In preparing the proviso response, DAJD and PSB staff explored the types of staff that the Harborview Medical Center (HMC) and Western State Hospital use for checks on psychiatric patients. Because they are not corrections facilities, neither institution uses corrections officers to staff the checks. Instead, HMC uses either nursing staff or Hospital Assistants to perform checks. Hospital Assistants are also used to perform constant watch. Hospital Assistants earn minimum wage and are required to have a high school education and six months health care education or training. Hospital Assistants perform delegated tasks such as:

- transportation of patients, supplies and specimens;
- ordering and stocking of supplies;
- maintenance/set up of special equipment;
- assisting patients with daily living activities;
- preparing patients for surgery;
- non-invasive lab procedures; and
- keeping close observation of patients and report changes in patient activity and/or symptoms such as vital signs, respiration, discomfort, intake, output, weight, and bleeding.

Consistent with their job description, in the Psychiatric Ward, the Hospital Assistant's role in checks is solely to visually observe the patients to determine that they are still breathing and are not engaged in

self-harming behavior. They record their observations in a log. If they observe that a patient is not breathing or is trying to harm him or herself, they will call medical staff to intervene. Hospital Assistants do not intervene with patients in crisis.

At Western State Hospital, checks are performed by Psychiatric Security Assistants (PSA), who are paid between $2,482 and $3,117 a month. Western State is not a jail and therefore does not have corrections officers, but it is a secure facility in that patients may need to be confined or restrained and cannot leave without permission. As a result, it requires specific staff, PSAs, to maintain security in patient wards. The duties of a Psychiatric Security Assistant include:

- Maintains order and discipline in housing and treatment areas, protects employees and patients from acts of violence from recalcitrant patients.
- Performs security work and nursing care for psychiatric patients with charges and pending charges as well as those who have been found incompetent to stand trial for offenses.
- Assists professional staff with evaluation process for residents that have court commits awaiting competency determination.
- Inspects patient areas for cleanliness and order; searches ward and person for contraband. Escorts residents to active treatment and appointments, as per CFS security protocol.
- Provides for patient safety and comfort through attention to general health and assistance, and guidance and nourishment.
- Maintains an attractive and comfortable ward environment. Maintains adequate supplies, inventory of patient's property and personal clothing.
- Provides guidance toward rational behavior and implementation of treatment strategies as outlined in the treatment plan; reports and documents observations of patient response to treatment.
- Pursues and assists with containment of potentially dangerous patients.

If a PSA observes a patient in crisis while performing checks, he or she will alert other hospital staff and will intervene to keep the patient from harming himself or herself.

4. Cost Comparisons

A comparison of the base hourly pay rates for relevant job classes from JHS, Public Health—Seattle & King County (PH), HMC, and Western State against DAJD corrections officers shows that health care staff are comparable to or as little as half the cost of corrections officers, depending on the classification, as shown in Table 10.

Table 10

Agency	Job class	Salary Range (hourly rate)*
JHS	Medical Assistant	$18.67 to $23.66
PH	Healthcare Assistant	$18.67 to $23.66
JHS	Psychiatric Evaluation Specialist	$32.21 to $40.82
JHS	Advance Registered Nurse Practitioner	$37.46 to $52.68
JHS	Licensed Practical Nurse	$22.16 to $28.35
JHS	Registered Nurse	$30.95 to $43.32
DAJD	Corrections Officer	$25.05 to $33.42
HMC	Hospital Assistant	$11.95 to $17.09
Western	Psychiatric Security Assistant	$14.60 to $18.34

While lower-level health staff are less expensive than corrections officers, given the limitations on their training it would not be possible to do a simple one-for-one substitution. Occupants of the Medical, Healthcare, and Hospital Assistants job classes could not be expected to intervene with an inmate in a mental health crisis because it is well beyond their job description. As a result, corrections officers would have to be available to respond in emergencies, limiting the extent to which their ranks could be reduced. It is within the job description of a Psychiatric Security Assistant to intervene in mental health emergencies; however, such a job class does not exist in King County and would have to be created. Regardless of job description, shifting the work away from corrections officers is not legally viable.

