

SEATTLE POST-INTELLIGENCER

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Dan Weiss, one of seven Department of Corrections special needs unit officers, scans the street for mentally ill offenders under their supervision who are in violation or have outstanding warrants. Many offenders are homeless or live on the street. About once a month officers patrol at night checking to see if offenders are where they're supposed to be. A computer in the van allows them to check the warrant status of offenders. (Dan DeLong / P-I)

Dangerous and mentally ill: A system in restraints

Wednesday, March 26, 2008

Last updated 7:59 a.m. PT

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P-I REPORTER

Before James A. Williams was charged with stabbing a young Seattle woman to death, he stood before a King County Superior Court on a different occasion, accused of assaulting a different stranger, and asked to speak in his own defense.

In the midst of a passionate and rambling argument explaining why he shot a stranger at a Seattle bus stop, he paused to deliver this judgment:

"I didn't even ask to be born," he told the judge. "If I had my way I would never have been born, but unfortunately, I was."

In some sense, it is a wish echoed by a mental health system that failed to predict the emergence in the last few decades of a class of violent, mentally ill offenders, such as Williams.

The year Williams, 48, was born, the United States was on the cusp of a grand experiment to free the mentally ill from insane asylums, a shift that would eventually and disastrously claim him as a casualty and, if what he is accused of is true, cost Shannon Harps, 31, her life. Harps, a Sierra Club worker, was walking outside her Capitol Hill condominium at about 7 p.m. on New Year's Eve when a man attacked her with a butcher knife and commanded her to die. Williams' DNA was found on the knife.

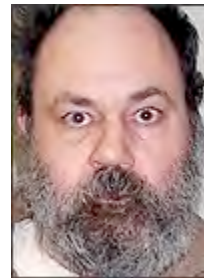
That such a tragedy occurred in King County, which offers a comprehensive and progressive system for dealing with mentally ill parolees, has both the public and the mental health community asking what went wrong.

It's a question underscored by a spate of gruesome killings linked to mental illness around the country, from the most recent campus shooting in Illinois, to the psychiatrist who was hacked to death in her New York office last month.

Since April 2000, 512 Washington inmates have been designated as dangerous and mentally ill, the same designation Williams received when he got out of prison in 2006 for the bus stop shooting. Of those, 466 are living in the community. Those who volunteer to enroll in a special supervision program receive extra help with housing and mental health care in addition to being closely monitored by the Department of Corrections.

But about half of the "dangerous mentally ill" either can't or don't participate. Only 222 actually receive services through the program -- some because they live in areas of the state where no mental health counselors will take such patients on, or where no housing will accept them. Others simply reject the help.

Williams' case, like the nearly identical case 10 years ago when a psychotic man stabbed a Seattle firefighter to death outside the Kingdome after a Mariners game, has once again forced the issue of how society deals with those who are severely mentally ill and have criminal histories -- a population that has been exploding even as the resources to deal with it have dwindled. At the same time, laws intended to safeguard the rights of the mentally ill seem instead at cross-purposes with keeping the public safe. To be committed to a mental hospital today, even for a brief period, an individual must be in imminent, provable danger of harming himself or others.



Shannon Harps, a Sierra Club worker who lived on Capitol Hill, was murdered with a butcher knife outside her home on New Year's Eve. James Williams (below) has pleaded not guilty to the crime.

Nervous breakdown

Williams should have been a success story. He was one of 70 dangerous mentally ill offenders living in King County, which does provide services and has some housing that takes psychiatric patients with violent histories. Despite getting intensive intervention, supervision and financial help, he slipped the grasp of the medication that kept him somewhat stabilized, and the efforts of a dozen caseworkers, corrections officers, counselors and others who struggled to keep him from exploding.

The reasons have their roots in the history of psychiatric care in the last half of the last century. Williams' own story, pieced together from psychiatric records included in public filings, and court records obtained by the Seattle P-I, is a case history of the dark side of deinstitutionalization.

Williams was born in 1959 in Camden, Ark., at the tail end of the decade that also produced Thorazine, the first "miracle" anti-psychotic medication. For the first time, doctors had a medicine to treat delusional symptoms, opening the door for treatment outside the restraints of a hospital. Like the social change it helped instigate, however, the medicine also had nasty side effects that made many patients refuse to take it. Neither deinstitutionalization, nor the medicines that spawned it, worked as intended.

Williams was only 8 when his mother died under mysterious circumstances. He never knew his father. After his mother's death, he was shuffled among households, living with various aunts and grandparents.

