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The offender profiles listed below are representative. In every case but one the underlying offense involved methamphetamine possession and addiction.

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   Diagnosis: Post-traumatic stress syndrome, major depression, antisocial personality disorder.

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6. Female, 26 years: Her mother was murdered in her presence over a dispute involving drugs when she was four years old. She started drinking

Some of the Problems Centering Around Implementing a 2 Person Intensive Treatment Team in Orofino, When it is an Extension of Region II's Already Existing Rural ACT Team in Lewiston

The legislative initiative for granting money for enhancement of Rural ACT Teams is to be used solely for the addition to existing ACT Teams who work with the judicial branch to provide services through the Mental Health Courts.

A. So the only proposal that meets these criteria is hiring two more staff for the ACT Team to be based in Lewiston and to drive to Orofino and the outlining areas. It has been recommended that one staff full-time nurse and one staff a full-time clinician would be the best arrangement moving the Region II ACT Team closer to fidelity with State and National standards for ACT Staffing. The existing Lewiston ACT Team staff can act as liaisons with Social Security, Idaho Housing Administration and the CAP payee program or other Lewiston based agencies. ACT Team doing outreach to Orofino and outlying areas would work closely with these communities to ensure wrap around services (like office location, medication monitoring services, support staff, referrals to private agencies, etc.), and would provide intensive Case Management, Psychiatric and Medication services, and PSR for their clients in the outlying areas.

Some of the problems with this proposal would be:

A. Primary function of two additional staff is to participate in Mental Health Court which requires the ACT Team to be located in the same county as the Mental Health Court.
B. Who would do medication monitoring? This would be almost impossible for two new staffers to handle.
C. Not being centrally located new staff would have to travel be 2 hrs or more, a day just to get to outlying service areas.
D. Problem of needing two vehicles from already depleted Lewiston motor pool.
E. Daily ACT Team staff meetings would be difficult because outlying area staffers would need to leave the office early in the day.
F. Coverage issues, staff rotation issues, new hires would be on their own to service outlying areas and might not like unequal schedules, lack of rotation and unequal responsibilities.
G. There would be the issue of DE's in the outlying areas, which would be an extra burden on existing ACT DE's because of travel and scheduling issues of Lewiston DE's having to go to outlying areas and Courts until new hires are qualified to become DE's.
H. Comp time accumulation for new staff. It will build-up real fast if they are doing med. Monitoring.
I. Supervision of two more staff with entirely different client case loads.
J. Primary resources for client (S.S., IHA, etc.) located in Lewiston will require shuffling a lot of paperwork back and forth.
K. In short, to even try to implement this staff addition at the present time would stretch existing staff way to thin!

DISTRICT COURT
SECOND JUDICIAL DISTRICT
STATE OF IDAHO

JOHN BRADBURY
DISTRICT JUDGE

IDAHO COUNTY COURTHOUSE
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FAX (208) 983-2376
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December 20, 2005

Senator Joe Stegner
216 Prospect Blvd.
Lewiston, ID 83501

Dear Senator Stegner:

Representative Mike Mitchell recently requested information about the need for long term residential mental health care in Idaho. Because of the importance of the problem I am forwarding to you a slightly modified version of the letter I sent him.

Enclosed is a brief synopsis of several real-life people all but one of whom have come before me charged with possession of methamphetamine. The descriptions have been sanitized to protect their privacy. These accounts are typical of what I encounter on a daily basis. Methamphetamine is almost always present in the criminal proceedings over which I preside.

Also enclosed is a brief description of the state resources available to district judges when dealing with drug addiction and mental illness. The drug courts can successfully deal with certain addictions, and the rider programs at Cottonwood, Boise, and Pocatello target the reform of criminal thinking and behavior. But these programs do not treat the underlying traumas and mental

illness that lead to the substance abuse and its attendant criminal behavior. The predictable result is that the largest mental health facility in Idaho is the Idaho state prison system.

Out of a prison population of 6,800 prisoners, about 1350 of the inmates are on psychotropic medication. Of that number about 60 inmates are acute care patients who need constant supervision. Another 190 need regular follow-up and monitoring to remain stable. The remaining inmates on medication are mainstreamed into the general prison population with regular but infrequent follow-ups. There are another 200 to 400 inmates have been diagnosed with mental disorders that are not on medication.

Dr. Michael Emery, the clinical psychologist who examined the persons described in the attached synopses of offenders, put it best when he said this in one of his reports:

> [T]here is a mental health issue here as well as a substance abuse one, and the substance abuse issue will not be cured without attention to the mental health [issue].

The question for the Legislature is whether it wants to send people like these defendants to prison or to provide mental health care so that the mental health problems are dealt with and the subsequent addictions and criminal behavior are either avoided or controlled by early intervention and treatment.

A brief history of Idaho mental health care is instructive. Dr. Myrick Pullen is a psychiatric physician who is now retired and lives in Orofino.