5. Legal Environment

Utilizing health care staff such as Medical or Healthcare Assistants, or creating job classes equivalent to Hospital Assistants or Psychiatric Security Assistants, is not simple in Washington State's legal environment. Under RCW 41.56.140(4), bargaining units hold the exclusive right to bargain regarding the work of the employees they represent. For an employer to assign work that has historically been performed by one bargaining unit to another is called "skimming," and is an unfair labor practice. The only ways to legally reassign such work are to successfully negotiate with the incumbent union the ability to skim its work, or take the issue to an arbitrator and have the issue decided in the County's favor.

Policy Changes for Refusing or Transferring Mentally Ill Inmates

Proviso language: "4) policy changes needed for the county to either not accept these inmates when they are not a public safety risk or allow for the transfer of these inmates, after intake procedures, to a more therapeutic setting."

1. *Current Policies for Booking and Transfers*

Current County practice allows DAJD to refuse booking to people who have severe medical trauma and who should be treated in a hospital. These individuals are transported by law enforcement to Harborview Medical Center.

Because the laws governing jails vary from state to state, DAJD did not ask the four jurisdictions surveyed for other parts of this report about booking restrictions. Instead, it surveyed jails in Washington State and found that its policy to have no booking restriction, except for severe medical conditions, is consistent with other jails. Only those jails with capacity constraints or who contract with other jurisdictions have stated deferral policies. See Table 11 for more detail.

Table 11

Jail	Description of Booking Restrictions
Asotin County	Cap status at 46 inmates or 8 female inmates. When in cap status only felony arrests, felony warrants and DV misdemeanor arrests are accepted. No out-of-county misdemeanor warrants.
Clark County	Booking restrictions and early release options will be implemented if jail population reaches 683 inmates. See Clark County Jail Overcrowding policy and procedures for more detailed information.
Grays Harbor County	Capacity of 130 inmates due to current staffing levels . At 130 inmates, only felony arrests, felony warrants and felony commitments are accepted. Misdemeanor warrants and misdemeanor commitments are restricted.
King County	No booking restrictions, except for emergency medical condition
Kirkland	No booking restrictions stated
Kitsap County	No out-of-county misdemeanor warrants except DV related crimes.
Kittitas County	No booking restrictions stated
Klickitat County	No booking restrictions stated
Lewis County	No restrictions since new jail was built in 2004.
Lynnwood	46 bed municipal jail for misdemeanant bookings. Restrictions are due to lack of on-site medical, psych and space. Contracts with Snohomish County.
Marysville	Several agencies contract with Marysville. Agencies are restricted from booking persons who are not being charged with a new crime or booked for a warrant not from Marysville court. Other restrictions are: medical reasons, physical handicaps, mentally ill, suicidal persons, clearance for booking (determination of the admitting ER doctor to determine individuals housing location - Marysville or Snohomish County).
Pend Orielle County	No booking restrictions stated
Skagit County	No out of county misdemeanors and local misdemeanors only with permission ahead of time based upon space availability.
Snohomish County	No restrictions, other than emergency medical, for county or contract city bookings, as long as Snohomish is the primary booking facility. Will not book out of county warrants less than $500 and must be extradictable if out of County.
Spokane County	Booking restrictions will occur if the jail count is over 620 inmates (Emergency Status) or over 650 inmates (Critical Status). See Spokane County general order for more detailed information.
Thurston County	No booking restrictions stated
Whatcom County	No booking restrictions since opening minimum security jail.
Yakima County	Booking restriction may occur for medical reasons.

Although not technically a deferral or transfer, the County operates the Regional Mental Health Court (RMHC), which is a therapeutic court designed to address the underlying mental illness that may be the cause of the behavior that led to arrest and booking in the first place. A key component of RMHC is placing defendants in appropriate psychiatric treatment. Thus, RMHC serves as a means by which inmates with mental illness can find treatment outside the jail and have their legal matter resolved as part of the treatment and recovery process.

