Episode 3 - Civil Commitment

[Music]

SYP
I think it's very healthy and good to have people who are not faced with these horrible catch-22s to be able to see the bigger picture and say, "Actually, none of this should be happening." And it's a lot harder once you're inside the system to ground in that.

Laura

I always felt for the patients that when I left a ward and had to lock the door behind me, they didn't all automatically lock, I always felt that I was committing a crime that I was locking people in.

[music**]**

Meredith:

Hi everyone, this is Meredith

Leah:

And this is Leah. Welcome back to Episode 3 of “In-care-ceration”, a podcast that explores the connection between jails, prisons, and behavioral healthcare in Washington State. We are both members of the No New Washington Prisons collective, a group of incarcerated and non-incarcerated community members seeking to end investment in Washington’s prisons and carceral institutions.

In our last episode, we talked about the concrete links between the criminal legal system and forensic hospitals whose purpose is to make people “competent” to be prosecuted. We talked about the drive to expand these spaces. This time, we’re going to dive further into psychiatric commitment, and thinking through jail-like practices of hospitals.

Meredith:
Ya, we’ve been talking about how incarceration expands through the concept of providing “care” but what is the “care” available for people with acute mental health needs? Politicians and even regular people often point to the need to invest in hospitals and other institutions as a way to break from more carceral and coercive forms of social control like jails and prison. We can’t speak for the people we’ve interviewed but to us, it seems like an investment in psychiatric hospitals where people are held against their will is eerily similar to the investment in jail and prison institutions that do the same – just with a nicer face.

Leah:
And, tying back to the overall issue, like we started to discuss in the last episode where we talked about No New Washington Prison’s unsuccessful campaign to stop the expansion of Western State Hospital – what makes it so difficult to divest from these systems and invest in other forms of care – what we might think of as real care?

Meredith:
To help us with these questions, we;ve interviewed SYP, an ER nurse in rural Washington and Laura Van Tosh, a long-time advocate for improving treatment of patients, also known as “survivors” or as “consumers” of the behavioral health system. Laura has both been held at and worked at Western State Hospital. Both of these folks know a lot about Washington's psych system, and they both also have a lot to say about what seems coercive or carceral about psychiatric care in Washington State. They’ll also share some reflections about how to navigate the psych system to reduce harm.

[music]

Leah:

So to start, we’re going to go through how these two understand the psych system in Washington works. We’ll talk first with SYP, who we also heard from a little bit in episode 2. To remind you, SYP is not only an ER nurse but someone who has worked as a street medic and also in an abolition-oriented crisis care setting. SYP, can you walk us through what happens when someone goes to the ER looking for care during a mental health crisis?

SYP
When I talk about working in the ER, going to the ER is a tool that we all have in our toolkit if we need it medically or psychiatrically. And so knowing what that tool or resource is, is important, because otherwise it's kind of this black box, and we don't know – or people who go to the ER just don't know the process of how the psych system works. And then it becomes really traumatic. And it could be traumatic, either way, but if you know how it works, then you kind of know what you're in for and whether you want that or not. And so, I do think the only voluntary moment of psych is when you walk through the door or are brought in. And so it's really key that people are aware of that.

I see a lot of people getting caught when they come in voluntarily, realize they can't leave, and then it becomes hell. And that makes a lot of sense because it's very strange to walk into a setting that you think is voluntary and realize that it's not. But actually the moment of walking into the ER is a voluntary thing that we can talk to others about.

So you walk into the ER, and you disclose that you're supposedly at risk of hurting yourself or hurting others. And there's a lot of bias that goes into that, of course, from providers, from the triage nurse--the nurses are the ones who are doing the triage, so it all comes down to what nurse you have.

Meredith:
What comes next in the process for the person who walks in?

SYP

And so then the process, which I'm sure you know about, is then the doctor will assess them, and it's the doctor's call, not the nurse's call, whether to call a DCR, a Designated Crisis Responder, to the bedside….

And the DCR is the only person in the whole mental health system who has the power to say someone is going to be involuntarily committed or not.