He was formerly superintendent of State Hospital North (SHN) and was later the director of the mental health program for Idaho in the 1960's. He recently told me that SHN had 400 residential patients while he was superintendent. Since that time the state population has more than doubled. Yet SHN and State Hospital South today have a combined patient population of only 170 patients.

Up until the early to middle 1990's Idahoans could voluntarily commit themselves for treatment at a state hospital. There was also a detox center at SHN where addicts could withdraw from their addictions and confront their mental health problems with much needed medical supervision. Today, no voluntary commitments are accepted (although the statute provides for them) and the detox center has been closed for several years.

To be eligible for an involuntary commitment to a state hospital a person must be likely to injure himself or others or be gravely disabled due to mental illness. The available resources at state hospitals today are so limited that there is up to an eight week waiting list for those who have been involuntarily committed. The consequence is that gravely ill people who may be a danger to themselves or others are held untreated in jails or are treated in expensive private hospitals at state expense for extended periods of time.

People who are seriously ill but not ill enough to be involuntarily committed have two choices. If they live in or near Lewiston and are

aware of their right to do so, they can voluntarily commit themselves to the psychiatric ward at St. Joseph's Regional Medical Center. The costs there range between $1,800 and $3,000 per day. SHN estimates its cost per patient at $380 per day.

Where a voluntary patient is indigent, the cost of private hospitalization is borne by either the county or the state, and I have enclosed a brief description of how these costs are allocated. But neither the county nor the state plays a role in the admission process when an indigent self-commits at a private hospital. The first notice to the county is when the hospital applies to the county for payment. The result is that additional costs are incurred. In a recent Nez Perce County case, a voluntary commitment cost $16,000 for eight days of treatment at St. Joseph's. The individual involved was then involuntarily committed. Because of the waiting list at SHN, St. Joseph's continued to treat the individual for 21 more days at a cost of $19,000.

Had this person been able to voluntarily commit himself to SHN for the sixteen days, it would have cost $6,080, resulting in an almost $10,000 savings. If there then had been a bed available immediately at SHN, avoiding the wait of 21 days, the cost for those 21 one days would have been $7,980, for a savings of $11,220. The total savings of public funds would have been $21,140 for just one individual. An explanation of the way private hospitalization costs are allocated between the counties and the state is enclosed.

The alternative to those who cannot or do not know how to access a medical center is to remain untreated. That involves the vast majority of the people I see. The sad result is that these people only get treatment when their condition leads to a criminal offense and a judge orders treatment.

The cost of such neglect is very real to those who are affected. Such costs include the cost of law enforcement apprehension and confinement, the cost to the victims of crimes, the costs of professional evaluation and treatment, and the costs to the judicial system, the prisons and the departments of probation and parole.

The county sheriffs in the three counties where I sit will tell you that a very high percentage of their time involves dealing with the mentally ill. Mentally ill jail prisoners are sometimes so disruptive that they are driven around in a patrol car all night so that the other prisoners can sleep.

The costs to the victims can be tragic. About three years ago in Lewiston, an incident involved a man who had been treated for schizophrenia twice in Kootenai County and twice at the SHN but had each time been released when he was stabilized. Without professional supervision he got off his medications and became psychotic. He then decapitated a totally innocent man who lived next door to him. The crime was unprovoked and the offender was so psychotic that he may not even have been sure what he had done. He had to be treated until he became

competent to stand trial. He then pleaded guilty and was sentenced to life imprisonment without parole.

The human and financial toll is incalculable. The victim lost his life and the state will now pay approximately twenty five thousand dollars a year to confine this gravely sick man for the rest of his life. Given his life expectancy this will amount to almost one million (current value) dollars for just one incident.

A long term (at least one year) residential facility for mentally ill and addicted persons with a detox facility is needed. Such a facility could be a non-secure or low security facility like Cottonwood, depending on admission criteria. It should be available for voluntary commitments and referrals from the court system. Ideally it would be located near a county jail or prison for those patients who need to be confined until given a medical release for a less secure facility. You also might consider locating it where a community college is available to provide vocational training.

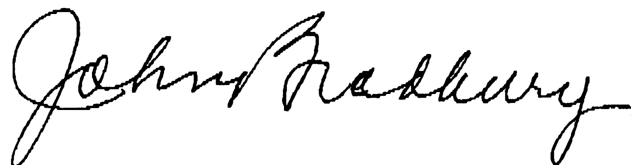
The Seattle Community College model merits consideration. Each semester or year the students there build a house for low income families. Under such a model the students would learn carpentry, electrical wiring, plumbing, cement laying, tile and finishing work, roofing, etc., while being treated. This would help them learn a trade, which most of them need. It would also provide low income housing to people without any and skilled workers to the trades that local employers say are in short supply.

