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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON

KETEMA ROSS; DANIEL GAUTIER; JESUS MARTINEZ; B.T., J.G., B.Y.; and DISABILITY RIGHTS WASHINGTON, a nonprofit membership organization for the federally mandated Protection and Advocacy Systems,

Plaintiffs,

vs.

JAY INSLEE, in his official capacity as Governor of the State of Washington; KEVIN QUIGLEY, in his official capacity as Secretary of Washington Department of Social and Health Services; and WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES,

Defendants.

NO. 2:14-cv-00130-TOR

FIRST AMENDED COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF

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I. INTRODUCTION

1.1 People being treated for mental illness at Washington State's psychiatric hospitals are patients, not prisoners. They are thus entitled to therapeutic, rather than punitive, treatment. As stated by the Supreme Court: "Persons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish." *Youngberg v. Romeo*, 457 U.S. 307, 321-22, 102 S. Ct. 2452 (1982).

1.2 Yet, as a result of stigma deeply rooted in our society and culture, people with mental illness often suffer far greater deprivations of liberty, respect, and dignity than those convicted of crimes. This stigma often expresses itself in the creation of unconstitutional and discriminatory laws and practices designed to segregate those with disabilities from the rest of society.

1.3 This stigma has recently had a dramatic impact in Washington State. In reaction to a single isolated incident in which a person with a mental disability walked away from his group during an outing, the Washington Legislature passed RCW 10.77.145 and RCW 10.77.270. The clear purpose and effect of these laws is to keep an entire class of people—those who have been acquitted of a crime by being found Not Guilty By Reason of Insanity (hereinafter "NGRI")—confined in locked facilities and isolated from the outside community. Defendants have undermined the forensic commitment statute by denying individualized treatment,

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withdrawing additional patient rights and freedoms, and creating unnecessary barriers all patients must overcome in order to reintegrate into society.

1.4 Swept up in these reforms are the individual plaintiffs and many other patients who have been determined by clinicians to be stable and substantially recovered from their disability. Patients are no longer provided the most integrated or individualized therapeutic treatment available in order to give them a realistic chance to be cured and released. Instead, they are merely warehoused in state hospitals, their rights and freedoms forfeited in the name of "public safety." Their confinement is due to political, rather than therapeutic, concerns.

1.5 The results of these laws and practices have been devastating to patients. The intentional isolation of mental health patients deprives them of a critical treatment modality and significantly harms their quality of life. It hinders efforts to provide patients with gradual, clinically managed transitions into the community, thereby delaying or preventing release. Most important, it deprives patients of their sense of dignity, respect, and worth.

1.6 The practice of isolating and detaining this class of mental health patients away from the community, without regard for providing the most integrated setting appropriate to their needs, violates Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132, *et seq.*, and the regulations promulgated thereunder, and section 504 of the Rehabilitation Act, 29 U.S.C. § 794, *et seq.*, and the regulations promulgated thereunder, as recognized by the Supreme Court in *Olmstead v. L.C. ex rel. Zimring,* 527 U.S. 581 (1999).

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1.7 The practice also violates patients' constitutional rights to minimally adequate treatment, equal protection under the law, and freedom from being placed in double jeopardy or subjected to *ex post facto* punishment.

1.8 This civil rights complaint seeks to end the government-sanctioned discrimination described herein. Plaintiffs ask this Court for declaratory and injunctive relief in order to prevent further harm.

II. PARTIES

2.1 **Plaintiff Ketema Ross** has been a patient at Eastern State Hospital ("ESH") in Medical Lake, Washington, for over six years, after being acquitted of criminal charges as NGRI in 2007. Mr. Ross is 36 years old. Prior to having schizophrenia, Mr. Ross was a law student at Yale University with no criminal or violent history, and today remains equally intelligent and driven to contribute to society. Despite the fact that he has maintained a stable recovery and demonstrated safe behavior for a number of years, Mr. Ross has been unnecessarily confined and deprived of the most appropriate treatment.

Prior to 2010, Mr. Ross's treatment plan included a number of community integrated therapeutic interventions intended to address emotional and cognitive triggers. These interventions included walks on the hospital grounds, participation in sports, and escorted trips to bookstores, parks, museums, churches, and restaurants. Mr. Ross, substantially recovered from the symptoms that caused his past instance of violent behavior, consistently demonstrated fully responsible behavior during each and every community-based treatment activity. Upon the

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passage of RCW 10.77.145, however, Mr. Ross lost all of these community-integrated treatments, without any therapeutic justification.

This loss of freedom and community-integrated treatment has occurred despite the fact that Mr. Ross has shown even greater recovery. His treatment notes reflect that his symptoms of mental illness have been in remission for a number of years, with "no signs of any psychosis." Clinicians describe him as "a positive role model for his peers," who demonstrates responsible behavior and very few rule infractions. He displays no physically violent tendencies, thoughts, or behaviors. Mr. Ross has long held a level 8 designation, the highest level available at ESH.

Yet, for several years following the passage of the RCW 10.77.145, Mr. Ross was not even allowed grounds privileges. Only recently has Mr. Ross been permitted to leave the hospital to walk outside, participate in treatment, or visit family, and he obtained these rights only after he successfully challenged Defendants in court. And still, despite his undeniable recovery, Mr. Ross is denied the level of community integrated treatment that he previously received.

2.2 **Plaintiff Daniel Gautier** has been a patient at Western State Hospital ("WSH") in Lakewood, Washington, for the past nine years. Mr. Gautier is 38 years old and has schizoaffective disorder. He actively participates in his treatment, has experienced lengthy periods of remission, and has developed a relapse prevention plan. Mr. Gautier has been granted a Level 7 designation by clinicians, the highest level available at WSH.

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When Mr. Gautier agreed to accept an NGRI plea on criminal charges, it was with the understanding that he would be treated in a hospital rather than imprisoned. Upon his admission to the hospital, Mr. Gautier was given community integrated clinical interventions that highlighted the important distinction between treatment and incarceration: clinicians were able to provide treatment that included opportunities to walk outside on the grounds of the hospital and regular escorted trips into the community for those patients who were deemed sufficiently stable. Mr. Gautier greatly benefitted from these community-integrated treatment interventions, as they gave him irreplaceable opportunities to practice the skills he had acquired and advance in his recovery.

Upon the passage of RCW 10.77.145, however, the hospital took all community-integrated treatment away from Mr. Gautier, without any therapeutic justification. For four years, he has been confined inside the hospital, without the ability to travel into the community with an escort or even take an escorted walk on the grounds. This is despite the fact clinicians have determined that Mr. Gautier "is stable," "medication compliant," has "no behavioral issues," and "has had no signs of aggression since 2009 and before then it was secondary to med changes and psychosis."

In order to regain the community integrated treatment and freedoms he once had, including simple grounds privileges, Mr. Gautier would have to obtain a court-ordered conditional release. But the nature of Mr. Gautier's mental illness makes it exceptionally difficult for him to obtain this release, particularly when he

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cannot present to the court evidence of successful community integration. Because of this paradox, it is very possible that Mr. Gautier will not be able to obtain a release in the foreseeable future. Mr. Gautier is, therefore, facing an indefinite imprisonment in WSH, deprived of basic freedoms even when there is no therapeutic justification. His mental state and quality of life have, predictably, deteriorated as a result.