While the jail is not a therapeutic environment and not an ideal place for people with mental illness, booking and holding an individual in jail may help expedite the resolution of an outstanding legal matter, particularly if the individual has a history of failing to appear for court appearances. People with mental illness may have difficulty remembering to show up for their court appearances. When someone fails to appear for a court appearance, a warrant is typically issued for their arrest. While someone is in jail, he or she can be taken to court to resolve the original charge as well as the failure to appear warrant, if their mental state allows.

2. Policy Changes Needed to Defer Booking for Mental Health Reasons

Because the jail is not a therapeutic environment, it would be ideal if inmates with mental illness who are not a public safety risk could be deferred from booking or transferred to a therapeutic environment. Accomplishing that goal relies on the availability of treatment options in the community. Given the recent cuts in funding to social service and mental health agencies around the state, such alternatives are not realistically available in King County.

If King County wished to restrict the booking of inmates due the presence of a mental illness, with consideration of the severity of the charge, significant procedural changes would be needed.

- Clear public safety criteria would need to be established, possibly based on the current charge and the person's criminal history. These criteria would be needed to provide DAJD staff guidance in determining who could be considered for deferral.

- Clear mental health criteria would need to be established, to provide JHS staff guidance in determining whether an arrestee could be denied booking based on mental illness. The evaluation process would be challenging given that people who may be highly agitated as a result of the incident that led to their arrest or by the process of being arrested and brought to jail may calm down as they proceed through the booking process. Further complicating the evaluation, many people with mental illness also have co-occurring substance abuse issues and it may be difficult to distinguish between behaviors resulting from mental illness and substance abuse. This distinction is critical to determining the treatment needed.

- Consideration would need to be given to tort liability implications. As Washington State has relinquished sovereign immunity, the County would be exposed to undue liability risk should a deferred person later commit a further crime. A tort protection mechanism, such as a non-discretionary court order instructing the jail to not book if the arrestee matches the criteria, would be an important piece of any deferral process.

As a practical matter, evaluation for mental illness and public safety risk would have to occur in the pre-booking period after law enforcement has brought the arrestee to the jail, but before the jail has accepted custody. Because DAJD would not have completed the booking process, the law enforcement officer would have to retain custody of the arrestee until the evaluations are complete. If the evaluations determine that the arrestee would not be booked, the law enforcement officer would have the choice of taking the arrestee elsewhere or releasing him or her to the street. If the law enforcement officer was not willing to wait for the evaluation to be completed, release to the street would be the assumed option. Someone who has not been booked cannot remain in the jail without law enforcement oversight.

In the alternative, the presumed action for a deferral might be to contact a Designated Mental Health Profession (DMHP) for evaluation of the arrestee for a civil commitment proceeding. If the arrestee is booked, the jail may hold the person for 72 hours beyond the end of a charge in order to be evaluated by a DMHP. If the arrestee is not booked, the person would need to be taken to an Evaluation and Treatment facility (E&T), most commonly HMC, for up to 72 hours to await a DMHP's evaluation

Under the existing Jail Services Agreement (JSA), the County may only defer booking a contract city misdemeanant if the inmate needs urgent medical care, the city has failed to timely pay a billing, or capacity limits are exceeded. However, the JSA provides for a "specialty rate" for contract inmates who are housed the in the medical or psychiatric units of the jail. Thus, deferring booking for city inmates with mental illness has potential revenue implications for the County. If the County were to pursue booking restrictions based on mental illness, it would have to renegotiate the JSA to allow for the change. Otherwise, DAJD would have to implement a system where some inmates who were evaluated as low public safety risk and having mental illness would be booked or not booked based solely on arresting jurisdiction.