I can call the DCR, I've done this many times, I've called the DCR back repeatedly and said your decision was wrong. You know, that's not the correct decision. At that point, it's a legally binding document, they write. And so then to fight it becomes a lot harder. And so intervening before the DCR makes a determination is really the point where I talk to family, I call in all the resources I can, I talk to the DCR, I get witness statements, and say, you know, this would not be an appropriate fit for involuntary treatment.
I think it's worth noting that also the DCRs, just like everybody else in this system, are doing their jobs out of what they think is care, and also are all personally impacted themselves. And so it becomes really thorny.

Meredith:
Okay so someone has gone to the ER for help, or been taken there, and the DCR has decided that they are going to harm themselves, someone else, or can't take care of themselves to a level where they are in danger.

Leah:
Then what? How does someone go from asking for help at an ER to being involuntarily held at a hospital for days, weeks, or months?

Meredith:
Now we're entering into civil commitment territory

Leah:
Right, different than forensic commitment - there's no criminal offense, no one is being prosecuted.

Meredith:
True - no one is being prosecuted, these folks are in a medical facility or a hospital, not jail. But, they're still being held and there's still a legal process. The DCR makes the decision, and people can be held for 120 hours based on that.

Leah:
Not including weekends or holidays.

Meredith:
Yes. So the initial facility or responder, usually a hospital, has an initial 120 hours once the DCR files a "petition" based on their decision. After that 120 mark, the person being held is entitled to

a court date to see whether or not they'll be involuntarily committed beyond that, usually for 14 days to start but the facility can petition for a longer stay (90 days) after the 2 weeks.

That stay could be in a hospital or a smaller, private behavioral health facility. When commitment might get pushed to the 90 days, that's when people end up in state hospitals. At court, the person is also entitled to a public defender. A lot of times what happens in that hearing, the court is just going to take the position of the medical provider who evaluated the person. So if that medical provider says they're still a danger to themselves, others, or "gravely disabled" that's probably what the court is going to say.

Leah:
And if that person gets held longer, they get a review after 90 days but could be held beyond that…

[music]

Leah
So you have a person who is being involuntarily held, going through a court process led by a prosecutor, with a small number of decision-makers getting to decide on their freedom.

Meredith:
Sounds a lot like jail to me. We're going to get a first-hand look on what it's like to be committed from Laura Van Tosh. Laura, can you introduce yourself?

Laura:
Okay, great, and just stop me when you need me to, if you don't mind. I have a long resume of working in the field, but also a fairly long story as being a survivor, and what people call "peer" or "consumer" activity as well, and – Anyhow, my name is Laura Van Tosh. I live in Seattle, Washington now, however, most of my career has been working in the DC metro area, basically on mental health policy, specially from a peer consumer perspective. I'm back in Washington after being away for quite a while, and then away and back another period of time when I actually worked at Western State Hospital, and then way before that I was a patient at that hospital. And now my perspective has been about really taking a hard look at the reasoning for having these large institutions, and the fact that we could certainly be reinvesting dollars that are not spent on incarceration, to a community based service system that's patient centered, patient driven, and what I mean by that are actually where people who are— who are survivors of the services can work in the system and make our services much more amenable to people in need, and representing kind of a community based civil rights movement where people should not have to be locked up in order to get care.

Leah:
Laura was hospitalized at Western State Hospital as a young person. We asked her to tell us about that experience.

Laura
At 19, I was hospitalized in a state hospital, so— and then I was homeless right after that, and for a brief— considered a brief period of time, and then back into the community based services system at a clubhouse, which is a different kind of community based program, not in-patient but kind of day services. So my experience has generally crossed the definitions of the terms in many ways. When I was in the hospital, especially the state hospital, it was really a dismal environment, with actually not crowds and crowds of people. The days of those crowded wards had come to an end. This was the late 1970s and there were still large, very large state hospitals with fewer people than way in the, way way in the dark ages of those facilities. So I did notice, however, even with fewer people, that people were treated – were mistreated, wherein their needs were barely addressed, it was sort of a custodial environment.

Leah:
One of the aspects of civil commitment at Western State that Laura really highlighted for us was how hard it was to get out once she was in.

Laura
Unfortunately, it took a really long time to get people out of Western State, even when I worked there. And when I was a patient, I had like a rally or demonstration of one, which was me and in order for me to get out, I actually sat on the floor of my social worker's office, when the door was closed, before she got to work every day. And when she walked by me to get into her office, I'd always say, "Can you get me out of here?" and she finally did, but it was not "yes" the first time.