2.3 **Plaintiff Jesus Martinez**, 33 years old, has been a patient residing at Eastern State Hospital for approximately fourteen years, since he was found NGRI a teenager. Treatment records and assessments make clear that Mr. Martinez's central problem, and underlying cause of past conduct, is drug addiction. His only Axis I diagnoses are Polysubstance Abuse and a history of depression that is now in remission. Mr. Martinez has achieved and held a level 8 designation, the highest level available at ESH, and clinicians report that he has been compliant with treatment. For years, he has not taken any psychotropic or antidepressant medications, nor displayed any psychotic or depressive symptoms. He does not receive mental health treatment at ESH: his treatment consists of substance abuse counseling at other treatment centers.

If he had been convicted of the crimes with which he was charged, Mr. Martinez very likely would have been released from prison several years ago, receiving supervised release and outpatient substance abuse treatment. Instead, he continues to occupy a bed in a psychiatric hospital, while completely mentally

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stable and receiving no mental health treatment, with a maximum commitment of up to life.

2.4 **Plaintiff B.T.** was adjudicated NGRI on April 17, 2009, and committed to Western State Hospital. As early as 2010 and continuing to present, B.T.'s treatment team at WSH has repeatedly noted that B.T. is not mentally ill. He is prescribed no psychiatric medication. His sole diagnosis is "History of Substance Abuse" and clinicians have acknowledged that B.T. "had no significant mental illness history prior to his substance abuse, and he has been free of psychotic symptoms" during the many years he has spent in the hospital. B.T.'s primary medical condition is physical, as he is suffering from acute renal failure, for which he cannot receive adequate medical treatment at WSH.

Even in light of this undeniable lack of mental illness and acute medical condition, Defendants will not authorize or recommend B.T.'s discharge or conditional release. B.T. petitioned for conditional release in August 2012. In a letter to the court, B.T.'s treating clinician stated: "In terms of justification for continued hospitalization, [B.T.] does not need to remain hospitalized for psychiatric reasons and should be receiving adequate medical care in an alternative facility. There is no change in his diagnosis."

Yet, the Risk Review Board at WSH opposed B.T.'s petition for release, stating that the WSH treatment team will support his "discharge desires" only if certain criteria are met, such as "No reports of inappropriate comments or behaviors for a minimum of 1 year" and accepting staff feedback. These

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conditions and criteria are unrelated to the basis for his commitment, and have nothing to do with mental illness or dangerousness.

B.T., meanwhile, continues to suffer from his lack of reasonably convenient access to medical care and inexcusably harsh and restrictive conditions at WSH. B.T. regularly sees a doctor who is treating him for his end stage renal failure. He is routinely shackled when going to these outside medical appointments despite WSH's "Independent Movement Screening Checklist" documenting no past escape history and no attempts or plans. During a medical appointment in 2013, B.T. was not allowed to remove the shackles in order to toilet himself after a bowel movement. He was forced to sit in his own waste throughout the appointment and ride back to WSH.

2.5 **Plaintiff J.G.** was adjudicated NGRI on March 5, 1999, and committed to WSH. His current mental health diagnosis is "Schizophrenia, Paranoid Type, in Remission." Medical records establish that J.G. has responsibly followed treatment and controlled the symptoms of his illness, stating that he is medication compliant and "has maintained his current treatment regime without incident for the required length of time." As a result, J.G. was conditionally released on May 1, 2003, and lived in the community with his children without incident, displaying no indicators of mental illness or dangerousness.

Yet, J.G. has spent the last four years again locked away in WSH, away from his community and family, solely because he has committed rule violations unrelated to mental illness or dangerousness. His conditional release was revoked

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in June 2010, after seven successful years living in the community with his children, because he was found to have used marijuana. In July 2013, after J.G. had earned a second conditional release that allowed him to leave the hospital temporarily, WSH revoked this release because J.G. bought back pizza for the other patients on his ward without first getting treatment team approval.

Defendants openly acknowledge that these rule violations are the sole reason for his continued confinement, rather than mental illness or dangerousness. Indeed, WSH has documented that J.G. is "stable," "follows directions," and "has not attempted to escape in the 18 years he's been in the [mental health] system." On April 23, 2013, his treatment team stated, "He appears free of symptoms of mental illness at this time…his thinking is clear and logical." This assessment was repeated in an April 24, 2014, court letter that stated: "He takes his medications as prescribed and his thinking is reality based. He is not a behavior problem. He has not engaged in any violence or threatening behavior since the last court letter." The letter goes on to note that "[J.G.] tends to minimize the importance of following rules. Seemingly due to this tendency he lost his [conditional release]. In this treatment plan, one of the behaviors preventing discharge is "thinking about the consequences of my actions before doing anything 100% of the time." This behavior goes on to note, "…I will recall how my breaking of rules, despite seemingly trivial to me, cost me my [conditional release]."

2.6 **Plaintiff B.Y** has been committed to WSH since 2007, as a result of a temporary drug-induced psychosis. His treatment team at WSH tapered B.Y. off

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all anti-psychotic medication in 2011. Consistent with WSH's own risk assessment in 2013, B.Y. does not have a mental illness: multiple evaluations have determined that B.Y. no longer has any psychiatric symptoms and there are insufficient clinical observations to support a current mental health diagnosis. A 2014 assessment concluded: "The risk of psychosis as a independent risk factor for re-offense appears less at this point, given his lack of psychosis symptoms off of medications for over two years, and the likelihood that his psychosis at the time of the crime was substance-induced."

Similarly, B.Y. has demonstrated that he is not dangerous. WSH treatment records from 2009 reflect that he "continues to model positive behavior for other patients on the ward by demonstrating prosocial and community minded awareness." He was subsequently conditionally released to the community program and for two and a half years he has been allowed to leave the hospital on weekend overnight passes. He has not had a single problematic incident that would indicate dangerousness while in the hospital or in the community.

Yet, B.Y. has been confined for years without a mental health diagnosis or evidence of dangerousness. A large reason for this is the influence of the Public Safety Review Panel ("PSRP"). Second-guessing clinical judgment of actual treatment providers, the PSRP has objected to and sought to prevent B.Y.'s conditional release, even going so far as to request that the hospital reconsider its decision to discontinue anti-psychotic medications.

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B.Y.'s confinement is expressly punitive. When B.Y. indicated that he would like to raise a court challenge to the PSRP's proposed modifications to his conditional release, Defendants retaliated by placing him on "ward hold" and removing virtually all of the rights and privileges B.Y. had attained through treatment compliance and success: not only was he no longer allowed to leave the hospital for weekend passes, he was prevented from even leaving the ward to go to the treatment mall. There was no indication from B.Y.'s clinicians that the ward hold was clinically necessary or appropriate. Defendants coercively withheld these privileges for over a month, restoring them only in exchange for B.Y.'s agreement to waive his due process right to judicial review of his release conditions.

