

BEHIND THE ELEVENTH DOOR



Solitary Confinement of Individuals with Mental Illness in Oregon's State Penitentiary Behavioral Health Unit

An Investigative Report by Disability Rights Oregon



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Thank you to Juhi Aggarwal, Phyllis Burke, Alice Forbes, Esther Harlow, Bob Joondeph, and Kathy Wilde for their valuable contributions to the development of this report.

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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.

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Cover photo: Entrance to Section 1 of the Behavioral Health Unit at Oregon State Penitentiary. Photo © Oregon Department of Corrections

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I. INTRODUCTION

As the federally designated Protection and Advocacy System for Oregon, Disability Rights Oregon (DRO) is charged with protecting the legal rights of individuals with disabilities in our state.

DRO first became aware of problems at the Behavioral Health Unit (BHU) of the Oregon State Penitentiary (OSP) in May of 2014 when two prisoners contacted us. They complained that they were being kept in their cells for 23 hours a day and that prisoners on the unit were routinely being punished for self-injury and other symptoms and behaviors driven by their mental illness.

DRO receives many complaints from prisoners across the state, but the BHU complaints sparked particular concern because they were unusual in their consistency and level of detail. Additionally, the complaints focused on aspects of incarceration that we assumed would have been better addressed in a specialized unit that was designed to provide a therapeutic and safe environment for prisoners with serious mental illness.

In August, we contacted Oregon Department of Corrections (ODOC) Director Colette Peters to convey our concerns and request information that would allow us to assess the situation at the BHU. We asserted our legal authority to investigate under law and our Memorandum of Understanding with ODOC, and invited them to meet with us and explore potential solutions.

Since then, ODOC and the Assistant Attorney General who represents the department have met with us on multiple occasions. They have assisted our investigation by providing access to BHU prisoners and have allowed us to visit and observe the unit as needed. ODOC also agreed to waive fees associated with collecting and providing requested records, documents, and videotapes. That level of cooperation has allowed us to thoroughly investigate conditions at the BHU. Our report is written to explain what we have learned about the BHU and, where appropriate, make recommendations for changes.

To complete our investigation, we relied on the following sources of information:

1. Interviews of 19 BHU prisoners,
2. Approximately 4,500 pages medical and other records contained in the files of seven prisoners whose situations were particularly alarming to us,
3. Videotapes of seven “suit ups” or cell extractions that involved the use or potential use of force against prisoners at the BHU,
4. Unusual Incident Reports (UIRs) related to the videotaped prisoners,
5. Written ODOC policies that define some of the procedures and practices at the BHU,
6. Records provided by ODOC that document BHU practices,
7. Interviews with eight ODOC mental health employees and contractors,
8. Three monitoring visits to the unit.

As part of that cooperative effort, we provided ODOC with a draft copy of our report and have considered the Department’s subsequent comments and suggestions for changes and corrections. We have incorporated that input into the report where we judged it appropriate. In light of ODOC’s suggestion that the report might be improved with input from correctional staff, we will seek to interview past and current BHU correctional officers who are willing to speak with us. If this source of information alters our conclusions or findings in a significant way, we may issue a supplementary report.

This report does not identify any former or current ODOC staff by name. We have written our report in a manner that, whenever possible, does not include information that might allow these individuals to be identified. To protect our clients’ confidentiality, we have used pseudonyms to describe individual prisoners.

II. EXECUTIVE SUMMARY

The corrections system has become the nation's largest provider of mental health services. The Oregon Department of Corrections (ODOC) has determined that more than half of Oregon's prison population has been diagnosed with a mental illness. Many of the prisoners who are most profoundly impacted by their mental illnesses are held in solitary confinement in the Behavioral Health Unit (BHU) at the Oregon State Penitentiary. These men spend months and sometimes years in an approximately 6 x 10 foot cell, with no natural light, no access to the outdoors or fresh air, and very limited opportunities to speak with other people. While ODOC policy requires these prisoners to be offered regular opportunities to shower and "go to rec,"¹ our investigation revealed that few BHU prisoners are actually able to access these opportunities more than once or twice a week. Stated more simply, BHU prisoners are subjected to long periods of solitary confinement.

