A Merry Go Round that Never Stops:
Mental Illness in the Multnomah County Detention Center

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Disability Rights Oregon extends deep gratitude for our ongoing partnership with the Lewis & Clark Law School Criminal Justice Reform Clinic. In particular, we wish to thank Professor Aliza Kaplan and law students Jody Davis and Hannah Teig for their valuable contributions to the development of this report. Thanks to Chad Marquez for taking the photographs that are used in the report, and to volunteer Phyllis Burke for assistance with monitoring visits and interviews. Finally, thank you to DRO staff Joel Greenberg, Kathy Wilde, Bob Joondeph, Esther Harlow, Elizabeth Seaberry, and Jamie Jones for your valuable editing and formatting assistance.

Disability Rights Oregon is tax-exempt under Section 501(c)(3) of the Internal Revenue Code. Contributions are tax-deductible and will help us provide services to Oregonians with disabilities.

This publication was funded 100% by support from Substance Abuse and Mental Health Services Administration (SAMHSA). These contents are solely the responsibility of the grantee and do not necessarily represent the official views of SAMHSA.

Disability Rights Oregon is the Protection and Advocacy System for Oregon.

Cover photo: MCDC Psychiatric Infirmary, photography by Chad Marquez

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Introduction

When a community fails to invest in mental health and social safety net services, its jails fill with people who are held because of behaviors driven by their psychiatric disability. Jail is frequently described as a "revolving door" because people with high needs are re-incarcerated at alarming rates. The Chief of Police for Pendleton, Stuart Roberts, analogizes the criminal justice system for people with mental illness to a sickening merry-go-round that spins faster with each touch. Court dates, probation, and even specialty mental health or drug courts all present a complicated set of requirements, dates, and directives that share a common penalty: jail time. For a person who is not mentally equipped to meet these requirements, the justice system is a trap.

This report examines what happens in Multnomah County when a person with a severe mental illness gets caught in that trap. It makes recommendations on how the County can use its jails more efficiently and effectively to improve the lives of those in its custody and better protect public safety.

The conditions in Multnomah County are emblematic of flaws found throughout the state. Shortages of affordable housing, supportive housing, mental health services, dual diagnosis drug and alcohol treatment, and medical/behavioral health respite care mean both that people with mental illness are disproportionately in the streets, and that law enforcement agencies lack resources to offer in lieu of jail. The jail in turn is overwhelmed with the steady flow of individuals who have intense behavioral health needs. Medical and mental healthcare in jail is woefully inadequate and so the jail relies on correctional tools: rampant use of solitary confinement, punitive use of restraints and suicide watch, and routinized force against people with mental illness.

There is a growing body of policy recommendations that address overrepresentation of people with mental illness in the criminal justice system. On a local level, there is no shortage of recent reports on various important topics at stake in Multnomah County's criminal justice system, including racial disparities, violence in jail, diversion of arrestees with mental illness, and justice reinvestment initiatives. This report is intended to contribute a critical and often missing element to the conversation by viewing such concerns through the actual experiences of individuals with mental illness who are ensnared in this system.

As the federally designated Protection and Advocacy System for Oregon, Disability Rights Oregon (DRO) has the authority under federal and state regulations to monitor facilities that care for or confine individuals with disabilities, and to inspect individual

records if we suspect abuse or neglect of a person with a disability. This access creates a unique ability and duty to discover the conditions in which people with mental illnesses find themselves and to develop an in-depth understanding of their experiences through interviews, observations, and review of records.

The stories contained in this report present complex facts that defy simple solutions. These are individual stories that may not be representative of everyone's experience in the jail. The report is organized under headings describing various problems in Multnomah County Detention Center, but the individual stories are not necessarily meant to illustrate a policy flaw or bad practice. Rather, they are presented for their own sake, in their complicated entirety, with the hope of conveying a deeper understanding of the profound suffering that is a constant reality behind the walls of the Justice Center – right in our midst and yet invisible to the public eye.

Methods

Over the past two years, DRO has conducted monitoring visits at Klamath, Lincoln, Yamhill, Clackamas, and Lane County Jails. These were generally two-day visits involving a tour, review of policies, interviews with jail leadership and medical staff, cell-front contact with many detainees in restrictive housing units, and confidential interviews with 10-30 detainees. We also visited with dozens of individuals in the Department of Corrections intake unit at Coffee Creek Correctional Facility, and we make regular contact with hundreds of state hospital residents who hail from jails around the state.

During the past eight months, DRO has focused our attention on Multnomah County. We have conducted monitoring visits in the Multnomah County Detention Center (MCDC) on five occasions, and toured Inverness Jail. Our visits involve informal conversations with staff, viewing all areas accessible to detainees (such as the booking area, the clinic and recreational space), and spending extended time talking to detainees in the housing units (in particular, the psychiatric infirmary, medical infirmary, disciplinary housing, designated mental health units, suicide/special management units, administrative segregation and protective custody). We held brief cell-front conversations with detainees during these visits and followed up with confidential interviews with a cross-section of individuals. Approximately 45 people detained at MCDC were interviewed in confidential settings. Most of those interviews arose out of our cell-front conversations, but we also responded to direct inquiries to our office from detainees, and referrals from public defenders and family members.

We additionally reviewed thousands of pages of records related to incident reports and uses of force at MCDC, inmate discipline, and medical care both at the jail and at private hospitals or the Oregon State Hospital. Sometimes we accessed these records with a signed release of information. When we had credible evidence of abuse or neglect of a person with a disability whose whereabouts were unknown, we invoked our records access authority as Oregon's federally designated Protection and Advocacy System.[1]

We interviewed staff in leadership positions with the Multnomah County Sherriff's Office (MCSO) and Multnomah County Health Department Corrections Health. Via email, we invited all Sherriff's Office and Health Department staff who work at MCDC to contact us to arrange a confidential conversation (via phone, email, or in person) regarding conditions in the jail. Three Sheriff's Office staff agreed to speak with us. No Health Department staff members agreed to speak with us.[2] We also interviewed a psychiatrist who spent a six-month rotation at MCDC as an OHSU forensic fellow.

The Sheriff's office has facilitated our access to the jail, cooperated with requests for records, and

[1] 42 U.S.C. § 10805(a)(4) (2012); 42 C.F.R. § 51.41(b),(c) (2016); Or. Rev. Stat. § 192.517 (2015).

[2] One Health Department staff person did agree to speak with us, but he worked infrequently on an on-call basis and had little relevant information.

has worked with DRO throughout the investigation in a spirit of openness and collaboration.

To protect the privacy of the individuals who we interviewed and whose records we reviewed, no real names or initials are used in this report. References to names in the narratives presented are pseudonyms.

1. All Roads Lead to Jail: Criminalization of Mental Illness

"If we had the services in the community, I could take 100 people with mental illness out of the jail tomorrow."

- Judge Ed Jones, Chief Criminal Judge for Multnomah County Circuit Court

In jails that we visited around the state, the Jail Commander expressed concern about people in his or her custody who should not be there; people with mental illness (often combined with another need or barrier such as poverty, addiction, or other health problems) who have been funneled into jail not because of "criminal" behavior, but because of the lack of resources in the community and lack of public tolerance for mental illness related behavior. DRO has also witnessed a tension between jails and hospitals over a population that neither facility seeks to house or treat. Hospitals turn away patients who are deemed not to meet hold criteria for a civil commitment and sometimes hospitals proactively send patients to jail because of behavioral problems or the patient's reluctance to discharge. Law enforcement feels obligated to charge and jail these individuals because they lack other resources to ameliorate an untenable situation. Jails are a uniquely nontherapeutic environment, but they are nevertheless inundated with detainees who have significant mental health problems.

The lack of alternative destinations (other than hospitals or jail) was identified by the January 2015 Multnomah County Feasibility Assessment Mental Health Diversion Project as the most prominent system gap standing in the way of decriminalization. Creating a 24-hour crisis drop-off center was the primary recommendation of that report. Advocates are hopeful that the recent opening of a new psychiatric emergency services hospital, the Unity Center for Behavioral Health, will meet some of these needs, but not all. Unity's criteria for a pre-booking referral from the jail is limited to individuals with minimal criminal history (relative to psychiatric history), a low risk for violence or aggression, and "ideally" willingness to engage in mental health treatment post hospitalization. Unfortunately, aggression, mental illness, distrust of providers, and criminal justice involvement are factors that are often quite entangled. Many people

will not meet diversion criteria for Unity, and those that do may be difficult to identify through a brief pre-booking screening.

The story of "Mr. Novak" encapsulates the many ways in which our current clinical and criminal systems collectively fail, neglect, and ignore people with mental illness. Mr. Novak was arrested and jailed for non-violent, disability-related behavior that occurred in the inpatient psychiatric unit at Oregon Health Sciences University (OHSU). His arrest triggered a saga of jail time under abysmal conditions interspersed with trips to federal institutions out of state for competency evaluation and treatment. In total, he spent 14 months in custody. Finally, he pled to violating parole by being present in the United States, received credit for time served, and was transferred to a an Immigration + Custody Enforcement detention center to await deportation.

"Mr. Novak": an arrest for non-violent behavior in a psychiatric hospital leads to over 14 months in jail.

"Mr. Novak" is an individual who was raised in Eastern Europe although he has lived in the US for many years. He has a long history of serious mental illness and in December of 2015, attempted suicide by jumping from a major bridge. He survived and was admitted to the chronically over-booked psychiatric inpatient unit at OHSU. Perhaps due to language barriers or his recent trauma, the OHSU psychiatrists had difficulty engaging him in conversation.[3] After four days in the hospital, Mr. Novak had made some modest improvements but remained generally uncommunicative. His treating doctors contacted OHSU police and instructed the officer to tell Mr. Novak that he would be discharged if he refused engage in his treatment.

When the OHSU officer approached him, Mr. Novak was sitting on the floor of his room and eating a meal. He said "no talk today; talk tomorrow." The officer consulted with the doctor and they agreed that Mr. Novak would be given five minutes to either leave voluntarily or be arrested for trespass. Mr. Novak continued to insist that he wanted to "eat today; talk tomorrow." According to the officer's report, Mr. Novak agreed to talk "at the 30 second mark" but was told it was too late and that he was under arrest for trespass. In the police car, Mr. Novak continued to apologize and state that he would be willing to talk to a doctor. The officer told him he had missed his chance and was going to jail.

[3] According to some sources, Mr. Novak speaks English well, but his jail records identify his primary language as an Eastern European language, and jail records indicate that he communicated best with a nurse who was a native speaker of that language.

Mr. Novak spent most of the next 14 months in solitary confinement at MCDC where he deteriorated physically and psychologically. He refused food, rarely exited his cell even when given the opportunity, and engaged in serious acts of self-harm that included removing one of his teeth. By the time he left MCDC to be transferred to a Bureau of Prisons medical facility for competency restoration services, he had lost enough weight that medical and corrections staff described him as dangerously emaciated.[4]

More on his experience in jail is found at page 15 of this report.

2. The Jail's Flawed Continuum of Care: Isolation, Discipline, Force, and Deprivation

"The people who work there [at MCDC] are, for the most part, good people trying to do the best they can. However, the product of the system as a whole is that we're torturing very sick people. I hate myself for being part of it, and then I feel I don't want to be there, and I feel guilty for leaving those patients behind. The cognitive dissonance required to work there is exhausting; it's crazy making. There are various coping strategies: you can burn out, you can detach, you can become sadistic . . ."

- Dr. Wil Berry, former OSHU Forensic Psychiatric fellow (after a 6 month rotation at MCDC)

a. Overview of Multnomah County Jails

Multnomah County operates two adult jail facilities: the Multnomah County Detention Center (MCDC), and the Multnomah County Inverness Jail (Inverness). Male and female adults are housed at both the MCDC and Inverness. Inverness has the capacity to house 803 individuals, while MCDC, a ten-floor vertical maximum-security facility, can house 447 inmates. The booking facility for both institutions is located within MCDC and processes roughly 35,000 individuals entering custody per year. In December 2016, the average daily jail population for both buildings combined was 1,080, which is 81% of capacity.[5] The jails are operated by the Multnomah County Sheriff's Office, and health

[4] The trespass charge was dropped, but Mr. Novak had violated the terms of a prior supervised release by being present in the US, and therefore faced federal charges.

[5] *Monthly Jail Report—December 2016*, Multnomah County Sheriff's Office, p. 2, (2016). Available at: http://www.mcso.us/profiles/pdf/jail_stats.pdf

services within the jails are provided by the Corrections Health Division of the Multnomah County Health Department.

Many of the individuals held at MCDC have not been convicted of the alleged crimes that put them in jail. In a 2015 snapshot, 44% of the jail population was pretrial. Probation/parole violators constituted another 28%, and 15% of the population was being held on an outstanding warrant. Only 8% of the jail population was sentenced.[6] In Oregon, individuals sentenced to one year or less on a low-level offense spend their period of incarceration in a local jail rather than a state prison.