2.7 **Plaintiff Disability Rights Washington (DRW)** is a nonprofit Washington corporation. DRW maintains its offices at 315 Fifth Avenue South, Suite 850, Seattle, Washington, 98104. DRW is designated by the governor as the protection and advocacy system for individuals who have physical, mental and developmental disabilities in the state of Washington. RCW 71A.10.080. DRW has a federal mandate to pursue administrative, legal and other appropriate remedies to ensure the protection of individuals with disabilities. 42 U.S.C. § 10805(a)(1); 42 U.S.C. § 15043(a)(2)(A) and (B). DRW is governed by a Board of Directors that includes a majority of members who have disabilities, including mental health conditions. Additionally, the Board is advised by a statutorily required Mental Health Advisory Council that is composed predominantly of individuals with mental health conditions. The Board of Directors, with input from

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the Advisory Council, staff, and public, sets DRW's service priorities and evaluates its progress in reaching positive outcomes for people with disabilities.

DRW's constituents include the named individual plaintiffs and all other individuals who are patients at the state psychiatric hospitals. Through the access authority granted to it by federal law, DRW regularly monitors the hospitals by visiting the various units, disseminating rights based information, discussing rights violation concerns with patients, and meeting with hospital administrators to advocate for remedies to systemic rights violations. DRW also maintains a toll free phone line and accepts letter from people across Washington in order to provide information and assistance to individuals with mental illness and their family members/guardians regarding patient rights. Moreover, DRW routinely investigates numerous allegations of patient abuse, including but not limited to the blanket use of shackles during out of hospital transport and the lockdown of patients after an ESH patient walked away from a state fair.

When necessary, DRW has filed several lawsuits on behalf of patients at the state psychiatric hospitals due to violations of their rights that lead to unnecessarily restrictive or prolonged detention. These cases include: *Allen, et al. v. Western State Hospital, et al.*, U.S. Dist. Ct. for the Western Dist. of Wash., C99-5018RBL (class of patients at WSH with a dual diagnosis or developmental disability and mental illness denied appropriate treatment in the hospital and community, leading to a lack of discharge); *Marr, et al. v. Eastern State Hospital*, U.S. Dist. Court for the Eastern Dist. of Wash., CS-02-0067-WFN (class of patients at ESH with a dual

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diagnosis or developmental disability and mental illness denied appropriate treatment in the hospital and community, leading to a lack of discharge); *D.S., et al. v. Western State Hospital, et al.*, U.S. Dist. Ct. for the Western Dist. of Wash., C03-5271BL (lack of adequate discharge planning at for WSH patients with a dual diagnosis of developmental disability and mental illness); *Rust, et al. v. Western State Hospital, et al.*, U.S. Dist. Court C00-5749 RJB (inadequate treatment and unsafe conditions for patients in the forensic unit of WSH); and *Pierce County, et al., v. State of Washington, et al.*, Thurston County Superior Court No. 03-2-00918-8 (insufficient treatment and discharge planning for patients of WSH).

As a result of these lawsuits, there has been increased access to both community and institutional services for people with mental health disabilities with very significant and complex needs. DRW and DSHS have made extensive use of internationally known experts in the monitoring and implementation of the settlements in the above-mentioned actions.

Courts have uniformly held that DRW has organizational standing to represent the interests of people with disabilities, to include patients in Washington State's psychiatric hospitals. *See Oregon Advocacy Ctr. v. Mink*, 322 F.3d 1101, 1112 (9th Cir. 2003); *In re Lamb*, 173 Wash.2d 173, 196-197, 265 P.3d 876, 889 (2011)(citing to federal law providing DRW with the authority to "pursue legal, administrative, and other appropriate remedies . . . to ensure the protection of, and advocacy for, the rights of people with disabilities.").

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2.8 **Defendant Jay Inslee** is sued in his official capacity as Governor of the State of Washington. Governor Inslee, in his official capacity, exercises general responsibility, supervision, and oversight of the policies, practices, and operations of the Department of Social and Health Services (hereinafter "DSHS") and the hiring, supervision, and retention of the Department's Secretary. As the Chief Executive of the State of Washington, Governor Inslee is responsible for implementing and ensuring compliance with state and federal constitutional and statutory protections for people detained in Washington's hospitals for inpatient mental health treatment.

2.9 **Defendant Kevin Quigley** is sued in his official capacity as Secretary of DSHS. Secretary Quigley, in his official capacity, exercises general responsibility, supervision, and oversight of the policies, practices, and operations of DSHS pursuant to RCW 43.20A.050. Secretary Quigley's responsibilities include, but are not limited to, the care, custody, and welfare of persons with mental illness who receive services at those state facilities and programs that are funded, operated, licensed, or supervised by DSHS.

2.10 **Defendant Washington State Department of Social and Health Services** is the sole Washington State agency designated to administer or supervise the administration of mental health treatment to people committed by the courts to long-term inpatient treatment pursuant to RCW 71.05.010, et seq. (involuntary civil commitment), and RCW 10.77.010 et seq. (involuntary forensic commitment), at Eastern and Western State Hospitals. In so doing, DSHS utilizes

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federal and state funds. DSHS is responsible for implementing and ensuring compliance with state and federal constitutional and statutory protections for people involuntarily detained in order to receive mental health services.

III. JURISDICTION AND VENUE

3.1 This action arises under federal law, including the United States Constitution and federal statutes. This Court has jurisdiction and authority to enter declaratory and injunctive relief pursuant to 28 U.S.C. §§ 1331(a), 1343(3) & (4), 1367, 2201, 2202, 42 U.S.C. §§ 1983, 1988, 12205, and Rules 57 and 65 of the Federal Rules of Civil Procedure.

3.2 Venue is appropriate under 28 U.S.C. § 1391(b), as all of the acts and omissions of all defendants occurred in the State of Washington. All of the parties reside in the State of Washington and Plaintiffs' claims for relief arise within this state. Each cause of action arises at least in part in this district. This district provides the most convenient forum for the litigation of these issues.

IV. FACTS ENTITLING PLAINTIFFS TO RELIEF

A. The Treatment of Those Found NGRI

4.1 RCW 10.77.080 allows a court to acquit a criminal defendant if the defendant proves that due to a mental conditions he or she meets the rigorous legal definition of "insanity" at the time of the act relating to the criminal charge and should therefore not be held criminally culpable.

4.2 Plaintiffs agreed to resolve criminal charges against them by accepting plea deals that classified them as NGRI, based on the representation that

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this would lead to them being treated by the State as persons in need of mental health treatment, rather than prisoners.

4.3 If a person is acquitted under RCW 10.77.080, RCW 10.77.110 provides that the person shall be released from custody unless he or she is "a substantial danger to other persons" or presents "a substantial likelihood of committing criminal acts jeopardizing public safety or security." If the person acquitted as NGRI is not released after the verdict, the court "shall order his or her *hospitalization*, or any appropriate alternative treatment *less restrictive than detention in a state mental hospital* . . . ." *Id.* (emphasis added).