I do not know how many of the current prisoners on psychotropic drugs would qualify for a non-secure or minimum security treatment facility. If just a third of them qualified, this would free up more than 400 prison beds. The rate at which the prison population is increasing obviously could be reduced if the mental disorders and addictions could be treated before serious offenses occurred.

A long term residential facility would treat the people who really suffer from mental disorders. It would relieve local law enforcement, the prison system, and the judiciary of sole responsibility for a public issue for which they are not specifically trained. It would avoid the heartache of innocent citizens who become victims of untreated disease.

We can do better if we recognize the basic truth that mental disease is a health problem that is most effectively dealt with by health professionals. Providing for treatment when the problem is illness and not criminality would allow the criminal justice system to deal with people who want to commit crimes because they really are criminals. I respectfully submit that such an approach would be both more effective and much more economical.

Sincerely,



John Bradbury

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when she was fourteen, began using marijuana when she was fifteen, and progressed to using methamphetamine when she was sixteen.
Diagnosis: Post-traumatic stress syndrome.

7. Male, 21 years: Born to older parents, he suffered an adolescent onset of schizophrenia. The result was isolation from other students in school and estrangement. "I hate all strangers. I've always been that way. . . . I was an outcast. No one liked me." is how he describes his life. He hears voices which tell him to hurt himself and others and say that he is useless and bad. He uses marijuana to control his anxiety and methamphetamine to help him identify his own voice from the other voices he hears.
Diagnosis: actively psychotic, schizophrenia of the paranoid type.

8. Male, 36 years: His parents divorced when he was five years old and he does not remember his father. His mother remarried and his stepfather physically abused him, his mother, and all three of his siblings. He started drinking at ten years of age, ran away from home at thirteen, and began using marijuana when he was fourteen. He started using methamphetamine when he could not afford medication for his schizophrenia.
Diagnosis: Schizophrenia of the paranoid type, mild mental retardation.

9. Female, 39 years: Adopted as an infant, her father was very physically abusive. She ran away from home at thirteen and began living with a man who was seven years her senior. He also was abusive, breaking her jaw, cheek bone, and six ribs during one beating. She began using cocaine and methamphetamine when she was twelve.
Diagnosis: No evaluation.

10. Male. 34 years: He never met his biological father, and his mother divorced his stepfather when he was in the fifth grade. Both men were alcoholics. He began drinking and smoking marijuana heavily in his early teens. He was sent as a youth to a camp for troubled teens, and has a long record of misdemeanor offenses. He believes that he has enemies who keep putting poison in his drinks and in his marijuana. He never received mental, psychological, or psychiatric counseling or treatment until he was incarcerated on a felony charge.
Diagnosis: schizophrenia of the paranoid type, anti-social personality disorder.

Facilities Available for the Mentally Ill

State Hospitals

Available only to patients who have been involuntarily committed. There is currently an eight week waiting list. The hospitals have a combined patient population of about 170.

Health and Welfare

There are ACT teams in the major population centers that treat mentally ill people in those cities. The criteria are such that only a few very sick people qualify. In rural areas such services are not available at all, although a model rural ACT team, comprised of three members as opposed to the full complement of eight, is being started in Orofino in conjunction with the state's first rural mental health court.

Mental Health Court

There are mental health courts in Idaho Falls and Coeur d'Alene, and both Boise and Orofino are starting them. They depend on the availability of an ACT team to function. The preliminary results are promising.

Drug Courts

Drug courts are established in all seven judicial districts. They have proven to be quite effective for addicts whose mental problems are not organic (e.g., not schizophrenia or bipolar disorder) and whose addictions have not been prolonged during adulthood. Offenders whose offenses involve violence or sex abuse do not qualify.

The "Rider" Program

The "Rider" program is operated by the Department of Correction at Cottonwood for men and at Pocatello and South Boise for women. The program is therapeutic in nature and is aimed primarily at cognitive changes in criminal thinking, GED education, anger management, and relapse prevention.

The program provides a carrot and stick approach to criminal sentencing. Under the program an offender pleads guilty to the criminal charge and is sentenced for the offense. The court then retains jurisdiction for 180 days while the offender enters the program. If the offender successfully completes the program the court will place the offender on probation. If probation is successful the criminal charge is reduced to a misdemeanor and a felony record is avoided. If the offender fails the program the sentence is imposed. The program lasts between 120 and 180 days.

The program has proven successful for many but is more problematic for those in need of treatment for mental health issues. In the case of those with organic disabilities such as schizophrenia and bipolar disorder, there is little hope of a successful outcome if the offender is not first stabilized by treatment prior to beginning the program.

Private Facilities

People who do not qualify for the state hospitals, ACT teams, or drug courts are left untreated unless they live in a city with a psychiatric facility and know that they can self-admit at county expense. The cost for psychiatric treatment at St. Joseph's Regional Medical Center at Lewiston is between $1,800 and $3,000 per day. It currently has two psychiatrists and is hiring two more to meet the increased voluntary commitment patient load.

