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?

Suicide is the 10th leading cause of death in America.

About 2,000 people receive mental health care at the Spokane jail each year.

'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.

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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.

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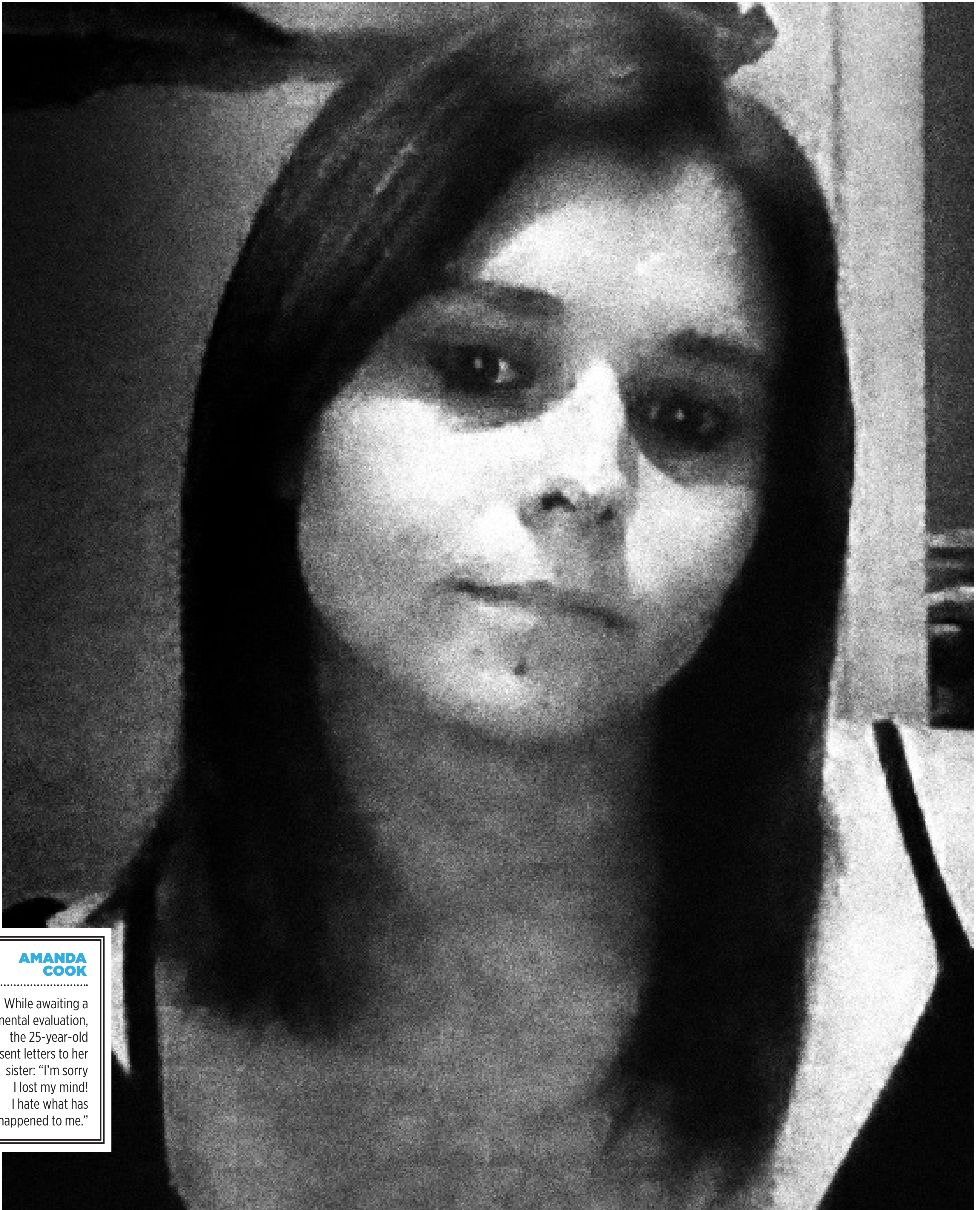
EDITOR'S NOTE: These special reports are the first in our "State of Mind" series delving into the issue of mental health. Besides exposing serious problems, we will also strive to tell success stories and examine potential solutions. If you have feedback or a story to share, please email us at editor@inlander.com.

STATE of MIND



AMANDA COOK

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.”

Alecia Crider, left, and her mother Tammy. Alecia was diagnosed with bipolar disorder, ADHD and general anxiety at the age of 11. YOUNG KWAK PHOTO

"THESE PEOPLE ARE US," CONTINUED...

80 MILLION AMERICANS

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.

Otto Zehm, a mentally ill janitor, died in 2006 after a violent confrontation with Spokane police

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.