4.4 Eastern and Western State Hospitals each have "forensic" units designed specifically for NGRI acquittees. Forensic units have heightened security beyond that found in other locked units of the hospitals. The security includes, but is not limited to: video surveillance of points of egress and virtually all common areas; electronically controlled locks at points of egress operated from a secure setting; "sally ports" allowing only one of two locked doors to open at one time; metal detectors; and extensive training of staff in security precautions.

4.5 The treating professionals serving patients in the forensic units, like all other units at Eastern and Western State Hospitals, are bound by the Fourteenth Amendment, which requires them to provide adequate care, treatment, and protection of harm in a manner that is consistent with professional judgment. This professional judgment must be exercised to provide treatment that meets the

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individual needs of their patients and provides patients with access to mental health treatment that gives them a realistic opportunity to be cured and released.

4.6 The treating professionals are also under an affirmative obligation to make their programs, services, and activities accessible to otherwise qualified individuals with disabilities under Title II of the Americans with Disabilities Act, the Rehabilitation Act, and the regulations promulgated thereunder.

4.7 One such regulation, known as the "integration mandate," requires a "public entity [to] administer . . . programs . . . in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR § 35.130(d).

4.8 The treating professionals at Eastern and Western State Hospitals exercise their professional judgment in part by assigning patients numeric levels indicating their level of recovery, behavioral compliance, trustworthiness, and ability to interact in more integrated community settings. Levels are assigned according to the condition, health, and needs of each individual patient.

4.9 The level assigned to a patient determines the amount of restrictions that are placed upon each patient. Patients that are assigned a higher level have historically been able to exercise more freedom by, for instance, taking walks outside on the hospital grounds, leaving the hospital to visit family, taking monthly, staff-supervised trips into the community to go shopping, watch a baseball game, go to a restaurant, or participate in other community events.

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4.10 The treatment providers at Western and Eastern State Hospitals are cautious when assigning patients to higher levels. Treatment providers routinely take months before allowing patients to move to a higher level.

4.11 While there has been at least one documented instance of a forensic patient walking away from staff during an outing, there have been no known reports of forensic patients leaving the hospital unauthorized and hurting anyone or otherwise exhibiting dangerous behavior during an outing.

4.12 The use of gradual reintegration into society has been shown to be very effective in aiding patients' recovery and ability to safely return to the community. Western State Hospital has reported that the recidivism rate of forensic patients that return to the community is a mere 0.6%. This means that very few forensic patients who are released back into the community through a very deliberate, clinically-based treatment program go on to commit new crimes.

4.13 These opportunities to leave the restrictive institutional setting and participate in community life play a critical role in the treatment and recovery of patients. Indeed, these recreational and cultural experiences were listed as key parts of Plaintiff Ross's treatment plan for recovery from psychosis. Community reintegration significantly improves patients' mental health and quality of life by helping them reorient to reality, decrease stress, boredom, and isolation, and by providing family relations, social contacts, independence, cultural enrichment, and hope. The trips into the community provide indispensable opportunities for patients to apply and practice the skills they learn in treatment to different situations, and

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for treating providers to observe patients' overall progress and ability to readjust to a community setting. The advancement to higher levels with additional privileges also serves as a key incentive for patients to actively participate in difficult treatments and obey the myriad rules and restrictions placed upon them.

4.14 All of the effects just listed are highly clinically significant. Patients' recoveries can easily plateau or regress if they are isolated in a hospital setting, lonely, stressed, or without hope or expectation of moving forward. Moreover, patients must be able to demonstrate their treatment progress in more integrated settings in order for clinicians to be able to assess any needs for further treatment. Thus, when community reintegration is denied or delayed, patients are not provided minimally adequate treatment that gives them a realistic chance to be cured.

4.15 Community reintegration is also an essential component of minimally adequate treatment that gives patients a realistic chance of being timely released. Without the opportunity to demonstrate their recovery and ability to safely reintegrate into the community, patients lack indispensible evidence needed to prove to a court that release is appropriate.

4.16 Because they were admitted to Eastern and Western State Hospitals prior to the imposition of the policies currently in place, Plaintiffs Ross, Gautier, and J.G. initially received community integrated treatment. As Plaintiffs progressively recovered from the symptoms of their illnesses and demonstrated safe and appropriate behavior, clinicians assigned them progressively higher

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privilege levels and deemed it clinically appropriate for Plaintiffs to participate in community outings and take walks on the hospital grounds.

4.17 Plaintiffs Ross, Gautier, and J.G. benefitted greatly from this community integrated treatment, with faster recoveries, improved quality of life, and better opportunities to demonstrate their eligibility for release. None of these Plaintiffs displayed dangerous tendencies or presented safety risks. Yet, following the elopement of a different patient in 2009, Defendants withdrew from Plaintiffs this integrated treatment that had already been determined to be most appropriate to their needs.

B. RCW 10.77.145 and 10.77.270

4.18 In September of 2009, a patient in the forensic services unit at Eastern State Hospital, acquitted under the NGRI statute decades earlier, walked away from an arranged hospital outing to the Spokane County Interstate Fair. This patient did not injure or threaten anyone during the three days before he was found. He reported that, after 22 years in the hospital, he simply wanted to go home.

4.19 Despite the fact that this patient had been deemed by clinicians to be adequately recovered from his illness such that he did not pose a public threat during community outings, the media depicted the patient as a "homicidal loon" and menace to society. Indeed, the entire group of patients on the outing—all of whom were approved by clinicians—was deemed "criminally dangerous."

4.20 The Washington State Legislature responded to this incident with new legislation. RCW 10.77.145 states:

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> (1) No person committed to the custody of the department for the determination of competency to stand trial under RCW 10.77.060, the restoration of competency for trial under RCW 10.77.084, 10.77.086, or 10.77.088, or following an acquittal by reason of insanity shall be authorized to leave the facility where the person is confined, except in the following circumstances:
>
> (a) In accordance with conditional release or furlough authorized by a court;
>
> (b) For necessary medical or legal proceedings not available in the facility where the person is confined;
>
> (c) For visits to the bedside of a member of the person's immediate family who is seriously ill; or
>
> (d) For attendance at the funeral of a member of the person's immediate family.
>
> (2) Unless ordered otherwise by a court, no leave under subsection (1) of this section shall be authorized unless the person who is the subject of the authorization is escorted by a person approved by the secretary. During the authorized leave, the person approved by the secretary must be in visual or auditory contact at all times with the person on authorized leave.
>
> (3) Prior to the authorization of any leave under subsection (1) of this section, the secretary must give notification to any county or city law enforcement agency having jurisdiction in the location of the leave destination.

RCW 10.77.270 states:

> (1) The secretary shall establish an independent public safety review panel for the purpose of advising the secretary and the courts with respect to persons who have been found not guilty by reason of insanity, or persons committed under the involuntary treatment act where the court has made a special finding under RCW 71.05.280(3)(b). The panel shall provide advice regarding all recommendations to the secretary, decisions by the secretary, or actions pending in court: (a) For a change in commitment status; (b) to allow furloughs or temporary leaves accompanied by staff; (c) not to seek further commitment terms under RCW 71.05.320; or (d) to

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permit movement about the grounds of the treatment facility, with or without the accompaniment of staff.