3. Policy changes needed to allow for transfer to a more therapeutic setting

If King County wanted to move an inmate who had been booked and was in the custody of DAJD to a different physical location that is considered to be a more therapeutic setting than the jail, several policy issues would need to be resolved.

- Clear public safety criteria for transfer would need to be established, possibly based on the current charge, institutional behavior and the person's criminal history. These criteria would be needed to provide DAJD staff guidance in determining who could be transferred.
- Clear mental health criteria for transfer would need to be established, including current diagnosis by JHS mental health professionals. These criteria would be needed to provide JHS staff guidance in determining who could be transferred.

Transfer could be done in two ways. Either the inmate could stay in the custody of the DAJD, but be housed in a separate mental health facility, or the inmate could be released from custody and housed in a separate mental health facility. If the former, a decision on how and if to guard the inmate while not in a County facility would be needed. Would DAJD treat this like an admission to HMC where an officer is

posted to the inmate for the duration of his or her stay, or would the County depend on the facility's own security as it does with Western State Hospital? The latter option would require an order from the court or courts having jurisdiction over the cases that are holding the inmate in custody.

4. Community alternative for people with mental illness

A change in County policy to allow for deferral or transfer of inmates with mental illness presumably relies upon the availability of mental health treatment in the community. If an arrestee is not booked or is later transferred from the jail, where will he or she go? The answer is that there are very few alternatives available in the community and the street is the most likely destination of arrestees not booked or held in the jail. Local psychiatric hospitals are operating beyond their capacity. The State has reduced resources for treatment and housing of mentally ill people in recent years. Most people in jail lose any Medicaid eligibility they may have had if they had it to begin with, and, along with it, access to services in the community. The one potential alternative to jail for arrestees with mental illness is the Mentally Illness and Drug Dependency (MIDD) funded Crisis Solutions Center, which is scheduled to open in the summer of 2012.

In King County there are five E&T facilities that provide acute, in-patient care for mentally ill people: Fairfax Hospital in Kirkland, Harborview Medical Center in Seattle, Navos Mental Health Solutions in West Seattle, Northwest Hospital and Medical Center in North Seattle, and Seattle Children's Hospital in Sand Point. The purpose of acute psychiatric hospitalization at an E&T is to evaluate, diagnose and stabilize acute symptoms and is intended to be of short duration. In the last two years, these hospitals have been deluged with patients and are not able to admit new patients in a timely fashion. In 2011, 1743 individuals, or 52 percent, of the 3367 people who were detained for 72 hours in King County under the Involuntary Treatment Act were "boarded" at emergency rooms and inpatient hospital units not meant for involuntary psychiatric treatment. These hospitals have "one-bed certifications" from the State to give them the authority to treat these individuals. Boarding often means that a person is restrained on a gurney for extended periods waiting for a bed at an E&T. Often, patients do not receive any treatment during the time they are boarded. Based on the first quarter of the year, it is anticipated that up to 70 percent of people committed in King County will be boarded in 2012. Any person deferred or transferred from the jail would likely be boarded and add to the pressure on psychiatric hospitals.

Western State Hospital, which serves adults age 18 and older who have been referred by the court for a civil or criminal commitment under Revised Code of Washington (RCW) 71.05 or RCW 10.77, has also exceeded its capacity. Western State is the regional state psychiatric hospital for 19 western Washington counties and provides evaluation and inpatient treatment for individuals with serious or long-term mental illness. Due to budget cuts, Western State has closed wards and reduced the number of people it can accommodate to 500. Unfortunately, people whose competency needs to be evaluated or restored must wait in local jails or mental hospitals until a bed is available at Western State. The increase in the wait time adds burdens to the Courts and local facilities, leading to an increase in the number of people with acute mental illness housed in local facilities.

As a result of this overflow in usage of E&T facilities and constraints on Western State Hospital, it is extremely unlikely that someone deferred at booking would find a bed and associated treatment in a psychiatric facility. Further, there is no facility to which inmates can be transferred while in custody, secure or otherwise.