At age 12, he had his first "nervous breakdown" and was admitted to Arkansas State Hospital for about a month for treatment of "obsessive, psychosomatic thoughts." After his release, he dropped out of

seventh grade and started doing drugs. Eventually, he graduated from huffing lighter fluid off rags to shooting methamphetamine.

At 17, he was convicted of burglary and landed in an Arkansas penitentiary for the first time. Meanwhile, his mental health continued to deteriorate, and signs of a virulent anti-social personality disorder began to emerge in a foreshadowing of his future.

In 1982, after breaking up with a girlfriend, he told doctors he had "such hatred for her that he has serious thoughts about taking a knife and going and cutting her up." According to his treatment notes, "He spends a great deal of time thinking about how he would like to get even with people whom he believes to be the blame for what has happened to him." Doctors diagnosed him with schizophrenia. He was 22.

The conclusion doctors made 25 years ago: "Prognosis is considered poor at this time because of apparent lack of motivation to follow through with any treatment recommendations"

That prognosis would prove prophetic.

Missing pieces

Over the next decade, a series of progress notes from Arkansas mental hospitals and prisons traces Williams' dizzying circuit among hospitals, jail and the streets, a loop that mimicked that of countless other psychiatric patients. Hospitals, gutted by budget cuts after deinstitutionalization, had neither the beds nor legal grounds for keeping them. Prisons and jails were not equipped to treat them. And landlords didn't want them.

This was not the intended consequence of the push for community care of the mentally ill. Three decades ago, it was far too easy to warehouse patients for abnormal social behavior, a loose criterion that let families offload their more difficult or embarrassing relatives.

"People in state hospitals in the early '60s did not get there based on imminent danger," said Richard Kellogg, director of the Mental Health Division of the state Department of Social and Health Services.

In 1963, when President Kennedy signed the Community Mental Health Centers Act, the vision was to provide prevention, intervention and treatment outside of institutions for all ages and incomes based on ability to pay.

"But when patients were deinstitutionalized, no one envisioned such a subset (of patients) with this degree of violence," Kellogg said.

The visionaries missed other pieces necessary to help psychiatric patients succeed in the community, in particular the need for affordable housing.

"The 1963 act didn't envision the relationship (of outcomes) to housing, and mental health service is not housing," Kellogg said. "That major point got lost."

Nor did the reformers foresee the effects of a rising street drug culture on crime and a growing consumer appetite for violent entertainment.

"Our culture changed. We have a more violent culture today," he said. The right infrastructure wasn't in place to safeguard either them, or the public.

Instead they went to jail, in droves.

"The census of mentally ill in King County Jail is second only to that at Western State Hospital," said David Aiken, supervisor of the Special Needs Unit, the section of the Department of Corrections that oversees dangerously mentally ill offenders after release from prison. A 2006 Department of Justice report says 45 percent of federal prisoners have symptoms of serious mental illness. The percentages are even higher in local jails -- 64 percent -- and state prisons --56 percent.

The population of people with mental illness in jails in turn jammed up what was left of the state hospital system. The number of beds nationwide, which peaked at about 565,000 beds in the 1970s, is now down to about one-tenth of that, which some argue is no longer sufficient to meet demand.

Before 1990, Western State Hospital did about 300 evaluations for "competency restoration" a year, said Mark Allen, a mental health counselor in the forensics unit at Western. Today, the hospital does about 3,000 outpatient admissions a year to determine whether a person is competent to stand trial.

Western, which is at capacity, has a current patient census of about 1,000 patients, including 300 criminal offenders. In addition, there are about 230 beds sprinkled around King County that will take psych patients who are committed involuntarily.

But that isn't enough. At any given time, an estimated 20 percent of those who have been identified as qualifying for involuntary commitment under the state's strict committal laws still can't get beds and wait out their 72-hour "holds" in ERs or other nonpsychiatric facilities. When the holds are up, they walk.

To qualify for a longer stay in the hospital, a patient has to do something extreme. Allen recalls a mother who pleaded with the mental health community for six months to try to have her mentally ill son hospitalized. Finally, he stabbed her.

Then he was committed.

"The majority of people with mental illness in the community are not violent and in fact are not more likely to commit violent crimes than nonmentally ill people," Kellogg said. "But there is a subset, that we have growing knowledge of, coalescing around co-substance abuse, multiple admissions, including jail time, and a history of social inadequacy."

That was Williams' subset.