(2) The members of the public safety review panel shall be appointed by the governor for a renewable term of three years and shall include the following:

(a) A psychiatrist;
(b) A licensed clinical psychologist;
(c) A representative of the department of corrections;
(d) A prosecutor or a representative of a prosecutor's association;
(e) A representative of law enforcement or a law enforcement association;
(f) A consumer and family advocate representative; and
(g) A public defender or a representative of a defender's association.

(3) Thirty days prior to issuing a recommendation for conditional release under RCW 10.77.150 or forty-five days prior to issuing a recommendation for release under RCW 10.77.200, the secretary shall submit its recommendation with the committed person's application and the department's risk assessment to the public safety review panel. The public safety review panel shall complete an independent assessment of the public safety risk entailed by the secretary's proposed conditional release recommendation or release recommendation and provide this assessment in writing to the secretary. The public safety review panel may, within funds appropriated for this purpose, request additional evaluations of the committed person. The public safety review panel may indicate whether it is in agreement with the secretary's recommendation, or whether it would issue a different recommendation. The secretary shall provide the panel's assessment when it is received along with any supporting documentation, including all previous reports of evaluations of the committed person in the person's hospital record, to the court, prosecutor in the county that ordered the person's commitment, and counsel for the committed person.

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> (4) The secretary shall notify the public safety review panel at appropriate intervals concerning any changes in the commitment or custody status of persons found not guilty by reason of insanity, or persons committed under the involuntary treatment act where the court has made a special finding under RCW 71.05.280(3)(b). The panel shall have access, upon request, to a committed person's complete hospital record, and any other records deemed necessary by the public safety review panel.

4.21 This legislation is plainly motivated by fear, stigma, and a desire to segregate people with mental illness without serving any clinical or restorative purpose. As just one example, the sponsor of RCW 10.77.145 testified: "There was quite a bit of concern in our community that he had escaped at the fair and was within feet of our children."

4.22 The legislation also reflects a clear intent to punish those deemed NGRI, despite the fact that they have not been convicted of a crime. For instance, the State Psychiatric Hospital Safety Review Panel stated in its final report to the Secretary of DSHS that "contemporary psychiatric treatment for serious mental illness has advanced such that individuals who commit serious offenses while psychotic can be rapidly stabilized. In this hospital setting, this customarily leads to efforts to reintegrate patients back into the community, *often far earlier than prosecutors, victims' families or the general public feels is appropriate* for individuals whose offenses involve serious personal injury or death to others." (emphasis added). If the goal of hospitalization is treatment, reintegration should occur as soon as recovery is achieved.

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The consideration of the "appropriate" length of confinement based on the nature of criminal charges reveals the underlying punitive intent.

C. Effects of RCW 10.77.145

4.23 Defendants' implementation of RCW 10.77.145 has caused, and continues to cause, Plaintiffs and other forensic patients to suffer irreparable harm.

4.24 Rather than simply requiring additional monitoring or oversight during outings to prevent future elopements, these statutes prevent all forensic patients from leaving the hospital under almost all circumstances, even going so far as to restrict patients' movement about the grounds of the treatment facility, with or without the accompaniment of staff. Patients can only leave the secure forensic facility when ordered by a court, to attend medical appointments or legal proceedings, to visit the bedside of a "seriously ill" immediate family member, or attend the funeral of an immediate family member.

4.25 By imposing these blanket restrictions, RCW 10.77.145 and 10.77.270 have effectively stripped patients' clinical treatment providers of their authority and ability to provide care in the least restrictive and most integrated setting appropriate for each patient. Indeed, Plaintiffs Ross, Gautier, and J.G., like many other patients admitted prior to the enactment of these statutes, had previously been deemed by clinicians to be eligible and appropriate for less restrictive community-integrated treatment but had this integrated treatment taken away from them by the legislature, without any individualized therapeutic or safety rationales.

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4.26 DSHS has also imposed restrictions and restraints beyond those set forth in the statute and have made the conditions within the hospitals akin to a prison. The individual plaintiffs and other forensic patients, even those at high levels who have achieved substantial recovery and exhibit no dangerous tendencies, are often required to wear shackles around their hands and feet when they leave their treatment ward regardless of their individualized needs or risks. This include instances in which patients are attending medical appointments, whether on or off campus, and going to court hearings. Plaintiff B.T. was not permitted to remove the shackles in order to toilet and was therefore subjected to the humiliation of sitting in his own waste throughout a medical appointment until his return to the hospital. This degrading and unconstitutional violation of patients' rights to be free from unreasonable restraint and to receive individualized treatment adds to the stigmatization of mental illness.

4.27 Like prisoners, most forensic patients can no longer take walks outside, even when escorted by staff and on hospital grounds. Unless there is a court order in place, Defendants prohibit even the most stable and responsible forensic patients from going beyond a small fenced area. This results in a sharp limitation on patients' access to fresh air, sunshine, and exercise.

4.28 Like prisoners, forensic patients are forced to endure routine body searches and have their rooms "tossed" in routine searches for contraband. Some searches have even resulted in strip-searching patients for tobacco or tobacco related products. Patients have also had their shoelaces confiscated, including

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those who have been prescribed orthopedic shoes. Patients in Western State Hospital have been told they will soon have their electrical devices taken away, as electrical power cords are no longer allowed. Again, this is true even for patients who have earned high levels and who are not deemed to pose any particular risks.

4.29 Forensic patients also live under constant fear of being transferred from the hospital to a state prison, pursuant to RCW 10.77.091. Under the statute, this can occur solely based on a determination by the secretary, without any formal hearing or due process. This law has already been used once to transfer a forensic patient to prison, and Plaintiff Gautier has heard hospital staff threaten to transfer patients to prison if they do not follow their direction. Unsurprisingly, this greatly undermines the clinical relationships and trust that are critical to recovery and quality of life.

4.30 The restrictions imposed by DSHS result in forensic patients losing most or all opportunities to interact with their community outside of their institutional setting. This includes an inability to visit family or friends, pursue educational opportunities, experience cultural enrichment such as artistic or sporting events, go shopping, or eat at a restaurant.

4.31 Defendants have also obstructed forensic patients' right to petition their government for redress of grievances and participate in the political process. For instance, when a bill was introduced in the legislature to repeal RCW 10.77.145, no forensic patients were able to travel to the Capitol to testify, despite the fact that the bill intimately concerned them, because they were required to be

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confined to hospitals. Defendants have limited how forensic patients may reach out and personally invite legislators to come to the hospitals to hear from patients, and tried to prevent patients from speaking to reporters. It has also been reported that Defendants have violated the privacy of patients by sharing protected health information with the media and with the prosecutor's office in order to make patients look bad.

4.32 Another critical consequence of confining forensic patients is that it deprives patients and treatment providers of an indispensable treatment and assessment tool. That is, it prevents recovering patients from practicing and demonstrating their ability to interact with the broader community in a pro-social and responsible way. This slows patients' recovery, which in turn makes it take longer for them to meet discharge and/or conditional release requirements. As a result, their overall confinement is longer than necessary.

