MENTAL ILLNESS TOUCHES EVERY CORNER OF AMERICA.

Our streets, schools, jails, hospitals, families. This crisis isn’t unknown. We’re reminded of it in every violent outburst of a troubled person. And yet how many pleas for help go ignored? How many sick people are warehoused behind bars? When will America find a way to do better?

‘THESE PEOPLE ARE US’

A primer on mental health, the costs and the high stakes for Americans

BY HEIDI GROOVER

The first warning signs were the toys scattered all over the floor. The night before, Tammy Crider had watched her 3-year-old daughter Alecia go quietly to bed. Now, the next morning and the room a mess, it was clear the little girl had been up all night.

Things would only get worse: violent tantrums, screaming matches, school suspensions. Tammy sought out behaviorists to try to help manage Alecia’s outbursts, but the changes didn’t stick. They saw a psychiatrist, but Tammy worried the doctor was overmedicating Alecia.

Inside, Alecia only felt more mixed up the older she got. Her moods would shift suddenly and unexpectedly. She said things she didn’t want to say, but couldn’t seem to help it. She’d swell with anger at herself and then shut down to avoid saying anything at all.

The behavior wasn’t entirely surprising. Tammy adopted Alecia and knew her biological family had a history of mental illness, but that didn’t make the puzzle any easier to solve. At 11, Alecia was diagnosed with bipolar disorder. She was at once unpredictable and “like a zombie” from medication. At 15, Tammy moved her daughter into a group home.

“Don’t make me stay here,” Alecia cried.

...continued on page 22

LOCKED AWAY

From the Spokane jail, Amanda Cook sent heartbreaking letters to her family. But help would come too late

BY JACOB JONES

At her best, Amanda Cook could still give off the light of her former self — the bright, giggly girl who grew into a doting young mother. A photo from last summer shows Cook posing confidently with a deep-dimpled grin, one leg jutting forward, one shoulder cocked back, a warm reflection of the Spokane woman who once loved shopping and doing her sister’s hair.

“She liked music and she liked fashion,” her older sister Melissa Parker says. “She had a very good heart. … If anyone in her family needed anything, she was right there.”

At her worst, the 25-year-old Cook turned unpredictable, paranoid and sometimes violent. Parker says “everything went all bad” a few years ago. Her sister fell into drugs, lost her daughter to the state and racked up a string of arrests for increasingly troubling crimes.

While Parker blames the drugs, she says she had noticed lingering effects on Cook’s mental state. She would hallucinate, suffer long bouts of crying and fear those around her. In a fit of frustration last March, Cook intentionally set fire to a trailer where she lived near Elk. In early October, she was arrested for assault after smashing through a window into her mother’s Spokane home and attacking her with a wooden club.

...continued on page 27

EDITOR’S NOTE: These special reports are the first in our “State of Mind” series delving into the issue of mental health. Besides exposing serious problems, we will also strive to tell success stories and examine potential solutions. If you have feedback or a story to share, please email us at editor@inlander.com.
While awaiting a mental evaluation, the 25-year-old sent letters to her sister: “I’m sorry. I lost my mind! I hate what has happened to me.”
For Tammy, the moments that told her something was wrong were dramatic. For the nation, they may be less tangible. Yet across the Inland Northwest and beyond, mental illness — and the cobbled-together health care system meant to address it — is becoming impossible to ignore. A quarter of the U.S. population — nearly 80 million people — has a diagnosable mental illness, including conditions like depression and attention-deficit disorder, and about 6 percent live with a serious mental illness, like schizophrenia or bipolar disorder, according to the National Institute of Mental Health.

Estimates vary, but spending on mental health care totals at least $113 billion a year in the United States, or about 6 percent of national health care spending. Still, only about half of those with mental illness in the U.S. get the treatment they need.

Service providers say they’re seeing an increased demand for mental health services. The recession may be at least partially to blame: A national survey commissioned in part by the National Alliance on Mental Illness showed that jobless Americans were four times as likely as the employed to “report symptoms consistent with severe mental illness.” Those who experienced pay cuts or decreased hours were twice as likely.

The national suicide rate, which dropped between 1990 and 2000, has been steadily rising since. Today, it’s the 10th leading cause of death. About a quarter of homeless adults in shelters, and 20 percent of those in local and state prisons and jails, have a mental illness as streets and prisons become homes for those not receiving treatment. A 2007 study of veterans returning from Iraq and Afghanistan found that 31 percent of them received mental health or psychosocial diagnoses when they returned home.

Meanwhile, states across the country, including Washington and Idaho, sliced a total of $1.6 billion from mental health funding during the years of budget slashing between 2009 and 2012. Among the states with the most dramatic cuts, Alaska hacked 35 percent of its mental health budget while Arizona trimmed 23 percent, according to an analysis by NAMI Idaho and Washington fared better, but each still cut mental health funding by about 11 percent.

Tightening the squeeze, federal stimulus dollars that had temporarily increased the federal match for Medicaid — the government health care coverage program utilized by many low-income people with mental illness — expired in the summer of 2011. So even in states where spending on mental health care has risen since then, care may not have increased because new dollars were simply filling in the gap left by the temporary stimulus. And despite the benefits of Medicaid programs, a growing gap exists, consisting of those who make too much to qualify for government aid but not enough to afford good private coverage. That shortfall is especially dire in states like Idaho where lawmakers opted not to take federal dollars to expand Medicaid under the Affordable Care Act.

Locally, some decision-makers are taking notice. A recently released report from the Spokane Regional Criminal Justice Commission called for an evaluation of the Mental Health Court, a specialty court run by Municipal and District Courts. The report also called for an expansion of the Spokane Police Department’s training to respond to mentally ill offenders. The rallying cry for better training has intensified in the nearly eight years since Otto Zehm, a mentally ill janitor, died after a violent confrontation with Spokane police. When his family settled its lawsuit against the city, crisis-intervention training for SPD was a requirement of the settlement.

Priority Spokane, a group of local organizations including the city, county and nonprofit groups, has named mental health care the next biggest challenge facing the region. Providence’s Sacred Heart Hospital recently added seven emergency room beds in an observation unit specifically for those with mental illness. The rooms are designed to be more safe for those suffering from symptoms of mental illness, with sharp tools out of reach and fewer stimuli to help patients stay calm. They’re nearly always full.

“The hardest thing I ever did was make the decision to not parent her on a daily basis.”
“There is not a family in the entire country that doesn’t know or live next door to or work with someone [who has experienced mental illness]. It’s time for us to start stepping up and owning this,” says Sandi Ando, the public policy chair for NAMI’s Washington state chapter. “These are not sick people. These people are us.”

STRETCHED THIN

As Tammy struggled to find care for Alecia, she sought help from Passages Family Support, a local agency that pairs people who have a mental illness or who have children with mental illness with other people or parents. There, Tammy got advice on the wrenching decision of whether to place Alecia in a group home. She struggled, feeling like she owed it to her daughter to take care of her, to not cast her off as someone else’s problem. But over time she realized Alecia’s outbursts were endangering them both, and she wanted to see her get better.

“The hardest thing I ever did was make the decision to not parent her on a daily basis,” Tammy says, her voice cracking. “It was hard to ask for help, but I knew I had to ask for help because I couldn’t do it by myself.”

Today, Tammy works as the office manager at Passages, where other parents often come looking for direction.

The ways in which people find, access and pay for mental health care are complex. Hospitals, private doctors, nonprofits and government-funded service agencies all play a role, and patients pay for care with private insurance, state aid and often out of their own pockets.

A large majority of patients receive outpatient care, like counseling or prescription drugs, rather than long hospital stays or institutionalization — a major shift since the early 1900s — but about a fifth of them say they or their family paid most of the cost, signaling significant gaps in insurance coverage.

Most people accessing mental health care (about 60 percent) are covered by private insurance and around 20 percent are covered by public insurance, like Medicaid and Medicare, according to the most recent data from the National Survey on Drug Use and Health.

Today, both the public and private systems are in flux with the implementation of the Affordable Care Act. While coverage should expand under the ACA and parity laws have attempted to mandate that insurance companies cover mental health care to the same extent they cover other types of care, the results so far remain mixed. Some say insurers have responded by raising premiums or cutting benefits.

For Medicaid recipients, eligibility requirements vary from state to state, and even with the promise of expansion in Washington state, roadblocks face some clinics serving people in need. Peg Hopkins, CEO of the Community Health Association of Spokane, a group of clinics that provide sliding-scale care to uninsured and underinsured patients, says her agency is reimbursed per month rather than based on what care is needed for a patient, stretching resources.

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**THE DARK AGES**

Today’s community-based system has not always been the model. America’s early history is littered with stories of dank asylums and questionable treatments: lobotomies, malaria inoculations and insulin-induced comas. In 1887, Nellie Bly feigned insanity and penned her famous *Ten Days in a Mad-House.*

“The insane asylum on Blackwell’s Island is a human rat-trap,” she wrote. “It is easy to get in, but once there it is impossible to get out.”

The *Life* magazine exposé “Bedlam 1946” gave an account of state psychiatric hospitals plagued by inadequate staffing and poor care. “The vast majority of our state mental institutions are dreary, dilapidated excuses for hospitals, costly monuments to the states’ betrayal of the duty they have assumed to their most helpless wards,” wrote Albert Q. Maisel, who described the institutions as “concentration camps that masquerade as hospitals.”

In the decades to come, much of that would change. Between 1955 and 1980, during a movement known as “deinstitutionalization,” the population of mental institutions across the country fell from 559,000 to 154,000. Drugs were becoming more effective for treating the symptoms of mental illness, making it more socially acceptable to allow people with mental illness to live in the community. Chlorpromazine, marketed in the U.S. as Thorazine, was first used in France to sedate surgical patients after a surgeon found that the drug calmed patients’ anxieties about their upcoming procedures. When doctors tested it on a 24-year-old man who had experienced psychotic episodes, he was stable...
Between 1955 and 1980, the population of America’s mental institutions fell from 559,000 to 154,000.

“The time has come for a bold new approach,” John F. Kennedy told Congress in a “Special Message On Mental Illness and Mental Retardation” in February 1963. The question of caring for the nation’s mentally ill had come to the forefront, with hundreds of thousands of people institutionalized and the public cost growing.

“When carried out, reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability,” Kennedy said, outlining a plan to encourage more research of mental illness and more community-based care.

The move was an important shift toward compassion for those with mental illness, but building the services that were supposed to take the place of institutions took more time and money than some anticipated. Slowly, states moved people to nursing homes and other facilities, but it wasn’t until 1993 that states were actually spending more on community services than state-run institutions. Patient advocacy groups like NAMI recognize the good done by deinstitutionalization, but say a lack of funding left some without sufficient care, a lapse the system is still making up for.

“The history of deinstitutionalization began with high hopes and by 2000, our understanding of how to do it had solidified. But it was too late for many,” wrote the authors of a 2007 report, “Learning From History,” from the Kaiser Commission on Medicaid and the Uninsured.

“Looking back it is possible to see the mistakes, and a primary problem was that mental health policymakers overlooked the difficulty of finding resources to meet the needs of a marginalized group of people living in scattered sites in the community. Multiple funding streams were uncoordinated. Even when needs were eventually recognized it was difficult to braid together a comprehensive service package.”

‘I FEEL NORMAL’

In her four years away from home, Alecia, now 19 with chin-length blonde hair, has softened in her feelings about the staffed facility where she lives and toward her mom for sending her there. She visits Tammy each weekend, when they go shopping and watch movies together.

“It’s nice for me, but it’s not here,” she says, fidgeting with the sleeve of her magenta sweater on Tammy’s couch. Along with bipolar disorder, Alecia has some developmental delays, so she often seems to be hovering between her own age and a few years younger, but both she and Tammy say she’s made significant progress since the move. Her favorite books lately have been the Maximum Ride series by James Patterson, stories about a tight-knit group of teenagers who are part human and part bird. They’re orphaned and on the run; societal misfits with secret powers. At the group home, her room is painted “Pepto-Bismol pink” with an Eiffel Tower drawn on the wall. Sometimes, when her feelings overwhelm her, she slips under her tall captain’s bed, blasts Shakira or country music from her phone and focuses on breathing deeply. She hopes to graduate from high school in another year or two and move out on her own or with her boyfriend.

“I feel normal,” she says. “I think of myself picturing normal, but not like real normal.”

Tammy has worked to give her that semblance of normalcy, but it’s never been easy. When Alecia was...continued on next page
small and would have an outburst in public, Tammy could feel the heat of others’ judgment. Once, when she started screaming because Tammy wouldn’t buy her a candy bar at Safeway, the woman in front of them in line told Tammy her daughter was a “brat” who needed to be disciplined better.

“Why don’t you try talking to her right now?” Tammy shot back.

Family members didn’t know how to react to Alecia’s sharp mood swings and often didn’t recognize them as symptoms of an illness. Tammy hopes that increased awareness of mental illness — its prevalence and its severity — might reverse that and make people pause before ridiculing a family like hers.

“It’s not anything anybody’s chosen,” she says. “[People with mental illness] deserve to have a good life just like anybody else.”

Historical evolution in mental health care has brought a slow decline in public stigma about mental illness. Yet media coverage of high-profile incidents like school and workplace shootings can blur the lines between violence and mental illness, leading the public to connect the two. In fact, statistics tell another story.

Studies of the connection are complicated because both mental illness and acts of mass violence are rare, but the connection appears weak. The increased likelihood of violent behavior among those with mental illness, if it exists, is small. More significant may be that people with mental illness are about 11 times more likely to be the victims of violent crime than the general population.

As stigma continues to fade and more people seek treatment, the system will only be under more stress.

Dr. Saj Ravasia, the medical director of Sacred Heart’s psychiatric department, says demand for care is increasing and the conditions his patients are in are getting worse. Often, Ravasia says, those without insurance or financial help are waiting longer to seek mental health care, meaning their conditions are more severe once they arrive at the hospital, increasing the strain on hospital resources. (Where his unit once saw about 25 percent of its patients being involuntarily committed because they’re a danger to themselves or others, he says that segment is now around 75 percent.)