According to the most recent available Census data, Multnomah County demographics break down as follows: 80% of the county is White, 11.3% is Hispanic/Latino, 5.6% is Black or African American, 1.5% is American Indian, and 4.4% identified as two or more races.[7] African Americans, however, are significantly overrepresented in the jail population, constituting 19-21% of individuals who are incarcerated in Multnomah County.[8] Women make up 22-25% of individuals booked into custody.[9]

MCDC houses the most acutely mentally ill inmates in the county and contains 99 beds that are specifically dedicated to individuals with a mental health designation,[10] despite the fact that somewhere between 400 and 800 of MCDC's daily 1,000+ residents have been diagnosed with mental illness. Corrections Health has reported that "nearly 40 percent of the jail population is diagnosed with mental illness," and other estimates range as high as 80%.[11] Individuals with mental illness experience longer and more frequent incarcerations compared with their non-mental-health-impacted counterparts.[12] Black detainees are hugely overrepresented among detainees experiencing mental illness. A 2015 study found that Black detainees constituted 41% of

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[6] *MacArthur Foundation Safety and Justice Challenge Grant Narrative,* Multnomah County Local Public Safety Coordinating Council, p. 2, (2015). Available at: https://multco.us/lpscc/macarthur-safety-and-justice-challenge

[7] *Multnomah County, Oregon Quick Facts,* U.S. Census Bureau, Available at: http://www.census.gov/quickfacts/table/PST045215/41051

[8] See *Monthly Jail Report—December 2016*, *Supra* p. 8.

[9] *Id*. p. 5.

[10] *Review of the Correctional Facilities within Multnomah County, OR.* Multnomah County Corrections Grand Jury 2016 Report, p. 16, (2016). Available at: http://mcda.us/wp-content/uploads/2017/01/please-click-here.pdf

[11] *Id*. p. 9-10.

[12] Among the sample examined it found detainees experiencing mental illness had longer lengths of stay – 18.27 days compared to 13.51 – than other detainees. Inmates with mental health problems were booked an average of 2.98 times during the reporting period.
Multnomah County Feasibility Assessment: Mental Health Jail Diversion Project, prepared by Lore Joplin Consulting, p. 10, (2015). Available at: https://multco.us/file/38259/download

those identified in a sample of detainees with mental illness, as compared to 19.7% of all bookings.[13]

b. People in Behavioral Health Crisis are Booked Rather than Diverted

"[Johnson] looked confused and kept repeating 'I don't want to get hurt," Sergeant [J] kept informing [Johnson] that we didn't want to hurt him and that we just wanted to take his cuffs off. . . . [Johnson] did not seem to be in full control of his thoughts or actions at that time, he had mentioned that he 'didn't want to get hurt' and that he just wanted to 'talk with us so that he didn't have to listen to his thoughts."

- Individual being booked at MCDC after treatment at OHSU and arrest by OHSU police; excerpt from MCDC Incident Report.

Historically, MCDC has not been proactive in refusing to admit individuals whose medical needs exceed the acuity level that can be treated at the jail. A recent review by the National Institute of Corrections issued the following critique: "unlike many jails today, the first person to see the arrestee at the MCDC was a deputy, not a nurse. Many jails now have the arrestee immediately cleared by medical personnel, before acceptance." [14] A proposal to the MacArthur Foundation Safety and Justice Challenge would have funded a registered nurse in the booking area to provide immediate medical/behavioral health screening and divert where appropriate for crisis treatment in the community.[15] Unfortunately, the proposal was not funded. Local funds for the position have been discussed but not secured. Jail administration appears reluctant to invest these resources in part due to a scarcity of community placements that will accept a person who has been diverted from MCDC because of a mental health (or medical) crisis. Hospitals, we are told, usually declare the prospective patient medically cleared and send her right back.

Dr. Will Berry, a former OHSU forensic fellow who completed a rotation at MCDC, explained, "Hospitals do not want to take people from jails because they figure that the person can get treatment in jail, but that's not true. Being in jail often times makes the condition much worse. If the idea is that "treatment" is just a lockdown to prevent the

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[13] *Id.*

[14] Timothy Ryan, *Use of Force Policy and Procedure Review: Multnomah County Sheriff's Office Jail System*, National Institute of Corrections Technical Assistance Project #16J [1048], p. 26, (2016). Available at: http://www.wweek.com/news/2016/12/16/new-independent-audit-cant-determine-if-use-of-force-in-multnomah-county-jails-is-racially-discriminatory/

[15] See *MacArthur Foundation Safety and Justice Challenge Grant Narrative,* Supra p. 9.

person from killing himself, then jail can do that. But, jail is not a therapeutic environment."

The importance of trained medical screening is bolstered by the fact that symptoms that appear like psychosis or mania can, in rare cases, indicate emergency medical conditions. Dr. Berry offered an example in which he was called to the jail psychiatric infirmary to see a patient who staff identified as "manic." The patient had received psychotropic medications but the symptoms persisted. Dr. Berry continued, "When I arrived at her cell, she was naked, she was almost running (despite being confined in such a small space), she was sweating, spouting rapid gibberish. And, I could see a goiter on her neck. My immediate impression was that this was not psychiatric. Rather, she was thyrotoxic, which is a very dangerous medical state. I had to throw a fit with the jail medical director to explain why this was a medical emergency and get this patient transferred to the hospital."

The story of "Ms. Fowler" provides another illustration of how dangerous it can be for people in need of emergency medical care to land in jail. Rather than medical triage, individuals arriving at jail are greeted by deputies whose focus is ensuring compliance with the booking process; compliance that is sometimes enforced at a high cost.

"Ms. Fowler": extended period in prone restraint followed by loss of consciousness, cardiac arrest, acute respiratory failure, encephalopathy

Information in this section derived from MCDC Incident Reports, video footage from the jail booking area, Corrections Health records, and OHSU records.

In the spring of 2015, police responded to several calls regarding "Ms. Fowler," a 32-year-old woman who was homeless and known to have a history of methamphetamine use. She was arrested for disorderly conduct after police found her acting erratically in a park. She appeared confused and disoriented; however, police reported she did not meet the criteria for a psychiatric hold.

When she arrived at the reception area of MCDC, incident reports note that Fowler was, "shouting incoherent gibberish and actively resisting contact from Deputies." Staff placed a spit sock over her head and escorted her to the booking counter where, because she was resisting orders, she was held down over the counter by five officers. She was bent over the booking counter face down and held in this position for over 10 minutes. Video footage shows an officer applying consistent pressure to Fowler's back and ribcage, while another

held her head and neck down. Leg restraints were applied and a second spit sock was placed directly over the first. The Sargent on duty noted that the decision to hold Fowler over the counter was made due to concern that she could be injured by the body weight of the officers that would be needed to restrain her on the floor. During this time, medical staff determined that she was not fit for admission based on general presentation and elevated vitals and called an ambulance to transport Fowler to the hospital.

Over the course of the incident, Ms. Fowler's behavior shifted from combative flailing to complete passivity. There is no indication from reports or video footage that staff were concerned with her breathing while she was held face down, though the last motions she made before becoming unresponsive were attempts to lift her head and upper body in a manner consistent with someone struggling to breathe.

Incident reports state that Ms. Fowler "became limp and lifeless" as staff held her up against the booking counter. Nevertheless, deputies chose to place her in a restraint chair while waiting for an ambulance. In video footage, Fowler can be seen slumping to the floor and, though she appears unconscious, she is carried and secured in the restraint chair. After nearly four minutes, a deputy observed that Fowler, who was restrained at her wrists and ankles, and wearing two spit socks over her face, appeared unconscious. A report states that a deputy asked, "is she breathing?" after noting, "her eyes appeared glazed, lips were turning blue, and she did not appear to be breathing." Medical staff began to perform sternum rubs and retrieved the crash cart, but she was not fully removed from the restraint chair until paramedics arrived. In total, Ms. Fowler spent 16 minutes restrained (on the booking counter and then in the restraint chair). The exact moment when she lost consciousness, stopped breathing, and lacked a pulse is unclear. At no point did jail medical staff perform CPR.

When the paramedics arrived, they placed Ms. Fowler on a gurney where they performed CPR for two minutes and were able to revive her, though she remained unconscious. Paramedics loaded her into the ambulance at approximately 3:30pm, at which time MCDC's involvement concluded. The arresting officer ultimately decided to issue a citation in lieu of booking. She was taken by ambulance to OHSU.

Hospital records indicate Ms. Fowler was brought in to OHSU's Emergency

Department in cardiac arrest and with acute respiratory failure. She suffered one or more strokes during the event and was intubated and sedated in the Emergency Department. Additionally, she was hypoglycemic and showed signs of encephalopathy (swelling of the brain). After being stabilized, she was admitted to the Medical Intensive Care Unit. She was diagnosed with drug-induced delirium and damage to her liver and renal systems, likely a result of a Methamphetamine addiction. Physicians were unable to conclusively determine the etymology of the seizures or cardiac arrest, but records indicate a suspicion that the event was, at least in part, a result of drug use. She was released four days later and no further information is available.

Ms. Fowler arrived at the jail in the midst of a medical emergency. Critical minutes were lost while she was restrained by deputies rather than receiving medical care. Deputies lack the training to distinguish symptoms of medical crisis from behavioral noncompliance. By forcefully restraining Ms. Fowler for 16 minutes (mostly in a prone position under physical pressure by multiple deputies), the deputies' actions may have contributed to medical factors which caused Ms. Fowler to lose consciousness and ultimately suffer damage to her brain and other organs.

c. Isolation and Lack of Programming for People with Mental Illness

On May 16, 2016, the Sheriff's Office informed DRO in a written letter that "plans are presently underway to review policies effecting [sic] inmates classified as 'mental close and acute mental close.' This group of inmates has limited access to programs, recreation, and little ability to privately speak with a mental health professional." Individuals in MCDC are segregated based on the acuity of their mental health needs and, contrary to the recommendations of numerous clinical studies; those with the most serious conditions are placed in the most restrictive environment. The more acute the illness, the less likely it is that an individual will have access to regular human contact, fresh air and natural light, programming, freedom of movement, and out-of-cell time. Inmates with mental illness in MCDC are placed in solitary confinement not in spite of, but *because of* their mental illness.

A note about "solitary confinement:" Most sources, including the United Nations, define conditions in which a prisoner spends 22 or more hours per day without meaningful human contact, as solitary confinement. Of importance for county and jail leadership is the fact that the title of the unit (e.g., Administrative Segregation, Disciplinary Segregation, Protective Custody, Mental Health Housing, and Medical Housing) and the reason that the person was put there are

not relevant to the question of whether the conditions on that unit constitute solitary confinement.

i. Solitary Confinement as the Default Destination for Detainees with Mental Illness

Individuals housed in the "Mental Close" unit at MCDC are theoretically entitled to 2 hours out-of-cell per shift. Individuals with more serious conditions are housed in one of two "Acute Mental Close" units where they receive 1.5 hours per shift out-of-cell. Finally, those in the Psychiatric Infirmary (4D) receive only 1 hour per shift out-of-cell. (See Exhibit 1). Staff interviews and our review of records indicate that the theoretically available hour per shift out-of-cell is only offered in practice under "best case scenario" circumstances, for cooperative patients.

Many of the detainees and prisoners that we interviewed in various settings report that one generally must "act out" or be suicidal in order to access services in jail. Dr. Berry, a former forensic fellow at MCDC explained, "The decision regarding who needs treatment is driven by behavior. An individual could be nearly catatonic, but if he's able to follow orders, no one cares." It follows then, that the highest acuity setting in the jail is designed, not to provide treatment and promote recovery, but to tamp down behavioral disturbances. Dr. Berry continued: "4D is not set up to provide treatment; it is set up to control behavior. The interventions on that unit (the smock, isolation, very limited access to phone and shower and socialization) make it one of the most severe places to be in the jail."

There is ample research establishing that social isolation and sensory deprivation exacerbate mental illness symptoms in individuals with a pre-existing illness and in some cases, can cause mental illness in individuals with no such history.[16] According to the National Commission on Correctional Health Care, prolonged (more than 15 consecutive days) solitary is cruel, inhumane, and degrading treatment and harmful to an individual's health, and juveniles, mentally ill individuals, and pregnant women should be excluded from solitary confinement of any duration.[17] MCDC's graduated system of reduced out-of-cell time and human contact based on increased acuity of mental health

[16] *See* Jeffrey L. Metzner & Jamie Fellner, Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics, 38 J. AM. ACAD. PSYCH. L. 104, 105 (2010); Stuart Grassian, Psychiatric Effects of Solitary Confinement, 22 WASH. U. J. L. & POL'Y 325, 335-36 (2006); Terry Kupers, Prison and the Decimation of Pro-Social Life Skills, in THE TRAUMA OF PSYCHOLOGICAL TORTURE, 127, 131, 135 (Almerindo E. Ojeda ed., 2008).

[17] *Solitary Confinement (Isolation)*, National Commission on Correctional Health Care, (2017), Available at: http://www.ncchc.org/solitary-confinement

need is precisely the opposite of evidence-based recommendations for conditions and treatment.

According to jail policy and confirmed through staff interviews, inmates in the "Acute Mental Close" (7B+C) and psychiatric infirmary (4D) never receive indoor or outdoor recreation. Detainees interviewed by DRO indicated that they spent periods between 3 – 12 months without fresh air or exposure to the outdoors. When asked how prolonged isolation impacted his patients, Dr. Berry stated:

> "My experience is consistent with the research: solitary confinement is very detrimental to people's health. There is a kind of softly magical belief in the power of medications. But in solitary, a person's worsening psychological state is a normal response to the conditions. It's not something that can be fixed with more medications."