Cost Allocations for Private Hospitalization

Voluntary Commitments

If an indigent person voluntarily commits him or herself to a private hospital, the county pays for the first $10,000 incurred over a 12 month period. Any amount in excess of that is paid by the State Catastrophic Health Care fund.

The county has no notice that a voluntary commitment is being considered and has no say in whether it occurs. It usually learns about a commitment and its duration only when the hospital sends a bill, which it is then obliged to pay up to the $10,000 cap.

Involuntary Commitments

When a person is found by two designated examiners to be a danger to him or herself or to others, or to be gravely disabled, the state can move to have a court commit the person to a state hospital until there is recovery from the symptoms that warranted the commitment. The counties pay for the pre-commitment hospitalization. Once the person has been committed to the custody of the state, the state pays the costs of any private hospitalization which continues until transfer to a state facility occurs.

Practical Considerations

Given the procedural hoops involved in committing a person involuntarily, private hospitals will often encourage persons who qualify for involuntary commitment to voluntarily commit themselves. There is no court involved, no oversight by the county, and the bill will get paid regardless of who pays it.

This results, however, in the counties paying more of the hospital costs because they have to pay the first $10,000 only on the voluntary commitments. That does not comport with a statutory policy designed to redress the disproportionate burden which counties bear in financing mental health services. I.C. § 39-3125.

WEEKS AND VIETRI COUNSELING AND COMMUNITY SERVICES, PS

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Moscow, Idaho 83843
208-882-8514
Fax: 208-882-2784

Orofino Office:
430 Michigan Ave
Orofino, Idaho 83544
208-476-9141
Fax: 208-476-5495

I think the best way to describe the difficultly with providing substance abuse and mental health treatment in rural Idaho is to describe why I am closing my Orofino office.

We initially opened the Orofino office to provide PSR services. We had difficulty finding staff to work, but managed to always have at least one person working in Orofino. A few years ago we realized that there was a greater need for clinic option Medicaid than PSR so we expanded to include clinic option and also started taking some insurance. At the time I had one master's level clinician working for me to provide the service. We hired more staff, but most were employed for a short period either because they did not meet my standards or they lived in Lewiston and they did not feel that they made enough money to commute to Orofino. There were many months that our Moscow office supported the Orofino office.

Last year things became worse. The state changed the requirements for Clinic Option Medicaid so that we had to have a M.D. Clinic Director who basically agreed to take responsibility for our work. Also, physicians whose patients came to our clinic had to sigh an "affiliate agreement" taking responsibility for our work. Most physicians view this as a huge liability risk and would not sign the agreement. In Moscow we were able to find a MD to be our Clinic Director and many agreed to be Affiliates, but we were unable to find Doctors who would sign the agreements in Orofino. We were therefore forced to discontinue this service. I know there is another Clinic who found a Doctor, but we were unable to do so.

Also last year, we heard about Mental Health Court starting in Orofino. Since we provide mental health counseling and substance abuse counseling it seemed natural for us to be a provider for mental health court in Orofino. Although we are a State Substance Abuse Provider in Moscow, we had to complete a packet of information to become a provider in Orofino and the site had to be reviewed and approved. We are required to have a building inspection and fire inspection and for a state worker to visit the site and give approval before we are able to see clients. I understand that the state wants to assure the safety of clients, but one would think that a building inspection and fire inspection would be sufficient. On the day she was to visit us, Sherry Johnson became ill and had to cancel the trip. She was unable to schedule again for a couple more months, leaving us unable to provide services to mental health court clients. We eventually were approved for services.

My plan was to provide treatment for dually diagnosed clients in mental health court as well as others because I knew that the other substance abuse treatment provider in

Orofino did not provide mental health counseling. I advertised for a CADC or Master's level clinician to provide services and did not get even one application. By this time I only had one employee in the Orofino office. We currently have 4 mental health clients and some other clients on insurance and other programs. However it is nowhere near enough to support the office.

In August of this year I made the decision to close the Orofino office. I called the other substance abuse provider and asked if they would be willing take Mental Health Court clients. However they did not feel that they had staff with the appropriate education and experience to work with these clients. I wasn't surprised because I know that I am somewhat unique in that I typically hire master's level clinicians who can provide mental health and substance abuse counseling. We are now closing our office and there isn't anyone to take over the substance abuse treatment for the clients. This saddens me, but I held on to that office far too long. I now run the risk of losing my entire business because it is in significant debt.

So the major roadblocks to rural treatment is lack of employees and poor reimbursement.

Professionals who might be willing to travel do not feel that they make enough money to commute. For Drug Court and Mental Health Court, we are reimbursed between $38-$40 per individual session and approximately $30 for a 1 1/2 hour group session. For clients in general treatment the reimbursement is slightly higher, $45 for an individual session including the client co-pay which is often difficult to collect. Clinic Option Medicaid pays $55 per individual psychotherapy hour. The going rate for private insurance is between $100-$125 per psychotherapy hour.