The stress, angst, and boredom of solitary confinement are extremely harmful to an individual's mental health. As one court concluded: "the record shows, what anyway seems pretty obvious, that isolating a human being from other human beings year after year or even month after month can cause substantial psychological damage, even if the isolation is not total."² For individuals with serious mental illness, solitary confinement is widely acknowledged to be detrimental and clinically contraindicated. The American Bar Association, the American Psychiatric Association, and the United Nations oppose solitary confinement for people with mental illness. Beginning with the U.S. Supreme Court in 1890³ and continuing in recent years, courts across the country have decried the practice. By 1995, a

¹ "Rec" in the BHU is solitary recreation in a small, walled area with a ceiling partially open to the sky. The rec areas contain an exercise bike, and some contain a punching bag.

² *Davenport v. DeRobertis*, 844 F.2d 1310, 1313 (7th Cir. 1988).

³ *In re Medley*, 134 U.S. 160, 180 (1890) ("[a] considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service.")

federal judge compared placing an individual with a serious mental illness in solitary confinement to putting an asthmatic in a place with little air to breathe.⁴ In recent years, this problem is being addressed across the country. Some of our recommendations are modeled after a 2014 settlement with the state of Arizona.⁵

The desperation and exacerbation of symptoms resulting from isolation can significantly decrease a person's ability to conform his actions to rules and behavioral norms, thus creating a cycle of lashing out and increased penalties that further reduce mental health. That sort of cycle is not only a disaster for the prisoners who cannot escape it; it is an endless source of danger for the correctional officers who have to maintain order in an already difficult environment.

Originally, the BHU was designed to break this cycle by better addressing the unmet mental health needs of prisoners with serious mental illness. In recent years, however, clinical staff and mental health treatment have been marginalized in favor of an ever-increasing deference to the safety and convenience of correctional staff. This shift has created an environment in which individuals are deprived of basic human rights.

BHU prisoners and the past and present BHU mental health employees who spoke with us were consistent in their belief that many BHU prisoners have been subjected to the practical equivalent of torture during their often very long stays in the unit. The conditions that they describe undermine the health and well-being of the prisoners. In addition, they expose ODOC to legal liability and jeopardize utility of the unit within the ODOC system.

We have learned that there are many serious problems at the BHU, but have focused on identifying a limited set of primary concerns that must be corrected if the BHU is to fulfill its mission and meet constitutional standards of care.

⁴ *Madrid v. Gomez*, 889 F. Supp 1146, 1261 (N.D. Cal 1995) discussing the effect of placing prisoners with serious mental illness in a solitary confinement unit.

⁵ www.aclu.org/news/arizona-agrees-major-improvements-prison-health-care-crucial-limits-solitary-confinement

Those three primary concerns are:

1. Isolation.

Most BHU prisoners are out of their cells for one hour per day or less, and many report that this severely affects their ability to cope with life in the BHU.

2. Lack of access to mental health treatment and services.

Records and interviews confirm that BHU prisoners are unable to reliably receive timely Mental Health (MH) services when in crisis or undergoing decompensation. Despite the fact that they experience severe mental illness (SMI), most see the psychiatric physician who oversees their mental health two to three times per year in a setting that provides no confidentiality. Many incidents of staff force against BHU prisoners are triggered by the inability of BHU prisoners to access mental health staff or their psychiatric provider.

3. A culture that promotes unnecessary violence and retaliation by correctional staff.

The BHU is currently ruled by a culture in which BHU correctional staff consistently override or ignore the advice of mental health professionals. In the absence of empowered and physically present clinical staff, corrections officers handle mental health crises with tasers, pepper spray, riot gear, and restraint chairs. Retaliation against BHU prisoners who have caused problems is common.

To address these three concerns, we offer the following recommendations:

- 1. BHU should adopt policies and practices to ensure that every BHU prisoner will be out of his cell for a minimum of five hours per day of structured activity and daily showers and recreation.**

BHU should adopt policies and practices to ensure that every BHU prisoner will be afforded an opportunity to shower and exercise at least twice daily. In the case of any prisoner who declines those opportunities more than three times per week, the BHU treatment team will create a plan to offer those opportunities more effectively.

Structured activities could include jobs, classes, group counseling, or socialization.