He and his colleagues are also seeing an increase in patients in need of both mental health and substance abuse treatment, complicating their needs. And while the need for psychiatric services is growing, interest in the profession among aspiring doctors isn’t, necessarily. Ravasia is blunt: Psychiatry, especially in the emergency room, isn’t a glorified profession. Aspiring doctors rarely anticipate ending up doing this sort of high-demand, high-stress work, he says, and once they do it can take a toll.

According to the U.S. Department of Health and Human Services, nearly 95 million people already face a shortage of mental health care, compared to about 60 million facing a shortage of primary care and 47 million facing a shortage of dental care. A shortage of providers means the systematic issues currently at play could get worse in the years to come as today’s providers retire. The DHHS, which designates “Health Professional Shortage Areas,” estimates that about half of the need for care is going unmet nationally. Washington is meeting only 43 percent of its need and Idaho meets about 62 percent.

The array of challenges means the solutions must come from all corners, Ravasia says, but change will start with both government dollars and a shift in thinking.

“There needs to be a real change in political will to care for the underprivileged in our society, because there’s still this misconception that people just have to pull their bootstraps up and get on with it,” he says. “These are medical illnesses. This is not because they don’t want to do better.”

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“She was a good girl before all of that,” Parker says. “She liked to draw. She drew butterflies.”

With her most recent booking, Cook returned to a jail system overrun by mental health challenges, a system where inmates spend all day locked down, where medication comes slowly and where a simple evaluation can stall proceedings for months, leaving people stranded behind bars regardless of guilt or innocence — a system that ultimately could not save Cook from herself.

From jail, Cook wrote letters about her growing confusion, fear and regret. On Dec. 3, she was released from her cell to take a shower. Somehow, she smuggled a bedsheet.

“I have hurt everyone who has cared about me. … I’m really not sure what has gotten into me honestly.” – Cook wrote in a letter, Nov. 3

Within the black-mirrored glass monolith of the Spokane County Jail, the regional criminal justice system bears a responsibility it was never built to shoulder. In the wake of deinstitutionalization in the 1970s, local jail facilities have become the modern asylums, granted dwindling resources to meet the growing demands of a nuanced population of inmates with diverse treatment needs and sensitivities.

The country jails in Chicago, Los Angeles and New York now stand as the three largest mental health facilities in the nation, together treating more than two and a half times the combined capacity of the country’s top three mental health hospitals.

Spokane County Sheriff Ozzie Knezovich argues that federal and state lawmakers have forced mental health care onto underfunded local governments. With state and community facilities cutting programs, jails across the country have evolved into warehouses for locking up large numbers of the mentally ill. A 2012 survey of 20,000 jail inmates found 17 percent met the criteria for serious mental illness.

“The criminal justice system,” Knezovich says, “is not really the proper place for mental health treatment. … The jail is [already] way beyond its limits.”

In 2009, the Spokane County Jail took the unprecedented step of obtaining certification as a licensed mental health provider, becoming the only jail in the state to do so and making it the second largest mental health facility in Washington. It now provides mental health services for more than 2,000 inmates a year — one in six of the approximately 12,000 adults under age 55 who received mental health services of any kind in Spokane County each year.

Kristina Ray serves as manager of the jail’s mental health department. Since joining the jail staff in 2007, Ray says mental health personnel have worked to provide the same level of care as any other treatment facility, even as those types of facilities have closed their doors or cut their numbers of beds. Her staff of three mental health professionals, plus a few contract and intern positions, remains on call 24 hours a day. They assess inmates, provide stabilization, offer short-term counseling and develop discharge plans for follow-up upon release.

“When I first started here, corrections and mental health were two very separate fields,” Ray says. “I have seen a complete 180-degree shift.”

A 2012 audit of the Spokane County Jail by the Regional Support Network, which oversees mental health services across Eastern Washington, found the staff responsive and well organized. Mental health advocates with the nonprofit Disability Rights Washington and other organizations have commended the Spokane jail for several proactive policies, but they also argue the system and services remain insufficient all while new demands continue to multiply.

Ray says the number of local inmates with mental health issues has gone up slightly, rising from about 1,700 in 2010 to 2,050 in the 2013 contract year. But the severity of conditions also has increased. As other facilities have cut community-based services, she says, the people showing up in the Spokane jail have suffered from more significant problems, more dangerous signs of crisis.

“They’re more symptomatic,” Ray says. “They’ve been off their medication longer. They’re higher risk. It’s a lot more severe cases.”

Five years ago, the jail might have had five people on suicide watch.

“Now, it’s 20,” she says, “and that’s not uncommon.”

“I’m sorry I lost my mind! I hate what has happened to me.” – Nov. 3
Locked Away, Continued...

Wrapped in a blanket, the man says he sees nonexistent numbers wallpapering his cell. He had an argument with God, he explains, over the pounds per square inch of force needed to break the skin of an apple. God won, of course. In a strained voice, he starts listing the religious significance of prime numbers. He stops to rub his face.

"Ahh. I just want my meds," he moans. "You guys have been working on it since Monday."

It's now Thursday.

Jail officials say nearly nine out of 10 mental health inmates require some kind of medication stabilization, but the process can be complicated. Standridge tells the man she has to have him sign a release to get his prescription from his doctor, then his doctor has to confirm the medication and dosage, then the jail's physician has to approve the dosage, then the jail has to actually order the medication from the pharmacy, then he can get his meds.

The process can take several days. Inmates cannot bring their own supply for fear it could be tainted or misused. The jail's mental health professionals also can prescribe medications, but inmate accounts suggest that process can still take weeks in some cases.

In the case of Amanda Cook, her sister says the Pend Oreille County Corrections Facility in Newport had Cook on medication last fall that helped moderate her mood, but when she was released and soon rebooked into the Spokane jail in October, she could not get back on those meds. Spokane officials would not comment on Cook's treatment.

"They should have known about the medication she was on," Parker argues. "I don't understand why they weren't communicating [with Pend Oreille County]. I don't understand why Spokane wasn't doing anything to help her."

Many factors determine if and when an inmate receives medication. Spokane jail nurse manager Cheryl Slagle says the jail transitioned from a Pennsylvania-based pharmacy to a local pharmacy in September, which has helped speed up parts of the process. They can now fill emergency prescriptions in less than two hours, but they still have to follow proper safeguards.

Standridge tells the man in the blanket that she will follow up on his medication and see about getting him access to a phone.

"You're never coming back," he growsls.

"Look, we all know my mind got f---ed up!" — Nov. 3

At her desk in the nearby county Public Defender's Office, defense attorney Kari Reardon tallies her caseload from last year — 262 separate charges. Of those, 29 charges — more than 11 percent — were dismissed because the defendant was not mentally competent to assist in his or her own defense. She then counts up her 64 open cases, 17 of which have stalled as defendants wait for mental health evaluations.

Reardon, who sits on the mental health advisory board for the Spokane County Regional Support Network, acknowledges her client ratio might be a little higher than average, but there's still a huge number of mentally ill defendants in the local criminal justice system — tying up courts, law enforcement operations and especially the Spokane jail.

"Our folks with jail mental health have a tremendous burden," she says. "I know they try. It's just an overwhelming amount of people."

Reardon, like many other advocates, argues the criminal justice system should not be expected to provide primary housing and treatment for those who need mental health services. Jails were never really meant to be mental care facilities. But for many, they have become the only option.

In July, one of Reardon's clients allegedly started throwing rocks at cars outside Spokane Falls Community College. Court records indicate that when campus security confronted him, the 32-year-old man admitted the offense, saying "he wanted to go to jail to receive medication."

"That gentleman needed mental health help and was literally damaging cars so he could go to the jail and get his medication," Reardon says. "That a person commits a crime to get help is a really sad state of affairs."

Jail officials confirm similar stories from other inmates. One 46-year-old Spokane woman recently booked into the jail has a long history of committing petty crimes to receive a monthly injection. During an interview outside her cell, the woman tells the Inlander she had few options for treatment at the time. She was homeless. She didn't have insurance. So every other month she would go to the emergency room, and the month she would get herself arrested on a minor crime.

"It's just tough," the woman says.

For those with few options, mental health manager Ray says the jail can serve an important role in stabilizing individuals and connecting them to long-term community care providers. Navigating any medical or mental health system can be difficult, even for those without mental issues, so the jail at least provides an accessible route to those who need it. Ray acknowledges it's not ideal, but says other services can have long wait lists, high costs or confusing restrictions — the jail has to admit and treat everyone immediately.

"We'll see them at any time for any reason," Ray says. "They don't get billed. There's no charge to receive mental health care. ... They don't have those barriers to getting treatment here."

"You guys want your sister back and I want to be a part of my family again. I've got a lot of shameful guilt. I just need to let go of, but it's hard. Honestly, I feel like a freak show. I'm really hoping to still have a chance to get my mind right and be able to be with you where I belong." — Nov. 18

Dark pink doors seal the segregated cells along the double-tiered block of Four-East where most of the jail's male offenders with acute mental health issues wait out their time. Each door has a small slot about three feet off the floor. Eyes peck out from many of the openings as men in yellow jumpsuits crouch down to stare or shout through their only hatch to the outside world. An arm emerges from one slot, clutching an envelope, passing it to a neighboring door where another hand snatches up the letter.

Four-East has 46 single-person cells, almost always full. Due to staff shortages and security protocols, mental health inmates remain locked down in their cells for 23 hours a day, sometimes more. During their one hour of "out time," they can wander the carpeted common area, pick out books, shower or watch the flat-screen TV on the wall. Jail officials say they dislike the heavy restrictions, but have limited resources.

In cell 4E31, 28-year-old Scott Adams perches on the edge of his bunk. He wears two jumpsuits, doubling layers for warmth. The Army veteran has rough-cut brown hair and the word "GRUNT" tattooed in black capital letters down the length of his forearm. He seems tired, but agreeable, as he leans forward with a sort of resignation regarding the concrete all around him.

"I've started to name the walls," Adams says, pointing. "That one's Kennedy. The door is Logan."

His cell has high ceilings and a small vertical window. By the door, a stainless steel combination sink-toilet fixture bolts into the corner. You can talk to other inmates through the sink if you blow all the water out of the pipes, Adams explains, but the toilet plumbing also is connected, so whatever gets flushed upstairs ends up in his toilet bowl until he flushes it down the line. He looks up to the ceiling as a loud clanging starts up from the cell above him.

"It's a horrible atmosphere," he says, adding, "No [other jail] has a setup like this where they just lock you
Many of Washington’s jails do, though. While jail officials say mentally ill inmates have trouble “maintaining” if they are not housed by themselves, civil rights advocates argue constant lockdown forces inmates into de facto solitary confinement, which is typically used as extreme punishment. Research studies going back to the 1970s associate solitary confinement with increased depression, hypersensitivity, fear, hallucination and incidents of self-mutilation.

Reardon notes that Death Row inmates in Walla Walla get more time out of their cells than local mental health inmates at the county jail.

“If you were already sane, that would probably drive you insane,” she says of the isolation and disruptive environment.

Adams says he appreciates the Spokane mental health staff, but says the jail conditions come close to “torture.” He can’t sleep. He suffers constant nightmares. His fellow inmates will scream and holler as they struggle with their own demons next door. And the inmate above him continues banging away at all hours. Adams sometimes uses toilet paper to plug his ears against the racket. He takes anti-anxiety medication to calm his nerves.

“There’s nowhere to go,” he says. “You just lay here and take it.”

“I talked to my attorney today. She says Eastern is gonna come and give me an evaluation here in the next week or so. I’ll let you know. Please pray for me … I need to pull myself together. I’m losing my mind.” — Nov. 18

Any defendants with suspected mental health issues must undergo a psychological evaluation to determine whether they are competent to stand trial or whether they can assist in their own defense. Once a question of competency is raised, nothing can move...continued on next page
“Locked Away,” continued...

forward until a state-licensed evaluator can meet with and question the defendant for about an hour. Eastern State Hospital provides seven evaluators to cover 20 counties across the east side of the state.

“There’s a severe bottleneck on that,” Sheriff Knezovich says. “We really need to get that system fixed.”

Ray, the jail mental health manager, says Eastern State has a lengthy waiting list. Inmates can face weeks or months of sitting in jail just for an evaluation, before they can even begin any trial proceedings. Mental health inmates can sometimes serve more time in jail awaiting an evaluation than they would have if convicted of their underlying charge. It’s a major frustration for all involved.

In May of 2012, the Washington State Legislature imposed new standards requiring state hospitals to conduct evaluations within seven days if a defendant was in custody of the jail. A new legislative audit report released Jan. 7 shows Eastern State Hospital met that deadline in only 1 percent of hundreds of evaluations it conducted. The average waiting period stretched to 33 days.

Monthly waitlist records from Eastern State Hospital show the backlog of jail inmates who have waited longer than seven days for an evaluation has continued to increase in the past year, steadily rising from 19 people in January 2013 to nearly 50 by the beginning of this year.

Public defender Reardon says she sent Eastern State an urgent letter on Dec. 2 over a client she considered “extremely, extremely depressed,” asking for help to arrange a faster evaluation. She sent a follow-up letter on Dec. 28, reinforcing her plea. “The best she could get was Feb. 5, more than two months after his initial booking.

“I’ve had a case recently where I finally just brought a motion to hold Eastern in contempt,” she says. “That got my client evaluated more quickly, which is an unfortunate reality.”

Amanda Cook was booked into the Spokane County Jail on Oct. 12. Her attorney filed a motion seeking a mental health evaluation on Oct. 28. Seven days went by. Then 33 days passed without any evaluation. Cook sat waiting, locked down alongside dozens of other inmates facing similar challenges. Her letters turned despondent. “I don’t know what the heck happened,” Cook wrote her sister on Thanksgiving. “My head really got twisted, Melissa. Why did things happen like this? I think I see where everything is going.”

Parker says Cook needed medication and inpatient treatment as she grew increasingly afraid of the jail staff and depressed over the loss of custody of her young daughter. On Dec. 3, just days after her daughter’s 6th birthday and with the holidays quickly approaching, Cook came to her breaking point.

“I really don’t understand why Spokane didn’t have her on suicide watch,” Parker says. “They kept putting [her evaluation] off and putting it off, until finally she couldn’t take it anymore.”

Cook crept into the showers at about 11:40 a.m. and threw her bedsheet up over part of a vent, investigators say. Jail staff found her hanging, alone and unconscious, about 30 minutes later. She never woke up and on Dec. 6 was declared dead.