4.33 The provision in RCW 10.77.145 that permits patients to leave the facility with a court ordered conditional release or furlough does not cure the myriad harms inflicted on patients. Rather, it places additional burdens upon them, and significantly delays, or prevents, patients' recovery and release.

4.34 Rather than simply being permitted the freedoms to which they were previously entitled, and which were deemed appropriate by their treating providers, Plaintiffs and all other forensic patients now bear the onus of initiating judicial proceedings and obtaining a court order for virtually every occasion in which they leave the facility in which they are confined.

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4.35 Obtaining a court order is a long, arduous, and uncertain process, requiring many months of sustained effort. Defendants do not routinely obtain these orders on patients' behalf, even when treatment providers acknowledge that community integration would aid patients' recovery. Patients must first find an attorney willing to assist them in navigating a complicated legal process. They must compile records and recommendations from the treatment team, appropriate written affidavits, and identify people willing and available to testify live in court.

4.36 Even when their treating clinicians agree that additional freedom is appropriate and safe, patients must also convince the hospital's Risk Review Board that community integration is appropriate. Despite this thorough review, the obstacles and delays placed in front of patients continue. A separate, independent Public Safety Review Panel ("PSRP"), created by the Secretary pursuant to RCW 10.77.270, examines these requests for privileges, including simple requests for supervised grounds privileges, in order to provide a recommendation to the Secretary. The PSRP allows law enforcement personnel and other individuals who have no involvement in the patient's treatment to contradict clinical judgment and recommend against the conditional release, despite never having met the patient.

4.37 By statute, the additional PSRP review adds at least 30 to 45 days to the review process. In practice, the additional PSRP review results in significant delays of court hearings and status update letters to courts, substantially delaying the integrated treatment to which patients are legally entitled.

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4.38 In situations in which the PSRP disagrees with treating clinicians' recommendation to provide more community integrated treatment, the DSHS Secretary may, without any clinical training or expertise, overrule the treating clinician's professional judgment and join the PSRP in recommending against less restrictive treatment, thereby failing to provide treatment in the most integrated setting appropriate to the needs of the patients that allows realistic progress toward being cured and released. For example, in 2011, the PSRP denied B.Y.'s treatment team's support for a conditional release and instead recommended that B.Y.'s treatment team review his diagnosis and consider medicating him. Yet, a clinical assessment determined there was no "clear clinical indication or necessity for [B.Y.] to be prescribed an antidepressant or anti-anxiety medication" and that such recommendation appeared to be based not on clinical need but rather "administrative reasons."

4.39 Patients must then face off against the prosecutor's office that filed the initial charges against them. Prosecutors can, and often do, oppose the patient's request for conditional release. In so doing, prosecutors often present evidence related to the impact on the victim or the victim's family, the fear in the community, and the allegedly bad precedent that would come from "releasing a criminal." In short, the State presents evidence that has nothing to do with the patient's recovery, mental health, or treatment goals, and everything to do with punishing the patient for criminal charges on which he was not convicted, shaming the patient, and stoking fear.

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4.40 The process then requires the scheduling of court hearings in the county in which the patients were initially charged, which can be very far from the hospital in which they are confined and require travel. These hearings are often delayed and rescheduled. The result is that the treatment plan recommended by clinicians is, at best, set back many months or even years. At worst, the professional judgment of treating clinicians is overruled based on the non-clinical opinion of the PSRP or Secretary, and patients are denied integrated treatment. For example, in 2014, Plaintiff B.Y. challenged efforts being made by the PSRP to further restrict his conditional release by forbidding him from going to Seattle to visit his mother. In response, the PSRP placed B.Y. on a ward hold, thereby denying him the right to even attend the treatment mall, without any indication of whether this was clinically appropriate. Only when he was coerced into agreeing to this modification to his conditional release was B.Y. allowed to leave his ward.

4.41 The obvious, and likely intentional, effect of these obstacles is to deter patients from even attempting to obtain a court order. Patients must go through the daunting process just described in order to simply take a walk outside; they know it becomes even more difficult if they are seeking additional freedoms, such as the chance to visit family for the holidays or go to a community event, and that a court order would be untimely in any event. Patients may not be able to procure counsel to assist them, or may not receive the recommendation of one of the review panels. They may not feel up to the emotional strain and effort of the process. They will therefore have no choice but to submit to being treated, indefinitely, like prisoners.

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4.42 The result of the policies and practices just described is that Plaintiffs and other forensic patients are no longer provided treatment consistent with the Americans with Disabilities Act and constitutionally protected rights to due process. Defendants do not allow clinicians to exercise their professional judgment in a reasonably prompt and reliable manner to provide mental health treatment that meets the individual needs of their patients in the most integrated setting possible and offers patients a realistic opportunity to be cured and released. Defendants continue to detain Plaintiffs without finding them currently mentally ill and dangerous.

4.43 Plaintiffs and other forensic patients are trapped. Rather than being treated, gradually reintegrated into the community, and eventually released, they are simply warehoused in state mental hospitals. They are stuck at the same level, forced to repeat treatments and classes they have already completed, with nothing left for the hospitals to offer and nowhere else to go. The hospitals continue to take away additional rights and privileges that other citizens take for granted, such as the right to take a walk outside without shackles. The patients have become *de facto* prisoners, with no release in sight, despite the fact that they have not been convicted of a crime and have demonstrated significant recovery from their illnesses.

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V. LEGAL CLAIMS

COUNT ONE

VIOLATION OF TITLE II OF THE AMERICANS WITH DISABILITIES ACT, 42 U.S.C. 12131, et seq.

5.1 Title II of the Americans with Disabilities Act ("ADA") provides that "no qualified individual with a disability shall, by reason of disability, be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity or be subjected to discrimination by such entity." 42 U.S.C. § 12132.

5.2 In enacting the ADA, Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem[.]" 42 U.S.C. § 12101(a)(2).

5.3 Regulations implementing Title II of the ADA provide: "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d).

5.4 Defendant DSHS is a public entity within the meaning of Title II of the ADA.

5.5 Regulations implementing Title II of the ADA provide: "A public entity may not, directly or through contractual or other arrangements, utilize criteria or other methods of administration: (i) that have the effect of subjecting

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qualified individuals with disabilities to discrimination on the basis of disability; [or] (ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the entity's program with respect to individuals with disabilities. . . ." 28 C.F.R. § 35.130(b)(3).

5.6 The United States Supreme Court in *Olmstead v. L.C. ex rel. Zimring,* 527 U.S. 581 (1999), held that the unnecessary institutionalization of individuals with disabilities is a form of discrimination under Title II of the ADA. In doing so, the Supreme Court interpreted the ADA's "integration mandate" as requiring persons with disabilities to be served in the community when: (1) the state's treating professional determines that community-based treatment is appropriate; (2) the individual does not oppose community placement; and, (3) community placement can be reasonably accommodated. *Id.* 527 U.S. at 607.

5.7 The ADA prohibits discrimination based on type of disability.

5.8 The ADA's regulations further provide that "[a] public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered." 28 C.F.R. § 35.130(b)(8).