I don't know how long but it sure feels like it was long. I mean, I think when you decide to do that, it's already been too long. You know what I'm saying?

[music]

Meredith:
Laura, can you tell us what it was like to be staff at Western State after having been a patient there? What were some of the issues you saw?

Laura
25 years after I was a patient at Western State Hospital, I worked there, I was hired to be the Consumer Affairs Director. So I came back after a long history of working in different kinds of programs and environments, and it was a lot to take in. The buildings were basically about the same. They've done some kind of, on the ward— —what's it called when you remodel? Remodeling took place, but the buildings were basically the same. The doors were basically the same, the locks were basically the same. I had a set of keys when I worked there. So that was sort of bizarre in a way, to go on wards that I may have been a patient on and had a key, and also the feeling you get when you lock yourself in and how that might feel. Especially, I always felt for the patients that when I left a ward and had to lock the door behind me, they didn't all automatically lock, I always felt that I was committing a crime that I was locking people in. And I never really said that until now, to be honest with you, that I was committing a crime but I kind of

felt that I was doing something like this, that I never would want to lock other people in but I had to because it was my job, that kind of mentality

…Anyhow, I did do a lot of good in that job. Unfortunately, though, I was the only one that was kind of out of the closet in a very – there were over 2000 staff— people were staff, there were about 1000 people total. And I think that more could have been done if there weren't leadership changes and really disasters that happened at the hospital, no disasters with peer staff like myself but just general issues that occurred that were really devastating to the system at large….

And they never had other peers permanently in roles that they could have had. So I've always had kind of a bad taste in my mouth about the way the system is kind of— the way we let the state hospital fall to pieces.

[music]

Leah:
Western State Hospital has been the site of a number of scandals, dangerous situations, and abuses -- understaffing, workplace discrimination, litigation around sexual harassment, violence between patients and staff, escapes, and what Laura has highlighted above -- excessively long patient admissions. And then in 2018, after years of problems identified in inspections, Medicare and Medicaid stripped the hospital of its federal certification, which meant it lost access to $53 million in federal funding. We'll link to some news coverage of this in the show notes.

Laura also talked to us about some of the aspects of psych commitment that feel carceral, in addition to being held involuntarily for long periods of time, whether at Western State, a hospital, community facility, or an ER:

Laura
We chain people to beds for what they call it "boarding" in emergency rooms. If we don't have a hospital bed, we put them in an emergency room to which I was there not long ago, I had a slight episode where I needed help. And I was in a boarding situation in an emergency room, and then eventually I got a hospital bed. After that happened, things moved quicker, but I was still in that boarding situation which is retraumatizing. And those kinds of things kind of add on a lack of trauma-informed care that we have grown accustomed to. I say that's another issue that's the same then as it is now, we're not taking trauma seriously enough to start remodeling our, or modifying our community based services so that we don't put people in handcuffs when they're in crisis because that's retraumatizing, and we do that now. So there are a lot of actions like that that need to be closely examined and changed.

Leah
I picked up on when you said that you felt like you were committing a crime when you were locking someone in, and it's interesting you said that because so often the experience of being

in crisis and asking for help— seeking help leads to the person who's in crisis being put in handcuffs, restraints, being locked in.

And that is the experience also of feeling like one committed a crime.

Laura
Yes. Yeah, it's very very hard. It was very stigmatizing, it just really— it makes people who thought about stigma even more likely to think it again, which are generally our safety officers, peace officers, which are cops, they often don't understand us. So they're retraumatizing without even realizing it, and playing, it's a blame game. It's a who's on top and who's not, you know, kind of issue. And that's all like George Floyd, that's stepping on the neck, completely. And, you know, we've got to stop, that just needs to be taken out of the tutorial of the way we have these services. Every service training video needs to take out the part when you're handcuffing people, you know, erase it from the tapes, you know, basically.

I would know without speaking and working at Western State Hospital, I would actually counsel people that were in restraints. I didn't restrain them but someone else did, and then they would call on me, and ask me to sit with the person while they were in restraints, which kind of bothered me on that issue, but I also was helping them get through the experience. And then eventually they'd be out of the restraints, you know, that was the goal. But to some degree, they're— it's like, you know, being a criminal and knowing how to operate inside a jail or a prison, you know, there's some mentality that comes into play where you know you're surviving what's going on, you know?