“I didn’t mean to cause so many problems … I wish I would have gotten my head together … Then none of this would have happened.” — Nov. 28

Ray could not comment on Cook’s death, but says her staff works tirelessly to provide the best possible care to everyone in the jail. She knows they could do better with more staffing or money. A new jail with advanced treatment facilities would go a long way. Her staff also could use a full-time position to follow up with inmates after release to make sure they attend appointments. County officials also could direct more defendants into specialized Mental Health and Drug courts.

Eastern State Hospital has requested funding for more beds and evaluators to expand treatment and speed evaluations. Disability Rights Washington recommends increased involvement with families and reducing the amount of time offenders spend in isolation. They say some jails have introduced policies to refuse inmates with severe conditions, directing them to a facility of higher care.

“There’s so much more that everybody could do,” Ray says. “We could offer more services here if we had more resources and more staffing. Everybody could offer a higher level of care so [people] don’t get stuck in the system, so they don’t kind of go from the jail to Eastern to the streets and back and forth. But that all boils down to funding.”

As Reardon again counts through her many clients with mental health issues, she says she reminds herself each defendant is somebody’s sister or father or grandparent. They’re all people who deserve the same compassion as anyone. But instead of getting treatment through a hospital, they are getting trapped in a legal system that is failing them.

“Our system is broken,” she says. “It’s nothing any one person in particular is doing wrong, but our system is broken.”

Next week in the State of Mind series: Ketema Ross is a poet, a scholar, an advocate, a diagnosed schizophrenic and, by law, an innocent man. Seven years ago, he committed a violent crime for which he was later acquitted by reason of insanity. He’s not serving time behind bars, so why does he feel like a prisoner of the state?
PATIENTS AND PRISONERS

“Homicidal loon” Phillip Paul took off. Then one patient strangled another with an electrical cord. And that was it: Life at Eastern State Hospital dramatically changed. To some, it’s no longer a place to heal, but rather a grim prison from which there is no escape.

By Deanna Pan

They found Phillip Paul three days later, on a Sunday afternoon, walking toward a two-lane country road in Goldendale, Wash., 10 miles or so from the Oregon border. He had emerged from the brush, red-faced and weary, with a backpack and an acoustic guitar slung over his shoulders.

State Patrol hovered in a chopper overhead. He was the only soul they’d seen all day as they combed the back roads and highway, passing an occasional cattle yard or languid wind farm and otherwise boundless, wheat-colored hills.

When plainclothes deputies burst onto the scene from an unmarked van, guns drawn, tensions high, an exhausted Paul sunk to his knees.

“I’m done,” he said.

They cuffed him and gave him some water to drink. At the finale of the region’s largest manhunt in years — a $37,000 undertaking involving local, state and federal agents — Paul’s capture took less than a minute.

Paul was a patient in the forensic services unit at Eastern State Hospital in Medical Lake, one of Washington’s two state-run psychiatric hospitals for adults, and until three days earlier, he was, in the words of then-hospital CEO Harold Wilson, “a fairly model patient.” He had been admitted 22 years before, after pleading not guilty by reason of insanity to the murder of an elderly neighbor, a retired teacher named Ruth Mottley, in the farming town of Sunnyside, Wash., where he grew up.

The details of the crime were especially grisly: Paul had strangled the 78-year-old, slit her throat and doused her body in gasoline. He dug a shallow grave in her garden. Paul, who had been diagnosed with paranoid schizophrenia, told deputies voices in his head insisted he “kill the witch on Emerald Road.”

So on Sept. 17, 2009, after hospital staff notified authorities that Paul was missing from a supervised field trip with 30 other patients to the Spokane County Interstate Fair — one minute, he was smoking a cigarette; the next, gone — local media seized on the story: A psychopathic killer was on the lam and ready to claim his next victim.

But Paul just wanted to go home.

A few days later, during a phone interview with a local TV reporter, Paul admitted he “messed up.” He said he never planned on escaping, as law enforcement officials claimed, or hurting anyone (no one was). But after more than two decades spent in the hospital, he couldn’t resist the temptation to quietly slip away.

“When I got down to the fairgrounds, I just thought I’d try and go see some sunshine for a few days or something,” he said. “I guess I want freedom, and it eats at me so bad sometimes.”

How did this happen? How did a “homicidal loon,” as Spokesman-Review columnist Doug Clark pondered in one of his polemics on the episode, elude his sentries? And what was Paul — along with 30 other “criminally dangerous” patients — doing at a family event in the first place? (“Here’s a thought,” Clark goes on in another column. “Next time Eastern State decides to make it Hannibal Lecter Day at the fair, how about letting the public know so families can skip the giant pumpkins and barnyard fun and head to a mall for a movie?”)

The realization that institutionalized patients with criminally violent pasts live and work among us rocked the public consciousness. People demanded answers — from Eastern State, the Department of Social and Health Services, lawmakers, the governor — and assurance that this horror-flick farce would never happen again.

Meanwhile, the patients whose lives were suddenly thrust under the microscope watched as their privileges were eroded, and access to the outside world was cut off. Forensic mental health providers face a unique challenge of treating patients’ mental illness, which includes helping them reintegrate into society, and ensuring public safety. But advocates say the pendulum has swung too far on the side of public safety, at the expense of patients’ rights and recovery.

“The purpose of this confinement is supposed to be treatment,” says Mary Pat Treuthart, a constitutional law professor at Gonzaga University. “You’re putting them in the correctional system basically, when the result of their circumstances should not be punishment.

... I seriously question the constitutionality of this.”

Public defenders say the process by which patients gain free-
dom is mired in bureaucratic red tape; they say their clients are stuck. Patients feel disposed of; they say they’ve given up hope. And when policymakers institute barriers that hamper these patients’ ability to transition into the community, one has to wonder: Does it really make us safer? Or does it, as some say, do the exact opposite?

On the day we were supposed to meet, Ketema Ross called me, unusually agitated. He told me he was dragged out of bed at 8:30 in the morning by five hospital staffers who discouraged him from talking to a reporter. It was like “an ambush,” he said. They warned him that he’d get taken advantage of, that he’d make the hospital look bad.

“It’s a symptom of a greater problem here at the hospital where they treat us like kids,” he railed. “It’s very insulting, it’s very degrading and it’s very dehumanizing.”

Administrators told me I was the first reporter to speak with a patient inside the hospital in at least 12 years. After Ross sent a letter to the American Civil Liberties Union of Washington, the hospital arranged a meeting for the two of us in a secure basement conference room below the forensic services unit.

Ross was admitted to Eastern seven years ago after pleading not guilty by reason of insanity, or “NGRI.” Like Paul, Ross, who’s 36, was diagnosed with paranoid schizophrenia. Like Paul, his disorder manifested in a violent crime that landed him in court and eventually institutionalization. He’s clean-cut with straight teeth, a self-effacing smile and a neatly trimmed beard dusting his chin. He’s built like a wide receiver — tall and sturdy with wide hands and broad shoulders — but his affect is pensive and strikingly self-possessed. He speaks somewhere between a hush and a whisper in a tranquilizing tenor that draws you in like a current — carefully, clearly.

It’s been five years since Ross showed symptoms of psychosis, but his odds of getting a final release have hardly improved. This past fall, he finally obtained his first partial conditional release from the court allowing him to walk on hospital grounds unescorted. On a crisp November day, he strode back and forth from the hospital cafe to a bus stop on the grounds. It felt surreal, his first taste of freedom in years, simply existing without being watched.

Ross lives with 39 other patients on 2 South 1, one of Eastern’s two long-term commitment wards for the “criminally insane.” They arrive with different diagnoses, levels of stability and functioning capacity. Some charged with lesser crimes will max out of the system in a few years. Some may die here. He shoots pool with murderers, rapists and necrophiliacs. He learned early on not to ask about the others’ pasts. You don’t judge.

To enter 2 South 1, Ross passes through a set of secure Sally Port doors and a metal detector. On the ward, a control panel operator monitors 18 different cameras at a time on her computer screen. The gray hall is dimly lit and unnaturally quiet while the patients are away. The hospital has recently installed 75 new cameras in this ward alone.

There are two patients to a 172.5 square-foot bedroom, about the size of a college dorm room. But inside, no posters hang on the walls or curtains over the windows. Here, there are no television sets, videogames, lamps, computers or books. Just two parallel twin beds separated by a steel cabinet and a desk. Ross doesn’t bother hanging photos on a set of bulletin boards. (As soon as he does, he figures, pushpins will be banned from the ward.) A laundry basket full of socks and underwear sits on a chair. Everything must be picked up off the floor. “We try to make this as much as a living experience as we possibly can,” explains Bob Mair, the forensics services unit nurse manager.

Days begin and end largely the same: Coffee is served between 7:10 and 7:30 am. Breakfast is at 7:45, along with morning medications. Some charged with lesser crimes will max out of the system in a few years. Some may die here. He shoots pool with murderers, rapists and necrophiliacs. He learned early on not to ask about the others’ pasts. You don’t judge.

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Days begin and end largely the same: Coffee is served between 7:10 and 7:30 am. Breakfast is at 7:45, along with morning medications. A medstation dispenses 21,000 pills in a single month. Yard starts at 8:15. At 8:50, staff inspects every bedroom. From 9:05 until 2 pm, Ross goes to the “treatment mall” across the street where patients take classes in anger management, pharma-
“PATIENTS AND PRISONERS,” CONTINUED...

cutaneous education and substance abuse addiction, but also in volleyball, table games, billiards and basket weaving. In one class, patients watch TED Talks; in another, they read magazines; in a third, they scour Ancestry.com for distant relatives. As far as psychiatric treatment goes, Ross says he spends an hour a week with a counselor—a session he specifically requested. Most patients don’t have this one-on-one time with their therapists.

At 3 pm, he checks his mail. At 3:30, he’s back in the yard. Dinner starts at 4:20 on the ward or 5 in the patient dining room; at 6, they can visit the store. At 7, the weight room opens. The day ends with snacks at 8. Ross is in bed by 10.

And on and on.

Learning to live at Eastern as a forensic patient is like a grieving process, says Ross: First there’s the denial. You arrive thinking you’re an exception to the rule, that despite your maximum lifelong sentence, you’ll prove to your judge that you’ve recovered, that you’re no longer dangerous. You aren’t like those people—the chronically mentally ill. You think you’ll be out the door in less than a year.

But that doesn’t happen. So then comes the anger—at your attorney, the hospital and the criminal justice system. You bargain for your release. You petition hospital and the criminal justice system.

And if you’re Ross, you eventually accept the inevitable truth: You may very well live under DSHS supervision for the rest of your life.

“Is it right?” Ross asks me from the other side of the conference table. “If this happened to you, is this the way you’d want to be treated? If this happened to your son, your mother, your father, your daughter, is this the way you’d want them to be treated? Would you want to be forgotten, ignored, marginalized to the point where you are literally voiceless. … Is that right?”

A t one time, Ross was a promising law student with a scholarship to Yale. He admired Thurgood Marshall and had dreams of becoming a Supreme Court justice. But during his first year at Yale Law, his mental health began to deteriorate. He believed the FBI and the CIA were using satellites to beam messages into his mind. His paranoia drove him into deeper isolation. He went to one class during his second year of school before he dropped out. Ross flew to Thailand. He spent his childhood, Ross was a time bomb waiting to explode.

Earlier that morning, Ross had woken to the voice of President George W. Bush, telling him that his neighbors, a couple in their 70s, were government traitors who needed “to be dispatched.”

For Ross, in the throes of psychosis, it was a matter of “life or death.” His only option. If he didn’t listen to the things he heard, he believed he’d be killed. He left five minutes later, his neighbors bruised and beaten, but alive. “If I got to formally apologize to [them], I would,” he says. “Tell them I’m very sorry. … I regret it to my core.”

Afterward, he walked to a supermarket and called the police.

In the aftermath of Paul’s escape from the fair, DSHS officials immediately suspended all off-ward outings for forensic patients at state psychiatric hospitals and launched an investigation into the facilities’ security measures. The CEO of Eastern State resigned. Seven Eastern employees were formally disciplined.

It wasn’t long before changes to the
hospitals’ field-trip policies were codified into state law. Four months after Paul’s escape, Rep. Matt Shea, R-Spokane Valley, introduced legislation effectively banning patients committed to state psychiatric institutions from leaving hospital grounds except under special circumstances, like funerals of immediate family members or necessary medical and legal appointments. For those, DSHS mandated that they leave in shackles. Anything else required a court order.

“There was quite a bit of concern in our community that he had escaped at the fair and was within feet of our children,” Shea said, testifying before the House Human Services Committee. “It was a very traumatic event for Spokane County.”

His bill was ramrodded through the legislature. Not a single Senator or House member voted against it. By June 2010, reintegrations trips for high-level, NGRI patients had officially ended. No more shopping trips to Walmart or Auntie’s Bookstore or lunches at McDonald’s. No more Spokane Indians or Chiefs games. No more bus rides to see the Christmas lights downtown. For the first time, they couldn’t go outside and take a stroll on the grounds without a judge’s approval. Before, patients even could attend community college. But that opportunity was snatched away, too.

Then, on Nov. 20, 2012, an Eastern NGRI patient named Amber Roberts murdered another patient, Duane Charley, by strangling him with an electrical cord. In the wake of Charley’s murder, the hospital cracked down on the forensic patients again. Anything that could be used as a weapon or strangulation device — potted plants, portable gaming systems, headphones, cored alarm clocks, stereos, guitars, belts and multiple shoelaces — was banned. Television sets were locked up. Patients weren’t allowed to sit in any rooms with ceiling fans.

“There was almost a full-scale riot here. There was no time to even grieve,” Ross recalls. “We’ve gotten back a...continued on next page
few of the things we lost, but we’re still definitely in a state of recovery from the loss of our quality of life.”

Chad McAteer, a community forensics social worker, admits patient morale has taken a hit in recent years, but he says things are getting better. Patients are “learning to adapt” to the new rules and restrictions, and adapting is instructive for patients, he says.

“If they can handle [stress] here in a controlled environment, they’re more than able to handle it in an uncontrolled environment with less eyes on them and less supports available,” McAteer says, adding, “I think the pendulum is hopefully swinging back to where it’s more of a happy medium and we can start getting things back for patients. Anything we can do for the patients, no matter how small, is a benefit to their mental health.”