"The hardest thing I ever did was make the decision to not parent her on a daily basis."

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.

"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 *those* 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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Idaho Gov. C.L. "Butch" Otter called on lawmakers to create regional "behavioral health crisis centers" in Boise, Idaho Falls and Coeur d'Alene during his State of the State address last month.

"THESE PEOPLE ARE US," CONTINUED...

"Even though we know we can look at that young mom and know she's depressed and know what it would take to get her back on track and her whole family stabilized, there is [sometimes] no money to do that," Hopkins says. "That's tough."

For many with serious mental health needs, emergency rooms are increasingly becoming triage centers. A *Seattle Times* investigation last year found that "boarding" mentally ill patients in hospital rooms and hallways has become an increasingly common practice in Washington, which ranks near the bottom of states for psychiatric beds per capita. In Spokane, Frontier Behavioral Health operates two evaluation treatment facilities and one crisis stabilization facility (48 beds total), which provide short-term care, and the 287-bed Eastern State Hospital in Medical Lake offers long-term institutionalized care. But cutbacks at hospitals like Eastern State have pushed some people with serious needs toward scarce community facilities or into emergency rooms.

FACT

Some leaders, including Washington Gov. Jay Inslee, are calling for more coordination between mental illness and substance abuse treatment in hopes of better treating the 9 million American adults who have co-occurring mental health and addiction disorders.

Some change may be coming. In caring for children with mental illness, a 2009 lawsuit alleged that the state of Washington was failing its youngest vulnerable citizens. That prompted plans for a significant overhaul of mental health care for children in Washington. Then a bill passed last year in Olympia mandated that the Legislature create a task force to study possible reforms of the adult system and report to the governor by the end of this year.

To the East, Idaho transitioned management of its public behavioral health care system to Optum, a private, Minneapolis-based company, in September. With promises the switch would make providing mental health care more efficient and affordable, the state Department of Health and Welfare now pays the company $10.5 million a month to oversee services for Medicaid recipients. But in a state Senate committee meeting in late January, providers slammed the new system, telling lawmakers it's plagued with long telephone hold times and difficulty for people trying to find out if they're covered for certain services.

Meanwhile, lawmakers are considering a $5 million proposal to open regional "behavioral health crisis centers" in Boise, Idaho Falls and Coeur d'Alene, which could help reduce mental health visits to hospital emergency rooms in the state.

"Folks, this can work," Idaho Gov. C.L. "Butch" Otter told state legislators last month in his 2014 State of the State address, calling on them to support the proposal. "The response to such programs elsewhere has been encouraging, and communities have been more than willing to join in these investments as they see declines in use of local emergency rooms, hospital beds and jail cells."

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 injections 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

➤ LETTERS
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enough to be released after 20 days of treatment. Throughout the '50s, the drug's use spread globally, and it became a staple in American psychiatric hospitals.

"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

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FACT

Between 1955 and 1980, the population of America's mental institutions fell from 559,000 to 154,000.

"THESE PEOPLE ARE US," CONTINUED...

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.

FACT

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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“LOCKED AWAY,” CONTINUED FROM PAGE 20...

The row of cells used for inmates on “suicide watch” at the Spokane County Jail. The “30” magnet on the cell door indicates the inmate must be checked on every 30 minutes. JACOB JONES PHOTO

“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 out 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 county 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

Behind the door to 2W19, one of several suicide watch cells on level Two-West, a 45-year-old man with a salt-and-pepper beard lets out a string of broken wails, seemingly drowning in his own screams. He then goes quiet, pressing himself hard into the far corner of his cell as Cory Standridge, one of the jail’s mental health professionals, steps in to check on him.

Each inmate receives a mental health assessment upon booking. People may self-report a previous diagnosis or admit thoughts of self-harm. Police officers can make referrals or corrections staff may flag unusual behavior. Inmates with severe symptoms may require immediate “crisis intervention” to control their outbursts.

“Sometimes when you guys hear me scream, it’s to get the raging thoughts out of my head,” the man tells Standridge, pausing, “You know what I see right now? Math.”

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"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 growls.

"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."

Public defender Kari Reardon notes that Death Row inmates get more time out of their cells than local mental health inmates at the county jail. YOUNG KWAK PHOTO

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 next 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 peek 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

in your room all day. … I think this is extremely counterproductive."

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

STATE of MIND

"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 lost 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 am 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

Parker says her family wants answers. Despite Cook's previous letters, investigators did not recover any note. Detectives found no sign of any criminal involvement and family members do not dispute the death was suicide. But what Parker wants to know is what else should have been done? What could be done in the future so other people don't suffer the same fate?

"It could have been prevented," Parker says. "Eventually, with proper treatment, she could have been helped."

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." ■

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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?