The following story chronicles the physical and psychiatric decompensation of one man who spent almost a year in the psychiatric infirmary at MCDC.

"Mr. Novak": neglected medical and psychiatric needs resulting in dangerous weight loss over many months, and psychiatric decompensation.

Information in this section derived from Corrections Health records and OHSU records.

"Mr. Novak" attempted suicide and was arrested for trespass at OHSU because, after four days in the hospital, he remained uncommunicative with his treating psychiatrist and refused to leave promptly upon notice of discharge. His arrest is described earlier in this report.

At the beginning of his incarceration, jail records note ample symptoms of mental illness, but no acute distress. He is described as responding to internal stimuli, giggling to himself in a childlike manner, responding to questions in nonsensical ways, and occasionally appearing statue-like or catatonic. After months of solitary confinement, however, Mr. Novak began to fall apart. He became emaciated and withdrawn. He was tormented by frightening hallucinations and frequently harmed himself.

Despite his bizarre behaviors, Mr. Novak was consistently able to communicate his concerns about his weight: "I am skinny, I want more food, real food." (5/24/16) "Cl requests a 'clean room, clean food, clean air.'" (5/28/16).

On July 1, following a jail visit, DRO contacted jail administration to notify them that Mr. Novak appeared underweight, possibly catatonic, and needed mental health attention. A later review of Mr. Novak's records shows that his healthcare staff agreed that over the course of several months, he had become dangerously underweight:

6/22/16, RN note: "Cl asks deputy for cleaning supplies and a towel. Later approaches RN and asks 'Can you bring the scale over today? I want to weight [sic] myself'" "Appropriately advocates for weight check, does appear to have lost weight since intake." (There is no documentation, however, indicating that a weight check was performed.)
7/14/16, Dr. note: "he is rather thin and his ribs are somewhat prominent." . . . "Continues to have poor PO intake and continues to lose weight"
7/19/16, RN note: "appears underweight"
7/24/16, RN note: "appears emaciated"
7/27/16, SW note: "refused dinner, then later asked for food, stating he was

hungry. Cl was also noted to be too unstable to walk, hiding in his cell most of the day."
8/6/16, RN note: "appears undernourished"
8/9/16, SW note: "Cl appears quite thin, his stomach is concave and his ribs are quite evident. Cl does not respond when writer attempts to engage him multiple times."
8/10/16, RN note: "Cl did not respond to verbal engagement by this RN." "Has been losing weight. Had wt scheduled 7/20, not seen."
8/11/16, Dr. note: "he appears thin and undernourished"
8/17/16, RN note: "Had wt [weight check] scheduled 7/20, not seen."

Each weekly doctor's note recommends that the client have weight and BMI checked. Each weekly nursing contact notes the following: "Had wt [weight check] scheduled 7/20, not seen." Despite the concerns of numerous healthcare staff, there is no evidence in the file to indicate that Mr. Novak was ever weighed.

It is well documented that, due to his paranoia and active psychosis, Mr. Novak often retreated fearfully from both security and healthcare staff and refused medical care. He also refused meals or spread his food around his cell in bizarre patterns. Nevertheless, clinical staff should have had the skills to both coax a reluctant patient to the scale and address the psychosis that prevented him from eating and attending to his own basic self-care. In the alternative, someone involved in Mr. Novak's care should have concluded that interventions available at the jail were insufficient to meet his serious psychiatric needs, and he should have received care at a hospital.

Mr. Novak received a weekly visit from an OHSU psychiatry resident, but each visit was equally futile in addressing his needs and served only to document, rather than interrupt, Mr. Novak's psychiatric decompensation and physical deterioration. Each week, the doctor simply viewed Mr. Novak through the food port of his cell, noted his alarming weight loss, and recited the list of assessment categories that Mr. Novak's communication barriers prevented the doctor from assessing.

7/14/16, Dr. note: "Patient is dressed in jail attire and naked, but holding the blanket in front of him; he is rather thin and his ribs are somewhat prominent. Orientation is not assessable at this time. Working memory is not assessable at this

time. Long term memory is not assessable at this time. Speech selectively mute with selectively mute [*sic*] and tone not assessable at this time. Patient speech intensity is not assessable at this time.
Affect is flat. Eye contact is fair. Mood is not assessable at this time.
Thought associations are not assessable at this time. Thought process is not assessable at this time. Patient was unable to be assessed for delusions.
Patient cannot be assessed for hallucinations at this time.
Patient cannot be assessed for homicidal ideation at this time. Patient cannot be assessed for suicidal ideation at this time.
Insight is unable to be assessed. Judgment is unable to be assessed. Impulse Control is poor."

7/20/16, Dr. note: "Patient is dressed in jail attire and appears cachectic, filthy, and room is filthy with food scraps strewn about. Orientation is not assessable at this time. Long term memory is not assessable at this time. Speech nonverbal: waves me off whenever I try to speak to him with nonverbal and hand gesture indicates frustration/annoyance possibly. Patient speech intensity is not assessable at this time. Affect is irritable. Eye contact is poor. Mood is not assessable at this time.
Thought associations are not assessable at this time. Thought process is not assessable at this time. Patient was unable to be assessed for delusions.
Patients cannot be assessed for hallucinations at this time. Patient cannot be assessed for homicidal ideation at this time. Patient cannot be assessed for suicidal ideation at this time.
Insight is unable to be assessed. Judgment is unable to be assessed. Impulse Control is poor."

On August 12, 2016, DRO staff attempted to visit again with Mr. Novak. He was wrapped in a blanket in a fetal position on the floor, his cell was strewn with litter, and he yelled, "go away." The Sergeant on duty reported that Mr. Novak appeared to be getting worse. DRO made a written request to the jail that Mr. Novak be seen immediately by the on-call doctor and evaluated for transfer to a hospital. That night, Mr. Novak was finally brought to a hospital "for concerns of deterioration and failure to thrive." However, the hospital declined to admit Mr. Novak and returned him to the jail several hours later.

Over the many months that Mr. Novak spent in jail, there was no effective mental health intervention. Towards the end of his incarceration, Mr. Novak was no longer giggling and spinning in circles; he was banging his head against

the wall, spending long hours watching his drool slowly swirl in his toilet or curled in a fetal position on the debris-strewn floor of his cell. He was plagued by hallucinations of monsters coming through his window and believed his cell was full of poisonous gas. He pulled out a tooth, which bled profusely, but refused medical or dental attention.

Clinical staff consistently documented the external evidence of his suffering; the blood on the walls of his cell from persistent head banging, the food smeared on the floor, the dry urine near the toilet, his unkempt and malodorous presentation. No staff person, however, created conditions under which he could have reasonably been expected to feel safe and to engage in treatment. Almost all visits occurred at his cell front through the narrow opening of his food port (where he would have had to crouch through the interview), in earshot of other staff and inmates, over the din of noise on the unit, and without an interpreter.

> 8/17/16, MH note: "This writer meets with client at his cell, through open food port. Client is observed sitting on his bunk wearing suicide watch smock. He is sitting in the corner of his cell furthest from the door with his knees pulled up to his chest. Clients speaks quietly and is difficult to hear over the noise in the day room. This writer observes what looks like food splattered on the cell side of the food port and all over the floor, as if client threw his food tray. There are also spots of what appears to be blood on the floor. Client states, 'I hurt myself.' Client reports that he did not mean to harm himself. He states that he has not been sleeping or eating. Client does not respond when this writer asks if he is taking his medications. He reports experiencing AH [auditory hallucinations] 'sometimes.' He reports being depressed 'most of the time.' This writer asked about coping skills and client responded but this writer could not hear him over the noise in the day room. This writer asked client to speak more loudly but client did not."

With the exception of one nurse who spoke his native language, Mr. Novak engaged very minimally with staff. To the nurse, he confided: "I want to leave here, I want to go back to [home country in Eastern Europe]. I am tired of going in circles with nothing happening." The nurse's note continues, "[r]eports concern over his food being poisoned I the past. 'They (the feds) gave me a sandwich with number 7 on it, I know what they tried to do . . . . I am not crazy, I can tell what's going on. I can protect you. I have protected others, but I cannot do it forever . . . There are things here, coming in here (points to the

window), I need to leave out of this building.' States he wants to return to 'an orchard with shimmering fruit.'"

Mr. Novak remains far from "an orchard with shimmering fruit." After 14 months in custody, he pled guilty to a parole violation. At DRO's last update, he had been transferred to an Immigration + Customs Enforcement detention center to await deportation.

ii. Lack of Access to Programming and Services

Due to the bifurcation of mental health services and programming (the former housed at MCDC, the latter at Inverness), people with mental illness in jail in Multnomah County are effectively barred from accessing all programming. Inverness offers programming (including 19 groups, programs, or classes such as Alcoholics (AA) or Narcotics Anonymous (NA) GED and literacy classes, anger management, money management, parenting classes, or a food handler's test), but is very sparsely staffed for mental health services. MCDC has mental health staffing but offers no programming at all. Consequently, any detainee who requires mental health services is barred from accessing programming.

Corrections officials and advocates agree that failure to provide programming not only means a missed opportunity for individuals, but also makes it harder to manage the institution. Extreme, prolonged boredom creates an atmosphere that is ripe for behavioral problems and conflict, both with other detainees and with staff. Deputies complained to

us that, without programming, they have nothing to offer to incentivize good behavior. Inmates lack the future-oriented hopefulness that might come from making progress towards a GED, drug treatment, or working towards a certificate in a Cognitive Behavioral Therapy class. Instead, they perceive that there are no prospects for a positive path forward.

This problem is particularly profound in terms of access to drug and alcohol treatment. The fact that there is a strong correlation between mental illness and addiction is widely acknowledged. Yet, in Multnomah County jails, people with mental illness are barred from accessing AA or NA, and effectively barred from the Treatment Readiness Dormitory at Inverness, which would provide a pathway to continued treatment in the community. Sheriff's Office staff have cited a number of hurdles to providing treatment and programming for detainees with mental health diagnoses, such as the cost associated with additional staffing, the potential difficulty of housing people with mental illness in a dorm, and the concern that community drug and alcohol treatment providers often reject any prospective participant who is prescribed psychotropic medications. Community providers have confirmed that there is only one residential treatment provider for people with dual diagnoses in Portland, and it does not serve women. These are not insurmountable barriers, however. Substance abuse treatment providers, both in jail and in the community, cannot continue to use mental health diagnoses as a reason to deny services to a group of otherwise eligible participants.

iii. Architectural and Facility Problems at MCDC

Part of the challenge in delivering mental healthcare or programming at MCDC is inherent in the architecture of the building. MCDC was designed with a maximum-security layout: units that house 5-32 individuals in single cells, with no space for confidential interviews and no rooms anywhere within the facility that are currently available for programming.

The majority of medical and mental health contacts occur at cell front. DRO has conducted dozens of conversations with people through their cell doors at MCDC. When a unit is noisy, it can be almost impossible to communicate above the din. When a unit is quiet, the conversation reverberates through the space, and it is impossible for bystanders not to hear. Detainees have legitimate concerns about protecting the confidentiality of information they might share with mental health staff: their diagnosis, symptoms that could be stigmatizing, the nature of the alleged crime, their fears, their families, or concerns about staff. This is information that, in the wrong hands, could jeopardize their safety or be used against their interests.

One client complained to DRO that when his unit mates were out-of-cell (generally one at a time), a particular deputy would leave his food port open to allow the other inmates to throw cups of urine or packages of feces into his cell. Because he was always in earshot of the others on the unit, he was understandably reticent to share candidly with his mental health counselor during cell front visits. DRO requested that he receive visits with his counselor in a confidential setting. On follow-up, this client reported that the jail had accommodated the request by bringing him in shackles and belly chains to an attorney/client visiting booth where, cuffed to the belly chain, it was nearly impossible to hold the phone (which was required to communicate with his counselor on the other side of the glass). He reported that his counselor was required to exit the jail through the main lobby and subjected to the time consuming process of being buzzed in and out of the elevator and hallway adjacent to the visiting booths. Almost her entire allotment of time for the visit was consumed by the logistics of getting the client and counselor to the opposite sides of the visiting booth.

Recreation space at MCDC is equally inaccessible. Unlike Inverness Jail, which has a small, outdoor recreation area attached to each unit that detainees can utilize at any time, the recreation space at MCDC requires an escorted elevator ride from any of the units. Staff and detainees reported that recreation is a rare privilege at MCDC because scheduling the shared space is so complicated and providing the required escorts is so staff intensive. At our initial site visit, five detainees reported to us that they had never accessed outdoor recreation during the course of their jail stay. Over the course of our investigation, DRO interviewed numerous individuals confined at MCDC who reported spending 3-12 months without exposure to fresh air. In addition to its inconvenient layout, the environment at MCDC is gloomy, poorly lit, with very little natural light. It is a profoundly bleak environment.

d. Disciplinary Segregation: Over-used, Unduly Harsh, and Triggered by Disability-Related Behavior

Individuals with mental illness are also frequently placed in disciplinary segregation units. People confined in Multnomah County jails can be disciplined for an exhaustive array of behaviors, for an unlimited amount of time, and with little consideration of whether the problematic conduct was related to a disability or whether disciplinary conditions are contraindicated given an individual's mental or physical health.