Amy Sullivan, a Spokane County public defender who represents civil commitment cases, remembers a time when Eastern wasn’t so closed off to the public. Every October, during Mental Illness Awareness Week, the hospital would bus patients to a spaghetti dinner with community members at a downtown church. During the “Walk a Mile in Our Shoes” event, the public was invited to join patients for a march on campus. Now, it’s only a handful of patients with grounds privileges and Eastern staff circling the softball field.

“Back then, they were real human beings,” Sullivan says. “To penalize everyone for just one thing, it takes away people’s hopes and their humanity.”

There’s a misconception that people who plead NGRI are taking the easy way out by bypassing prison time. But that couldn’t be further from the truth, Sullivan says. The sentences in hospitals are often much harsher. Studies show that for the same offense, NGRI patients are hospitalized for far longer periods than convicted criminals serving time behind bars. One such study in California found that insanity defense acquittees spent twice as much time in confinement as defendants found guilty of similar offenses.

“I try to advise the attorneys in our office to not enter ‘not guilty by reason of insanity’ under most circumstances, because you end up usually doing significantly more time under an NGRI than most prison sentences,” says Jeff Leslie, a Spokane public defender. “I find a lot of times, even though [hospitals] say they’re more treatment-oriented, they tend to be more punitive and hold people back on minor rule violations.”

“PATIENTS AND PRISONERS,” CONTINUED...

Western State Hospital, near Tacoma, works to transition patients gradually into the community. Of the hundreds released on staff recommendation, only 0.6 percent committed new crimes.

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Leslie’s most frustrating case involves David “DB” Brent, an Eastern patient who’s been committed since 2006. In that same basement conference room, DB saunters in to meet me. He’s a big man and, as usual, he’s dressed to the nines: Blue tinted glasses, blue plaid shirt, blue newsboy cap and Air Jordans. Two quarter-sized gold hoops hang from his ears. He lifts the bottom seam of his sweatshirt around the waist of his jeans.

“Look at this, girl. Look at that,” he says. “It’s undignified and it’s inhumane.”

If you meet DB, he’ll tell you he has schizophrenia, that he’s not schizophrenic. “There’s a difference.” He says, in spite of nearly a decade of institutionalization, staff at the hospital don’t really know him.

“They have me labeled,” he says. “They say I’m a hustler, a wheelin’ dealin’ kind of guy.”

But he’s not anymore, he says. DB grew up in Mississippi, where he started selling marijuana at the age of 13: “You learn to do what you gotta do to survive.” His rap sheet spans from Olympia to Spokane: assault, domestic violence, violation of a protection order and receiving stolen property. He’s been in and out of prison. His drug of choice was crack cocaine, and it exacerbated his symptoms. He heard voices, saw “tree people.”

One night in May 2005, DB came home to his West Broadway apartment when the electricity had been cut off. His aunt, his payee, had forgotten to pay his bill. DB was high and off his medication. He thought he heard people on the balcony threatening him. Scared and unable to see, DB lit a match and set his curtains on fire.

He was facing 28 to 48 months in prison and one to three years of probation for first-degree arson. His public defender at the time entered an NGRI plea. Because first-degree arson is a Class A felony, his commitment at Eastern is indefinite. So far: seven years and counting.

DB says he only experiences symptoms when he uses drugs or alcohol; he hasn’t exhibited any signs of psychosis since he’s been at Eastern, which even his treatment team acknowledges in his most recent court order. DB only takes 15 mg of Abilify, an antipsychotic, which his doctors prescribe “as a safeguard.” He pulls out a shiny gold Narcotics Anonymous coin from his pocket and slaps it on the table. He’ll be 10 years clean on his birthday, April 6.

“I’m in the wrong system, girl. I shoulda gone to prison,” he says. “If I been stable since 2006, why am I here?”

Leslie is working to get DB a conditional release that would allow him to live with his aunt, a school administrator and his uncle, a Pentecostal pastor, in Spokane. Leslie also is in talks with the state prosecutor to bring DB’s case back into the criminal arena. He says there’s a slim chance this tactic will work, but if the prosecutor agrees to charge DB with a felony, DB would get credit for the time he’s served at Eastern. He’d be on probation for just a few years.

“Then he would know he’d have an ending to this,” Leslie says. “Otherwise, with first-degree arson, DB will have this hanging over his head for the rest of his life.”

Eastern officials won’t comment on specific patients’ cases, but Dorothy Sawyer, Eastern’s new CEO, touts a close working relationship between the hospital and the courts that allows patients to reintegrate into society when the time is right. And she personally hasn’t heard any “significant” patient complaints.

“One of our main concerns as a state hospital is to make sure we provide a safe environment for our patients and our staff, and also to provide for a safe community,” she says. “For those patients … who are here for very long terms, it’s really our commitment to work with those patients to be integrated as appropriately within our clinical setting as possible.”

Public defenders and disability rights advocates say it’s unconstitutional to keep patients like DB...
warehoused in psychiatric institutions when they no longer need treatment. The statute in question, RCW 10.77.200, says a committed person who no longer presents a “substantial danger” or “likelihood of committing criminal acts” as a result of mental illness has to be released. Otherwise, says David Carlson, the legal director of Disability Rights Washington, “legally we have no legitimate purpose for detaining them.”

“There’s a lot of concern about when it’s appropriate for them to be discharged. That’s a completely legitimate and important question to be asking, and we should be answering that question with the best knowledge we have about how their mental illness is impacting them,” Carlson says. “Unfortunately, a lot of times politics gets in the way of that.”

During last year’s legislative session, Rep. Tami Green, D-Lakewood, introduced House Bill 1438 to repeal the 2010 law confining patients inside hospital walls. It had its first hearing in the new session last month. Green, a psychologist who represents the district where Western State Hospital is located (she worked at Western for a time), bowed to the furor surrounding Paul’s escape and voted for Shea’s bill even though she secretly opposed it. It wasn’t until NGRI patients at Western invited Green to a meeting that she realized “how horrible the consequences had been.”

“At that point I was like, ‘I don’t care if people say I’m not tough on crime,’” Green says. “I feel like if I don’t work to get this repealed, then I’m giving credibility to that stigma that the mentally ill are dangerous and should be locked up forever.”

Western State Hospital sits on a sprawling 274-acre campus near Fort Steilacoom, a 19th century military outpost, in Lakewood, Wash., near Tacoma. There are 56 buildings — chapels, offices, patients’ wards, historic cottages, a morgue and a butcher shop. Western has almost three times the capacity of the Eastern. Of the 827 patients living at Western, about 120 are NGRI.

Roberta Kresse runs Western’s community program, which helps high-level NGRI patients gradually transition back into society. It’s a five-level program for patients who’ve obtained a court-approved conditional release. They start by taking escorted walks around the campus with staff, then with their peers, and finally alone. As they demonstrate their ability to responsibly handle each additional privilege, they gain increasing autonomy. They take trips to the local strip mall. They visit their families. They move into their own places, where therapists stop by as often as once a week. It’s a slow transition — often taking 18 to 24 months — that involves intense monitoring and consistent treatment. There’s a very low threshold for patient error. One man was brought back to Western from his community placement after his therapist found a beer in his fridge.

What’s unique about Western’s program is there is no oversight from the Department of Corrections, unlike at Eastern, where patients with conditional releases allowing them to visit the outside world are supervised by a community corrections officer.

Kresse’s program works: Since its inception in 1978, 0.6 percent — yes, less than 1 percent — of the hundreds of patients released into the community on the hospital’s recommendation have committed new crimes. By comparison, the recidivism rate for mentally ill offenders in state prison facilities is 25.8 percent. (For offenders with acute mental illness, the recidivism rate for mentally ill offenders in state prison facilities is 25.8 percent. For offenders with acute mental illness, the recidivism rate for mentally ill offenders in state prison facilities is 25.8 percent.)

“For my point of view, they are not guilty,” Kresse says. “Something has gone right for us, and I think it’s our intense focus on mental illness.”

A DSHS workgroup comprised of clinicians, corrections officials and attorneys is currently meeting to standardize community release orders for NGRI patients at Eastern and Western. But according to Sonja Hardenbrook, the sole public defender on the committee, most of the members have endorsed Eastern’s model and would like to involve DOC at every step of a patient’s transition into society.

Promoted by Paul’s escape, in 2010 the legislature also created the Public Safety Review Panel, an independent board appointed by the governor, to examine petitions for release from NGRI patients at the state’s psychiatric hospitals. The panel adds an extra layer of scrutiny to NGRI cases that go to the court. And the process by which patients are reintegrated into the community has naturally become longer, or as Richard Mathisen from the Spokane Public Defender’s Office says, “built of delays.” In 2004, for example, long before the creation of the Public Safety Review Panel, 16 patients at Western were granted conditional releases. Last year, only three were.

“They end up getting people who run out of time and they’ve done nothing toward transitioning them into the community,” Mathisen says. “So they basically set them up for failure.”

This is true for NGRI patients who have committed lesser felonies, and as a result have a five- to 10-year maximum sentence under DSHS supervision.

“They would like to be better prepared to go out into the community through a gradual transition,” says Dr. Marylouise Jones, the clinical director at Western. “And in some ways, this makes it more difficult to do that.”

Beyond elongating NGRI patients’ petitions for release, experts worry about the public safety risk of delaying patient reintegration.

“If we’re interested in public safety, which of course we are, the more integrated a patient is, I believe, the safer he is,” Kresse says. “Some of these patients have been in the hospital for years and years, so it’s contraindicated to suddenly just shoot somebody home without preparation.”

Somebody like Mark Grable.

He lives on 2 South 1 with Ross and DB. He’s bipolar with psychotic features. Next month, on March 30, five days before his 50th birthday, Grable will “max out” of DSHS supervision and return to Walla Walla to live with his aging father. He’s a mid-level patient at Eastern, meaning he’s not eligible for a partial or conditional release allowing him to explore the grounds or make trips into the community. He also hasn’t been given a reintegration or discharge plan.

When we meet on the ward, he’s wearing a black leather jacket and a silver Mayan calendar ring. His long hair tied back in a braid. In his most recent hospital progress report, his forensic therapist and psychiatrist describe him as “very articulate and charismatic,” but with “maladaptive personality features.” A self-professed anarchist, Grable is known for resisting rules he doesn’t agree with.

“They give you a real nice frosting over a really crappy turd with NGRI,” he says.

A decade ago, Grable made a series of threatening phone calls to a Superior Court judge in Walla Walla County. His psychiatrist at the time had put him on a “med holiday” to see how he’d manage without, and Grable was angry and symptomatic. For the charge of intimidating a judge, a Class B felony, he faced 16 to 22 months in DOC. But he’s spent a decade at Eastern.

“I did 10 years on a 16-month sentence. I would have gotten five off for good time. I would have been out in two months with my county jail time and instead I’m here,” he says. “So yeah, I am mad. I am bitter. But you would be too if you did 117 months extra because you have a mental illness.

“I’m so angry right now, I don’t know what I’m capable of and that scares me.”

On Ross’ first day of “authorized leave” during the second week of January, he takes the No. 62 bus to downtown Spokane and walks straight to Our Club on the corner of Madison and Second. It’s a path he, DB and their buddy “Zoop,” another NGRI patient, aren’t allowed to deviate from.

They arrive almost two hours early to their Narcotics Anonymous meeting at noon. They order coffee from the liquor-less bar and make their “surveillance call” to hospital security at 11. At one of the mismatched tables, an old man in a Stetson plays cribbage with a younger man with a tattoo sleeve. “God bless you all,” the old man says.

Normally, Ross calls his time away from the ward his “zen time.” But on this first trip out he’s anxious. Meeting new people. Blending in. He steps outside, his hands in the pockets of his leather jacket, onto the snow-covered sidewalk. Around the corner, DB smokes from a pack of vanilla BlackStone cigarillos.

“DB… I’m tempted, man,” Ross says. He hasn’t smoked in six months.


DB laughs and takes one last drag before handing his cigar to Ross, who cradles it between his thumb and index finger, draws it to his lips and takes three puffs.

“I ain’t seen nothin’!” DB says, chuckling. “And I didn’t give it to ya!”

At Eastern, sharing smoke in the yard is considered a “major rules violation.” Here, it’s a gesture of freedom. A moment not dictated by doctors, therapists, nurses, men and women in suits who tell you when to wake up, when to sleep, what to eat and when, from sunup to sundown, with no end in sight. No clear path to independence. Maybe Phillip Paul wasn’t all wrong with his three days in the sun.

“Are you feeling less stressed?” I ask.

“I am,” Ross says as he inhales warm smoke deep into his lungs.

DB laughs again. “Look at him smiling!”

There’s a perpetual scarlet letter attached to an NGRI acquittal. There are the unavoidable comparisons to James Holmes, who pleaded insanity in the murder of a dozen people at an Aurora, Colo., movie theater; Jared Loughner, who was diagnosed as paranoid schizophrenic after his shooting rampage in Tucson, Ariz., that claimed six lives; and Adam Lanza, whom countless have speculated was mentally ill when he massacred 20 children and six adult staff members at Sandy Hook Elementary in Newtown, Conn. “The stigma part…” Ross says. “It’s devastating.

“I feel like I’m not given a chance to be who I am,” he says. Ross hopes that one day he’ll leave Eastern forever, travel the world, write poetry and advocate for people like him. “I’m judged instead by the mistakes I’ve made and the disease I have. It’s hard to swallow sometimes, but that’s how a lot of other people see me. It takes away even a chance of hope. It takes away hope before you even have a chance of recovery.”

“FEBRUARY 13, 2014 INLANDER 27

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“So yeah, I am mad. ... But you would be too if you did 117 months extra because you have a mental illness.”
Twisting his head forward and to the side, Aaron Johnson reaches back with his right hand, his still functioning hand, to point out a quarter-sized knot of purple scar tissue at the base of his skull, just behind his left ear.

“There’s the exit wound,” he says. A .40-caliber bullet had struck Johnson just below his jaw, passing through his neck and out the back. The entry wound, another tinted pucker of flesh, lies hidden beneath a patch of wiry beard.