[music]

Meredith:
Laura has just had such a varied experience and knows

Leah:
Knows everything that is going on basically.

Meredith:
Exactly -- but we also wanted to get some perspective on just being in the ER and what that process is like from someone who is currently working in the field. We asked SYP to reflect more on the system for psychiatric commitment in Washington, and she also brought up ways that she saw this system as being carceral.

SYP
Yeah. I've come to a place where I think by definition, it's carceral. And I have a little bit more nuance around it than I used to. I think the thing that makes it bad is that it is carceral, but not the fact that it's involuntary, if that makes sense.

I'll just speak for myself--the thing that I oppose is not actually the involuntary part of it because

I think there is a time that I might not be able to make my own decisions or care for myself, just like if I'm dying, or if I'm being born, or if I'm very, very ill. So that's not the piece that is actually the problem. The part that's the problem is the implementation of how we do that is carceral. And I think it is based in the desire for care, people do care who are working in these systems. And the families around people do care, but it's the way that it's implemented that immediately gets twisted and feels so awful, and so punitive and harmful.

The way it's implemented is--I mean, just the way that psych wards are set up with individualized rooms, with, you know, forced medications, which is a whole other topic that I'm completely opposed to. I think there are things about it that make it really messed up and traumatic. I think it could be done better. But it's this really sad situation where everybody in the system doesn't want it to be working the way it does. Most of all, the person who's seeking help or being… But it's hard because it's almost like this alternate world or reality where you could see what it could be, and it looks in some ways similar. The way it was set up was not to be punitive in the way that prisons are, from what I've seen. But the way it's implemented and the way it actually looks, ends up being very punitive feeling, and is.

Leah:
It's a fine line between care and coercion, isn't it?

SYP:
Yeah. I think that a lot of that comes from--I mean, when I think about coercion, I feel like coercion is often out of fear of what we think people, the harm that people might do, like I think about drug courts and coercive recovery, and then the warrant and how that comes from the War on Drugs, or people who are using drugs and then are hallucinating and do not need to be injected with Haldol or involuntarily treated--those feel really coercive to me. And all of that for nurses, I think, is because there's no staff training time, like real care, dedicated to distinguishing those situations from people who might actually benefit from resources that they don't have.

[music]

Leah:
One intersection between healthcare and jails and prisons that maybe doesn't get talked about enough is how healthcare facilities can get more and more security focused in the name of protecting nurses and healthcare staff from patients. We talked about this for a while with SYP.

Is there conversation at the nursing station about safety and security at the workplace? I ask because someone brought our attention to how the nursing union at Western State Hospital had worked towards hardening the nursing station around – around the issue of forensic commitments, and safety and security of the nurses who are working there. Hardening the station meaning putting thick plexiglass, like plastic--around the nursing station and separating the nurses from their patients. Just wondering what you all are talking about, or what you're hearing.

SYP:
I've been hearing, you know, ongoing there's always this talk of workplace assault, like the ENA, the Emergency Nursing Association, has their magazine out this month, the entire topic of it is workplace assault. But then, of course, I read the Disability Rights Washington report a couple years ago about how many people are going from ERs and inpatient units into jails because of charges being pressed against them.

Leah:
Just to give context, we also read the report – it came out in spring 2020, so it kind of got buried at the time. Disability Rights Washington found that in just one year, calls from medical providers to police at 7 facilities in Seattle resulted in 100 arrests of patients in mental health distress. The report documents a tendency to handle understaffing and overextension of the mental health system through a reliance on police and jails. Back to SYP.

SYP:
Again, it's like this call I had with the campaign and the union rep where nurses really are being assaulted, it's true. And being hurt and sometimes becoming disabled themselves because of assaults. And I think people don't understand – I really think that many nurses and people working in health care don't understand the prison system and what a charge against someone actually does and the weight that a health care worker's report can have in charging someone with a felony. I saw that recently because somebody came in and threatened to shoot up the whole unit--this happened just a month ago--and then left. And...

Leah:
Where you work?