- 2. BHU should adopt policies, practices, and resource allocations to ensure that MH staff can regularly observe BHU prisoners and meet with them in a confidential setting as needed.**

BHU should adopt policies, practices, and resource allocations to ensure that MH staff are either housed within the unit or can otherwise access BHU prisoners upon request without waiting for the consent of correctional staff or the availability of a two-man tether transport team.

- 3. BHU should adopt policies and practices that require a 30-minute cool down period prior to forcibly removing a prisoner from his cell or otherwise subjecting him to planned physical**

force. During that time, policy should require a visit by a Qualified Mental Health Professional (QHMP) or MH provider who will attempt to gain compliance or devise a resolution of the concerns at hand without force.

BHU should adopt policies and practices that prohibit the planned use of force against any BHU prisoner until the prisoner has been seen by MH staff who determine that there is no way to ensure the safety of the prisoner or others the without the use of force.

The BHU mental health team should review all videotapes of planned force incidents and all Unusual Incident Reports and then convey any recommendations for changes in practice, procedure, or their implementation to the treatment team and the Director of Special Housing at OSP.

III. OUR FINDINGS

A. The BHU today



Entrance to Section 1 of the BHU
Photo © Oregon Department of Corrections

The pictures of the Behavioral Health Unit that we have included in this report cannot accurately convey what it is like to be there. To see the cells where each BHU prisoner spends an average of 23 hours a day, you walk through other parts of the prison. The hallways and rooms are reminiscent of an aging high school. As you get close to the cell tiers and the last of eleven electronically locked and controlled doors, you begin to hear prisoners randomly screaming, talking to themselves, and rhythmically banging walls and metal. You pass underneath a glassed-in control tower where clipboards, face shields, and radios are hung. You then wait to go through one of three heavy, metal mesh doors that are controlled by the tower. After that, it's about a 40 foot walk across a deserted floor to a two-level tier of cells. The feeling that you get as you get closer to the cells is

that you are seeing conditions from a past century when mental illness was primarily “treated” through a combination of warehousing and isolation.



Empty cell in Section 2 of the BHU
Photo © Oregon Department of Corrections

The cells in the BHU are about 6 feet wide and 10 feet deep. Each has a single prisoner’s last name over its top and contains a thin mattress on a concrete platform. There is a stainless steel plumbing unit with a sink on top of the toilet at the back wall. Officers have a clear line of sight to the toilet from the front of the cell. Correctional officers and prisoners address each other by last names. Those prisoners who were interested enough in our visits to stand and look out of their cells were hard to see through cell fronts that consist of metal pierced by holes that are about the size of pencil eraser. Many cells are additionally covered by sheets of Lexan™, a hard, translucent and yellowish plastic that reduces the prisoners to blurry shadows even if you are directly in front of them and a few inches away. To speak with a prisoner in one of these cells and be heard, you have to bend down and talk through the cuff port, a waist-high slot used to cuff prisoners

before taking them out of their cells, and even then, it is often difficult to hear a prisoner over the din of the unit.

The BHU has no natural lighting and no windows. It is semi-dark even during the middle of the day. It smells of cleaning chemicals, body odor, dirty clothing, and mold. Each of the three units on the BHU contains a small shower at the end of the top tier and a recreation area which is surrounded by two-story high walls on all sides. The ceiling of the recreation area is partially enclosed and partially covered by a grate that is two stories above the floor and the only point of contact with natural light or air that is available to BHU prisoners.

B. Creation and original intent of the BHU

Out of the approximately 7,000 prisoners within the ODOC system who experience mental illness, ODOC has identified approximately 125 individuals whose serious mental illness and behavior are so severe that they require special housing.

The Behavioral Health Unit was created to more safely and humanely house 48 of the most seriously affected prisoners in the state. The prisoners who end up there are frequently individuals whose serious mental illness had previously driven them to extreme forms of self-harm, suicide attempts, or assaults against staff and other prisoners. ODOC acknowledges that when these “problem behaviors” are driven by psychosis, delusional belief systems, trauma, or mental instability, the usual systems of graduated privileges and deterrents employed elsewhere in the prison system are ineffective.