In addition to the low pay there are many requirements in the substance abuse program for which we don't get reimbursed. Clinical supervision is required. The state provides a really good training for a great program. We are required to attend and don't have to pay for the training, but obviously we can't be seeing clients during that time so there is no income. As I said, the training is good and I like the program. Obviously supervision is important and I have always provided supervision to my staff. However in this program we are required to write a plan with goals for each employee, write progress notes about how they are progressing as well as meet with them regularly. We don't get reimbursed for any of this. It is good practice, but the requirement is for no pay to employees or me as supervisor.

Every 90 days we are required to write treatment plan updates and provide documentation to BPA indicating why a client continues to qualify for treatment. Again, this is good practice and helps assure that people receiving state dollars for treatment still need it. However we do not get reimbursed for this either. It generally takes me approximately 30 minutes to complete the written portion of these.

Regarding dually diagnosed clients, a master's level clinician must provide the services. Bachelor level, which most substance abuse counselors are in other agencies, is not qualified to provide the services. The state substance abuse program is set up for

bachelor level clinicians who get paid less. If a clinician is paid $10 per client contact hour, there is plenty of money left over for administrative costs, rent, insurance, etc. However I pay my employees $20 per reimbursable hour. They do a lot of things for which they don't get paid – supervision, notes, treatment plan reviews, trainings, meetings, etc. This does not leave enough for regular business costs. At ICADD there were some great trainings on the importance of treating clients with co-occurring disorders. We know that there is a huge percentage of clients who have co-occurring disorders, especially Post Traumatic Stress Disorder, Depression, Anxiety Disorders, Bipolar Disorder and ADHD. Everyone acknowledges that this is an area of tremendous need, so why can't we get paid for hiring qualified staff? If clients are expected to see a separate provider for substance abuse treatment and mental health, which I thin is bad practice but is generally the case, they often can't find a mental health provider. Most our clients don't have insurance or they wouldn't be on the state program. If they have Medicaid we can see them for a short time, but they run out of hours very quickly. There aren't very many Medicaid providers due to their regulations, so clients are left without services. In Moscow we are one of the very few Medicaid providers. We provide treatment for clients with co-occurring disorders. If they have Medicaid we use those hours than switch them to the state substance abuse program. We do it because it is the right thing to do but I feel like I am enabling a dysfunctional program at the expense of myself and my employees.

This Fall I took a teaching job at the University because my business cannot support me. I make less money than some of my clients who work construction and less than many bachelor level social workers working in agencies. Most of my employees view their job at W&V as a way to gain experience so they can move on to other jobs where they will make more money. I can't provide any benefits to my employees. I often wonder why anyone wants to work for me!

Problems we typically deal with BPA are that we, and our clients, often have to wait on hold for up to an hour to talk to anyone. I have had clients leave their names for a call backs for approval/authorization and have never received a call back. I know BPA is working on this, but we all know that in this field we must be opportunists and asking an addict to stay on hold for an hour to ask for treatment funding is unacceptable. My agency is criticized for billing errors and other mistakes. I am the first to admit that we have made some mistakes and we are working on them. I guess I could take the criticism better if BPA did everything right from their end, but they don't. It is not at all unusual for us to not receive faxes they say they have sent and for them not to follow through on things they told us they would do. If we make a mistake there are usually significant consequences, usually loosing money. As far as I can tell, there are no consequences when the state of BPA make mistakes. Last year there was a moratorium on new admit to the program because the state ran out of money for the program. This year we have ATR-I, but admissions to programs is now being limited. When restrictions are placed on admissions, we usually hear about it as it is happening. It would help to have some warning.

As I criticize BPA, I understand that they likely deal with issues that I don't know about or don't understand. There are many good people working for BPA, but the current system doesn't work for most providers.

Cathy Weeks

IN THE DISTRICT COURT OF THE SECOND JUDICIAL DISTRICT OF THE STATE OF IDAHO,

IN AND FOR THE COUNTY OF LEWIS

STATE OF IDAHO, Plaintiff, vs. LELAND K. STANTON, Defendant	) Case No.: CV-2005-22) AMENDED) MEMORANDUM DECISION))))

BACKGROUND

Leland Stanton is a 54 year old Viet Nam veteran with a long history of mental illness. The Veterans Administration and the Social Security Administration have adjudged him disabled for psychiatric reasons. He has been hospitalized for his mental illness at various V.A. hospitals, at St. Joseph's Regional Medical Center in Lewiston, at State Hospital North in Orofino and at State Hospital South in Blackfoot.

The available medical records reflect diagnoses of paranoid schizophrenia and post traumatic stress disorder. He suffers extensive, fixed and pervasive delusions that predominate his thinking. He thinks he is in a constant struggle with government "spooks" who spy on him so they can control him. He imagines that a thought control mechanism has been implanted in his brain and that he understands paranormal activity through infra red-light, T.V. sets and other media.