A third scar runs the length of Johnson’s left forearm where one bullet smashed the bone. Surgeons put in a plate, but his left hand remains frozen in a loose fist. A couple of more bullets – of nine total shots fired – ripped through his liver and lung, coming to rest near his spine.

At a lunch table in the psychiatric unit of Providence Sacred Heart Medical Center, he sits stiff with the forced posture of a plastic back brace. Between bites of double-cheeseburger, Johnson describes himself as a “good guy,” beset on all sides by judicial corruption, government conspiracy and demonic forces.

Johnson, 30, has spent most of his adult life in and out of both corrections and mental health facilities. His family knows him as a sweet, loving kid who struggled to focus and dropped out of high school. At 21, he went to prison on a forgery charge, and psychiatrists diagnosed him with schizophrenia. He’s gone from jail cells to group homes to the streets, on and off meds, searching for some sense of stability.

“I’ve been trying to get on my feet,” he says.

While research studies have shown again and again that people with mental health issues do not pose a higher risk of violent behavior, serious symptoms can sometimes cause people to become disoriented, act in bizarre ways or cause disturbances in public that can attract the attention of law enforcement. With about one in 17 people suffering from a serious mental illness, police have increasingly become the first responders to mental health crises.

A 2014 research analysis examining how law enforcement interacts with the mentally ill found many police organizations across the country lack consistent training on diagnosing and engaging people in mental health crisis, and as a result officers can unnecessarily use excessive or deadly force against people in need of help.

“Serving as de facto psychiatric specialists, police officers often must assume roles held by nurses, social workers and case managers as the [principal] referral source to psychiatric emergency services,” the analysis states. “For these reasons, it is crucial that officers are equipped with knowledge about various mental illnesses, ...continued on page 24
TOP: The alley behind the Truth Ministries shelter where, on Jan. 16, Spokane police shot Aaron Johnson (pictured last fall, left, and as a teenager, right.)
and have the appropriate communication skills to safely intervene [with an] individual who is experiencing a psychiatric crisis.”

In recent years, area law enforcement agencies have drawn intense public scrutiny over high-profile tragedies between officers and the mentally ill, most notably the in-custody death of Otto Zehm, a 36-year-old schizophrenic janitor badly beaten by Spokane police officers in 2006. A review of use-of-force records indicates a significant number of incidents still involve officers using force against people suffering from suicidal or mental health issues.

In 2013, Spokane police officers responded to a minimum of 1,100 incidents involving citizens with mental health issues, according to the city’s police ombudsman. Most of those did not require any police action. But the ombudsman’s analysis of Taser usage between 2010 and 2012 shows almost a third of those incidents — 23 out of 79 total Taser uses — involved signs of mental instability or suicidal intent.

As America’s law enforcement agencies have worked to improve officer awareness on mental health issues, many have adopted “Crisis Intervention Team” training as the gold standard for partnering with mental health providers. The Spokane Police Department first introduced limited, voluntary training in 2004, but a 2012 settlement with the Zehm family mandated $200,000 to put every SPD officer through the 40-hour training course.

The final class graduated last Friday.

Julie Schaffer, an attorney with the legal nonprofit Center for Justice that represented the Zehm family, says the expanded training serves as a much-needed step toward improving awareness and safety for both local officers and the mentally ill. Police officials must foster a department that recognizes its obligations to protect people with mental illness and connect them to treatment.

“I think it is overdue,” Schaffer says. “It’s unfortunate that we’ve had to have so many incidents. … There has to be a culture change at the department.”

In a bright classroom at the Spokane Police Academy near Felts Field, SPD officers look up at a “jumper” pacing on a table top. Behind the man, thick blue mats have been set out to catch him if he leaps from the “bridge.”

The jumper, another SPD officer acting as a distraught middle-aged man, shuffles precariously atop the table. He swears at officers, waves his arms and rattles off a long list of complaints. He finally throws up his hands as he curses his life.

“I’ve had it,” he tells the officers. “I’m done.”

Jan Dobbs, chief operating officer for Frontier Behavioral Health, watches the scenario from a nearby seat. She has led CIT training efforts in Spokane since the start of the program more than a decade ago. Now working with SPD Sgt. Anthony Giannetto, Dobbs says the program has made an unprecedented push to train all SPD officers over the past year, putting the entire department through the weeklong regimen of lectures, demonstrations, role playing and guest speakers to instill new de-escalation and psychiatric diagnosis skills.

“Police officers learn in a certain way,” she says. “They’re very visual. They’re very tactile. … You have to reach them in a different way.”

National law enforcement associations as well as mental health groups, like the National Alliance on Mental Illness, recognize CIT as an “evidence-based best practice” for engaging people with mental health issues. Police officials and researchers in Memphis, Tenn., first developed the CIT program in 1988, following the fatal
officer-involved shooting of a mentally ill man. As many as 2,800 police agencies now train with what’s known as the Memphis model. This includes dozens of departments in 12 counties across Washington and 13 counties in Idaho. (See “Regional Approaches” on page 27.)

Some sessions, like the jumper exercise, focus on communication strategy and real-life scenarios. Dobbs says other sessions strive to put officers in the shoes of the mentally ill, building personal understanding and empathy. Officers train alongside local mental health providers and interact with people living with mental health disorders, listening to intimate panel discussions on their everyday challenges. They learn about the difficulty of juggling meds or hearing voices.

“It’s unfortunate that we’ve had to have so many incidents. ... There has to be a culture change at the department.”

This particular afternoon is mostly dedicated to the role-playing exercises. After spending about five minutes talking with the jumper on the table, one trainee officer sees an opportunity and lunges for the man. Both trainee officers and the jumper go tumbling into the blue mats in a crashing clatter of toppled tables and muffled groans.

“Whoa,” the instructor shouts, halting the scenario. “Don’t snatch people off of bridges. It’s too dangerous.”

The instructor explains to the officers that he understands the instinct. Officers want to save lives. They want to pull people to safety. But with physics and weight and all the other unknowns, they could easily push someone accidentally or get pulled over themselves.

“Let’s go back out and let’s do this again,” he says.

Just a day after the jumper scenario in the January CIT training session, Aaron Johnson, then 29, arrives at check-in for the Truth Ministries shelter. Recently released from the Spokane County Jail on a probation violation, he had spent four nights in the 50-bed shelter. Director Marty McKinney says Johnson became upset when staff try to check his backpack. Johnson says later he believed the shelter had given away his bed.

McKinney says cuts to mental health treatment services have brought more mentally ill through his doors. He says staff suspected Johnson might have an issue after he once signed in with a Russian name, claiming to work for the KGB. But on Jan. 16, Johnson crosses a line when he allegedly starts threatening staff with a 4x4 board.

“He was acting really paranoid,” McKinney says, adding, “The police get a pretty hard time with all the shootings, but [in this case] I think they did exactly what they had to do, unfortunately.”

Still carrying the board, Johnson ducks out the back of the building while shelter staff call 911. Shortly before 9 pm, several SPD officers converge on the alley behind Truth Ministries. Investigators say the officers find Johnson huddled under a blanket. But as they approach and identify themselves, he allegedly jumps out brandishing a folding knife.

“I didn’t have a knife in my hand,” Johnson argues later. He acknowledges he had a knife in his pocket, but denies ever displaying it.

McKinney says video cameras inside the shelter show Johnson acting erratically and waving the 4x4 board, but they never show him with a knife. The shelter did not have a camera covering the alley. SPD officers also have not yet started wearing body cameras to record encounters.

“Johnson looked very agitated, and tense while gripping the...continued on next page
“CHANGING OF THE GUARD,” CONTINUED...

knife,” officers observed in court records. “Johnson apparently had a strange look on his face, like a ‘thousand yard stare.’”

Johnson remembers being surrounded by four officers, who the police department name as Officers Christopher Conrath, Michael Schneider and Holton Widhalm along with Sgt. Terry Preuninger. As Johnson moves close to one officer, Schneider reportedly fires his Taser.

Officers report Johnson stiffens up and goes tense, but he “fought through” and charges at officers. Two officers, Conrath and Widhalm, fire nine shots, striking Johnson several times.

Johnson says he remembers a short argument with officers, then with the shock of the Taser, he “started jumping everywhere.” As they opened fire, he crumples to the asphalt, bleeding and disoriented. He says he can’t remember anything else until he awoke in the hospital.

“They straight wanted to kill me,” he says.

With the lights dimmed low, CIT trainee officers stand before a curved 180-degree interactive video screen. The sophisticated training system allows officers to go through virtual enforcement scenarios to test their awareness and reaction times. Officers can change the scenario outcomes by using verbal commands or several types of force, including firearms.

In this scenario, the officers follow a video officer into a home where they encounter the owner along with a wheelchair-bound man in a camo jacket. Within four seconds, the man in the jacket draws a weapon and kills the first officer as trainees return fire.

“This is going to look like Spokane police shoot disabled veteran in a wheelchair,” the instructor says. “What I want everyone in the room to see is how fast this happens.”

Dobbs, from Frontier Behavioral Health, watches from against the wall. She says she recognizes how quickly officers must react to subtle clues in behavior or appearance. She says she admires the high level of training officers get at the department. As they move through other scenarios, officers Taser a violent homeless man. They also resort to shooting an armed suicidal man heading into an office building. All of the scenarios have been...continued on page 28
REGIONAL APPROACHES

In IDAHO, Crisis Intervention Team training runs through regional programs in which multiple jurisdictions send officers through joint training sessions. Ann Wimberley, a NAMI advocate and Region 1 coordinator for the state’s five northern counties, says Bonner County has hosted regional training annually since 2009.

Wimberley says North Idaho agencies utilize the Memphis model with an emphasis on practical “street” skills that officers can use on the job. In addition to the basic 40-hour course, they have also since introduced advanced training on “excited delirium” and youth mental health.

“We have had a lot of support for this program,” she says.

Many North Idaho mental health agencies also hold “services fairs,” she says, to introduce officers to local treatment facilities, staff and resources. State grants have helped fund the training and overtime costs in recent years.

SPOKANE COUNTY Sheriff Ozzie Knezovich says training overtime costs have become a significant limitation on the number of deputies he can send through the CIT course. He would like to see an easier, hybrid mental health training program that deputies could take online, or during shorter, routine training periods.

“We need to start thinking outside the box,” he says. “We have to find a better way. ... I think the skills are important.”

Knezovich says he would also support integrating CIT training into the Basic Law Enforcement Academy at the state level, so all officers graduate with the training. Some advocates support that idea, but others argue that state academy training would not provide officers with an introduction to local mental health agencies or resources that make up a key part of the program.

— JACOB JONES
recreated from real-life incidents.

“I don’t know that there’s a right answer,” Dobbs says of the variety of officer responses. “There could be better answers.”

Spokane Police Chief Frank Straub says he has always considered mental health training and community collaboration to be high priorities, developing a mental health steering committee with local treatment providers and researchers when he first arrived. He sees expanded CIT training as an important step forward in protecting officers and transforming the regional system.

“For the individual officer, the idea is to really put another tool on the officer’s belt,” he says. “We want to give officers the ability to engage people that are in crisis. ... It’s a recognition that there’s a whole bunch of things you can do other than just using force.”

Department records show all of the officers at Truth Ministries had previously graduated from CIT training except Preuninger, who completed the class a month later. Straub acknowledges the limits of CIT training, explaining some people in crisis may be too dangerous for de-escalation attempts.

The best way to keep such people — and officers — out of harm’s way, Straub says, is to support a robust local mental health system that can provide preventative treatment. A broader community approach can help stabilize people earlier and keep them from spinning out of control.

“By the time police arrive, they’re maxed out in terms of crisis intervention,” Straub says. “Then it becomes a very precarious situation as to whether the officers are going to be able to bring that person down. ... We can’t look to the police as the solution to this problem. We’re not.”

Beyond officer training and education, advocates say the Crisis Intervention Team model must serve as a larger community infrastructure for partnering law enforcement with mental health facilities, hospitals, shelters and other stakeholders. Officers need to know local mental health professionals and get practical introductions to drop-off facilities or other treatment resources.

Dr. Randolph Dupont, a leading national consultant with the CIT Center at the University of Memphis, tells the Inlander the training program combines useful tactics with a new appreciation for the complexities of mental illness.

“Officers value the training,” he says. “[They] usually have their hearts in the right place. ... It’s good to have a lot of officers that have those skills.”

Research studies by Dupont and others indicate CIT training not only protects vulnerable citizens, it can also reduce officer injuries, SWAT deployments, jail costs and use-of-force incidents. Mental health facilities may see
more referrals for treatment services. The program can also increase diversions to treatment facilities instead of jails, which one study connected to improved psychiatric symptoms in those people three months later.

Dupont took only one issue with the Spokane approach to CIT. He says the Memphis model only trains volunteers, many of whom have a pre-existing interest or awareness of mental health issues that helps motivate them. Mandatory CIT training can breed resentment or devalue the lessons.

Ron Anderson, president of the Spokane chapter of NAMI, echoes some similar concerns about the mandatory program, but he notes Spokane’s voluntary training sessions sometimes failed to get enough officers to sign up and were canceled. He remains encouraged by the department’s commitment to expanding its mental health training. He says officers need to know about local resources and should understand what challenges people like his daughter may struggle with.

“Mental health … is a huge factor in public safety and the welfare and well-being of our city,” he says. “We need more than just 40-hour training for our police department, [but] it’s a huge piece.”

Schaffer, with Center for Justice, says the department should embrace the “social work” side of law enforcement and give additional recognition to officers who successfully avoid using force. That’s the culture change that needs to guide officer recruitment, follow-up training goals and future community partnerships on diversion programs.

“That comes from the top,” she says.

Sitting at their dining room table, Geri and Sharon Johnson sort through old family photos. They adopted Aaron when he was 11 weeks old. A few weeks later, they also adopted his older sister, Megan, bringing them both to live at their home in Clarkston, Wash. The Johnsons were aware of the birth mother’s alcoholism and schizophrenia, but they fell for the sweet children.

“From the time that he was a baby, [Aaron] was all hugs and kisses,” Sharon Johnson says. “You dropped him off at school, and he’d give...continued on next page
you a kiss and a hug. He was just a real loving little guy.”

But Aaron struggled to express himself as a teenager and quickly lost interest in sports or other activities, she says. He dropped out of school, later getting his GED. The family had just started looking into psychiatric care as he approached 18, but then he could no longer be forced into a treatment or medication program. He didn’t receive any consistent treatment until prison.