5.9 Pursuant to the ADA, public entities are required to provide meaningful access to their programs, services and activities, and provide any

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accommodations or modifications necessary for people with disabilities to access those services.

5.10 Plaintiffs and other forensic patients are qualified individual with disabilities that affect one or more substantial and significant life activities.

5.11 Defendants have operated and continue to operate under color of state law.

5.12 Defendants, by their actions, inactions, and omissions, violate Plaintiffs' and other forensic patients' legal rights under Title II of the ADA, 42 U.S.C. § 12132, *et seq.*, the regulations promulgated thereunder at 28 C.F.R. Part 35, and 42 U.S.C. § 1983, by unnecessarily confining Plaintiffs in a hospital facility and depriving them of the opportunities to engage in community-based therapeutic outings provided to other similarly-situated patients at Eastern and Western State Hospitals, in violation of the ADA's integration mandate. It has already been established, based on Plaintiffs' prior opportunities to participate in community outings, that (1) community-based treatment methods are appropriate; (2) Plaintiffs do not oppose these community-based treatments; and, (3) community-based treatment can be reasonably accommodated.

5.13 Defendants, by their actions, inactions, and omissions, violate Plaintiffs' and other forensic patients' legal rights under Title II of the ADA, 42 U.S.C. § 12132, *et seq.*, the regulations promulgated thereunder at 28 C.F.R. Part 35, and 42 U.S.C. § 1983, by aiding and perpetuating discrimination against Plaintiffs and other forensic patients who have been acquitted by a court of law due

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to the presence of a mental illness, developmental disabilities, and traumatic brain injuries. Defendants perpetuate this discrimination by, among other things: presuming Plaintiffs' continued dangerousness, irrespective of the recovery they have shown from their mental illness; preventing Plaintiffs from participating in community-based therapeutic outings without any individualized, articulable, and contemporaneous safety concerns; forcing Plaintiffs to wear shackles when in public and outside of the facilities; and creating blanket prohibitions on certain property items like shoelaces.

5.14. Defendants utilize eligibility criteria and methods of administration that subject Plaintiffs and other forensic patients to discrimination on the basis of disability, in violation of 28 C.F.R. § 35.130(b)(3) &(8), and otherwise denied meaningful access to their programs, services and activities. Defendants fail to provide reasonable modifications to programs and services, such as expedited procedures and support in obtaining court orders that would allow Plaintiffs to participate in community-based therapeutic outings.

5.15 To the extent that RCW 10.77.145 and RCW 10.77.270 are inconsistent and incompatible with the ADA provisions just cited, they are preempted, invalid, and unenforceable.

5.16 Pursuant to 42 U.S.C. § 12133 and 42 U.S.C. § 1983, Plaintiffs seek declaratory and injunctive relief as well as reasonable attorneys' fees and costs incurred in bringing this action.

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COUNT TWO

VIOLATION OF SECTION 504 OF THE REHABILITATION ACT, 29 U.S.C. § 794 *et seq.*

5.17 Section 504 of the Rehabilitation Act of 1973, on which the ADA is modeled, sets forth similar protections against discrimination by recipients of federal funds, such as DSHS. 29 U.S.C. §§ 794-794a. These protections include the prohibition against unnecessary segregation. Regulations implementing Section 504 require that a public entity administer its services, programs and activities in "the most integrated setting appropriate" to the needs of qualified individuals with disabilities. 28 C.F.R. § 41.51(d).

5.18 Section 504 prohibits discrimination based on type of disability.

5.19 Section 504's regulations prohibit recipients of federal financial assistance from "utiliz[ing] criteria or methods of administration (i) That have the effect of subjecting qualified handicapped persons to discrimination on the basis of handicap [or] (ii) That have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program with respect to handicapped persons. . . ." 28 C.F.R. § 41.51(b)(3)(i); 45 C.F.R. § 84.4(b)(4).

5.20 Plaintiffs and other forensic patients are "qualified individuals with a disability" within the meaning of Section 504 in that they: (1) have mental impairments that substantially limit one or more major life activities; and (2) meet the essential eligibility requirements in that they are capable of living in the most integrated community setting possible, with assistance;

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5.21 Defendants' actions impose upon Plaintiffs and other forensic patients unnecessary confinement and deny them the most integrated community placements possible, in violation of Section 504's integration mandate.

5.22 Defendants discriminate against Plaintiffs and other forensic patients by, among other things, failing to provide reasonable modifications to programs and services.

5.23 Defendants utilize eligibility criteria and methods of administration that subject Plaintiffs and other forensic patients to discrimination on the basis of disability in violation of 28 C.F.R. § 41.51(b)(3)(i) and 45 C.F.R. § 84.4(b)(4), and otherwise deny meaningful access to their programs, services and activities.

5.24 Defendants' actions violate Section 504 and therefore discriminate against individuals with cognitive and psychiatric disabilities, based on their type of disability and stigma associated with those found NGRI.

5.25 To the extent that RCW 10.77.145 and RCW 10.77.270 are inconsistent and incompatible with Section 504 of the Rehabilitation Act, they are preempted, invalid, and unenforceable.

5.26 Pursuant to 29 U.S.C. § 794 and 42 U.S.C. § 1983, Plaintiffs are entitled to declaratory and injunctive relief as well as reasonable attorneys' fees and costs incurred in bringing this action.

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COUNT THREE

VIOLATION OF THE SUBSTANTIVE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT TO THE UNITED STATES CONSTITUTION, BY AND THROUGH 42 U.S.C. § 1983

5.27 The Fourteenth Amendment to the United States Constitution guarantees that no "State [shall] deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV, § 1, cl. 3.

5.28 Defendants are state actors and, as such, are obligated to provide all mental health patients due process of law when restricting their substantive rights under the United States Constitution and statutes.

5.29 Defendants are required under the Fourteenth Amendment to provide treatment that complies with the "professional judgment standard" articulated in *Youngberg v. Romeo*, 457 U.S. 307, 323, 102 S. Ct. 2452 (1982).

5.30 Defendants, by their actions, inactions, and omissions, fail to provide constitutionally required treatment to Plaintiffs and other forensic patients by preventing the professional judgment of treating professionals to be exercised in a timely and effective manner. Defendants fail to provide forensic patients with community-based restorative treatment consistent with the levels assigned to them by treating professionals.

5.31 Defendants are also required by the Fourteenth Amendment to provide forensic patients "more considerate treatment and conditions of

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confinement than criminals whose conditions of confinement are designed to punish." *Id.* at 321-22.

5.32 Defendants, by their actions, inactions, and omissions, fail to provide constitutionally required treatment to Plaintiffs and other forensic patients by subjecting them to unnecessary and unwarranted confinement, although they have not been convicted of committing a crime. Defendants deny Plaintiffs and other forensic patients the community integrated treatment and conditions of confinement that are provided to other similarly situated civilly committed mental health patients, instead subjecting them to drastically more restrictive conditions of confinement designed to punish. This is clearly evident in the treatment of Plaintiffs B.T. and J.G., as Defendants openly admit that their continued confinement is based solely on punishment for rule violations and behaviors rather than clinical necessity.