Mr. Stanton's criminal history is extensive. It dates back to at least 1981 and includes charges of murder, attempted murder, several charges of illegal possession of firearms and burglary. He was sentenced for three counts of assault with deadly weapons (a knife and .22 caliber rifle) at Reno, Nevada in 1987. In 1984 he was charged in Nevada for shooting a man in

the face with a .44 caliber pistol. During this time he was in and out of psychiatric care facilities during part of which he was declared incompetent to assist in his own defense. In 2003 in Lewiston police were called to Mr. Stanton's home where he was reported to be extremely agitated and in possession of a .45 caliber pistol.

A Criminal Information filed on November 13th, 2006 charged Mr. Stanton with eluding police and being a felon in possession of a .45 caliber handgun. After the information was filed the public defender moved to have him examined pursuant to I.C. §18-211 because she was unable to communicate with him and she did not think he could assist her in his defense. On November 19th, 2003 I ordered a psychological examination.

On December 3rd, 2003, Dr. Michael Emery, a clinical psychologist, examined Mr. Stanton who manifested the delusions earlier described. Dr. Emery concluded that Mr. Stanton could not assist in his own defense.

That same day I suspended the criminal proceedings against Mr. Stanton and committed him to the custody of the director of the Department of Health and Welfare until it was determined that he could assist in his defense of the criminal charges against him. On February 19, 2004, Dr. Dwight Peterson of State Hospital South informed me that Mr. Stanton's paranoid beliefs and thought disorder symptoms were in "substantial remission with psychiatric treatment." Based on Dr. Peterson's report on February 26th, 2004, I terminated Mr. Stanton's commitment and had him transported back to the Lewis County jail.

Mr. Stanton was arraigned on March 3rd, 2004, pleaded not guilty and his trial was set for June 1st, 2004. Because of renewed concern by the jail and his lawyer about his condition Dr. Emery again examined Mr. Stanton on March 24th, 2004. Dr. Emery found Mr. Stanton to be a danger to himself and others, incapable of making informed decisions about his treatment and that he was violent.

On April 8th, 2004 Mr. Stanton's lawyer again moved for a psychiatric examination on the bases of Dr. Emery's second examination and because Mr. Stanton's mental condition had so deteriorated in jail that he again was not able to assist in his defense. Dr. Emery examined Mr. Stanton a third time on April 14th, 2004, and concluded he was actively delusional and should again be restored to mental competence pursuant to I.C.§18-211.

I again committed Mr. Stanton to the custody of the director of the Department of Health and Welfare until he was again competent to assist in his defense. On May 25th, 2004, Dr. James Phillips, a private clinical psychologist, examined Mr. Stanton and concluded that he was unlikely to ever be competent enough to assist in his own defense or to make informed decisions about the criminal charges against him or about his treatment. At the recommendation of State Hospital North, Mr. Stanton's commitment was renewed on August 4th, 2004 and again on September 22, 2004.

On January 26th, 2005, the State of Idaho, as distinguished from the Department of Health and Welfare, petitioned to have Mr. Stanton involuntarily committed pursuant to I.C. §18-329. Mr. Stanton, with the benefit of counsel, consented to the commitment. He said:

> I hereby consent to the Mental Commitment in the above entitled case. As I understand it, I will be dispositioned to Idaho State Hospital North (SHN) at Orofino, Idaho; State Hospital North would then place me with an appropriate facility, possibly the Veteran's Home in Lewiston, Idaho. I have fully discussed this matter with my court appointed attorney, and I feel this is in my best interest.

Two designated examiners found him gravely disabled. Examiner James Phillips found in part as follows:

> The basis of my opinion that the proposed patient is "gravely disabled" as defined by I.C. 66-317(m) is: Mr. Stanton was criminally charged and due to his behavior evaluated and treated at State Hospitals North and South. Due to significant mental health symptoms he is not able to care for his needs and if released would be in danger of serious physical harm due to inability to care for his basic needs.

Examiner Mark Brandt said this:

> Leland does present as gravely disabled in so far as without the current treatment and provision for daily needs such as he currently receives at State Hospital North, he has historically become noncompliant with necessary medical treatment, exacerbating fixed persecutory delusions, and resulting in his inability to properly care for his daily needs.

On February 7th, 2005, based on those diagnoses, I committed Mr. Stanton to the custody of the Department of Health and Welfare for a year, with the condition that he would not be conditionally released unless ordered by the court.

On April 11, 2005, Mr. Stanton was released from physical but not the legal custody of the Department of Health and Welfare so he could be placed in a shelter home in Kooskia. The release was conditioned on Mr. Stanton's compliance with the State Hospital's treatment plan as provided by I.C. §66-338.

On September 1st, 2005 and January 3rd, 2006, examiner Joyce Lyons of the Department of Health and Welfare wrote to the court that the conditions justifying Mr. Stanton's commitment still existed. She advised the commitment would expire on February 4th, 2006.