Since the family moved to Spokane Valley, Sharon says, Aaron has bounced from jail to Eastern State Hospital to the streets, staying with them for short stretches. He can take care of himself while on medication, but he often refuses to take it. Sharon says she’s used to calling around to hospitals and county lockups, trying to keep track of where he may be on any given day.

“All you can do for Aaron is pray for him,” she says. “There are times when that’s all you have.”

“And when he’s off the medication,” Geri adds, “you never know when something’s going to happen.”

“That’s right,” she nods.

The Johnsons say Aaron can no longer live with them after a violent outburst last September, just days after Megan died at 31 of cirrhosis. Sharon says Aaron had been talking to himself when he came over and attacked her, striking her in the face and then turning on Geri. Aaron then fell to the floor and suffered a seizure while they scrambled to call 911.

When they heard about the Truth Ministries shooting, they went to Sacred Heart to check on him, but could not find any records regarding his location or condition. Sharon Johnson says they spent days trying to learn if he was OK. Investigators would not provide information and medical staff cited privacy restrictions. It took two weeks before they could even visit his bedside.

“That still haunts me, that I couldn’t go see him,” she says.

In the cold gray of downtown Spokane in late December, SPD officers look up at a man pacing the narrow railing on the Monroe Street Bridge. Authorities have closed the street, bringing the city’s core to a standstill, hundreds of eyes fixed on a solitary figure in bright blue, perched on a strip of concrete more than 75 feet above the thunderous Spokane River.

The 28-year-old man had taken to the railing at about 2 pm on a Wednesday. He strips off his jacket as he crisscrosses the railing. He waves his arms and kicks his feet, shaking out his legs, balancing on one, shouting and stamping. Then he leans back, arching out over the abyss below.

“He’s flailing like one of those meth-heads,” one bystander mutters.

Officer Davida Zinkgraf, the first to arrive, reports she could hear the man talking to himself in a loud voice. He speaks of satellites watching him and TV voices sounding in his head. He rambles about sex and death. He tells officers he wants to go to “heaven.”

“At one point, he began clapping his hands,” Zinkgraf writes. “[H]e would then talk very quietly to himself, and it appeared to me he was preparing himself to jump into the river below him.”

Straub, who soon responds to the scene, says officers took care to calm the situation. They turn off flashing lights and give the man room to vent. They offer to operate on his terms when possible. They bring in negotiators as well as mental health professionals.

“This is a very stressful thing,” Straub says.

Such standoffs can easily turn tragic. In 2007, SPD officers attempted to Taser 28-year-old Joshua Levy as he stood near the railing of the same bridge. The Taser missed, and he leapt to his death.

And in February, Spokane County sheriff’s deputies shot and killed Jedediah Zillmer near the Spokane Valley Mall. The 23-year-old former Army soldier reportedly armed himself with multiple weapons and forced a confrontation with authorities to commit “suicide by cop.”

“The intersection of law enforcement and mental health is a very dicey place,” Sheriff Ozzie Knezovich says, adding, “You are at the mercy of the person that you’re dealing with. If they’re bound and determined to die that night … there’s only so much you can do.”

After nearly 90 minutes of delicate negotiation on the bridge, Zinkgraf and others persuade the man to get checked out at Sacred Heart. He fights back tears as he struggles with the decision, she reports, but eventually he sits down on the railing and then slowly scoots off to the sidewalk.
“Yes!” someone shouts as onlookers sigh with relief.

Zinkgraf escorts the man down the bridge to a patrol car where he is allowed to smoke a cigarette. Then an ambulance crew moves in to check on him.

“He didn’t get taken to jail,” Straub says. “He got taken to treatment.”

In the coming years, Straub says, the Spokane Police Department will continue to expand mental health training and outreach efforts. He says he’s impressed with programs at the Los Angeles Police Department and the Portland Police Bureau in Oregon. Those programs involve multiple levels of advanced CIT training and proactive mental health units that team up with psychiatric specialists to visit high-risk individuals and monitor their ongoing treatment. (See “Alternative Programs” on the facing page.)

“That’s a direction we’d like to go,” Straub says. “My goal is to continuously ramp this up, continuously go out there and find out what the best practices are that are available.”

With the entire department now trained, local advocates look forward to seeing how the program moves forward and whether uses of force against the mentally ill will start to decrease. Will they see the cultural change many have called for? Can local mental health treatment shift from crisis response to preventative care?

Since the Truth Ministries shooting, Aaron Johnson has volunteered for a short-term commitment in the Adult Psychiatric Unit at Sacred Heart. His parents don’t know what his future holds. They say they don’t know the long-term implications of his injuries. They don’t know what charges he may face. They don’t know where he might find a stable home.

It’s all in “limbo” right now. They’re desperate for some treatment program or housing option that could give Aaron an opportunity to get his life under control.

But for now...

“He has no chance,” Sharon says, “... if something doesn’t get done.”

The Johnsons, like many others, believe it will take a larger community effort to develop a mental health system that can provide a place for their son, that can keep the mentally ill out of police crosshairs and offer the help people need before they’re teetering on the brink.

“This will happen again, something like this,” she says. “Somebody else is going to get hurt or killed.”
Dangerous Delays
Families say Spokane County Jail’s medication process risks unnecessary suffering
BY JACOB JONES

ifling through a briefcase full of legal files, Robert Lee argues that he did everything he possibly could have done. As soon as he learned his son would serve six months in the Spokane County Jail, Lee scrambled to coordinate attorneys, doctors, court orders and all the proper paperwork.

Lee’s 19-year-old son Danny requires medication for bipolar, attention deficit and other impulse disorders. The meds help stabilize his mental focus, anxiety and what can sometimes be violent mood swings.

“His life with medication is trying,” Lee says. “Life without medication is horrific.”

So before taking his son into the jail last May, Lee notified attorneys and his son’s psychiatrist, had the judge include the meds in her court order, and filled a new prescription. Lee asked the pharmacist to put a safety seal on the meds to ensure they had not been tampered with.

“I have all his medical records. I have his medicine — signed, sealed and delivered,” Lee says. “You could have got those pills into Canada, but you can’t get them in the Spokane County Jail.”

Jail staff refused to accept the medication, citing a longstanding practice that contradicted its own written policy. Even with Lee making numerous appeals, his son still went nine days without receiving his complete regimen of meds.

A few days, weeks, a month — multiple complaints from inmates, family members, advocates and attorneys contend the Spokane County Jail has a system that creates unnecessary and potentially dangerous delays in providing medical and mental health medication.

Jail officials say they have worked to improve the process, but Lee says it likely will take a federal civil rights lawsuit to force a true overhaul.

“What we have been seeing is a lot of needless suffering and pain, a lot of medical harm,” Finer says. “[But] the apparent belief amongst many of the policy makers is that everything is fine.”

John McGrath, director of the county’s Detention Services, acknowledges inconsistencies in the jail’s medication policies. He says his staff recently launched an in-depth review of all medical practices to look for ways to strengthen or improve inmate care. Part of that includes consolidating multiple contradicting policies and formalizing medication approval.

McGrath says the jail cannot dispense meds unless they are approved by the in-house physician. To do that, inmates must fill out a medical release that is then faxed to their doctor, who confirms the prescription and sends it back. Then the jail physician must approve dosages and file an order to the pharmacy, which then fills and returns the prescription.

“There are still some things that are beyond our control,” he says.

The jail budgets about $600,000 a year to provide prescription meds, but many things can stall the process. Inmates may improperly fill out forms. Doctor’s offices can be closed. Faxes get misfiled. And up until last fall, the jail ordered all medication through a pharmacy on the East Coast.

McGrath says the jail has since switched to a local provider that can fill emergency requests in less than two hours. Information about how to request medications before arriving at the jail has been added online. Jail officials have also apologized to Lee about his son’s delay.

“I have all his medical records. I have his medicine — signed, sealed and delivered,” Lee says. “You could have got those pills into Canada, but you can’t get them in the Spokane County Jail.”

“In his downtown office at the legal nonprofit Center for Justice, attorney Jeffry Finer says he has encountered an increasing number of Spokane County inmates who have struggled to get timely access to the simple medications they needed. He says many suffer medical complications, mental instability, anxiety and other unnecessary problems.

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“There were some process issues that we’ve addressed,” McGrath says. “I don’t think there’s too much more we could do.”
Finer notes that Danny suffered no permanent harm, but that’s not always the case. If the lack of medication had caused him to turn unpredictable or violent, he could have injured himself, a fellow inmate or corrections officers. Danny would then be punished for that behavior while the jail would potentially face new expenses over medical or legal costs.

“The well-being of himself and others is at risk if he’s not on medication,” Finer explains, adding, “[But] it wasn’t a behavioral problem. He was unmedicated. They created the risk by not medicating him.”

With funding from a recent grant, Finer now plans to package Lee’s legal case with other area families as part of a federal civil rights lawsuit. After filing an initial claim in February, he expects to move forward with the Lee lawsuit in the coming weeks.

“He may be the best documented collapse of medical care,” Finer says, “but it’s not the only one. … I’m seeing these line up and I can’t move them fast enough.”

In addition to Finer’s clients, the Inlander has also fielded independent complaints from inmates or family members. Martin Champagne called last month to report he had spent six days in the Spokane County Jail without medication for his bipolar disorder. After nearly a week, he was released when the charges were dropped.

“It’s scary,” he says, explaining that he filled out multiple release forms and medical requests without success. “They put my life in danger. … I was pushing paper like crazy trying to get them to help me.”

Another inmate with bipolar disorder, a 45-year-old man still incarcerated at the jail, also recently sent a long letter describing his frustrations with the medication process. He says he spent at least eight days without medication, locked down on suicide watch, during which time he experienced audio and visual hallucinations.

“I was denied my psych meds,” he writes, “and was treated without dignity and respect.”

The family of Amanda Cook, a 25-year-old Spokane woman, also shared its concerns about the jail’s inability to provide medication that improved Cook’s mental stability during a previous jail term. Records from the family show jail staff took more than two weeks to get a medical release, and Cook’s sister says she never received the medication she needed. Cook later killed herself in a jail’s showering area.

“We got to fix this,” Finer says.

McGrath, the jail’s director, says he expects his staff to complete its policy review and provide recommendations later this year. He says he could not provide specific proposals at this point. He says he’s aware of Lee’s case and a few other complaints, but maintains the process includes several safeguards to provide emergency medication to those in dire need.

After some personnel shortages, McGrath notes the medical team also will return to full staffing next month. Eventually, he would like to add an intake nurse to start the medication process right at booking — a best practice that advocates say is used at some other Washington jails.

Finer says he is encouraged by the jail’s review efforts. He would like to see an intake nurse as well as improved communications with physicians. He wants to see a policy that helps families navigate the system and gets people simple medications in a timely manner.

“Whether it’s got one cause or many causes,” he says, “it’s so evidently a pattern that people aren’t getting proper medical care when they need it.”

Lee remains frustrated, but determined.

He wants to see the jail provide better care, whether it takes a lawsuit or not, and believes it should not be that hard. He says Danny still suffers fear of small rooms and the dark since his release.

“We need to make it a safe place,” Lee says of the jail. “It needs to change.”
From Grangeville, Idaho, it’s a one-hour-and-18-minute drive to the closest Walmart and a one-hour-and-18-minute drive back. This blip of a town along Interstate 95 sits at the edge of national forest, somewhere between Lewiston and the middle of nowhere. Yet with just over 3,000 people, it’s the largest city in the most spread-out county in the entire state.

Jennifer Griffis and her family live outside of Grangeville, in a green-roofed house with bikes scattered across the lawn. “Sometimes our cellphones work out here and sometimes they don’t,” she says.

Griffis, her husband and their seven children moved here in 2010, drawn by how close the mountains were. But when something went wrong with her daughter Monique, Griffis learned exactly how far away they really lived.

There are no licensed psychiatrists in private practice in Idaho County, nor in neighboring Lewis and Clearwater counties. Yet there was no question Monique needed help. She’d hurt people, then smile. In one episode, Griffis recalls Monique choking her 2-year-old sister in the backseat of their Suburban. “She looked at me with this very cold expression,” Griffis says. “(She said): ‘I was trying to choke her. Because I wanted to kill her.”

Eventually Monique was diagnosed with a conduct disorder with limited prosocial emotions. “No remorse,” Griffis says. “No conscience, no empathy ability.” That disorder has meant a 140-mile round trip to Lewiston to visit a psychologist. It’s meant driving back from Boise in a blizzard after visiting Monique in therapeutic foster care. It’s meant five-hour trips back and forth to a treatment facility in Helena, Mont., with the whole family packed into the SUV.

“There are absolutely no residential treatment facilities for females under the age of 12 in Idaho,” Griffis says.

Rural communities are never going to have every kind of doctor. But in Idaho, the problem is compounded: The state is rural and underfunded, with a high incidence of mental illness. Despite its sky-high suicide rates, it was the last state in the nation to get a suicide hotline. (See “Stopping Suicide on p. 24.)

“The number of holes that are occurring in Idaho has been getting progressively larger,” says Casey Moyer, a program manager with Idaho’s Health and Welfare department.

With a third of its population living out in the country, Idaho ranks with Montana among America’s most rural states — and every Idaho county has a mental health care provider shortage. Analysis by the nonprofit Mountain States Group shows that a quarter of Idaho’s population lacks access to a psychologist or psychiatrist.

The state is last in the number of psychiatrists per person, according to 2012 Kaiser Family Foundation data. It also ranks last in mental health funding (though Idaho officials claim that ranking is skewed because it doesn’t include Idaho’s Medicaid spending).

“I’m trying to think of anything they do well, actually,” says Kathie Garrett, board member of the Idaho chapter of the National Alliance on Mental Illness and a former state representative from Boise. “We do very little on the front end. All our state-funded services are for those in crisis, who are a danger to themselves and others.”

On a sliver of a budget, Idaho is trying to change that, shifting its entire mental health care model and searching for ways to bring help to the farthest reaches of the state.

But to get there, it has a very long way to go.

ROADBLOCKS

It’s Tuesday evening at the Snake River Community Clinic in Lewiston. The clinic helps patients with both mental and physical problems, but today, a full two-thirds of the patients are suffering from depression. A few have anxiety. Clinic staff helps one woman — suffering from post-traumatic stress disorder after domestic violence — sneak out the back door.