Minor violations may be imposed for failure to make one's bed or sitting on a table. Major violations include everything from assault and riot to disrespect, failure to comply with an order, failure to work, or refusing to work. Frequently, one incident generates multiple infractions and almost any instance of misconduct can be construed as an act of "disrespect," "failure to obey an order," or "disruptive behavior," in addition to the underlying charge.

Not surprisingly, the broad discretion granted to staff to impose disciplinary sanctions for minor behavior creates a system that is perceived by detainees and sometimes staff, as rampantly punitive, arbitrary, and unfair. A use of force report contained the following critique by a Lieutenant:

> "Deputy XXX also has a history of holding unreasonable expectations of inmates and has been counselled by myself, supervisors, and peers to encourage him to try and be more reasonable. His prolific use of the inmate disciplinary process has been questioned by supervisors and peers and at times, appears to be possibly abusive. . .
> Multiple supervisors have expressed concern to me that they believe Deputy XXX is unreasonable with regard to his expectation of inmates and utilizes the disciplinary process excessively and unnecessarily."

Data reviewed by DRO indicates that African Americans are almost twice as likely to be the subject of disciplinary charges. There were 3,216 disciplinary hearings between January 2015 and August 2016. African Americans make up 19-20 % of the jail population, but 36% of those detainees who are the subject of misconduct hearings

A recent review by the National Institute of Corrections Technical Assistance Project confirmed that use of the disciplinary process in Multnomah County Jails is excessive and should receive some additional scrutiny:

> "Relative to the Disciplinary Process itself, it was said that there are over 140 appeals a month. In fact, it was intimated that there were really more. Given the Disciplinary Hearing Officers duties, during a 5-day workweek, this means 7-10 Hearings a day. This causes the TRP concern as it raises several questions:
>
> a. This must mean that there are 7 or more disciplinary citations written per day. This seems like too many? Are the deputies using this

system as a default to addressing misbehavior with discipline, rather than, IPC [interpersonal communication] skills?

b. Has there been a review of the deputies, supervisors, and shifts which use this system the most? Are the uses valid?
c. Is there a need for a policy review and/or a training effort?"[18]

The jail's policy allows wide latitude in the conditions and length of the disciplinary sentence. The policy lists a series of levels and corresponding restrictions, but it's not clear which type or number of infractions lands a person in a particular level. The first level of discipline limits out-of-cell time to 1 hour per 24 hours. The third level limits out-of-cell time to just 15 minutes per 24 hours (which is the only opportunity to shower and/or make a phone call), and requires belly chains, leg irons and a two deputy escort outside the housing area. Levels 4 and 5 eliminate any out-of-cell time on weekends and may include "enhancements" such as nutraloaf[19] for up to seven days (if food or feces were abused), belly chains and leg irons during all walk time, and "clothing restricted to a paper suit."[20] At all levels, personal property is confiscated (and stored) and there are graduated limits on access to books, paper, and writing supplies.[21]

One deputy who agreed to speak with us stated, "We really need a time limit on 4E and F [disciplinary units]. Conditions there are really harsh and people are in there for months. Sometimes they decompensate, and come to 4D [psychiatric infirmary) where they get somewhat stabilized, but then it's right back to DSU [disciplinary segregation], and we start all over again." He continued, "4E and F are so noisy; there's constant kicking, banging, and yelling, and only 15 minutes per day of walk time. People go crazy in there. And, people fake suicidality to get out of there, but who can blame them?"

"Ms. Clemente": excessive and counter-therapeutic discipline

Information in this section derived from a client interview, and MCDC Incident Reports and disciplinary records.

DRO met with a young trans woman who was detained at MCDC on misdemeanor charges. She has no prior criminal history and reported that this was her first time in jail. We were denied a contact visit (i.e., sitting in the same

[18] See *Ryan, Use of Force Policy and Procedure Review*, supra. p. 10

[19] Nutraloaf is created by putting an entire meal, including beverage and condiments such as mustard, into a blender and then baking the product into a loaf that is cut into slices and served as a meal.

[20] *Inmate Rules and Discipline*: *Policy 10.1.10,* Corrections Division Operational Policy and Procedures Manual. (2015)

[21] On the flipside, there are no positive incentives that can be offered to promote good behavior. See *Ryan, Use of Force Policy and Procedure Review*, Supra p. 10

room together) because of her disciplinary status. Instead, we spoke through glass, via telephone. "Ms. Clemente's" ankles were shackled and her wrists were cuffed to a belly chain, so she could hardly reach the receiver to her ear and had to crunch her body uncomfortably in order to talk. Ms. Clemente has a history of psychiatric hospitalizations, homelessness, and suicide attempts. Over the course of two and a half months in jail, she was disciplined repeatedly for things like telling a deputy he was a "rapist" and had a "shitty haircut," drumming a rhythm with combs and singing, or exposing her chest. She admitted to engaging in behavior that was disrespectful or provocative. But, the result was that she spent almost her entire incarceration in disciplinary segregation.

Whereas a clinical approach may have considered a variety of interventions to promote constructive behavior and involved Ms. Clemente in programming and socialization, the jail's hardline disciplinary approach meant months in solitary confinement, shackles, and belly chains whenever she left her cell. She had almost no access to visitation, phone calls, or any form of entertainment or stimulation. The profound boredom cannot be underestimated. These conditions fueled Ms. Clemente's sense of despair and set the stage for another suicide attempt, which occurred this past fall. At DRO's last update, Ms. Clemente had been released and was participating in mental health court.

Deputies receive little or no training to distinguish between willful uncooperativeness and behavior that is symptomatic of mental illness. Similarly, they receive no training about how to deescalate a mental health driven situation. One deputy interviewed by DRO expressed that many deputies want to help and "are passionate about mental health," but lack training and support. He continued, "I don't understand why Portland police officers get CIT [crisis intervention training] but we deal with mental illness every day, and we don't have any CIT training. We have plenty of use of force training, plenty of range time, why not CIT?" The result is that mental health crises in jail are not deescalated. Instead, mental health related behavior is treated just like any other disruptive behavior, with force and discipline. The story of "Mr. Garcia" illustrates the harshness with which these rules are laid down and how frightening a disciplinary response can feel for an individual experiencing active symptoms of psychosis.

"Mr. Garcia": psychosis responded to with five tazings, restraints, and excessive discipline rather than a mental health intervention.

Information in this section derived from MCDC Incident Reports.

In March 2016, “Mr. Garcia” was involved in an incident that began with a request for mental healthcare and ended with him being tased five times. Two deputies initially responded to Garcia, who had “displayed agitated behavior” in a transfer tank. Mr. Garcia told the deputy that he “could not stay in his cell because he was hearing things” and that he wanted “his meds.” After the conversation, the deputies attempted to push his cell door shut, but Garcia shoved his body weight against it and tried to charge out of his cell. Deputies handcuffed him and brought him to the elevator, noting that he was resisting but not fighting. In the elevator, he struggled against them, screaming that “someone was in his head,” repeatedly asked where they were taking him, insisting that he had done nothing wrong, and according to one deputy “staring off in a catatonic gaze,” “yelling nonsensically and convulsing.”

Deputies responded by grabbing each of his legs, which, given that he was handcuffed, brought him abruptly to the ground. Due to his flailing and kicking, deputies could not secure his ankles in leg irons, and a deputy “drive stunned” him in the back with a taser, twice. He then shot Garcia with taser probes in the buttocks; a method that the deputy noted would “have better results due to Garcia’s much larger size and current mental state.” The deputy pulled the trigger on the taser three separate times, each time sending immobilizing voltage through Garcia’s body. Back-up deputies described arriving on the scene to find Garcia handcuffed and face down on the floor, “breathing heavily, and repeating ‘don’t hurt me.’”

Throughout the incident, Mr. Garcia continued to state that he had done nothing wrong and that he was hearing voices. One report notes that Garcia was “very animated, he was paranoid and was clearly delusional[,] making it difficult to communicate with him and calm him down.” He noted that staff on the scene were concerned about excited delirium. According to another deputy’s report, “I was concerned that with Garcia’s mental health crisis, hallucinations, disorientation and the extreme strength he was displaying and his size, that Garcia was experiencing signs of Excited Delirium.” He went on, “Garcia continued to yell for help, and that ‘they’ were after him. He also asked why we where [sic] doing this to him and trying to stab him. Several deputies and myself tried to reassure Garcia that no one was trying to hurt him and that once he was secured on the chair we would leave him alone. Garcia was unable to comprehend this.”

Finally, Garcia was fastened into a restraint chair. A nurse came and injected him with Ativan. He was then wheeled to a disciplinary unit, but he was placed (while in restraints) in view of other inmates, and they taunted him. He was subsequently moved to a different disciplinary unit.

The reviewing Sergeant, Lieutenant, and Captain all justified the degree of force in part because of the Mr. Garcia's mental illness. According to the Sergeant, Garcia "appeared to be suffering from some sort of psychotic break." The reviewing Lieutenant concluded that the incident was "a professional response to secure a large combative inmate that displayed mental health issues." The Captain cited the fact that the subject was "acting psychotic" as a factor supporting the degree of force. Both the Lieutenant and the Captain made note that using a taser on a restrained inmate violates Sheriff's Office policy, but it did not appear that there was any follow up or disciplinary action against the deputy involved. Every layer of review found the use of force justified and appropriate.

Mr. Garcia was charged with the following disciplinary violations: Failure to do as Ordered, Disruptive Behavior, Assaulting, Fighting and/or Threatening a person/staff, Escape, Attempted escape, and Unauthorized departure.

e. Unregulated Use of Restraints

An exacerbation of symptoms and behaviors is the inevitable result of holding people with psychiatric conditions in prolonged solitary confinement without adequate mental healthcare. Yet, people with mental illness surviving in these conditions find themselves in a vicious cycle: isolation and sensory deprivation cause despair, agitation, or intensifying auditory/visual hallucinations. In turn, these conditions re-emerge as yelling, acting out, or self-harm, all of which trigger discipline, restraints, use of force, and a ratcheting down of restrictive and counter-therapeutic conditions.

Instead of a clinical intervention, it is far too frequently the case that an escalated and mentally ill person in jail is responded to by deputies who place the individual in a restraint chair. Restraints in any context are an extreme intervention, both due to the intrusiveness of the deprivation of the individual's liberty and the freedom of movement and the risk of injury.

Thanks to decades of advocacy and evolving standards of care in clinical settings, use of restraints against psychiatric patients in hospitals is tightly regulated. Clinical restraints

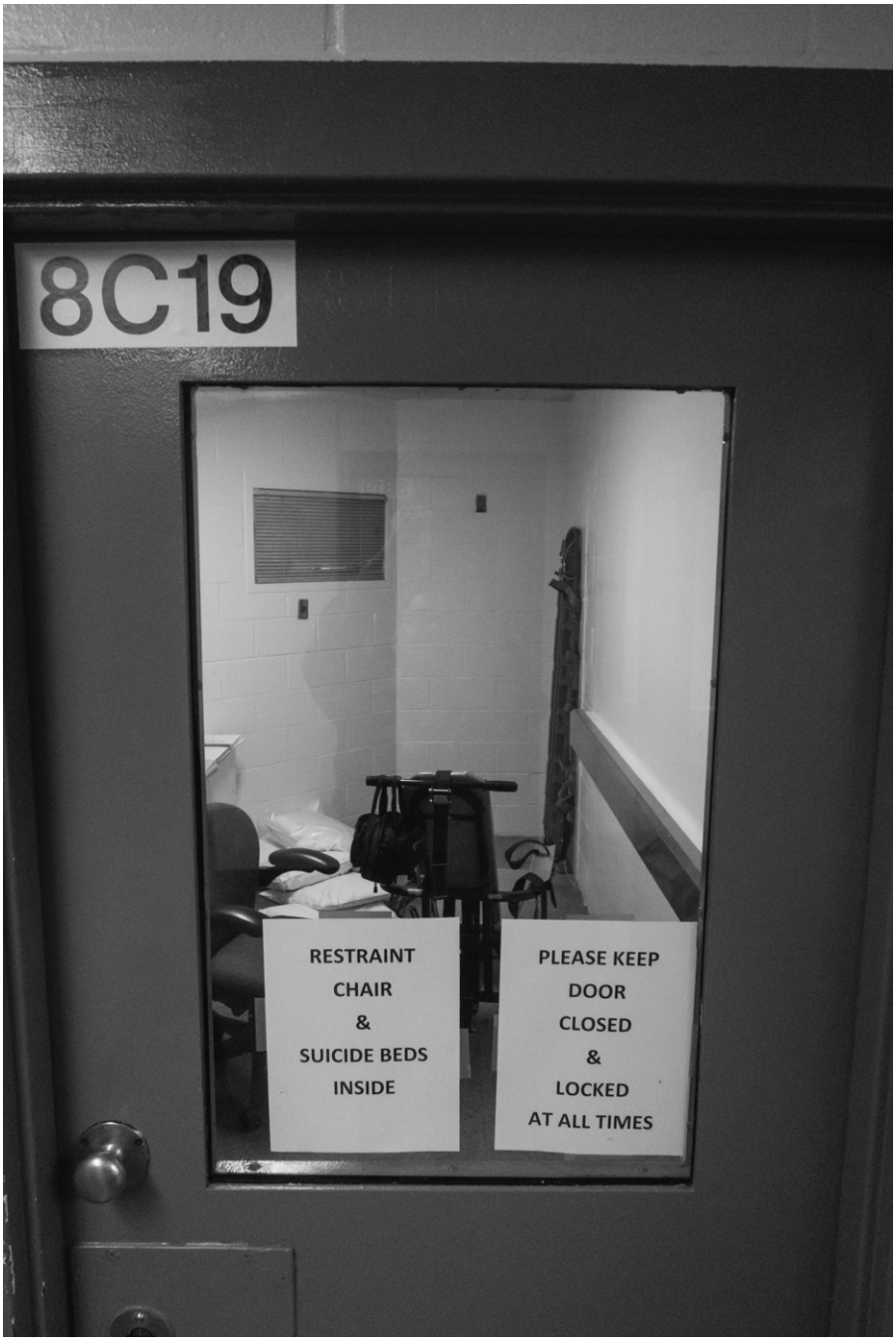
require a doctor's order, are subject to rules around maximum time periods, opportunities to exercise range of motion, and welfare checks at least every 15 minutes. Data from hospitals regarding the frequency and duration of restraints must be reported quarterly to the state and made available on an aggregate basis to the public.[22] Hospitals are also required to have seclusion and restraint committees that review and evaluate the appropriateness of all such interventions.[23]

Use of restraints in penal settings, however, is almost wholly unregulated and is not subject to outside oversight. Because restraints in jails are applied by deputies rather than licensed clinicians, there are no applicable licensing rules or board/agency oversight. There is no mandatory accreditation or licensing requirements for jails. Jails have their own internal policies, but these documents may be hard to obtain much less enforce, and as Multnomah County's policies demonstrate, may leave room for broad discretion.