SYP:
--where I work, yeah. Because they didn't like the care they were getting. And I think this is the thing with abolition, right, of course is – I did feel threatened. I did not think that person should be charged with a felony. My coworker, the doctor, called and had him arrested and charged with a felony. I was really upset by that and it took me a while– and sometimes it does, it takes me a few days--but I did confront her. And I was like, "Do you understand what a felony charge is? Do you know what you've just done to this person?" I really don't think she does, and that makes me--that really hurts because it's like there's – I just think that there is this idea that people have around workplace safety that maybe if I call the police or security and this person will go to prison, then they won't do this again. Of course, that's just not, not how the policing system works, and it just hurts people and puts them in prisons, so.

Meredith:
Or - I think we've talked about this, but an idea of like, "I just want this person to be somewhere else and handled by someone else, that is not me." But that is, I mean it is understandable to feel threatened when somebody literally threatens you and trying to hold space for like, what are

the consequences of my own actions and my inactions in this situation, is difficult. I'm sorry that that happened to you.

SYP:
Yeah, I think also one - just different articles I've read have always said that the thing that would make workplaces safer, especially ERs, is better staffing. Like it's just clear. And somebody does not need to be in restraints, for example, if there's somebody who can hang out with them, and sit with them. I think all of the safety issues I've had have been patients who are really understandably frustrated by not getting the care they need. And it's because I have eight patients, and one of them is intubated, and I just do not have time. What I would want in that situation is maybe two or three other nurses, not security to go tell that person off. So I think that there is some disconnect there for a lot of coworkers. At the same time, I do think that many nurses I've met are pretty protective over their patients and don't actually want police interfering with their care. So I think these conversations are sometimes being handled well by unions, at some times not well by unions. But kind of at this baseline people want to have the time they want to spend with patients, with the staff that they need to not feel threatened, to feel safe. I don't think people want police, but I think when it turns into these large systemic conversations, people just don't really know what else to do. Except ask for more security or for like a hardening of the nurse's station.

Leah:
In their book "No More Police", Mariam Kaba and Andrea Richie call it "soft police" when nurses and social workers and teachers turn towards increasing security and social control. Its so complicated, of course, when healthcare workers, who are workers, feel unsafe in their jobs, and so we really appreciated getting SYP's thoughts on this from a worker's perspective.

[music**]**

Meredith:
There's another perspective here on psych hospitalization that we'd also like to share, which is the notion that hospitals function as prisons, and that psych hospitalization should be abolished. This view emphasizes how psych facilities extend control over people's lives, strip autonomy and self-determination, re-traumatize, and segregate people.

At a teach-in on the Western State Hospital that we hosted we heard from Cindi Fisher. She is the mother of someone who has been involuntarily hospitalized and experienced great trauma in Washington's psych system, including at Western State Hospital, and among other things she had this to say:

Cindi:
It's a prison. It's a hospital in name, but its a prison. And why do so many people think we need more beds? It's the two-edged sword. Yes, we have thousands of people being mistreated, dehumanized in the jails. But we've never put funding into the hands of the people most impacted, where they get to be the majority of the decision making on what happens.

Meredith:
We will hear from Cindi a bit more in our final episode which looks at efforts to build care without carceral control. Here, we'd also like to highlight the work of Fireweed Collective and the Institute for Development of Human Arts -- two organizations that have generated a lot of resources and materials on psych abolition including webinars, analysis, tools, trainings, and more. These two groups' rooted in the experiences and knowledge of people who have direct experience with these institutions and who are building ways of caring that don't invest in carceral control. We'll add some of their materials in the show notes.

[music**]**

Leah:
SYP and Laura both had reflections on how to navigate the entry point into the psych system in order to avoid involuntary commitment and that level of control. We wanted to make sure to air their reflections on this:

SYP:
When I talk to someone and they say something, of course I don't listen to mandatory reporting laws. It's not about that at all. It's just about whether I legitimately wonder whether this person is okay, has the resources to be able to live a life they want to live or not. And then, of course, because of my organizing background, I think whether the resources we have are something that would be useful at all to them. And so even, it'll go so far, even to if somebody comes in and says that they want to kill themselves, then I say, Okay, well, here's the psych process, do you want to activate that process or no? Or is there someone you can call that is actually better than this process? Or, you know, it often happens that it's a teenager. And so even more so I talk about, to the teenagers, I say, here's what this process looks like, here's what you're up against right now, if you tell me this and I take it seriously. Do you want me to do that or not? Sometimes I feel like it is the best thing to do, even knowing this system is harmful. Sometimes, like somebody walked in the other day and had been--you know, I can tell you so many examples, but people who have already overdosed on their pills and are coming in and are about to lose consciousness. This is somebody who I'm like, Okay, this is a medical situation, it's also a psych situation, I'm not going to stabilize them and then send them back out without doing something else.