“Over 30 percent of our patients come here for mental health because they can’t go anywhere else,” says clinic director Charlotte Ash.

Nearly 1,750 different patients have come to the clinic over the past year. They...continued on page 22

EDITOR’S NOTE: This special report is part of our ongoing “State of Mind” series delving into the issue of mental health. Besides exposing serious problems, we will also strive to tell success stories and examine potential solutions. If you have feedback or a story to share, please email us at editor@inlander.com.
TOP: Along with a quilting store, the downtown of tiny Grangeville, Idaho, features a store that still rents VHS tapes.

BOTTOM: Jennifer Griffis’ family moved to this house about 10 miles outside of Grangeville, in part because they loved the outdoors.
drive from hundreds of miles away, from tiny towns like Riggins and Weippe and Enterprise, from at least five counties in Idaho, two in Washington and one in Oregon.

The rural counties in Idaho’s lower panhandle are among the state’s poorest, but at the Snake River clinic, there’s no sliding scale, no messing with insurance. If you can get in, it’s free. But getting there isn’t.

“A lot of our patients have to decide: Are they going to spend the money on gas to get here and get help, or are they going to get groceries?” Ash says.

The clinic sometimes mails out medications when clients can’t get to appointments. Other times, Ash gives patients a $20 bill for gas to get home. One state clinician says he’s personally driven clients down from Moscow in his state-provided Chevy.

There are other barriers: Sometimes the roads themselves are hard to traverse. One 2010 study called Idaho’s roads the second-worst-maintained in the nation.

“A lot of these patients live in these extra-rural wilderness areas,” says Fayth Dickenson, a clinical care manager at St. Joseph Regional Medical Center in Lewiston. “They’re on top of a mountain, [at the end of] a one-way dirt road. They call, and can’t leave their house because their roads are snowed in.”

In Boundary County, at the very top of the Idaho panhandle, a zoning ordinance warns prospective property owners of rugged living where “snows often knock out power, sometimes for days or weeks on end, and roads are often rendered impassable by snow or by flooding in the spring when the snow melts.”

Bonners Ferry resident Jini Woodward knows that county and its mental health system well. Her daughter, now 45, has dealt with severe anxiety and mood disorders for more than two decades.

“Because there weren’t enough services, her illness progressed,” Woodward says. “Boundary County has to depend on Bonner County, and Bonner County has to depend on Kootenai County. The services are so inadequate in Kootenai County. And we’re clear at the end of the road; we’re the last hair on the tail.”

Without enough services in Bonners Ferry, Woodward’s mentally ill daughter decided to move to Sandpoint. There weren’t enough services there either, so she moved to Hayden. That’s put her hours away from her parents.

“We rely on telephones and emails to keep in touch,” says Woodward, who’s considering moving to Sandpoint herself. “It’s a lot harder to monitor her situation.”

Social stigma around mental health can be another obstacle to care, especially in smaller towns. But some providers are now moving toward combining medical and mental health services.

At a clinic on the sprawling Nez Perce Indian Reservation, patients may come in with coughs, but a doctor might also tell them they’ve scored high on a certain depression measure. It may be their only chance to talk.

“When I see a patient, it may be the first and last time I see the pa-
tient,” says Kristy Kuehfuss, Nimiipuu Health’s director of behavioral health. That means Kuehfuss may have to streamline months of therapy — diagnosing and educating the patient — in less than an hour. She concentrates on immediate practical tips, such as encouraging depressed patients to get out of bed and go outside every day.

Kuehfuss says living rurally carries additional psychological costs. “For somebody who already has a mental health disorder, anxiety and depression,” she says, “it’s going to be exacerbated by the physical and social isolation.”

I.T. HELP

In a clinic in Cottonwood, Idaho, a child and parent talk with psychiatrist William Terry. They may talk about bipolar disorder, attention-deficit disorder or abuse, discussing how well their medication is working. It’s a typical conversation in almost every way but one: The kid and his parents are talking to a head on a high-definition screen hanging from a robot called the RP-Lite. The RP-Lite looks less like C-3PO and more like a coat rack with a face attached to the end.

Terry is 200 miles away, at a dual-screen terminal at Saint Alphonsus Regional Medical Center in Boise. Using the joystick, he swings the robot’s head and the video screen side to side. He can zoom in to observe a patient’s tremors or tics.

“You can move the camera so that we can focus in on the people’s face,” Terry says. “If they’re around the room, I can follow them in the room.” It only takes seconds for the distance to fade away, and for it to feel almost like any in-person session.

“One of the kids that has been seen by the psychiatrist saw the robot in the hallway,” recalls Pam McBride, special assistant to the president of St. Mary’s/Clearwater Valley Hospital and clinics. “The kiddo just ran up to it and hugged the robot and said, ‘Hi, Dr. Terry!’”

St. Mary’s Hospital in Cottonwood and Clearwater Valley Hospital in Orofino are in areas defined as “frontier” — the most rural of the rural. Psychiatric help for children is at least three hours away.

“Over 80 percent of the patients who took advantage of telepsychiatry services had never seen a psychiatrist before,” says McBride. “They had no access.”

When the first robots rolled into the two hospitals back in 2009, isolated communities were connected with psychiatric care for the first time. And it worked. A nonscientific examination of their data indicated a dramatic decline in primary care doctor, emergency room and hospital visits among those who’d conducted long-distance sessions with the psychiatrist.

In other words, it was not only helping patients — it was driving down costs for the entire system.

“We’ve seen kids go from almost getting kicked out of schools, because of behaviors that are out of control, to becoming Student of the Month,” McBride says.

In study after study analyzing Idaho’s mental health system, “telepsychiatry” continues to come up as one piece of the solution. The St. Mary’s hospital system wants to go further, using cheaper and more conventional video-chat technology to provide psychiatric help to even more far-flung clinics.

“Patients adapt to it much easier than health care providers do,” says psychiatrist William Hazle. “Think of how much time we spend watching the television screen. Now we talk to it.”

While telepsychiatry can bring help to remote locations, it doesn’t fix the fact that psychiatrists are in short supply everywhere in Idaho, even in Boise. Not all of them are comfortable conducting therapy sessions over video screen.

“Doctors weren’t trained to practice this way. You have to have a certain kind of doctor who’s willing to try this

...continued on next page
**STOPPING SUICIDE**

The correlation is undeniable: State by state, population density is one of the strongest predictors of suicide. All that loneliness, that isolation, that proud individualism that makes asking for help difficult adds up. Another major driver: access to firearms, which are used in more than half of Idaho’s suicides.

The state is sixth in the nation when it comes to suicide rate, according to 2010 data from the Centers for Disease Control. Nearby Montana ranked third.

Yet for years, Idaho was the only state without a suicide hotline. That finally changed in November 2012. The state amassed enough funding to reopen the Idaho Suicide Prevention Hotline, which went dark in 2006 due to budget cuts.

“I think it’s too early to tell if there’s been an impact,” says John Reusser, the hotline’s director. “Anecdotally, I can say we’ve saved lives.”

Last year, nearly 1000 Idahoans — including 120 military members — dialed 1-800-273-8255 to receive counseling from a team of 43 volunteers manning the hotline. This year, the hotline has already received 752 calls. Follow-up calls have shown suicides have been prevented and callers have been connected with outside resources to help them get better.

Currently, those calling on weekends or between 1 and 9 am on weekdays have their calls answered by a network of volunteers from other states, but by the end of the year, Reusser says the Idaho hotline will operate 24/7.

Local volunteers are crucial. When callers call from Idaho towns like Filer or Coeur d’Alene, Reusser says, Idaho volunteers know exactly where they’re calling from, and what rural life is like: “We understand what it’s like to live here.”

It’s far from the only effort to stop suicide in Idaho. Last year, the Idaho Department of Education won a three-year grant for youth suicide prevention.

— DANIEL WALTERS

**“FAR AND AWAY,” CONTINUED...**

method,” McBride says. “They’re used to having someone in front of them.”

Last year, Idaho doctor-turned-legislator Rep. John Rusche launched the Idaho Telehealth Task Force, which recently applied for a $2.3 million grant to train doctors and encourage providers to adopt telemedicine technology. Over three years, the Task Force estimates the state could save $19.3 million.

Yet there are places like St. Joseph Regional Medical Center, which once used telepsychiatry but longer do. The program ended when the provider left the practice. That’s the challenge with any rural innovation: Not just attracting the right talent, resources and programs – but keeping them.

**THE COST OF CUTS**

Nuclear engineer Ryan Mitchell had never heard the name Gerald Dark Simpson before Simpson shot him in the back.

Mitchell only happened to be at Mocha Madness in Pocatello on that day in September 2010 because he didn’t have Internet access at his apartment.

He was a few steps outside the coffee shop when Simpson, a schizophrenic 54-year-old, shot him point-blank. The bullet went through his back, through his left lung and embedded itself in his sternum. It missed the heart chamber by about an inch.

“It’s not like we wanted to become the poster children for mental health care in Idaho, but we kind of became that,” Robert Mitchell says.

Idaho’s Health and Welfare department is intended to fill a gap, providing mental health care for those without access to insurance or Medicaid. To balance the budget, Idaho eliminated redundancy. In the summer of 2010, 451 mentally ill Idahoans were kicked off state coverage and onto Medicaid or private insurance.

Simpson was among 70 Pocatello-area residents who’d been dropped from a state-funded, community-based treatment program that assisted them in living independently.

A month after the shooting, Ryan Mitchell attended a political candidates’ public forum in downtown Pocatello and asked a pointed question about why he got shot.

“The fact of the matter is this was caused by recent budget cuts to our mental health program,” he said. “My question is … What are you going to do to fix it?”

Two years later, the charges against Simpson were dismissed after a magistrate determined he lacked the mental capacity to stand trial. During those two years, Mitchell and his parents’ plea for more mental health care funding went unfulfilled: An additional $1.85 million was cut from the state’s mental health budget.

The recession devastated Idaho’s mental health care system in a way it still hasn’t recovered from. From 2008 to 2012, state funding fell by more than 28 percent. During that same period, federal funding collapsed nearly by half.

The cuts gouged deep through Idaho. In 2010, Health and Welfare eliminated 126 positions statewide and shuttered nine rural offices.

“We made it a goal to not stop serving people,” says Ross Edmunds, administrator of the department’s Behavioral Health Division. When the offices closed, the department continued working through local clinics. The state served more patients total, yet had to dramatically cut back on the breadth of services.

For patients who aren’t suicidal or homicidal, the state has stopped providing psychotherapy and case-management services.

Of course, in the midst of all this, Idaho had an option to give vastly more people mental health care, while saving the cash-strapped state more than $400 million across 10 years, according to a report from the Idaho Workgroup on Medicaid Expansion. It just had to expand Medicaid under the Affordable Care Act.

Initially, the federal government would pay the entire bill. But Idaho Gov. Butch Otter, like most Republican governors, rejected the offer, arguing that Medicaid should be reformed first.

**THE BRIGHT SIDE**

In fact, reform is happening. An in-depth 2008 report called Idaho’s mental health system “severely fragmented, with a significant lack of clarity.” It proposed solutions, like combining mental health and substance abuse departments. Now, Idaho has done
just that.

It’s also handed state regional mental health boards a little more power. “Previously they were only an advisory group. They couldn’t have their own budget or own staff. They couldn’t apply for grants. Nothing,” Edmunds says.

On July 1, the old regional mental health boards will disappear, replaced by behavioral health boards that focus on mental health and drug abuse. Each of the seven regions will have a small $45,000 budget, be able to hire staff members and apply for their own grants. The boards know their communities, the thinking goes. They know where resources are most needed.

That’s far from the biggest change. In September, Idaho switched from a fee-for-service model for Medicaid to a “managed care” model, run by a national organization called Optum. Instead of the health care business model that profits more the longer patients are sick, managed care organizations have financial rewards for getting people healthy quickly. They strictly monitor the cost and effectiveness of treatments. “The impact of that is tremendous,” Edmunds says.

In Grangeville, Griffis has been impressed. “They handled our very complex situation well,” she says. “We were able to get some answers to questions before I even needed to ask.”

Yet reviews have been far from universally positive. Some providers see Optum as another layer of red tape: more paperwork, more restrictions, less time with patients.

“We used to be able to do 60-minute sessions,” says Jenny Brotherton-Manna, who runs North Idaho Children’s Mental Health in Sandpoint. Now most sessions are limited to 45 minutes. She now has to ask for permission to give patients certain treatments, and getting it sometimes means waiting two or three days.

And since she’s only a therapist, there are now some practices Medicaid under Optum won’t pay for at all. “Medicaid has now stopped the payment of all testing to be done by masters-level therapists. I cannot get reimbursed,” she says. “It has to be referred on to a psychologist or psychiatrist.” Nearly half the counties in Idaho, according to the Mountain States Group, have neither. She says there’s now an unprecedented four-month-long wait in her region for kids to see a neuropsychologist.

“I want to be able to provide the type of service [a patient] needs at that moment, without having to make two or three phone calls a day to get him some services,” she says.

Optum has been given another huge responsibility: Fix rural access issues. Their contract demands there be at least one mental health care provider located within 45 miles or 45 minutes of any Idaho residence. In more densely populated counties, like Kootenai and Ada, the requirement is even stricter: 30 minutes or miles or less. If not, Optum is contractually bound to come up with a plan to fix it.

There’s more good news: The budget stopped plummeting. Since last year, the state of Idaho has slowly been restoring mental health funding, though even by 2015, it will still fall short of pre-recession levels.

In this past legislative session, Health and Welfare asked for funding to add three new behavioral health crisis centers. One would be in Boise, another in Idaho Falls, and another in Coeur d’Alene.

The legislature came through – but only partially. “The legislature has only funded one of those facilities. It’s embarrassing,” Robert Mitchell says. “At least that’s progress.”

Right now, Coeur d’Alene is intensely competing with the biggest cities in eastern and southern Idaho for the clinic. Kootenai County’s sheriff and four regional police chiefs signed a letter to state Sen. John Goedde last month, urging the state to pick Coeur d’Alene.