ODOC created the BHU to provide a coordinated system of intensive case management that would provide prisoners with serious mental illness the tools and supports that would eventually allow them to better control behaviors and symptoms. The three key elements of the BHU system of care are: Dialectical Behavior Therapy classes, counseling readily available by Masters’ level Qualified Mental Health Practitioners (QMHPs), and a Treatment Team that promotes the collaborative creation and implementation of an individualized treatment plan that reflects the input of each prisoner, clinicians, and security staff.

a) Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) is an offshoot of Cognitive Behavior Therapy. It is one of the few therapeutic treatment models that can claim a somewhat successful track record with individuals who have Borderline Personality Disorders. There is also evidence that DBT can be helpful for individuals who engage in substance abuse and self-harm.

DBT teaches individuals to recognize triggers of problem behaviors and then provides tools that the individual can use to change self-defeating

patterns. The DBT model relies on group classes where individuals who are learning these skills share frustrations and acquired knowledge under the eye of a skilled DBT trainer.

In the BHU, the successful completion of DBT classes is one of the requirements for transitioning out of the unit, and participation is a component of every BHU treatment plan. Participation and progress in learning DBT skills is also a stepping stone toward greater privileges in the BHU.



**Education room where DBT takes place
Photo © Oregon Department of
Corrections**

BHU prisoners are scheduled to attend one DBT class per week.

The classes are conducted in a small room where prisoners sit in four phone booth sized metal cages that do not allow them to properly see one another.

b) Qualified Mental Health Providers (QMHPs)

Mental health services are provided by a psychiatrist who splits her time with one or more other specialized units and four QMHPs who are assigned to the BHU. The psychiatrist works with a treatment team and is responsible for prescribing and monitoring medications. ODOC has indicated that she meets with BHU prisoners “every couple of weeks” despite the assertions of some prisoners who told us that they saw her only a few times a year. More immediate and routine mental health problems are addressed by the QMHPs. Each QMHP is assigned a roster of individual prisoners and is supposed to meet with those prisoners weekly.

c) Treatment Team

The BHU model relies heavily on the treatment team to deal with the problems of each BHU prisoner. The model seeks to create a way to harmonize and mediate the often conflicting perspectives of clinicians and security staff. Typical participants therefore include the unit head, Qualified Mental Health Professionals (QMHPs), and members of the security staff. Most treatment team meetings are convened around the problems of individual prisoners although some of the meetings may address more systemic issues. Behavioral Health Services administrators and treating physicians also attend some meetings. The treatment team creates each BHU prisoner's treatment plan and the model also seeks to secure prisoner participation and "buy in" to those plans. This can mean that prisoners meet with the team to discuss problems and ways to reduce them.

C. Extreme isolation and sensory deprivation

“For these inmates, placing them in the SHU is the mental equivalent of putting an asthmatic in a place with little air to breathe.”⁶

Madrid v. Gomez, 889 F. Supp 1146, 1261 (N.D. Cal 1995)

Despite the good intentions behind the creation of the Behavioral Health Unit, our investigation revealed that it is rare for BHU prisoners to be out of their gloomy cells for more than an hour a day (thus subjecting them to conditions widely defined as solitary confinement,) and that access to mental health care has been drastically curtailed.

Most BHU prisoners told us that they would prefer to be anywhere else in the prison (including Death Row or Disciplinary Segregation) and tried to dull the effects of their isolation in a number of ways, many of which are horrific. We learned that many BHU prisoners cut themselves, taunted one another, or spent the entire day pacing the circumference of their cells. Others banged their fists against cell walls for hours at a time, one to the extent that his cell was re-outfitted to reduce his ability to make noise in that way. Suicide attempts and threats are a commonplace in the BHU.

⁶ The SHU is a specialized housing unit that subjects prisoners to extreme isolation in another state’s prison system.

Case Study: Elliott Wynan

Like many of the men confined in the BHU, “Elliott Wynan”⁷ resorts to self-harm as a desperate strategy to get out of his cell or compel medical or mental health attention. Sometimes the result is a hospital visit or brief respite in the Mental Health Infirmary (MHI), but more often, the security-driven response to his self-harming behaviors is a mixture of physical force and the imposition of further isolation and deprivation.

In the fall of 2013, Mr. Wynan had been placed on suicide watch, and he was desperate to be transferred to the Mental Health Infirmary where he perceived staff to be more sympathetic and expected better access to mental health treatment. He reports that he told correctional staff that he was in crisis and needed to go to MHI many times with little response and no result. Eventually, a correctional officer⁸ told him that “you have to get pepper sprayed to go to MHI.” Mr. Wynan took the officer at his word and hung his sheet across the front of his cell.