5.33 Defendants are required under the Fourteenth Amendment to provide civilly committed patients mental health treatment that gives them a realistic opportunity to be cured or to improve the mental condition for which they were confined. *Ohlinger v. Watson*, 652 F.2d 775, 778 (9th Cir. 1980).

5.34 Defendants, by their actions, inactions, and omissions, fail to provide constitutionally required treatment that gives Plaintiffs and other forensic patients realistic opportunity to be cured or to improve the mental condition for which they were confined by substantially delaying or denying forensic patients' access to community-based treatment. The loss of this indispensable treatment and

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assessment tool slows or stops patients' recovery and makes it difficult or impossible for them to meet discharge and/or conditional release requirements. Instead, patients are often simply warehoused in the hospital, receiving no actual treatment and with no expectation for additional recovery, for no clinical reasons.

5.35 The effect of this constitutional deprivation is best illustrated in the cases of Plaintiffs Ross, Gautier, and J.G.. Prior to the 2010 legislative changes, each had already been approved for community-based treatment based on a finding that their participation was not a danger to public safety. The subsequent denial of this clinically recommended treatment has substantially slowed or stopped these Plaintiffs' recoveries and ability to demonstrate fitness for release.

5.36 Under the Fourteenth Amendment, and in the context of involuntary commitment, Defendants cannot restrict patients' liberty interest simply based on a finding of mental illness or dangerous; rather, there must be a determination that a patient is mentally ill *and* presently dangerous to public safety. *O'Connor v. Donaldson*, 422 U.S. 563, 575, 95 S. Ct. 2486 (1975); *Foucha v. Louisiana*, 504 U.S. 71, 77, 112 S. Ct. 1780 (1992).

5.37 Defendants, by their actions, inactions, and omissions, violate Plaintiffs' and other patients' due process rights. Defendants violate patients' liberty interest in community-based treatment, conditional release, and final discharge without making any specific findings that they are mentally ill and dangerous.

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5.38 This is evident from the situations faced by Plaintiffs Martinez, B.T., J.G., and B.Y. Mr. Martinez. B.T., and B.Y. have no active mental health diagnoses, only a history of substance abuse; J.G.'s illness has been in remission for over a decade. These Plaintiffs receive no treatment benefits from being confined in a mental hospital, nor is their confinement based on current dangerousness. Yet, these patients have been confined in psychiatric hospitals for years, including the revocation of prior conditional releases, without clinical justification. In so doing, Defendants violate Plaintiffs' constitutional due process rights.

5.39 Defendants violate Plaintiffs' and all patients' due process rights by denying, opposing, or delaying their release from confinement based solely on rule violations that do not have any relationship to mental illness or dangerousness. Simple commonplace rule violations—such as associating with the opposite sex, "inappropriate comments," or buying pizza for friends without permission—are routinely cited as a basis to deny or revoke patients' assigned levels or revoke or prevent patients' release, even when rule violations do not indicate mental illness or dangerousness. Worse, as is illustrated in the case of B.Y., Defendants use more restrictive confinement in a coercive manner to punish patients who exercise their due process right to judicially challenge the conditions of their release. Defendants thus deprive patients of their fundamental right to liberty in a punitive rather than therapeutic manner, in violation of patients' due process rights.

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COUNT FOUR

VIOLATION OF THE EQUAL PROTECTION CLAUSE OF THE FOURTEENTH AMENDMENT TO THE UNITED STATES CONSTITUTION, BY AND THROUGH 42 U.S.C. § 1983

5.40 RCW 10.77.145 and RCW 10.77.270 violate the Equal Protection clause of the Fourteenth Amendment by intentionally singling out NGRI patients for additional punishment—in the form of medically unnecessary confinement and loss of liberty—beyond that imposed on similarly situated individuals receiving mental health treatment who were not acquitted NGRI.

5.41 Defendants are state actors and as such are obligated to provide Plaintiffs and other forensic patients equal protection under the law.

5.42 Defendants, by their actions, inactions, and omissions, violate Plaintiffs' and other forensic patients' Fourteenth Amendment rights to equal treatment under the law by confining them and restricting their treatment options without any clinical, treatment-based, or punitive justification, when other similarly situated persons are not subject to such restrictions.

COUNT FIVE

VIOLATIONS OF THE U.S. CONSTITUTION ARTICLE I § 10 PROHIBITION OF *EX POST FACTO* PUNISHMENT BY AND THROUGH 42 U.S.C. § 1983

5.43 Article I, Section 10, of the United States Constitution also prohibits the use of *ex post facto* punishment through a change in law subsequent to the act in question.

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5.44 RCW 10.77.145 and RCW 10.77.270 violate the *ex post facto* clause by punishing Plaintiffs and others under a law that that was passed after they were acquitted, and imposing conditions of confinement that were not present when they agreed to plead NGRI. These statutes are, therefore, unconstitutional, invalid, and unenforceable.

5.45 Plaintiffs are thus entitled to declaratory and injunctive relief prohibiting Defendants from enforcing RCW 10.77.145 and RCW 10.77.270, as well as reasonable attorneys' fees and costs incurred in bringing this action.

5.46 Absent the requested relief, Plaintiffs will continue to suffer irreparable harm.

5.47 Plaintiffs have no adequate remedy at law.

VI. PRAYER FOR RELIEF

Plaintiffs respectfully pray that that this Honorable Court enter an Order:

1. Assuming jurisdiction over this case.

2. Declaring void and nullifying RCW 10.77.145 and RCW 10.77.270 to the extent that they violate and are preempted by Title II of the ADA and Section 504 of the Rehabilitation Act of 1973, and the regulations promulgated thereunder, and/or violate Plaintiffs' rights to: procedural and substantive due process and equal protection under the law as guaranteed to them by the Fourteenth Amendment to the United States Constitution; and right to not be subject to *ex post facto* punishments under Article I Section 10 of the Constitution.

3. Preliminarily and permanently enjoining Defendants from:

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a. Confining patients pursuant to RCW 10.77.145;

b. Preventing or delaying forensic patients' participation in clinically appropriate community-based treatment;

c. Confining, or failing to seek the release of, patients who are deemed by clinicians to be longer both mentally ill and dangerous;

d. Placing patients in shackles without specific, articulable and contemporaneous safety concerns; or

e. Denying or restricting patient property without an individualized determination based on clinical need or risk.

4. Awarding Plaintiffs reasonable attorneys' fees and costs.

5. Awarding any other relief the Court deems just and proper.

DATED this 19th day of December, 2014.

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CERTIFICATE OF SERVICE

I, Andrew S. Biviano, hereby certify that on December 19, 2014, I caused to be electronically filed the foregoing document with the Clerk of the Court using the CM/ECF System, which will send notification of such filing to the following:

Robert A. Antanaitis	Robert A1@atg.wa.gov stacyo@atg.wa.gov DorothyS1@atg.wa.gov KathrynS1@atg.wa.gov JeffreyN2@atg.wa.gov BeverlyC@atg.wa.gov
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DATED this 19th day of December, 2014, at Spokane, Washington.

THE SCOTT LAW GROUP, P.S.

By: *s/ Andrew S. Biviano*

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