5. Crisis Solutions Center

When it was approved by the King County Council, the MIDD Implementation Plan in 2008 included funding for the building and operation of a Crisis Solutions Center (CSC) to provide an alternative to incarceration or hospitalization for people who are in crisis due to mental or addictive illnesses and who are currently being sent to jails or hospitals because more appropriate, therapeutic options do not exist. The CSC is not intended as a replacement for people who require jail or hospitalization for their own safety or for the safety of others. Because it will target a population of high-users of local jails and hospitals, the CSC has the potential to reduce the strain on these facilities, reduce costs to taxpayers, and provide a therapeutic environment to encourage better outcomes for people needing mental health or substance abuse treatment. The extent and nature of the impact the CSC will have on jail operations and psychiatric housing will not be known until well after it is opened in July 2012. The data collected for this report, especially that in Table 5, can serve as a baseline against which impact of CSC on jail booking can be gauged.

The CSC will have 16 beds to provide 72-hours of care for people in a mental health or substance abuse crisis. The CSC is voluntary, but people cannot walk in off the streets. Only law enforcement, Medic One, King County Designated Mental Health Professionals and hospital emergency rooms can refer people to the CSC. People brought to the facility will be screened to ensure that they do not have a history of violence, including domestic violence offenses, before they are admitted. The criteria for entrance into the CSC were developed by representatives from the treatment profession, law enforcement, public defense, the King County Prosecuting Attorney's Office and the City of Seattle Attorney's Office. If a law enforcement officer brings someone to the CSC, he or she will only be admitted if the underlying charge is one of a defined set of misdemeanors.

In addition to the 16 crisis beds, the CSC will also include a two-week program known as Crisis Diversion Interim Services for homeless people who have completed the Crisis Diversion Facility 72-hour program. This "backdoor" will have 30 beds and provide longer term treatment for patients.

The CSC provides the best near-term alternative to housing mentally ill individuals in jail. In recognition of that fact, DAJD will meet with the CSC to coordinate as much as possible. For instance, DAJD will train Intake, Transfer and Release officers in the admittance criteria used by the CSC so that they may suggest law enforcement officers take arrestees to the CSC rather than booking them in jail. Even if the law enforcement officer does not accept that suggestion in the moment, he or she will be more cognizant of the alternative available in the future. DAJD will also ensure that its contract cities are aware of the CSC as an option to booking and that DAJD staff will suggest law enforcement use the facility for eligible cases.

Conclusion

The recent increase in the demand for psychiatric housing has strained the resources of both DAJD and JHS. As a result, both agencies have undertaken efforts separately and collaboratively to better understand the changes in the population and mitigate cost impacts. These efforts have led JHS and DAJD leadership to launch the Psychiatric Services Array Project, using a Lean process. This project is a targeted effort to align staff resources and work processes with best known clinical practices to improve patient outcomes and optimize the number of patients on checks while providing the least restrictive security environment that is appropriate. This effort is underway and expected to be completed in 2013. Until the Psychiatric Services Array Project is completed and the underlying forces driving the population are better understood, it is premature to make staffing changes in either agency.

In conjunction with JHS, FMD, the PAO, and PSB, DAJD explored two concepts for capital change in psychiatric housing: new group housing space in the West Wing of KCCF or at the MRJC, and using video to monitor isolation cells. In both cases, without having a better understanding of what is driving the psychiatric population, particularly the number of inmates on checks, it was unclear if the capital investment would be recouped through operating savings.

In the near term, the opening of the Crisis Solutions Center in July 2012, offers the best alternative to incarcerating people with mental illness who are arrested on low-level misdemeanor charges and alleviating the work and costs in psychiatric housing. DAJD Intake, Transfer, and Release officers will suggest law enforcement officers take arrestees to the CSC rather than booking them into jail. DAJD will also undertake outreach to its contract cities and the King County Sheriff's Office to encourage them to take advantage of the resources the CSC offers.