An ODOC videotape documented the incident that followed. A team of officers in riot gear arrive and order Mr. Wynan to remove his sheet. He refuses and is then simultaneously pepper sprayed through the cuff port and rear of his cell for approximately 20 seconds. Officers then pull Mr. Wynan from his cell and take him to the floor where they pull down his pants and he is injected in the buttocks. A sergeant tells Mr. Wynan that he can shower to remove the pepper spray and will be transferred to the infirmary. Mr. Wynan responds incredulously, “That’s all I wanted in the first place. Why was all of this necessary, man? I’ve been asking for this for a month.”⁹

⁷ To protect our clients’ confidentiality, we have used pseudonyms to describe individual prisoners.

⁸ Correctional officers may be referred to as COs, guards, or security staff. For ease of reading, we will refer to them as officers.

⁹ Our report includes detailed descriptions of these anticipated force videos because they provide compelling and indisputable evidence of reality of life in the BHU.

DOC typically responds to Mr. Wynan's acts of self-harm and decompensation by placing him on Suicide Close Observation (SCO). This has occurred at least eight times in the past two and a half years. During these SCO periods, he was typically allowed "no possessions" and was issued a Teflon® smock, a Teflon® blanket, and a paper cup and tray. He was not allowed to have eating utensils. Sometimes he refused to wear the smock and records indicate that he was observed to be naked during at least two of the SCO periods. Records also indicate that Mr. Wynan was deprived of his mattress during most of these periods.

Mr. Wynan described one period of SCO during which he was also punitively deprived of toilet paper by a particular officer. He believes that this went on for twelve days until another officer insisted that Mr. Wynan needed to be provided with toilet paper. DRO was unable to confirm the details of this account, but did verify that Mr. Wynan was placed on "dry cell status" (in addition to SCO) twice. Dry cell status is ODOC's tool for dealing with situations in which prisoners swallow potentially harmful items. The water supply to the cell is turned off and personal belongings (including toilet paper) are removed so that medical staff can confirm when and if the harmful item has passed. Per DOC policy, dry cell status should not last more than 72 hours, and toilet paper is to be offered after each bowel movement.¹⁰

Mr. Wynan's medical records appear to indicate that he was held in "dry cell status" for as many as eighteen consecutive days.

¹⁰ DOC Policy 40.1.11

1. Prisoners cannot reliably access showers and recreation

ODOC policy requires prisoners to be offered the chance to shower and exercise several times per week, but our review of 476 pages of BHU shower and rec logs indicates that very few BHU prisoners reliably access the opportunity to shower and “go to rec.” Daily logs for the three year period between 2011 and summer 2014 establish that the vast majority of



Shower in Section 2 of the BHU
Photo © Oregon Department of Corrections

BHU prisoners “refused” recreation for days at a time. For example, of the 39 inmates housed in the BHU on June 4, 2014, only three participated in recreation. Two are marked “n/a” due to cell-in status during which recreation is not offered. One notation is indecipherable and the other 33 are marked with an “R” for “refused.”¹¹ Shower logs also indicate spotty participation. For example, of the 33 inmates

housed in the BHU on April 12, 2014, 7 or fewer actually showered (records for two are inconclusive.)¹²

Conversations with BHU prisoners suggest that their consistent failure to shower or exercise is not caused by a lack of interest in those activities. They told us that they are not able to access showers and recreation because of how these opportunities are “offered.” Shower and rec invitations begin at 6am. The powerful psychiatric medications that most BHU



Rec area in Section One of the BHU
Photo © Oregon Department of Corrections

¹¹ See Appendix, Exhibit 1.