Meredith:
Honestly, it's hard even to think our way around this - people do come to the ER looking for care. Some people are able to get what they're looking for and it seems like many people are not, at least not without the possibility of being institutionalized.

Leah:
And based on what we've heard, being held for a long or short time might simply depend on which nurse or practitioner you're dealing with.

Meredith:
If you've never been through it before, you might not know that you can walk in voluntarily and then not be able to walk out. Or if you do have experience, you might be able exit more quickly on your own terms.

[music]

Leah:
We asked Laura about Emergency Rooms since she has had the experience of being committed (or not committed) after an ER visit. Laura recently had an experience at an ER which might be helpful for people to hear about.
Laura, can you talk us through what happened when you were hospitalized in the ER? How were you able to get through that experience without being held for a longer period?

Laura:
I have to say that I know I'm using my own experience and my own experience is only my own, but I know darn well, that there was a point where things could have taken a turn for a negative and I could have been put in a state hospital, and instead, I was using my head, I was actually very quiet during my stay in the emergency setting, and it was deliberate. And I'll tell you, that being quiet can actually be a lifesaver. One, you're listening to everything, and then if you're not, you know, making the staff feel uncomfortable, then when you speak, they actually listen, because you're not talking the whole time, and they obviously think something you're about to say is going to be important. And whether it is or it isn't they're patient, I think, about that. I felt lucky to be in the environment that I was in but the thing that was the clincher to me was actually engaging my therapist in the process, who immediately got in touch with the social work department, and immediately got in touch with this hospital staff of the hospital. And they had what's called the hospitalist, which is some kind of a role for the MD who is sort of like a primary care psychiatry expert, who watches, which is mostly for financial reasons, but watches how things are going in the environment, and then they make the call, usually about certain things that have to happen. And I kind of— my hospitalist kind of befriended me, and then my therapist really liked her and had a good relationship, rapport with her, basically on the phone, until he came to see me. And I was like, the last thing that would be good to do would be to talk. So I was quiet and I let them do their thing. And I felt that I was doing the right thing. And I think also engaging my therapist triggered the hospital to allow them to assign a peer to me. There was a peer employee based out of a provider that worked in the emergency room, and she came over and met with me and gave me a cell phone. I had lost my phone along the way, and so, even though I didn't really even have any phone number. Well I memorized my— my therapist….

Laura:
If someone's like, on the verge, that's one thing, if someone wants to learn more, I would highly recommend that you learn more about the commitment laws before you have a problem. And if you want to keep people from being committed, read the law of what happens when you do get committed. That's about all. There isn't a law of what happens if you do and, I mean, there's no

literature on how to not get committed, unfortunately, but there's plenty of laws and and, you know, journal articles and stuff about people who get committed.

[music]

Meredith:
A lot of what I'm getting from these interviews is that people end up in the ER and then possibly in a longer term hold when they don't have anywhere else to go. There aren't non-carceral options available to folks. One option that has been suggested is to make Crisis Care centers more available for people who need short-term assistance with stablizing. Although this discussion doesn't align perfectly with the other topics in this episode, namely hospitals, we still wanted to give Crisis Care centers some air time because they keep coming up and to be honest, we're not too sure about them

Leah:
Yeah we aren't. So, here's a little bit about them. In 2023, King County put funding for Crisis Care centers on the ballot, and it won. A Crisis Care center is supposed to be a place where people can walk in and get help rather than going to an ER. They provide "stabilization" services for up to 14 days before being discharged or referred elsewhere. Crisis Care Centers are a response to the lack of behavioral health services in the County, again using the language of care to get community to support funds being used in this way. Laura spoke to us a bit about her experience with crisis care:

Laura:
You know, I think there's always the problem we have, and that's why in the crisis system is I hope can save people a little bit is that we, we only talk about commitment, when we want to put someone somewhere, you know, the commitment goes to the bed, it doesn't go on some plan and on another in another universe, or on some puffy clouds somewhere, it's actually a bed in a place, which is dark and can be scary. And so, you know, unfortunately, we don't have a lot of those places yet. I have some issues about cookie cutter models. However, there's the model in Arizona, they're called Recovery Innovations. They're kind of a big national outfit, called Recovery Innovations. And you can search them. And they have a model that, for crisis beds, that other states are wanting to emulate. And I have a lot of mixed feelings, because some of these facilities, if you want to call it that, are like lounge chairs and waiting rooms. And I'm serious. They are lounge chairs. And they sometimes in our, we have a bill like that. And in our bill we called it Lazy Boy, they actually use the term lazy boy in our bill, like, Oh my God.

It's kind of weird and I hope we don't go there. But King County, by the way, the first facility in King County that's going to be open, it's going to be 2026. So we've got a lot of time. I'm on a work group now. And they've actually done a pretty good job of putting people on really good work groups and getting us going. So we're hopeful that we can actually, you know, sit back and not rush that, you know, because, and I was actually when I was homeless in 20...it was like 2013, 14, and part of 15. I actually ended up in Phoenix at one point and ended up in one of those reclining chairs in a very crowded provider office that looked like it had been a dentist

office or something before it became what it was. And I couldn't wait to get up and out of that building. And I did because I couldn't stand it there. And so I let people know that I've been there in these facilities that they want to – some of them want to copy that I'm not, I'm not for at this point. I think we can be a little bit more creative than that.

Meredith:
"Improvements" to the system we've seen so far involve more beds or more protection for staff (which seems to me is just the jail-i-fication of hospitals and treatment facilities)

Leah:
And it seems like this has been the direction for years.

Meredith:
I hope that there is room for advocacy in the King County crisis care centers to make them… not like that.

[music]

Leah:
In the final episode of this series, we're going to get deeper into how different people we've talked to actually think about care and create different models for care without investing us further into coercion, confinement, and isolation, and without building bigger and more complex spaces for locking people up. Come back for our final episode for our most in depth discussion of that.

In the next episode of In-care-ceration though, we're going to look into Washington's jails and how counties and cities in Washington State are using care as justification for building more jails.

[music]

Meredith:
Thank you for listening to In-care-ceration! This podcast was written, produced, and recorded by us — Meredith Ruff and Leah Montange. Our In-care-ceration music is by Scout Smedley. Our editor is Nest Audio Co. We received funding for this project from the Institute of Human Geography.

We'd also like to thank Laura Von Tosh and SYP for your interviews that shaped this episode! See the show notes for links to resources. And check out No New Washington Prisons on Instagram.

[music]

Show Notes:

Episode 3: Civil Commitment

In this episode, we take on the topic of civil commitment and experience. We address hospitalization, the emergency room, and the perspectives of people who work in the system and who receive treatment. We address ways that civil commitment resembles incarceration. We speak to SYP and Laura Van Tosh, and feature the words of Cindi Fisher – all people whose lives and advocacy have intersected with the civil commitment system. This episode contains descriptions of civil commitment and emergency rooms, including discussions of suicidality. Music by Scout Smedley and editing by Nest Audio Co.

Relevant news articles:

Joseph Wainer - There's a Crisis of Violence at Western State Hospital. I Know, I Used to Work There

Joseph O'Sullivan - Western State Hospital loses $53 million in federal funding after failing inspection

Updates:

Eílis O'Neill - Seattle Just Got 150 Psych Unit Beds - Is it Enough to Make a Difference?

King County DCHS Blog - First-Of-Its-Kind Behavioral Health Crisis Center Opens in North King County

Resources:

Disability Rights Washington - From Hospitals to Handcuffs: Criminalizing Patients in Crisis - https://disabilityrightswa.org/reports/from-hospitals-to-handcuffs/

Mariam Kaba and Andrea Ritchie: *No More Police: A Case for Abolition*

Fireweed Collective - https://fireweedcollective.org/

Instituted for Development of Human Arts - https://www.idha-nyc.org/