These factors led DRO to initiate a comprehensive review of MCDC restraint data. Lewis and Clark law students reviewed and analyzed all 109 restraint incidents at MCDC during the period of January 2015 to July 2016.

Restraint incidents were concentrated in the booking area, and the fourth and eighth floors (including 4D, the psychiatric infirmary). MCSO currently categorizes the use of restraints as either forced or "voluntary" (i.e. upon inmate request.) Both "voluntary" and involuntary incidents were more frequent between noon and 6:00pm. The average amount of time spent in restraints for all reported incidents was about two and a half hours (173.84 minutes) with those individuals restrained "voluntarily" spending slightly more time (three hours or 182.80 minutes) in restraints.

i. "Voluntary" Submission to Restraints



Remarkably, 61.4% (67 of the 109) incidents were designated as "voluntary" as opposed to forced submission to restraints. The prevalence of "voluntary" restraints raises a number of concerns. The assertion that individuals regularly request to have their shoulders, wrists, and ankles restrained to a chair or board is not credible, and is not reflected in the documentation around these events. Rather, these are often situations in which deputies negotiate with an individual who is engaging in self-harm or shows risks of self-harm. Unfortunately, these situations are not treated as urgent requests for mental healthcare, responded to by trained mental health clinicians. MCSO policy requires that use of restraints "upon request of an inmate" occur with the "concurrence of Corrections Health," but we found little documentation of any consultation with healthcare staff.

Of further concern is that Multnomah County's policy exempts "voluntary" restraints from any process of review. A hazard report, which triggers review of any use of force through the chain of command, is not required in cases of "therapeutic restraint." Consequently, there is little review or data collection regarding voluntary restraints, which in turn leaves the door open to an inordinate degree of individual staff discretion and potentially, bias.

ii. Racial Disparities

Racial disparities are rife throughout the criminal justice system in Multnomah County, and that trend is evident in restraint chair data as well.[24] While African Americans comprise between 19-20% of jail bookings for the relevant period, [25] African American detainees comprised 34% of individuals who purportedly submitted to the restraint chair on a voluntary basis. White detainees were underrepresented among those subjected to "voluntary" restraints.

Race	% of total bookings	% of total restraint	% of forced restraints	% of "voluntary" restraints
African American	19-20%	21%	23%	34%
Caucasian	65-67%	60%	71%	52.5%

iii. Psychiatric Crisis, Responded to with Force

Incident reports indicate that the majority of individuals subjected to restraints were experiencing an acute psychiatric crisis. In 28 instances, receiving psychiatric medications (sometimes explicitly by force, sometimes purportedly "voluntarily") preceded the person's release from restraints. Taking medication and promising not to engage in self-harm were the most frequent reasons for release from restraints. The time between the crisis and the medication is marked by an inordinate level of force, inflicted in the name of keeping detainees safe. In addition to restraints, hosts of other force tactics were employed, as indicated in the adjacent table.

Spit sock	30
Hobble	20
"Focused blows"	3
Hair Holds	5
Digital Control	4
Take Down	12
Taser (deployed)	10
Pepper Spray	2
Cutting off clothing	7

[24] *Racial and Ethnic Disparities and the Relative Rate Index (RRI): Summary of Data in Multnomah County*, Safety and Justice Challenge, (2014), p 3-5. Available at: http://media.oregonlive.com/portland_impact/other/RRI%20Report%20Final-1.pdf

[25] See *Monthly Jail Report—December 2016*, Supra p 2-6.

After release from restraints, 12 individuals (between January 2015 and July 2016) were sent to the hospital because their injuries were severe enough to warrant medical attention that the jail is not equipped to provide. Some of the injuries occurred prior to the individual being restrained while others were injured in the course of being restrained.

Both the prior and current medical directors for Multnomah County Corrections Health reported to us that medical staff has very little involvement in application of restraints, other than to periodically check the inmate's welfare. The decision to impose and remove restraints rests with the Sherriff's staff. Periodic opportunities to exercise range of motion (and prevent loss of circulation) appear to be at the Sergeant's discretion, even if specifically requested by medical staff. In one case, an inmate was tased through the food port of his cell (allegedly due to voicing intent to harm himself, refusing to cuff up, and kicking his door), placed in the restraint chair and spit hood, and rolled to the psychiatric infirmary. But, the Sergeant noted:

> "I was asked by medical staff to allow Inmate [name] to conduct a range of motion, which I refused to do" . . . "each time staff and I tried to communicate with him" he would growl and attempt to break free of his restraints." . . . "I felt that allowing range of motion would result in further use of force."[26]

It is difficult to gauge the degree to which behavioral health crisis response may be a source of contention between Sherriff's and Health Department staff, because no mental health staff would agree to speak with us. It is, however, safe to conclude that tasers, spit hoods, and restraints are not consistent with current clinical best practices for crisis intervention. Restraints are the antithesis of a trauma-informed response to mental health crisis.

At best, the restraint chair provides a temporary guarantee against self-harm. There is no attention however, to the conditions that drive people to harm themselves, namely, solitary confinement.

> "One of the most unsettling things about solitary confinement is the extent to which there are mentally ill prisoners there, the extent to which there are higher rates of suicide, and the very high rates of self-harm that take place inside these

[26] MCSO Incident Report

units." *Craig Haney: Solitary Confinement is a "Tried-and-True" Torture Device*. Frontline, April 22, 2014.[27]

Instead, staff repeatedly follow the steps in what is seen as an unfortunate but necessary procedure; the process is a hassle, but routine. One Sergeant told DRO: "Staff do not like to use the chair – it's a big hassle, so we won't do it if it's not necessary. But, I can't let somebody bash his head in on my watch, and the chair is the only tool I have."

For detainees, however, the experience may not feel routine at all. In some cases, the fear experienced by detainees is evident even in the deputies' reports ("He was screaming as if we were beating him when we were merely controlling his limbs as we placed restraints on them.")[28] People subjected to restraints may feel profoundly vulnerable and frightened, or may relive moments from a traumatic history. Men and women who are restrained in jail are typically surrounded by uniformed deputies, subjected to physical force, sometimes naked, and often involuntarily injected with medications.

"Ms. Mckenzie's" case provides an example that is both typical as an illustration of the use of restraints, and painfully atypical, in that it begs the question of whether a trauma-informed therapeutic intervention could have prevented her death, shortly after her release from jail.

"Ms. Mckenzie": use of restraints instead of addressing mental health and medical concerns with kindness; release from jail was followed by death.

Information in this section derived from MCDC Incident Reports, Corrections Health records, court records, and local news coverage.

In February 2015, deputies responded to a young woman in the psychiatric infirmary (4D) who had removed her clothing and smeared feces on her cell window. She was yelling and pounding on the cell door. The responding deputies told her that they would "place her in a restraint chair if she did not comply with commands to let medical administer medication." She was ordered to put her hands through the cuff port so that she could be handcuffed. When she didn't comply, deputies entered her cell and forced her to the ground. One incident report notes officers were "forcing her to a mattress that was on the floor." She was handcuffed and a spit sock was

[27] http://www.pbs.org/wgbh/frontline/article/craig-haney-solitary-confinement-is-a-tried-and-true-torture-device/
[28] MCSO Incident Report

placed over her head and face. She was placed in the restraint chair, where "The nurse then injected [her] with a sedative to calm her down." A deputy "covered her torso with a sheet because she was naked." Deputies checked the restraints and wheeled her to a new cell. While she was in restraints and forcibly sedated, deputies removed her nipple rings, which must have been overlooked during booking. She remained in restraints for 5 ½ hours until the medication resulted in her "acceptable behavior," justifying her release from restraints.

It appears that all contact with nursing or mental health staff occurred through the food port of Ms. Mckenzie's cell, where she would have had to crouch to make eye contact. She is reported to have described feeling suicidal, and she talked about wanting to skateboard at the Burnside skate park. She appeared "frightened, skittish," and "startled each time neighboring inmate kicks door and yells an outburst." "[A]ppears fearful, 'it's scary in here.'"

Ms. Mckenzie was in her mid-20s, with no prior criminal history. She was in jail on misdemeanor charges including trespass and disorderly conduct. At the initial booking, mental health staff determined that further assessment was needed and could not be completed in jail. They decided to put her on a Director's mental health hold and have her transferred to a hospital. She was diagnosed with psychosis, possibly substance induced, and returned to jail. The hospital also recommended that the jail consider hypo or hyperthyroidism. It's not clear from her jail medical records whether that recommendation was followed.

Sadly, four days after her release from jail, she was found deceased under a bridge. News coverage described the cause of death as a "medical event."

f. Punitive Conditions on Suicide Watch

The Sheriff's Office reports that 1,522 detainees were placed on suicide watch in 2014. In 2015, 1,371 detainees were placed on suicide watch.[29] In the past year, the Sheriff's Office has made significant architectural changes to reduce suicide risk in the jail, such as enclosing the top tier in 2-story units and redesigning air vents so that a noose cannot be supported. These changes were based on recommendations by Lindsay Hayes, a national expert on suicide prevention in jails and prisons. However, the jail has neglected a core tenet also supported by Mr. Hayes: suicide precautions that appear punitive or overly restrictive may deter reporting of suicidal ideation and therefore increase risk.

> "We must avoid creating barriers that discourage an inmate from accessing mental health services. Often, certain management conditions of a facility's policy on suicide precautions appear punitive to an inmate (e.g.,

[29] These numbers appear slightly higher than average for the larger counties in Oregon, which use suicide precautions on 2-4% of inmates booked annually; 399 out of 12,213 in Lane County, 286 out of 14,778 in Clackamas, 718 out of 17,944 in Washington, 1,522 out of 38,239 in Multnomah

> automatic clothing removal/issuance of safety garment, lockdown, limited visiting, telephone, and shower access, etc.), as well as excessive and unrelated to their level of suicide risk. As a result, an inmate who becomes suicidal and/or despondent during confinement may be reluctant to seek out mental health services, and even deny there is a problem, if they know that loss of these and other basic amenities are an automatic outcome. As such, these barriers should be avoided whenever possible and decisions regarding the management of a suicidal inmate should be based solely upon the individual's level of risk."[30]

According to MCSO policy, detainees who may be suicidal are placed in segregated housing with either constant supervision or random welfare checks, depending on the degree of risk. In practice, detainees on suicide watch are generally denied all personal belongings and are required to wear a heavy smock with no other clothing. Often, the mattress, sheet, and blanket are removed, and the individual is denied access to any programming, visits, phone calls, and showers. Jail administrators generally cite the concern that, if suicide watch is too comfortable, detainees will fake suicidality in order to avoid punitive segregation. The result is that suicide watch conditions are often worse than disciplinary segregation; detainees may be discouraged from feigning suicidality, but people who are truly feeling suicidal are punished for their despair.

Generally, access to reading materials, the physical comfort and dignity provided by safe clothing and bedding, and visitation or phone calls with loved ones actually ameliorate the risk of suicide. If any of these items or privileges appears risky in a particular situation, the risk can be dealt with on a case-by-case basis. The most important element of suicide prevention is vigilant observation of the individual. Several staff that we spoke with referenced a prior MCSO practice in which detainees who presented a risk of suicide were simply assigned to the bunk directly in front of the deputy's station. They received supervision for safety without losing their belongings or privileges, and the staff reported that the system was successful and far less contentious than the current practice. Suicidal individuals were observed, but not punished.