¹² See Appendix, Exhibit 2.

prisoners receive cause drowsiness so that many of them are asleep and difficult to rouse when the officers walk the tiers to offer showers and rec. Previously, showers and rec were offered twice, once in the morning and once in the afternoon. At some point that changed.¹³ Showers and rec are still technically offered twice, but when a prisoner “refuses,” the second offer is usually extended only a few minutes later.¹⁴ In a meeting with DRO, BHU leadership admitted that the second offer is a mere formality. Pursuant to a consistent practice in the BHU, when a prisoner refuses or is nonresponsive to the first request, he is not allowed to accept the second offer. Prisoners and some mental health staff believe that this system was specifically altered to minimize the number of showers and recreation periods that officers would be obliged to provide. ODOC rejected that suggestion. They noted that the unit simply does not have the staffing to provide a shower and recreation for more than twelve prisoners per day. Currently, the BHU houses 43 prisoners. The theoretical availability of 1-2 hours per day out of cell to shower and exercise is not reality for the vast majority of the men held in the BHU.

2. Property deprivation

Prisoners’ property is tightly regulated in the BHU. Property allowances correspond to an individual’s “level.” All BHU prisoners start at a level “A-2.” BHU prisoners who engage in “significant target behaviors” can be further restricted to Level A-1. The treatment team determines when to move and individual prisoner upward through the level system based on good behavior: A-2, B, C, and long term C.

Prisoners at level A-1 may only possess one book or magazine, a pen or crayon, and paper. They are only allowed to purchase envelopes (a maximum of five) and basic hygiene items from canteen. Once prisoners graduate to level A-2, they are allowed “1 pair red shorts, 2 complete sets

¹³ According to an undated BHU Rules list: “Recreation periods will no longer be conducted as AM and PM. They will be run in a wrap-around fashion starting at 6:00am.”

¹⁴ According to some prisoners, there are times when the interval between first and second offers is actually less than a minute.

of clothing,” and a radio. At level B, they are allowed to possess personal photographs. At level C, the final reward is a pair of shoes.

Items as basic as a mattress or a single crayon are not a reliable entitlement in the BHU. Two emails from BHU leadership to staff in February 2014 make this clear:

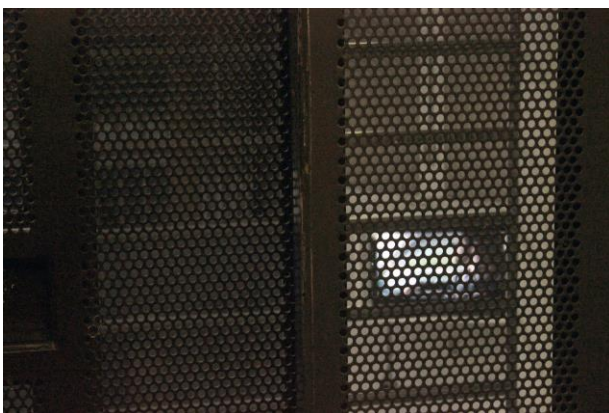
“If an inmate’s behavior has been egregious enough for management to approved [sic] a move to Section 2, it is appropriate to remove and hold his property until Treatment Team makes a decision in regard to his level.”

“I should have been more specific . . . I mean personal property . . . Please do not automatically confiscate basic property, like their mattress, unless their behavior warrants approval for a deprivation order.”

Another email from 2012 reminds staff that “inmates are generally allowed a writing instrument.” The message continues:

“In our case, at times, we can’t trust inmates with pens so we allow a crayon. Since sometimes crayons are used as a reward I don’t want the two confused. One crayon, as a writing instrument is different than several crayons and a coloring book.”

In this environment of extreme deprivation, therapeutic victories are rare. As one clinical staff member put it: “I can’t change anything that really matters for my clients, so I have to satisfy myself with giving out crayons.”



**View of TV from inside a BHU cell
Photo © Oregon Department of
Corrections**

The social isolation, lack of programming, and lack of personal items that might be used as entertainment cause many BHU prisoners to rely heavily on television to pass the time. Each of the three units has one television, located in front of the bottom tier. During the last year or so, even the minimal

entertainment value offered by those often hard-to-see televisions has been drastically reduced in a manner that suggests that the change was intentional.¹⁵ A policy change in 2014 restricted viewing to five channels, despite the fact that none of the prisoners we spoke to expressed any interest in those channels. Prisoners also complained that the selection available on the book cart is no longer refreshed as it used to be. “It’s always the same books that you’ve already read. And it’s like the books you’d find at your grandma’s garage sale.”¹⁶

3. Self-harm

Poorly addressed mental illness and the pervasive despair of the BHU frequently lead to self-harm. In fact, harming oneself seems to be accepted as a reasonable way to secure attention from the mental health staff. Some men bash their heads against the walls, others obtain razor blades and slice their wrists, and some attempt to hang themselves by creating nooses from their bedsheets.