A hearing on whether or not to continue Mr. Stanton's commitment was scheduled for January 11th and January 18th, 2006, but because one or more of the parties was not available the hearing was held on February 16th, 2006. At the hearing Mr. Stanton's lawyer advised me he had talked to Mr. Stanton who thought his status should remain the same. Because Mr. Stanton had already been committed, had been found not competent to make informed decisions about his treatment and with his lawyer's help had consented in writing to be committed, he was not forced to personally attend the hearing. Since Mr. Stanton agreed to continued commitment and the State supported it, I ordered his continued treatment for another year on February 16th, 2006, with retroactive effect to February 4th, 2006. The written Order for Commitment was entered on March 15th, 2006.

On March 20th, 2006, the Department of Health and Welfare moved for reconsideration of the Order for Commitment on the bases that the order did not have a legal or factual basis, that the court had no jurisdiction to enter the order because a new petition had not been filed and that Mr. Stanton had been denied due process because he was not at the February 16th hearing. A hearing (continued at the request of the Department's counsel) was held on April 20th.

When asked who in the Department of Health and Welfare had requested that the motion to vacate its custody of Mr. Stanton be filed, its counsel, Marcie Spilker, said she could not remember.

Ms. Spilker argued that a new petition and a new proceeding were necessary to commit Mr. Stanton for another year before he could get the treatment that every single mental health professional who has examined him says he needs. She argued that because the State had not refiled its petition to commit Mr. Stanton, he should be put out on the street. The Department took that position notwithstanding the following:

1. Mr. Stanton has a long history of mental illness, including schizophrenia;
2. When not medicated, Mr. Stanton becomes so violent that he has been convicted of attempted murder for shooting a man in the face.
3. Every professional who has examined him has concluded he is mentally ill and gravely disabled.

At the hearing on the Department's motion Ms. Lyons testified that Mr. Stanton remained gravely disabled and that he would get worse again (decompensate) if he did not remain in a supervised environment. There was no evidence presented at the hearing that Mr. Stanton's condition had changed or that Ms. Lyon's representations of September 1st, 2005 and January 3rd, 2006 that conditions justifying Mr. Stanton's commitment still existed were no longer true. Nor did the Department dispute or in any way challenge Dr. Phillips' conclusion of May 25th, 2004, that Mr. Stanton was unlikely to ever be competent to assist in defense or to make informed decisions about his treatment.

The Department and its counsel did not make any effort to inform Mr. Stanton or to have him present at the hearing regarding the Department's decision to have its custody of him terminated against his specific written wishes and against the wishes of the State of Idaho and of this court. Nor did the Department express any concern about what the consequences of Mr. Stanton's release from custody might have on him or on the public's safety.

I take judicial notice of *State v Cope*, Idaho Dist. Ct. Nez Perce County CR-2002-2275 (2002). Mr. Cope had much the same diagnosis as Mr. Stanton. He had been treated at State Hospital North on two occasions and had been released when his condition was stabilized. Untreated, he became psychotic and decapitated a totally innocent man who lived next door to him. He had to be treated until he was competent to stand trial. He pleaded guilty and was sentenced to prison for life without parole.

DISCUSSION

Leland Stanton has been diagnosed as mentally ill and gravely disabled by Dr. Michael Emery, Dr. James Phillips, Dr. Dwight Peterson, Mark Brandt, and Joyce Lyons. No evidence to the contrary has ever been presented by the Department. In fact Dr. Phillips examined Mr. Stanton for State Hospital North and Mr. Brandt and Ms. Lyons are employees of the Department. Idaho Code §66-317 defines someone to be mentally ill as "a person, who as a result of a substantial disorder of thought, mood, perception, orientation, or memory, which greatly impairs judgment, behavior, capacity to recognize and adapt to reality, requires care and treatment at a facility." Idaho Code §66-317(m) defines a gravely disabled person as "a person who, as a result of mental illness, is in danger of serious physical harm due to the person's inability to provide for his essential."

Based on the diagnoses of every single professional who examined Mr. Stanton I conclude as a matter of law that Mr. Stanton was, is and will continue to be a mentally ill person who is gravely disabled for the reason that he has a substantial disorder of thought that grossly impairs his ability to adapt to reality and as such requires care and treatment at a facility and because he will be at risk of serious physical harm due to his inability to care for his personal needs. I.C. §66-317(l) and (m).

When Mr. Stanton was committed to the custody of the Department of Health and Welfare, the court's role was "accomplished" and he became the "responsibility" of the Department. *Glasco v Brossard*, 94 Idaho 162, 164 (1971). Once Mr. Stanton became the responsibility of the Department he was "entitled to humane care and treatment." I.C. §66-344.