Clear and present danger

By the turn of the '90s, Williams was a 31-year-old vagrant described in records as "unkempt, very dirty, agitated, loud and cursing." Now labeled a "chronic paranoid schizophrenic" he had already cycled on and off powerful anti-psychotics multiple times, typically abandoning them as soon as he was out of prison or the hospital. Psychiatrists say going on and off meds multiple times can erode their effectiveness, creating a class of patients who become untreatable over time.

In the previous 10 years, he had been committed for "terroristic threatening" of his grandfather, then jailed for assaulting an elderly woman. He'd been in prison for writing hot checks, and back in treatment for delusions that his grandmother was trying to kill him with the TV remote control.

He claimed that medicine was destroying his brain. He was known to carry a knife and said he slept with a loaded gun. "If people try to mess with me," he told a counselor in 1990. "I will get pleasure in



zoom

Dan DeLong / P-I

A security officer walks the hall in the Center for Forensic Services at Western State Hospital in Lakewood on Monday. The hospital is at capacity with about 1,000 patients, including 300 criminal offenders.

killing them."

Throughout, notes from repeated mental evaluations show Williams' grounding in reality morphing to quicksand.

"He believed that he was an FBI and CIA agent, and that he also worked for the U.S. Army, God and the devil," said one such note.

Doctors in Arkansas called him a "clear and present danger" to himself and others.

Then he vanished, and the mental health facility where he was periodically seen throughout the 1980s "terminated" his chart.

In a disturbing prelude to events to come, Williams popped up in a new city, this time in Florida, where he racked up three convictions on separate occasions for assaulting a man with a knife, for bashing another man's face into a fire extinguisher and, ominously, for terrorizing a woman.

According to the 1993 police report from that incident, "As the defendant rubbed on her leg (victim), the defendant was talking about 'killing women' and 'cutting women from their eyes to their throat.' "

Stranger violence

It's not clear when, how, or why Williams arrived in Seattle, but this chapter of his life starts on another prophetic note.

In 1995, he was arrested for shooting a stranger at a downtown bus stop. In the police report of that initial incident, there is this bold-face warning: "DO NOT RELEASE!!! SUSPECT SHOT A STRANGER WITH A LARGE CALIBER PISTOL. THE SUSPECT IS A DANGER TO ALL CITIZENS ..."

Despite his record, prosecutors determined Williams' prior offenses in other states didn't qualify him to be prosecuted under the state's three-strikes criteria that would have put him in prison for life. Instead, Williams was convicted and sentenced to 11 years for the shooting. In prison, his behavior continued to spiral out of control. He was put in restraints for fits of rage, forced to take medication and racked up 248 violations for damaging property and assaults. When his release date came up in 2006, he was a textbook case for the Dangerous Mentally Ill Offender program. A judge ordered him to 24 months of community supervision, and Williams agreed to take part in the program.

Although he became increasingly difficult to handle, he was checking in with his corrections officer as he was supposed to, said those who were responsible for tracking him.

"Assuming he didn't commit a murder," Kellogg said, "the system worked."

Degree of imminence

The case raises a host of disturbing and complicated issues that come down to how much risk is too much for society to bear. For sexually violent predators, the state has decided there is a class of offenders -- Level 4 -- that should remain locked up for mental health treatment even after serving their prison time because of their danger to the public.

Should a similar risk category be created for violent offenders with certain combinations of personality disorders, mental health diagnoses and track records with treatment compliance? Should the public be notified -- as it is with sex offenders -- when offenders with violent and serious mental health histories are released? Is the bar too high for getting people committed? And should the three-strikes law be

applied differently for those who have severe mental illnesses?

David Weston, chief of mental health services for the state, said he knew of no other states that had tried such measures. Washington would be setting precedents.

"I don't think the public mental health system was ever designed to guarantee 100 percent safety," Kellogg said. "Whether it should be or not, is an open question."

Earlier this month, King County Prosecutor Dan Satterberg convened a task force to examine the Williams case. It is still in the fact-gathering stage and has yet to draw any conclusions or propose solutions.

Many of the issues boil down to money -- more money for housing, for treatment centers, for supervision, say those who are closely watching this case.

The program that monitored Williams is already under financial strain. In 2007, it overspent its budget by \$400,000, and in response may have to slash the number of years it will provide mental health help to those enrolled from five years to 2 1/2 years. Weston said he is trying to find other funds to keep services available for the full length of time, but hasn't found them yet.

And that won't help the many others who corrections officers say are equally likely to be dangerous, but who don't fit the eligibility requirements for the mentally ill offender program and receive no such coordinated assistance at all.

The high thresholds for commitment also frustrate those who track mentally ill offenders.