The harshness of current conditions on suicide watch make detainees less safe for three reasons: the extreme degree of deprivation and isolation imposed exacerbates feelings of despair; fear of a punitive response discourages detainees who feel suicidal from

[30] Lindsay M. Hayes, *Guiding Principles to Suicide Prevention in Correctional Facilities*, National Center on Institutions and Alternatives, (2011). Available at: http://www.ncianet.org/wp-content/uploads/2015/05/Guiding-Principles-to-Suicide-Prevention-in-Correctional-Facilities-2011.pdf

coming forward, and enforcing unnecessarily harsh conditions on suicide watch creates countless reasons to impose force against individuals in psychiatric crisis.

"Mr. Clifton": enforcing clinically unwarranted suicide watch restrictions results in tasing and six hours in restraints.

Information in this section derived from MCDC Incident Reports and a client interview.

"Mr. Clifton" was on suicide watch and according to deputy reports, had become agitated about wanting a "shower, phone call, and visit." Ultimately, he covered the window of his cell with his suicide smock or blanket. In some situations, this creates a safety risk because the line of sight is obstructed. In Clifton's case, the reports make it clear that deputies had an opportunity to view the cell and confirm that there was no immediate safety concern. Rather, the ensuing intervention was intended to retrieve prohibited items.

"[w]hen he took the blanket down I saw that he had bars of soap, paper, a large Band-Aid, and a book in his cell."
And according to another deputy, "I could see that he had two band-aids, multiple bars of inmate soap, a book, mattress, and two smocks. The majority of these things are not authorized while on active suicide watch."

Mr. Clifton was told to cuff up through the food port, which he did, and he was led out of the cell. He was told that he would be able to keep his smock and that his mattress would be returned at bedtime, but everything else would be removed. This made Mr. Clifton upset. He wanted his bedding and refused to return to the cell "if he didn't have a smock, blanket, and mattress." When a deputy took hold of his arm, he tried to run. The Deputies took him to the ground and attempted to carry him to the cell, but he resisted. They tried to hobble (tie together) his legs, and he kicked. Then, a deputy tasered him, using the drive stun mode, to his thigh. Subsequently, deputies were able to hobble Clifton and carry him back to the cell, laying him face down on the floor. He then began to bang his head against the floor. A deputy straddled him, pressing his knee against Clifton's head. Due to the head banging, they forced Clifton into the restraint chair, where he remained for over six hours.

On review, supervisors found the use of force justified and inevitable. After all, Mr. Clifton had covered (and later uncovered) his window, he physically resisted

returning to the cell, and he began to bang his head. The Lieutenant raised a meek objection to the use of the taser on a handcuffed subject, stating: "[h]owever, use of the taser on an inmate in restraints is not within MCSO policy." But, the Captain absolved deputies of any wrong-doing:

"I find the use of the taser in drive stun mode acceptable in this situation as it was used for a five second cycle in a specific place on the subject's leg, not unlike using fingers on a pressure point, to elicit compliance."

DRO met with Mr. Clifton about a year after this incident. During the interview, he communicated with unseen others and much of what he said was not coherent. He vacillated between coy and hostile. From a layperson's perspective, he appeared psychotic. At the time of the incident described above, it is safe to assume that Mr. Clifton was mentally ill and suicidal. The points of contention that triggered the use of force ("contraband" in the form of a mattress, soap, and book, and his refusal to return to the empty cell) did not relate to his well-being or mental health. Rather, these policies are designed to maintain a rigid order that is enforced through any means necessary, even when doing so jeopardizes the physical and mental health of those in custody.

3. Violence by Staff

Violence is an inherent element of the hierarchical structure and culture of jails and prisons. The only way to effectively prevent victimization of vulnerable people is to keep them out of jail whenever an alternative is feasible. Given the inevitability that people with mental illness will continue to find themselves in jail, however, jail administration has a duty to promote a safe environment by avoiding conditions known to be linked to high rates of violence and implementing basic safeguards against misuse of force and power. Failure to do so dictates that people with mental illnesses will become sicker while enduring harsh conditions that serve no legitimate penal or treatment purpose.

DRO has identified three primary areas of concern related to staff violence at MCDC. First, studies show that solitary confinement fuels violence and staff/detainee confrontations.[31] The National Institute of Corrections Technical Assistance Project

[31] See e.g., Alison Shames, Jessa Wilcox, and Ram Subramanian. *Solitary Confinement: Common Misconceptions and Emerging Safe Alternatives*. Vera Institute of Justice, (2015). Available at: http://www.safealternativestosegregation.org/resources/view/solitary-confinement- common-misconceptions

consultant hired by MCSO issued the striking finding that MCDC holds just 33% of the Multnomah County jail population, but accounts for 83% of uses of force by staff. The consultant explained that the high rates of force at MCDC may be driven by excessive "lock down" time:

> "Given the inmate population difference between Inverness, 800, and MCDC, 400, the discrepancy between the number of UOF [use of force] events should be examined also (17% vs. 83%). Obviously, it has to do with who is housed there, but could there be more to it. For example, the Inverness Jail is operated under more of the 'direct supervision model,' with considerable movement by inmates. MCDC appears to have a significant amount of 'lock down time.' The TRP did not fully examine the actual period of in cell time, but it is worthy of review. The jail studies 'seem to indicate' that as the time out of cell is increased, the fewer adverse events occur."[32]

Second, staff accountability can be improved through meaningful instead of perfunctory review of uses of force, installation of cameras so that a reliable record exists, and discipline or termination when warranted. Finally, victims of violence in jail deserve, at the very least, prompt and thorough medical attention.

a. Serious Injuries, Inadequate Medical Response

What follows are several accounts of individuals who were the subject of staff assaults resulting in serious injuries that were followed by a disinterested and lethargic response from medical staff.

"Mr. Hernandez": staff violence resulting in a shattered hip socket, followed by a wait of over 6 hours for a medical response. A prolonged recovery in jail, thwarted by the nontherapeutic environment and the patient's reasonable fear of staff.

Information in this section derived from MCDC Incident Reports, Corrections Health records, Legacy Emanuel hospital records, court records, and Oregon State Hospital records.

"Mr. Hernandez" is an individual with a known history of mental illness and who has made several trips to the state hospital in the past two years. During the

[32] See Ryan, *Use of Force Policy and Procedure Review*, supra p. 10.

summer of 2015, he was incarcerated at MCDC on misdemeanor charges. According to deputy reports, Mr. Hernandez exited his cell one morning without being fully clothed. He was instructed to get dressed. Deputy reports state that Mr. Hernandez refused and instead, grabbed a food tray and raised it above his head as if to strike the nearby deputy. Consistent with typical practice, the leadership staff reviewing the incident did not seek a statement from Mr. Hernandez or any inmate witnesses. The jail does not have video cameras with recording capacity in the housing units. DRO has not been able to locate Mr. Hernandez in order to obtain a statement. What happened next, however, is undisputed. A second and very large deputy tackled Mr. Hernandez to the floor, inflicting an injury that was later identified as a comminuted acetabulum (hip socket) fracture.

Following the incident, Mr. Hernandez had an initial contact with jail medical staff at 7:57am. He stated: "Why did he do that? I was getting my coffee. He attacked me. My hip is dislocated. Just grab my leg and pull on it! Pull it hard!" The nurse noted that Mr. Hernandez's first and fifth metatarsal appeared "deformed," continuing "Client winces each time author attempts to approach, very anxious and guarded, No bruising or discoloration, Client has tenderness with touch near lateral tensor fascia area." After that initial contact, jail medical records indicate that Mr. Hernandez received no care or contact with any clinical staff for six hours. There is no record of further examination, or even that he received Acetaminophen or Ibuprofen. Finally, *more than six hours after the injury*, the jail performed an x-ray, and Mr. Hernandez was brought by ambulance to Legacy Emanuel Hospital.

Mr. Hernandez arrived at the Emergency Department at 3:17pm where, in addition to his injury, staff noted active symptoms of psychosis (responding to internal stimuli, hearing voices). He was diagnosed with a dislocated hip and a closed comminuted fracture of the acetabulum (or shattered hip socket), which required surgery and insertion of screws to secure the bone fragments into place.[33] After three days in the hospital, Mr. Hernandez returned to jail.

Upon his return to jail, Mr. Hernandez's treatment and recovery was compromised by his fear that jail staff would continue to harm him; a fear rooted in his experience but likely exacerbated by his mental illness.

[33] Also called "Open Reduction Internal Fixation."

He was prescribed a daily injection of Luvenox, a drug used to treat deep vein thrombrosis,[34] but he regularly refused it. "Client reports he will refuse all care because he doesn't trust the nurses and is refusing medication (specifically the Lovenox shot)" 8/26/2015. Medical staff seem to sympathize with his concerns:

> "CI appears disheveled, slightly malodorous, states he has not showered since his surgery . . . Mood is "distrustful". TC appears delusion and paranoid at times, though fears for his safety may be appropriate given fx was result of corrections use of force."
>
> "Client has been refusing medical treatment of hip injury 'I have right to refuse medical treatment' went on to express disgust with corrections staff 'because they jumped me for no reason.' . . . Refusing treatment "may be in fear due to use of force"

He appeared to experience barriers in understanding his post-operation care instructions and limitations, and there were hurdles to receiving assistance with self-care due to the restrictive environment of jail. For example, the record contains references to nurses being unable to enter his cell to provide post-operative care due to the patient's disciplinary status. On another occasion, his untreated mental health symptoms prevented him from receiving care: "Client was on for clinic visit today, but has been psychotic and not safe to bring to the clinic."

Throughout his record, there is evidence of Mr. Hernandez grappling with the difficult reality of his circumstances. In addition to his concerns that without physical therapy (which was not provided to him in jail) he may never regain use of his hip, he worried about his ability to survive on the streets if he was released before he had recovered.

> "Client says 'I got jumped by a group of deputies! I was just trying to come out for my breakfast tray and they jumped me!' he reports he knew his hip was dislocated at that point. Asked health team to call his lawyer so he can tell the lawyer he wants to take a plea rather than take case to trial. He thinks he will get 6 months, which he wants so he can heal because he is

[34] "Deep vein thrombosis is a serious condition because blood clots in your veins can break loose, travel through your bloodstream and lodge in your lungs, blocking blood flow (pulmonary embolism)." *Deep Vein Thrombosis*, The Mayo Clinic, (2016) Available at: http://www.mayoclinic.org/diseases-conditions/deep- vein-thrombosis/basics/definition/con-20031922

homeless and doesn't have anywhere to go. He is hoping to be healed by the time he gets out."

Three months after his injury, Mr. Hernandez was ultimately found unable to aid and assist in his own defense, and transported to the state hospital for competency restoration treatment. He arrived at the state hospital in a wheelchair. Unlike in jail, at the state hospital Mr. Hernandez was offered physical therapy 2-4 times per week and encouraged to practice walking as much as he could tolerate. Notes throughout his state hospital record indicate that Mr. Hernandez continued to struggle with fears that staff or others might hurt him, and he worried that he would never regain the use of his legs.

"He stated a '600 hundred pound cop' jumped on him when he was in jail, causing his hip be fractured. He called this a 'catastrophic injury' and was concerned that he would never be comfortable walking again. He has started physical therapy and will continue to do so."

After almost three months at the state hospital, Mr. Hernandez was sent back to jail to face his charges. At his discharge from the state hospital, he remained largely dependent on a wheelchair.

Mr. Hernandez has paid $469.641 for hospital services related to his shattered hip socket, and has an outstanding balance of $1,958.59. Prior to his incarceration and hospitalization, he was homeless. His current whereabouts are unknown.

"Mr. Washington": medical response to a significant use of force was a cursory glance by a nurse through the food port of the cell, released to the streets without medical attention for a broken rib.

Information in this section derived from MCDC Incident Reports, Corrections Health records, and Legacy Emanuel hospital records.

"Mr. Washington," a 49-year-old man, was booked at the jail in December of 2015. At 1:37 am, he was screened by a nurse and reported that he had a history of back injuries, knee surgeries, and used a knee brace. He also reported being hard of hearing. He was cooperative with the interview. When he was transferred from booking to a housing unit in the early morning hours, Mr. Washington reports notifying the deputy of his hearing impairment and

requesting to be awakened for breakfast. Nevertheless, he slept through breakfast and awoke hungry. He requested food, became frustrated when the request was denied, swore, and refused to return to his cell at about 9:30 in the morning. A scuffle ensued as three deputies attempted to physically force Mr. Washington back to his cell. Although he admits to swearing, Mr. Washington reports that the deputies assaulted him without physical provocation. Deputies report that Mr. Washington tried to strike a female deputy. According to the reports, as many as nine deputies participated in taking Mr. Washington to the ground, cuffing his wrists and hobbling his ankles, cutting his clothes off his body, and escorting him to a disciplinary unit.

A nurse made contact with Mr. Washington at 10:24am because he reported that he "was injured during the use of force when he was punched in the ribs." The nurse states "Patient seen through cell door food port" and reports that she provided "reassurance" and advised him to use a MRF (medical request form) for any medical needs.

Mr. Washington was released later that day (after less than 24 hours in jail) and made his way directly to Legacy Emanuel Hospital via public transportation. Hospital records reflect Mr. Washington's account that "several officers punched, kicked, and held him down until he was subdued" ("PT reports that he 'had the shit kicked out of me' in jail this morning" . . . "believes he has broken ribs . . . but that he was not treated in jail, states 'they refused to help me, they threw me in the hole.'") and cites injuries to the chest, right elbow and right knee, with severe pain.