The Department's treatment and care of Mr. Stanton must be viewed in the context of the Legislature's declared policy governing the mental health care the Department is charged with providing. The Legislature has declared the State's policy regarding the Regional Mental Health Services Act, I.C. §39-3101 et seq., is "to provide treatment services for her citizens affected by mental illnesses." It concluded by saying that "it is the *policy of the State to provide mental hospital services to all citizens in need of such care,"* (emphasis added). The Act delegated that responsibility to the Department. IC. §39-3124.

The Idaho Supreme Court has held that I.C. §39-3101 does not confer a right to a specific type of treatment, but it was careful not to decide whether or not the Act confers a general right to treatment as distinguished from the specific type of treatment sought in that case. *Maresh v Department of Health and Welfare*, 132 Idaho, 221 (1998). While it not necessary to decide that issue at this time, it is instructive to measure the Department's conduct against the declared policy of the State of Idaho regarding the treatment of a mentally ill person who is gravely disabled.

Mr. Stanton, the State and I have no complaints about the care and treatment Mr. Stanton has received while committed. Mr. Stanton's mental health needs have been met and the public's safety has been protected during that time. I commend State Hospital North for the exemplary job it has done. But that is not the issue.

The Department complains that I ordered him committed without a new petition to commit pursuant to I.C. §66-329. The question, however, is whether or not the Department has exercised its legal responsibility for Mr. Stanton by attempting to terminate its custody of him.

What the Department did not acknowledge in its motion to reconsider is that once Mr. Stanton was committed his welfare was the responsibility of the Department, not of the court or the prosecutor. *Glasco*, 94 Idaho at 164. The evidence was overwhelming and uncontradicted that Mr. Stanton needs continuous care in a supervised setting. Absent that care, as happened twice with him while subject to the jurisdiction of this court, he became psychotic and, according to Dr. Emery, violent.

Based on the diagnoses of every mental health professional who examined Mr. Stanton, he "requires care and treatment at a facility" as a mentally ill person and he is "in danger of serious physical harm due to [his] inability to provide for his essential needs," as a gravely disabled person.

Idaho Code §66-329 provides that commitment petitions for the "care and treatment of mentally ill persons by the Department of Health and Welfare" may be initiated by "the director of any facility in which the patient may be." Once a person has been committed, no one is in a better position to decide whether a patient's commitment should continue than the person in charge of the facility where he is being treated. In this case that was State Hospital North at Orofino.

Yet one cannot be critical of the director of a facility for not petitioning to continue a patient's treatment when the Department's counsel cannot even remember if she consulted him regarding the decision. At the very least the petition to vacate the Department's custody of Mr. Stanton was grossly derelict in that it:

1. Ignored its legal responsibility for Mr. Stanton and his welfare by failing to consult him and the director of State Hospital North about whether the hospital's supervision of Mr. Stanton's care should continue;
2. It ignored the unanimous opinion of every single person who examined Mr. Stanton that he needed continuous supervised care;
3. It ignored the fact that every time Mr. Stanton was released from supervised care during the life of this case he quickly became delusional and psychotic;
4. It ignored the fact that Mr. Stanton becomes violent when he is untreated, that in the past has shot a person while untreated, and that in this case Mr. Stanton had a revolver while he was very agitated.
5. It ignored the fact that just four years ago a person with Mr. Stanton's diagnosis who was released from State Hospital North and was left untreated, decapitated an innocent bystander in Lewiston and is now serving a life sentence for murder.
6. It tried to foist its responsibility to file a petion for continued care onto prosecuting attorney when the situation demanded that the Department and its counsel should have done that on behalf of Mr. Stanton and the director of State Hospital North.
7. It filed a motion to terminate its custody of Mr. Stanton knowing that if the motion were granted Mr. Stanton and the public would be at risk of harm.

Because the Department did not timely file a motion to continue its custody of Mr. Stanton, I granted the State of Idaho's petition to commit Mr. Stanton to the custody of the Department because he is and will continue into the foreseeable future to be unable to assist the public defender in his defense of the charges against him in this case.

What I do not reach today in this case, as distinguished from the criminal case, is the issue of whether, under the circumstances of this case, Mr. Stanton had a cognizable right to treatment for his mental illness and whether or not the Department deprived him of his constitutional right to due process by attempting to deprive him of that care without involving

him in the process. I leave that issue to another day when it is squarely presented and I have the opportunity to appoint a guardian ad litem to protect Mr. Stanton's interests against the machinations of the Department into whose care he has been entrusted.

DATED this the 30 day of June, 2006.

JOHN BRADBURY
DISTRICT JUDGE

The undersigned does hereby certify that a copy of the foregoing was mailed to the following on this the _____ day of June, 2006.

Marcy J. Spilker
Deputy Attorney General
Department of Health and Welfare
PO Box B
Lewiston, ID 83501

Kimron Torgerson
Placed In Box

Mike Wasko
Placed in Box

Cathy Larson, Clerk

By:____________________________
Deputy Clerk