To be hospitalized, the person must be a danger to self or others, or gravely disabled. And there must be a trail of evidence, including witnesses, to persuade a court. The threat must be imminent, not based on hearsay, and specifically related to a serious mental illness. A threat made by a mentally ill person because he or she is angry or frustrated wouldn't qualify. In addition, the county, which evaluates people for involuntary commitment, is also bound by law to ensure they are treated in the "least restrictive" setting, which usually means in community clinics and housing.

Only "designated mental health professionals," who work for King County Mental Health, can decide to commit someone against their will. In 2006, these evaluators, most of whom are not psychiatrists, but do have master's-level degrees in psychology-related fields, did 5,500 such crisis assessments. Of those, 2,169 patients were hospitalized.

Critics say that isn't enough, and that of those who do get hospitalized, too few get held long enough. To hold someone for more than 72 hours requires an additional court order.

"We need to change the degree of imminence," said Randy Vanzandt, a community corrections officer who tracks dangerous mentally ill offenders for a living.

That, however, would cost more. State hospitals are expensive to run. Filling a bed in a state psychiatric hospital costs \$145,000 to \$190,000 a year.

Making commitments easier also raises constitutional issues. In our society, you can't lock people away just because they might do something, or say they're going to do something.

"There is no perfect way of predicting dangerousness is the bottom line," said Weston, who also heads the mentally ill offender program in Olympia. "It remains an inexact science."

Losing it

Reading the "chronos"-- a history of Williams' supervision -- is like watching a man self-destruct in slow motion.

The community corrections officers, nurses, counselors and social workers assigned to his case reached out repeatedly to help him. They got him clean-and-sober housing. He lost it for drinking and drugging. They got him an apartment. He got himself evicted for threatening residents with a butcher knife. They drove him to appointments at his mental health clinic and ordered him to take his meds. He flung the medicine in their faces. They arrested him multiple times for breaking his supervision requirements in the hopes of getting him back on meds, or committed to a hospital for treatment. Each time he eventually was released back to them. His primary supervisor kept at it even after Williams said he would lay in wait and shoot him with a sawed-off shotgun as he reported to work

The day Shannon Harps was killed, Williams checked in with his community corrections officer, who noted he was "barely holding it together."

"But that was his baseline," said Dan Weiss, who saw him that day. "That's how James was every day."

In September 2007, Williams went to jail for threatening a woman at his housing facility. He pleaded guilty and received a psych evaluation on his release. How or whether he was treated in a psychiatric facility after that evaluation is not known because laws keep those records private.

What is known is that Shannon Harps, an adventuresome traveler, who loved to backpack and was working to improve the environment, a young woman who impressed her friends with her grace and integrity, was killed 10 days after Williams' release from King County Jail.

Williams has pleaded not guilty to the crime.

TRYING TO LIMIT THE RISK

Washington's Dangerous Mentally Ill Offender program helps identify those inmates in state prisons who suffer from major mental disorders and based on their histories could pose a risk to public safety on their release. The program provides for up to five years of housing assistance and intensive mental health treatment to aid their transition into the community. Two challenges facing those who work with dangerous mentally ill offenders are finding housing for them, and finding hospital beds to take them when their mental states deteriorate.

Dangerous mentally ill offenders

In Washington as of February 2008

512 people have been designated DMIO since April 2000



Of those, **466** have been released from prison

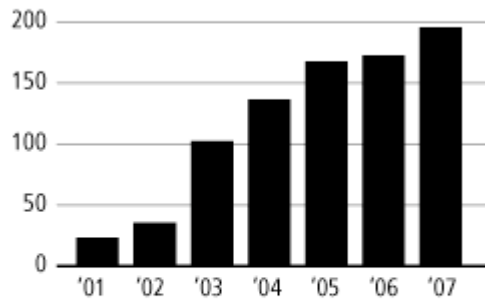


Of the 466, **222** have received mental health services and housing funding through program



DMIO receiving state services

Statewide per fiscal year



Inmates with symptoms of serious mental illness



Program costs

\$9,000

Amount the state spends each year per offender to provide housing and mental health services after their release from prison

37 percent

Reduction in recidivism attributed to the program

\$1.24

Amount the public gets back in cost savings for every dollar spent

Hospitalization options

365

Psychiatric beds available at King County hospitals including voluntary, involuntary, children and geriatrics

1,000

Psychiatric beds available at Western State Hospital

\$145,000 to \$190,000

Cost of filling one bed in a psychiatric facility per year

Sources: DSHS, Mental Health Division, 2006 Department of Justice report, Washington State Institute for Public Policy, Western State Hospital and King County Public Health

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