X-rays performed at the hospital indicate that Mr. Washington did in fact suffer a fractured rib.

The injuries described above may have been inflicted negligently rather than intentionally. If so, this evidence remains consistent with a culture that prioritizes avoiding potential harm to staff even if that means total disregard to potential harm to detainees. DRO reviewed multiple instances, for example, in which detainees were restrained in a prone (or face down) position for prolonged periods, often pinned underneath multiple deputies. [35] This is a practice that can be life threatening and is therefore barred in many school and clinical settings.[36]

[35] An example from an MCDC Incident Report is below. See also, p. 12.

> "Once Inmate ["Smith"] was hobbled and calmed down, we placed a pillow over his head to be sure nobody got any bodily fluids on them . . . To avoid injury to any deputies carrying his weight they placed

b. Failure to Rein In Staff who Repeatedly Assault Detainees

During interviews with detainees at MCDC, DRO heard a number of complaints of disrespectful comments and behavior by two particular Deputies and subtle but insidious efforts to provoke and enrage inmates (in one inmate's words, "constant needling"). In one instance (which was confirmed by a second witness), the Deputy reportedly orchestrated an opportunity for an inmate with a known grudge to assault another inmate. Two detainees separately reported to DRO that the Deputy allowed the assault to continue (stating to witnesses "I'm going to let them fight for a little") before calling for back up. Another detainee described finding his Koran open and face down under his toilet and his cell ransacked. One Sherriff's Office colleague was willing to corroborate that both deputies were widely regarded within the Office as having problems with anger management and excessive force. One, we were told, is a "really nice person," who would be the first to admit that he has a problem of repeatedly "getting carried away" when using force.

DRO reviewed reports related to dozens of incidents involving these deputies. Most contain no evidence to contradict the corroborating accounts from other deputies. Rarely, a deputy's own report contains a statement that gives the reader pause. Once, for instance, a deputy entered a cell to try to prevent a psychotic detainee from "cheeking" (i.e., not swallowing) his medications. This is a role generally left to clinical staff and in any event, not appropriate in a setting such as the jail, which does not offer the due process required prior to a state-initiated override of a patient's informed consent. The detainee reached towards the deputy's shirt and, according to the deputy's own account, he yelled, "don't you even try and touch me, don't ever fucking touch a deputy!" and then pushed the detainee with both hands.

Occasionally, staff reviewing the incident issued a mild reprimand. For example, when a detainee allegedly reached through the food port of his cell to try to grab him, a deputy slammed the port on the detainee's hand multiple times, requiring a trip to the hospital for stitches and x-rays. On review, the Lieutenant notes that the Deputy could have withdrawn since the inmate was safely contained in a cell, and describes the multiple

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him on the elevator floor face down . . . Multiple deputies had to place their body weight on top of him . . . .medical staff arrived . . . we removed the pillow off the head . . . they decided he should be sent out to the hospital . . ["Smith"] appeared disoriented and was having a hard time answering some of medicals questions."

[36] See e.g., *The Lethal Hazard of Prone Restraint: Positional Asphyxiation*, prepared by Protection and Advocacy, Inc. Disability Rights California, (April 2002). Available at http://www.disabilityrightsca.org/pubs/701801.pdf

attempts to slam or kick shut the food port as "poor decision making." DRO only found a referral to Internal Affairs Unit in the few cases where either video footage existed, or non-deputy staff happened to have witnessed an incident and submitted a contradictory report. In those cases, the Internal Affairs Unit nevertheless invariably determined that the deputy's actions were "proper and justified."

DRO requested that the Sherriff's Office initiate an independent investigation of both deputies and remove them from contact with detainees pending that investigation. Currently, the deputies have been removed from contact with detainees and an investigation is ongoing. The investigation is being conducted by the Sherriff's Office rather than an independent office or individual.

DRO has also requested an update on implementation of the "next steps" outlined in the September 2015 Corrections Use of Force Audit.[37] Among other recommendations, the audit identified the need for a strategy to address racial disparity in use of force, and a process to identify and monitor deputies who submit high numbers of use of force reports. Summaries of two instances involving violence by the each of the deputies identified by DRO are below.

"Mr. Wright": tased in the back with little provocation; no mechanism exists to hold the deputy accountable despite widespread concern among his superiors about repeated misconduct.

Information in this section derived from MCDC Incident Reports, which included records from the Multnomah County District Attorney's Office.

The first incident involves a detainee who was tased in the back and subsequently fell, injuring his head, after he allegedly refused an order to get dressed and return to his cell after his shower. The victim, "Mr. Wright," and a corrections counselor witness, reported that Wright was getting dressed as ordered, but perhaps not as quickly as the deputy would have liked. The deputy reported that Mr. Wright had

[37] *Corrections Use of Force Audit,* Multnomah County Sheriff's Office, (September 14, 2015). Available at: https://s3.amazonaws.com/wapopartners.com/wweek-wp/wp-content/uploads/2016/02/19175117/jailuseofforce.pdf

1. Develop a strategy for addressing racial disparity in use of force.
2. Develop and monitoring and reporting process for employees who submit a high number of use of force reports.
3. Tie use of force reporting to other sources to assess the risk of underreporting.
4. Evaluate complaints of excessive use of force, determine the risk of excessive use of force.
5. Assess current use of force reporting process to gain reporting efficiencies and improve data reliability. Add requirements to EZwriter to improve data completeness (e.g., making certain fields "mandatory" for users to complete).

his fists clenched and had an aggressive facial expression. All accounts agree that Mr. Wright had his back to the deputy, and upon being tased, went down screaming. Back up arrived to find Mr. Wright face down on the floor, with "a fair amount of blood on the ground surrounding [the individual's] head." "It appeared that Inmate [Wright] was unresponsive."

When medical support arrived, Mr. Wright regained consciousness and became combative. Deputies held him down and applied a spit sock. He refused medical attention and was subsequently placed in the restraint chair "for medical and attitude evaluation."

The reviewing Sergeant interviewed Mr. Wright later. Apparently, Mr. Wright had been housed previously in the unit regularly staffed by the deputy at issue. The deputy had used force against Mr. Wright and Mr. Wright was removed for several weeks, but returned prior to this incident. During the interview, Mr. Wright started to cry and said "I can't believe you guys put me back in there with that guy [the deputy] . . . he is out of control and needs counseling."

The supervisors who reviewed the incident issued an unusually damning critique of the deputy's conduct, perhaps because it was witnessed by a corrections counselor whose account of the incident differs significantly from the deputy's account. While the deputy described a threatening inmate who disobeyed orders despite several warnings, the counselor reported that the inmate was "tased, seemingly without provocation, in the back." No video footage of the incident exists.

The supervisor's critique continues to describe how the deputy repeatedly engaged alone with a "noncompliant inmate" rather than disengaging and calling for backup.

> "On multiple occasions I have utilized shift briefing time to request that staff do no physically engage with an inmate or attempt to place restraints on an uncooperative, hostile, or angry inmate without first calling for/waiting for assistance. I have explained that this behavior creates substantially higher risk and is unnecessary and in most instances other a sudden and unprovoked attack by an inmate. Deputy KQ has previously been individually counseled about not calling for/waiting for assistance. . ."

He instigates conflict, bullies and enrages, rather than using techniques to deescalate a difficult situation:

> "Deputy KQ has been described to me by supervisors, coworkers and inmates as condescending, unreasonable, antagonistic a "bully" and "on a power trip" with regard to his management of inmates and use of the disciplinary process. Deputy KQ appears to draw a sort of perverse satisfaction from his ability to escalate even the most basic and benign of inmate interactions into a crisis situation requiring significant staff response and resources."
>
> "It is commonplace that Deputy KQ contacts a supervisor regarding an ordinary disciplinary infraction and by the time escorts and/or a supervisor has arrived the inmate is in a rage and seething with hostility directed at Deputy KQ. Inmates have repeatedly reported unreasonable, disrespectful, inflammatory, and targeted behavior exhibited by Deputy KQ. This has been an ongoing theme for an extended period of time. While it is not uncommon for inmates to make untruthful claims about staff, in this instance it appears to be just one more supporting piece of an overall pattern of behavior as recognized by others."

The deputy's behavior is recognized as not only bad for inmates, but bad for management of the jail. His "extreme hard line approach" is described as ineffective. He creates strife and turmoil that in turn results in physical confrontations, jeopardizing the safety of detainees and staff. Yet, this deputy's bad behavior has persisted "for years" unchecked.

> "this use of force is indicative of many force situations Deputy [KQ] has been involved in over the years. It accurately reflects the concerns . . . as many supervisors on various levels along with senior staff have engaged him in regards to how he manages inmates."

The review concludes, "It appears the force used in this incident was not justified."

The incident was reported to the Internal Affairs Unit Police Investigative Affairs office, and eventually sent to the District Attorney's office, who declined to pursue charges against the deputy. In his consideration, the District Attorney noted that the alleged victim had already been sent to the hole for cursing, that he admitted to "taking his time" while getting dressed, and that he gave the deputy a "funny" look. The DA continued, "[t]his is described as a 'what the fuck dude/come on kind of look.'" The DA also declined to press charges against the detainee, despite the deputy's request.

“Mr. Jones”: closed fist punches resulted in multiple shattered bones in Mr. Jones’ face, yet the Deputy is commended for letting a patient with mental illness out of his cell at all.

Information in this section derived from MCDC Incident Reports and OHSU hospital records.

“Mr. Jones" is 55 years old, with a history of schizophrenia, who exhibited active symptoms of psychosis at the time of the incident. He was housed in the psychiatric infirmary, 4D. According to the Deputy’s report, Mr. Jones had been let out of his cell for an opportunity to shower, but he refused to shower and instead, charged towards the deputy. No other staff were present and, consistent with Sheriff’s Office practice at MCDC, no statement was obtained from Mr. Jones, no inmate witnesses were interviewed, and no video footage exists. The Deputy’s report indicates that when Mr. Jones charged towards him, he tasered Mr. Jones making contact with his torso and causing him to collapse. Then, rather than use the opportunity to retreat and wait for back up, the deputy straddled Mr. Jones and used his taser in drive-stun mode. He reports that the charge either had no effect on Mr. Jones or failed to make contact. Hence, the deputy reported that in order to subdue Mr. Jones, he “administer[ed] 2-4 focused blows” to Mr. Jones’s face.

When back up arrived, Mr. Jones was placed in a restraint chair. Deputy reports describe an excessive amount of blood on the scene with Mr. Jones’s face wounds as the source.

> “Inmate [Jones] had quite a bit of blood on the floor near his head.”
> “[Jones] was face down and there was a good amount of blood on the ground and on [the] deputy.”

Despite the flow of blood, two spit socks were placed over Mr. Jones’s head and his legs were hobbled (even though Mr. Jones was already secured in the restraint chair). When medical staff arrived on the scene, it was quickly determined that Mr. Jones required hospital care.

Mr. Jones arrived at OHSU in a blood-caked spit hood, with “extensive facial fractures.” A blanket was placed over his head “to reduce the impact at the hospital on civilians.” The following excerpts are from Mr. Jones’s OHSU records:

> Patient is a 55 yo male with history of psychosis who presents after agitated behavior from jail. Per his report he didn't want to get into the shower today and refused to do so. He then says he was tasered, taken to the ground, and kicked in the face. Also during my conversation he was yelling at "Steve" asking him to stop using the remote control devices which torture him. He denies any medical or psychiatric history. He is currently incarcerated in the psychiatric unit. Per report of the officers the leads of the taser entered left arm and abdomen. Patient say it went into his eye.
> [. . . .]
> Face: Fractures are seen involving the medial and lateral pterygoid plates bilaterally. Comminuted fracture is seen involving anterior and posterior lateral walls including the maxillary alveolus of the maxillary sinuses bilaterally. Fracture through the anterior wall of bilateral frontal sinuses and the nasal bones along with suspected fracture of the nasal septum. Minimally displaced fracture of the left zygoma.
> Orbits: Fracture involving bilateral lateral orbital walls, fracture through the inferior wall of bilateral orbital walls. No entrapment of the inferior rectus muscle.

These records reflect multiple, comminuted (bone shattering) fractures throughout Mr. Jones's face. Such extensive injuries seem hard to justify under any circumstances.

Perhaps even more disturbing is that the review of this incident resulted in Deputy TW being commended for "attempting to allow Inmate Jones time out of his cell which sometimes in our psychiatric unit does not happen due to safety/security reasons." The reviewing Sergeant cites the fact that Mr. Jones was later transferred to the state hospital, and that his record "clearly documents an inmate with serious mental health and behavioral issues" as further justification for the extensive force used against him.

> "He should also be commended for his ability to utilize several force options, from least to most serious, in attempt to control and subdue Inmate Jones, who for reasons unknown, suddenly decided to attack [the] deputy."

Mr. Jones, despite his psychological condition and need for treatment at a hospital, was issued four major disciplinary violations (including Failure to Do As Ordered, Disruptive Behavior, Assaulting/Fighting/Threatening a Person/Staff and Disrespect

or Harassment) and charged criminally with harassment. The reviewing Sergeant reported that he could not interview Mr. Jones due to the pending criminal charges.