One BHU prisoner regularly uses staples and Velcro® to cause himself to bleed. He described the impulse to us:

“When I see my blood coming, I feel release. I cut myself every day for one month, filled a cup, every day. After a while I was starting to feel weak, then I stopped. But I’m still doing it. It’s not because I’m crazy.”

He also told us that he had not engaged in self-harm prior to experiencing solitary confinement.

Another young man described, with real bafflement, his compulsion to bash his head against walls. He said head-banging became addictive for him and

¹⁵ It is also quite possible that the change was instituted to reduce prisoner arguments about what was watched, but the solution adopted meant that the level of boredom and pointlessness was elevated for every prisoner in the BHU.

¹⁶ Mental health staff told us that this change was explained to them as the result of fears about smuggling contraband through the multiple book carts that used to be rolled through the tiers, but they found that explanation unconvincing and suspected that security staff wanted to decrease their responsibilities.

he did it constantly. On one occasion, he described calling to an officer, “I can’t stop hitting the freaking wall with my head,” but he reports that no help was offered and he cannot recall ever speaking to a counselor about the problem.

Mr. Wynan described being so desperate to get out of his cell that he told his counselor, “If you put me back in my cell, I’m going to bash my head in. I’m going to bash my head until blood and brains come out.” The counselor responded that, “If you bash your head they’re going to have to suit up and spray you.” Following this exchange, Mr. Wynan was returned to his cell and began to bash his head against the wall. He reports that he was then sprayed with pepper spray. In one of the numerous accounts of head-banging in Mr. Wynan’s medical records, he is reported to have stated: “I am going to bang my head against the wall. I want to be sent to the hospital.” A nurse who described “moderate swelling to forehead with bleeding cut,” concluded that it was “attention-seeking behavior” and scheduled him for sick call the following morning.

Case Study: David Logan

With the exception of a period during which “David Logan” was transferred to federal prison for about a year and a half in 2013, he has been in the BHU since 2011. In the BHU, he has been tased and pepper sprayed many times and has been placed on close suicide watch repeatedly. These sorts of events were frequently triggered when Mr. Logan swallowed metal objects during long periods of desperation and mental health decompensation. On at least one of those occasions, surgery was required to remove objects that Mr. Logan had swallowed. Other object-swallowing incidents resulted in dry cell restrictions during which he was placed in a cell without operational plumbing so that his stools could be monitored to confirm that the objects had passed through his GI tract. Mr. Logan has experienced a few periods of relative calm and well-being in the BHU, usually when he had had access to art materials, but he has always engaged in self-destructive acts that have universally failed to win him a transfer out of the BHU. His longest periods of apparent stabilization and relatively good mental health took place after his return from federal prison in August of 2014, at least suggesting that the improvement may have been the result of better access to mental health care and reduced levels of isolation that he experienced while in federal custody.

In September of 2012, Mr. Logan swallowed objects attached to a string that he believed would allow him to “fish for things in his intestines.” A few days later, he told a mental health staff member that “I cannot take the noise and having nothing day after day, year after year in the BHU.” He later explained the swallowed objects as a means to “pull his guts out and end his ‘life in a box.’” The counselor noted that “he has frequent decompensating periods even when complying with treatment.”

In October of 2012, Mr. Logan broke off and swallowed the sprinkler head in his cell in a new attempt to kill himself or be transferred to another unit in the prison. Following an unfiled removal to a holding cell in the BHU intake area, his subsequent removal from that cell and placement in a restraint chair is documented in a videotape.

The tape begins with a typically short explanation of the intended action in which the leader of a six person (+ 2 nurses) security team explains to the camera operator that it is 8:15 p.m. and that Mr. Logan would be taken out of the holding cell and escorted to a restraint chair because he had cut himself, swallowed objects, and threatened further self-harm. The fact that the team is not dressed in the usual helmets and riot gear may signal that no resistance or danger is expected.