“Kootenai County has one of the highest suicide rates in the state,” says Claudia Miewald, director of the Kootenai Behavioral Health Center. “We desperately need this in our community.”

STAYING PUT

Activists have called for more psychiatrists in Idaho, more telenmedicine, more funding, more coordination and support. But change is slow, and many families of the mentally ill living in rural Idaho have had to consider another solution: packing up and finding somewhere else to live.

“We were told by two different people early on: ‘If you were going to be dealing with this, Idaho is not where you’re going to be,’” Griffis says. “There were times that we wondered if we needed to move.”

But she feels like she has a responsibility to stay, to change Idaho instead of leaving Idaho. Today, she’s on the State Planning Council on Mental Health. She urges the state to concentrate more on children’s mental health, respite care and day-treatment centers to give parents a break.

“We feel like we’re in a position to push for mental health services,” Griffis says. “It will take some time to see where that goes. It takes people willing to speak out.”
Ketema Ross has never been convicted of a crime.

But four years ago, Ross, a state psychiatric patient who had been exonerated as Not Guilty by Reason of Insanity, watched as his rights slowly were stripped away at Eastern State Hospital in Medical Lake. First, the Department of Social and Health Services banned patients’ community reintegration trips — visits to Walmart and Auntie’s Bookstore, lunches at McDonald’s, Spokane Indians games. Soon, patients couldn’t even take a walk on hospital grounds without a judge’s permission. The only legal channel available to patients seeking their freedom had become mired in so much bureaucratic red tape, Ross saw many of his peers on the ward lose all hope of ever getting out.

Now he’s joined two other patients at Eastern and Western State hospitals in a lawsuit against the state, alleging that these current restrictions violate their constitutional and civil rights to adequate mental health treatment.

Inspired by an Inlander investigation, a Spokane attorney has teamed up with insanity-defense patients to file a civil rights lawsuit against the state.

BY DEANNA PAN

Ketema Ross: “If we win, it will be a win for all patients.” - YOUNG KWAK PHOTO
The suit, filed last week in U.S. District Court in Spokane, names Gov. Jay Inslee, the state Department of Social and Health Services and DSHS Secretary Kevin Quigley as defendants. The advocacy nonprofit Disability Rights Washington is the fourth plaintiff in the case, representing all patients at Washington’s psychiatric hospitals. The plaintiffs are asking the court to invalidate two laws passed in 2010 in the aftermath of Eastern NGRI patient Phillip Paul’s high-profile escape from the Spokane County Fair.

The first law effectively bans NGRI patients from leaving hospital grounds, except under special circumstances, like medical and legal appointments or funerals of immediate family members. On those rare occasions, DSHS requires patients to leave in shackles.

The second law established the governor’s Public Safety Review Panel, an independent board comprised of clinicians, law enforcement members and attorneys, to review patients’ requests for conditional releases for grounds privileges or visits into the community. The suit alleges that the panel delays and deters patients trying to reintegrate into society.

“What people don’t understand, which I hope this lawsuit can help in its own small way, is that mental illness is not a character flaw,” says Andrew Biviano of Scott Law Group in Spokane, the lead attorney in the case. “It’s not something people choose to have, and it’s worthy of the same patience and understanding and accommodation as any other kind of illness.”

A former mental health case manager for Spokane Mental Health, Biviano says he was inspired to pursue the case by an Inlander story (“Patients and Prisoners,” Feb. 13), detailing the punitive conditions at Eastern State Hospital and the consequences of these laws limiting patients’ access to the outside world.

Biviano argues that isolating NGRI patients in state hospitals violates their federal protections under the Americans with Disabilities Act, which requires states to provide people with disabilities with the most community-integrated treatment available. He also argues that the practice undermines patients’ 14th Amendment rights to minimally adequate mental health treatment and equal protection under the law.

“We are resisting the legislature’s action to treat everybody with that same broad brush, that everyone is treated as if they are incurable and cannot be trusted in any capacity,” Biviano says. “It’s just that we are resisting the legislature’s action to treat everybody with that same broad brush, that everyone is treated as if they are incurable and cannot be trusted in any capacity, like Mr. Ross, who has shown incredible improvement.”

Ross, a former Yale Law School student whose story previously was featured in the Inlander, was diagnosed with paranoid schizophrenia. In 2007, he suffered a psychotic breakdown and assaulted an elderly couple in Pullman. He was acquitted by reason of insanity and admitted to Eastern. Although Ross hasn’t experienced any symptoms of psychosis in five years, his commitment at Eastern is indefinite. He’ll most likely live under the hospital’s supervision for the rest of his life.

“In response to the suit, DSHS says: “We strive, on
a daily basis, to balance the rights and recovery needs of the individuals who have been found not guilty by reason of insanity with the safety of the public.”

Studies show that the majority of defendants who are acquitted using the insanity defense often spend far more time — sometimes twice as long, if not much longer — confined in state psychiatric hospitals than defendants convicted of the same charges in prison. But data shows that NGRI patients’ recidivism rates are remarkably lower than those of offenders in Department of Corrections custody. For example, at Western State Hospital in Lakewood, 0.6 percent of the hundreds of patients released into the community on the hospital’s recommendation since 1978 have committed new crimes. By comparison, the recidivism rate for mentally ill prisoners in Washington is 25.8 percent.

Ross, along with the other plaintiffs, is not seeking any compensatory damages from the state, but says he expects the suit will draw more attention to the prison-like conditions at state hospitals — and more important, restore patients’ hope.

“If we win, it will be a win for all patients at Eastern State Hospital and Western State Hospital,” he says. “[And] for every clinician who believes people do recover from mental illness, and any and everyone who believes in second chances.”

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So many questions. How did he get his gun back? Why wasn’t her family notified? Could this tragedy have been prevented if he had gotten treatment? How do we make sure something like this never happens again?

There are no easy answers following the murder-suicide last week at Deaconess Hospital, where 37-year-old Christopher Henderson fatally shot his wife, Sheena, 30, before turning the gun on himself.

What we do know is that Christopher’s mental health had been deteriorating for months. On May 16, Sheena alerted police that her husband was suicidal. Officers found Christopher in a van, armed with a gun. They convinced him to hand over his weapon and transported him to Sacred Heart Medical Center for a mental health check, where he was released three hours later.

Then on July 7, sheriff’s deputies paid a visit to Christopher at his office after a coworker heard him talking about ending his life. Deputies questioned Christopher and determined he wasn’t a threat. Later that day, Christopher got his weapon back from police lockup. The next day, he shot his wife multiple times at Rockwood Cancer Treatment Center on the seventh floor at Deaconess, where she worked. Afterward, he shot himself in the head.

Could early treatment intervention have prevented last Tuesday’s violent attack? It’s hard to say, says Staci Cornwell, the direc-
tor of Crisis Services at Frontier Behavioral Health. “It is very
difficult to predict that someone will do something like this — kill
himself or kill someone else — unless they’re telling you to your
face.”

Under Washington’s Involuntary Treatment Act, the court can
commit individuals with severe symptoms of mental illness to the
hospital without their consent only if a county “designated mental
health professional” determines they are “gravely disabled” or an
“imminent” danger to themselves or others. Those who meet the
state’s criteria can be hospitalized at a psychiatric facility for up to
72 hours or longer after further court action.

Suicidal thoughts alone, however, aren’t always enough to trig-
ger an involuntary detention, Cornwell says.

“W e see and get calls from hundreds and hundreds of people
who are suicidal who don’t meet that criteria,” she says.

The Crisis Response hotline at Frontier gets thousands of calls
every month, Cornwell says, and between 600 and 800 referrals
requesting a mental health evaluation. Frontier is the only agency
in the county with authority to perform involuntary treatment
evaluations.

Cornwell would not confirm whether Frontier DMHPs or
hospital workers were involved in Christopher’s evaluation at
Sacred Heart Medical Center due to privacy concerns. But both,
she says, would have conducted the same initial assessment to
gauge his risk level and need for treatment. In that assessment,
mental health providers would see if the client had a plan to
commit suicide, a means do it and any protective factors that may
prevent him from doing so, like close family members or goals for
the future. Next, they would work to minimize his risk of suicide,
say, by taking away his weapon or cache of pills, and connecting
him to outpatient treatment services. Involuntary commitment is
usually a last resort.

“When you involuntarily hospitalize someone, it is a court
process; it is a civil commitment. It does strip them of those
rights,” Cornwell says. “W e do try and make sure we’re exhaust-
ing all options before we go into that direction.

“If we can prevent the downward spiral, then that’s our best
opportunity to really make a difference and changing the course
of where they’re headed,” she adds. “W e certainly don’t want
people to hit rock bottom or do something dangerous before we
intervene.”

But advocates from the Washington chapter of the National
Alliance on Mental Illness say that’s exactly what happens. Sandi
Ando, the public policy chair, argues that the state’s civil commit-
ment criteria is too narrow to get decompensating people the help
they need to avert a mental health crisis. Over the years, NAMI
has backed legislation expanding the state’s civil commitment cri-
teria by removing the “imminent” standard under the Involuntary
Treatment Act.

The most recent iteration of the bill was introduced last year
by Rep. Brad Klippert, R-Kennewick. The bill has never gained
traction, Ando says, because of the high costs of adding more
treatment beds.

“If we’re going to take care of people… we need to be sure the
system is adequate to respond to them and their needs, and there
is no way this system is adequate to do that,” she says. “The fact
is that nobody who is operating in a highly delusional state really
does have any liberty at all. They’re at the mercy of their delu-
sions; they’re not free anyway. The best way to get them free is to
get them well.”

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Waiting for Rights

A class-action lawsuit challenges the state on its failure to provide mental health treatment for those in jail

BY JACOB JONES

A ll across the state, defendants with mental health issues face routine delays of weeks or months waiting in cramped jail cells for a legally required mental evaluation from the state’s overburdened psychiatric hospitals – before they can even start their trials. Still presumed innocent, scores of defendants remain penned for longer than if they had been convicted, often without treatment and isolated in solitary confinement 23 hours a day.

While state law calls for such evaluations to be conducted within seven days, records show average wait times stretching from 30 to 50 days. In at least one case, a defendant has waited more than 120 days.

“The current [wait] lists are unprecedented,” says attorney Emily Cooper with the nonprofit Disability Rights Washington. “That’s a lot of people waiting.”

Right now, a 28-year-old man has spent more than 45 days in the Spokane County Jail awaiting a mental evaluation after a charge of driving under the influence, an offense that would commonly result in a 30-day sentence. After a psychotic episode, records say he recently was put on suicide watch.

Less than a year ago, 25-year-old Amanda Cook, a young mother who once enjoyed drawing and shopping with her sisters, wrote her family a series of letters describing her mental anguish as she waited for an evaluation at the Spokane County Jail. Her wait stretched several weeks and ultimately she took her own life in a jail showering area on Dec. 3.

Officials with the Department of Social and Health Services, which oversees jail mental evaluations through its psychiatric hospitals, acknowledge longstanding failures to meet deadlines on evaluation times. Agency reports point to staff limitations, ward overcrowding and budget cuts.

With wait lists now stretching longer than any time since at least early 2013, mental health advocates last week filed a federal class-action lawsuit against DSHS on behalf of dozens of defendants waiting for evaluations. Many groups, including Disability Rights Washington and the...
ACLU of Washington, have signed onto the lawsuit in hopes of forcing a systemic change.

“We’ve reached the breaking point,” Cooper says. “We can’t wait any longer for a solution because people are dying and people are being irreparably harmed.”

The new class-action lawsuit filed Thursday in Seattle cites four cases in which defendants, including the 28-year-old Spokane man, have waited weeks in jail without trial or conviction for a mental health evaluation. Advocates argue the Fourteenth Amendment of the U.S. Constitution and the Americans with Disabilities Act prohibit the state from holding defendants indefinitely without proper medical or mental health care.

“Unfortunately, [state psychiatric hospitals] have persistently failed to perform these services on a timely basis,” the lawsuit states. “[D]elays have caused individuals with mental health disabilities to suffer needless deterioration in their mental health as they sit in jails, frequently in prolonged isolation, for weeks and months before receiving the … services [hospitals] are responsible for providing.”

A 2013 audit of evaluation times at Eastern State Hospital, which conducts jail evaluations for the state’s 20 eastside counties, found the hospital failed to meet its seven-day deadline 99 percent of the time. Monthly reports show the number of defendants waiting in jail for evaluations continues to increase this year, with 67 individuals waiting in early September.

DSHS regional spokesman John Wiley acknowledges Eastern State Hospital rarely has the resources to meet the seven-day deadline. He explains that the hospital has hired additional staff in recent months, but still struggles with a regional shortage of qualified psychiatrists and licensed evaluators.

“[E]ven when patients are evaluated, there are not enough beds available for treatment and restoration,” he writes in an email. “DSHS will be asking the Legislature for funding to deal with the problems.”

Advocates argue insufficient funding does not justify violating the constitutional rights of a vulnerable population. They hope bringing the lawsuit to federal court will draw new attention to the issue.

“It’s deeply troubling,” says Margaret Chen, an attorney with the ACLU of Washington. “These are individuals who need to be evaluated and treated. … Jails are not the appropriate places for them.”

While the Washington State Supreme Court recently banned a common practice known as “psychiatric boarding,” in which state hospitals temporarily house mental health patients without treatment in under-equipped emergency rooms, jail evaluations will likely continue to face delays. State law does not include consequences for failing to meet deadlines. Some defense attorneys have resorted to filing motions to hold hospitals in contempt, but most are denied.

“Unless enjoined by the court,” the class-action lawsuit states, “[state hospitals] will continue to violate and cause the violation of the constitutional rights of the class plaintiffs and the class members.”

Cooper explains that hospitals have requested more staffing and resources, but also have failed to meet efficiency guidelines outlined by the legislature. She hopes a judge can bring some clarity to the stalemate and set new goals.

“The federal court is in the best position to provide relief,” she says. “Clearly the state hospitals haven’t been able to fix it on their own.”

Cooper says state representatives have agreed to meet on the issue, which she finds encouraging. She also finds hope in the broad coalition of attorneys and advocates who have joined the effort to address a problem that has stood for years, impacting the care and well-being of thousands of people.

“At this point, we’re left with no other options,” she says. “These are our mothers and our sisters and our children. … And this is how we treat them? It’s just appalling.”