A Sergeant, Lieutenant, and Captain reviewed each incident report written by those involved in Mr. Jones's case. All of the reviews indicated that an appropriate amount of force was used by the deputy, including the "focused blows" to the face that shattered multiple bones.

According to jail records, Mr. Jones was charged $4,268.65 for hospital care related to this assault and $25 as a disciplinary fine.

Conclusion

Problems in our community's jail run deep. A propensity towards abuse is built into the fundamental concept of jail; jails are locked and therefore shielded from public scrutiny or oversight, the power structure (both among staff and in terms of the relationship between detainees and staff) is starkly hierarchical, and the jail's premise and primary behavior management tool is punishment driven. These elements create a recipe for both rogue violence and routinized violence. Given this backdrop, it is no surprise that detainees with mental illness find themselves hospitalized with a shattered jaw or shattered hip socket, or that a 'what the fuck dude/come on kind of look' is responded to with taser probes to the back. It is also no surprise that the best-intentioned staff regularly respond to behavioral health crisis by imposing force, restraints, and implementing conditions of extreme social and sensory deprivation. That's what jails do. Mental healthcare is undoubtedly helpful, but it will always exist at the periphery of a fundamentally coercive and non-therapeutic structure.

Racial Disparities:

It is hard to ignore the role of race in the data that DRO compiled and reviewed from other Multnomah County studies. African Americans are 5.6% of the county population, but 19-20% of those booked in jail and according to one sample, an astonishing 41% of those with mental illness in the jail. Once incarcerated, Black detainees appear almost twice as likely to disciplined, twice as likely to be subjected to physical force, and almost twice as likely to be "voluntarily" restrained.

DRO has compiled a lengthy list of recommendations that would improve conditions and treatment for our clients in jail. It is important to bear in mind, however, that there is no amount of funding, staffing, or policy changes that could transform the jail into a safe, therapeutic environment for people whose primary need is behavioral healthcare. Our efforts as a community need to focus on ending the jail's role as a dumping ground for people who, for a number of reasons, lack a welcoming destination. The recommendations below are intended to provide concrete, doable steps across the continuum of entities that play a role in the criminalization and incarceration of people who would be better served through a robust community mental health system and an adequate social safety net.

Recommendations

1. Provide healthcare and community for people with mental illness, rather than criminalizing them.
2. Strengthen supports for people with mental health issues in custody.
3. Create new protocol for trauma-informed response to mental health related behavior in jail.
4. Improve oversight and accountability to remedy systemic race and disability disparities, and prevent staff misconduct.

1. Provide healthcare and community inclusion for people with mental illness, rather than criminalizing behaviors associated with mental illness

Reinvigorate efforts to create a pipeline that shifts people with mental illness from jail to community mental health resources

- Conduct medical/behavioral health triage to divert individuals with mental health needs in jail to treatment
    - Corrections Health should post an RN as the first point of contact in booking to divert anyone with an urgent healthcare need (physical or behavioral) to the hospital or other appropriate crisis resource.
    - Portland Police, MCSO, City/County/community leadership, hospitals and healthcare providers, the criminal defense bar and District Attorney: continue to explore and implement pre-booking diversion options to connect people with behavioral health needs to community resources rather than jail.
        - Implement the recommendations of the 2015 Mental Health Jail Diversion Feasibility Study. https://multco.us/lpscc/mental-health-jail-diversion-feasibility-study.
        - Continue and expand the Law Enforcement Assisted Diversion (LEAD) program. http://www.portlandmercury.com/images/blogimages/2016/07/13/1468428521-lead_program_draft__6-22-16_.pdf
- Look to the Sequential Intercept Model: https://www.samhsa.gov/criminal-juvenile-justice/samhsas-efforts and seek technical assistance from SAMHSA's GAINS Center for Behavioral Health and Justice Transformation.
- The courts should reevaluate recognizance screening and bail to review whether "stability" considerations lead to disproportionate and unnecessary incarceration of people with mental illness

- The District Attorney's Office should not pursue charges if the defendant does not pose a significant risk to public safety, and the alleged criminal conduct was disability-driven or the defendant's competency to stand trial is doubtful.
- Hospitals should not arrest patients or call law enforcement based on disability-related behavior that does not present an imminent safety risk.

Offer a full spectrum of community-based treatment options for people with mental illness to fill in the gaps in behavioral health services

- The County, City, and service providers should better match individuals' mental health care needs with services:
    - Collaborate to create dual diagnosis treatment resources, expand mental health crisis services
    - Create respite care options to provide healthcare for people that may not meet hold criteria for a civil commitment or require a hospital level of care.
    - Involve peers (people with lived experience as recipients of behavioral health services) in the design and staffing.
    - Hospitals should invest financially in these services.

2. Strengthen Supports for those with Mental Health Issues in Custody

End solitary confinement for people with serious mental illness

- Solitary confinement should be presumed contraindicated for anyone with a serious mental health history or diagnosis. Other than a brief cooling down period of no more than 24 hours, individuals with serious mental illness should never be housed in solitary confinement.
- Move most or all of the jail's designated mental health units to Inverness. The Inverness facility has space for programming and treatment, and easier access to the outdoors and fresh air. Meeting minimal constitutional requirements for access to programming and out-of-cell time may not be possible at MCDC, given architectural constraints. Inverness currently has four vacant dorms that could be retrofitted (if needed) to meet the needs of these various populations

Expand Programming, Services, Out of Cell Time, and Reentry Services for Detainees with Mental Health needs:

Housing and Programming

- House detainees with mental health concerns in areas of the jail where they can access programming, or bring programming to the areas where they are housed. Detainees cannot be denied participation in programming, education, drug and alcohol treatment or early release opportunities because of their disabilities.

Allow Community Partners to Offer Services in the Jail

- Open the jail to outside service providers and community partners. Inverness invites partners into the jail to provide services, but MCDC does not. In-reach by partner agencies provides continuity of care, leverages all available resources, and improves transparency.

Healthcare

- All detainees currently receive a cursory screening for healthcare concerns. Detainees with apparent behavioral health concerns should be offered a more thorough evaluation that considers mental health as well as neurological impairments, intellectual or developmental disabilities, or brain injury. Interventions and conditions of confinement should be tailored to address any identified needs or barriers.
- Detainees with mental health concerns should receive appropriate mental healthcare: confidential appointments with their counselor, regular appointments with a psychiatrist or psychiatric nurse practitioner, and groups such as Dialectical Behavior Therapy, Cognitive Behavior Therapy, and art or music therapy. Meeting these needs will require hiring additional clinical staff.
- Medical exams and mental health counseling should not occur through the food port of a cell.
- Currently, detainees are required to pay $10 to make a request for healthcare. This process should be free except in the case of repetitive or frivolous requests.
- Detainees should not be charged financially for treatment of their injuries, especially those that occurred as a result of staff violence.

Discharge Planning to promote stability and reduce recidivism

- Discharge planning should include initiating the eligibility process for any potentially available government benefits including residential care through Medicaid Long-Term Care. Jails should facilitate access for the appropriate state

or local agency that assesses eligibility to conduct the assessment in jail, and participate in the discharge planning.
- "In-reach" is required by service and housing providers so that applicants can be screened and accepted before discharge and transition directly to services.

3. Create New Protocol for Responding to Mental Health Related Behavior in Jail

End the Jail's Punitive Response (through Discipline, Restraints, and Suicide Precautions) to Mental Health Related Behavior, Rein in Violence

Discipline

- One incident should be punished by no more than one infraction.
- Lessen the restrictiveness of disciplinary sanctions, shorten timeframes
- Detainees should not be disciplined for behavior related to their disabilities
- Solitary Confinement should not be imposed against any detainee for longer than two consecutive weeks or more than three weeks in a 60-day period.
- The jail should track infractions by staff person, identify staff who issue disproportionate numbers of infractions, and make personnel changes to prevent excessive or abusive use of the disciplinary process.

Restraints

- Restraints should only be used when ordered by a licensed clinician (or on an emergency basis pending arrival of clinical staff to the scene), or when necessary for secured transport. Self-harm is a behavioral health emergency and should be addressed promptly by clinical staff.
- Restraints should never be considered "voluntary." All uses of restraints should be subject to the same reporting and review requirements.
- Seek technical assistance from the National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIC). https://www.samhsa.gov/nctic

Suicide Precautions

- Suicide risk should be addressed by assigning a staff person with basic mental health training to provide constant observation. This duty should be performed by mental health technicians rather than deputies.
- Any restrictions on property or privileges related to mitigating suicide risk should be determined on a case-by-case basis by clinical staff.
- Consider new technology that allows vital signs to be monitored remotely, thereby allowing a detainee to engage in normal activities.

Training

- Train staff to appropriately handle mental health crises and prevent violence.
- Require Crisis Intervention Training, basic mental health, and cultural competency training for all jail staff. Require an enhanced level of training for staff in designated mental health units.

Ending Racial Disparities

- MCSO should track demographics across multiple data points (restraints, suicide precautions, discipline, segregation, mental health needs) and make this information publicly available. Use demographics to identify and correct any staff members demonstrating a pattern of biased actions or decision-making.
- Commit to ending disparities related to race, gender, disability or other identity markers. Implement implicit bias training for staff, work with experts to create checks and balances to counterbalance the role of bias, improve staff accountability.

Preventing Staff Violence

- Staff should be assigned to mental health units at the Facility Commander's discretion, rather than by seniority bidding.
- Install video cameras at MCDC with recording capacity; store footage for 180 days. Camera coverage should include all areas of the jail, including housing units, hallways, elevators, and vestibules.
- Require handheld video of any anticipated use of force.
- Uses of force should be subject to substantive review. This requires at the very least, interviewing the detainee involved and any detainee witnesses, and reviewing video footage. Given the serious violence detailed in this report, and prior findings regarding racial disparities, MCSO should consider contracting with an outside agency to conduct review of any significant use of force.
- Prohibit manually restraining a person in a prone position.
- Identify, monitor, and where appropriate, discipline staff who abuse detainees. Terminate employment if a serious misuse of force is substantiated.

Exhibit 1

MCDC MODULE DESIGNATION

FACILITY TOTAL: 448 Funded

MODULE	4A	4B	4C	4D	4E	4F
CLASSIFICATION	MEDICAL INFIRMARY	AD SEG	AD SEG	PSYCHIATRIC INFIRMARY	DISCIPLINE	DISCIPLINE
POPULATION	10	8	8	10	5	5
GENDER	BOTH	MALE	MALE	BOTH	BOTH	BOTH
# ON WALK	BY GENDER	2	2	UP TO 4 BASED ON BEHAVIOR	1	1
WALK TIME	BASED ON CLASS	45 MINUTES PER SHIFT	45 MINUTES PER SHIFT	1 HOUR PER SHIFT	BASED ON L/D LEVEL	BASED ON L/D LEVEL

MODULE	5A	5B	5C	5D
CLASSIFICATION	CLOSE CUSTODY	DISCIPLINARY HOUSING	DISCIPLINARY HOUSING/SPECIAL MANAGEMENT OVERFLOW	CLOSE CUSTODY
POPULATION	32	16	16	32
GENDER	MALE	MALE	MALE	MALE
# ON WALK	TIER	BASED ON L/D LEVELS	BASED ON L/D LEVELS	TIER
WALK TIME	1.5 PER SHIFT	DEPENDANT ON LEVEL	DEPENDANT ON LEVEL	1.5 PER SHIFT

MODULE	6A	6B	6C	6D
CLASSIFICATION	GENERAL MCDC	PROTECTIVE CUSTODY	PROTECTIVE CUSTODY	GENERAL MCDC/WORKER
POPULATION	32	16	16	32
GENDER	MALE	MALE	MALE	MALE
# ON WALK	32	TIER	TIER	32
WALK TIME	2.5 HOURS PER SHIFT	2 HOURS PER SHIFT	2 HOURS PER SHIFT	2.5 HOURS PER SHIFT

MODULE	7A	7B	7C	7D
CLASSIFICATION	MENTAL CLOSE	ACUTE MENTAL CLOSE	ACUTE MENTAL CLOSE	TRANSITIONAL
POPULATION	32	16	16	32
GENDER	MALE	MALE	MALE	MALE
# ON WALK	TIER	UP TO 8 BASED ON BEHAVIOR	UP TO 8 BASED ON BEHAVIOR	BASED ON CLASSIFICATION
WALK TIME	2 HOURS PER SHIFT	1.5 HOUR PER SHIFT	1.5 HOUR PER SHIFT	BASED ON CLASSIFICATION

MODULE	8A	8B	8C	8D
CLASSIFICATION	CLOSE CUSTODY/MENTAL CLOSE	ACUTE MENTAL CLOSE/SUICIDE WATCH/DISCIPLINARY/ AD-SEG	SUICIDE WATCH/SPECIAL MANAGEMENT	GENERAL MCDC FEMALES
POPULATION	32	16	16	32
GENDER	FEMALE	FEMALE	MALE	FEMALE
# ON WALK	BASED ON CLASSIFICATION	BASED ON CLASSIFICATION	BASED ON CLASSIFICATION	TIER
WALK TIME	BASED ON CLASSIFICATION	BASED ON CLASS	BASED ON CLASS	BASED ON CLASS

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