When the team arrives at the cell. Mr. Logan is naked except for a purple towel that is wrapped around his waist and a pair of sandals. He seems calm and offers no objection or resistance while he is put in restraints and his head is covered with a spit sock. He is then escorted to a hallway where he is seated in a restraint chair. His shoes and portable restraints are removed one at a time as his ankles, arms, waist, and shoulders are strapped into the chair so that he cannot move any large part of his body other than his head. After a quick tug by a nurse to check the tightness, the camera is turned off.

When the tape resumes at 8:50, Mr. Logan is still in the chair which has been moved into his completely empty cell, and the door has been opened. The spit sock is no longer on his head. An officer checks the tightness of the straps. Mr. Logan continues to appear quite calm. He says that he is alright except for being cold. The officer promises to “check with LT” about that and the tape is turned off again. It resumes at 9:25 p.m. when the security check is combined with a medical check during which two nurses record vitals while an officer holds a spitshield in front of Mr. Logan’s face. He again complains “I’m freezing,” and asks for something to keep him warm and is again promised that “I’ll check with the LT about that and see what we can do.”

By the 10:25 p.m. security check, Mr. Logan is covered with a smock and tells the CO’s that “if you guys ever decide to let me out, I’ll go right to sleep.” Recorded medical and security checks continue every 20 to 45 minutes and Mr. Logan continues to complain of being cold. He also continues to request that he be released from the chair. During one of the checks, he confirms that the string attached to the objects he swallowed is

still in him. At the end of the 11:45 p.m. medical check, he asks the nurse to mark down that his body temperature is “ten below normal,” but there is no decipherable response. After another check during which Mr. Logan argues that he is long past any desire to hurt himself or anyone else, the tape records Mr. Logan being removed from the chair after it has been wheeled out of his cell. He is placed in portable restraints and attached to a tether after the team leader notes that he has been compliant and has been told that he will be returned to the chair if he threatens to harm himself or anyone else. He is returned to his cell at 1:52 a.m., almost six hours after being placed in the restraint chair. He trades the towel for a smock and a mattress is brought into his otherwise empty cell. He is told that he will be given a blanket and the tape ends.

4. Section 2

“When I was housed over there behind glass, I often suffered from severe panic attacks that made me feel like I was drowning. I felt like tearing the skin off my chest just so I could breathe. But I couldn’t do that so I would tear off all my clothes and scream at the top of my lungs.” - BHU Prisoner

The level of isolation that is experienced throughout the BHU is hard to fathom and intensely harmful for the mentally ill prisoners who live there, sometimes for years at a time. The situation is even worse for the prisoners who are sent to Section 2. In theory, Section 2 is intended to 1) provide a short-term way to stabilize BHU prisoners who have experienced serious difficulties in the unit, and 2) a place where prisoners who are new on the unit can be observed and evaluated. BHU prisoners universally see Section 2 as a specialized punishment unit within the BHU. For instance, Section 2 prisoners are not allowed to have batteries and therefore cannot hear the audio feed of the single TV that serves their cells. If they are moved out of their cells, they are in restraints and on a tether manned by one of three COs who are required to conduct escorts. They are allowed far fewer possessions than other BHU prisoners and their meals are served on paper trays. This is the section in which prisoners are likely to be deprived of clothing, bedding, writing utensils, pictures, and other personal belongings.

Although it is supposed to be a short-term step toward better conditions and a lower level of restrictions on one of the other sections, many BHU prisoners have lived in Section 2 for more than a year. This occurs when they are unable to recover enough control of their behavior to meet the requirements for moving to another part of the BHU, a difficult task for individuals who are often so desperate to escape their reality that they attempt suicide or seriously injure themselves.

Robert Wynan was confined to Section 2 for almost three and a half years. Mr. Wynan and BHU clinical staff quite consistently describe the negative impacts of BHU conditions on his mental health, especially those that that he experiences when housed in Section 2. He is distressed at being surrounded by loud, disruptive prisoners who he feels are hostile towards

him. His counselor noted that Mr. Wynan is fearful and anxious, concluding that he “appears to be experiencing increased paranoia in response to both the hostile nature of the unit as well as the sedating effects of recently prescribed medications.” Other symptoms, including visual and auditory hallucinations, are also aggravated by the environment. In the words of one member of the BHU clinical staff, the BHU is “an emotionally chaotic environment.”

A member of the BHU clinical staff explained to DRO that she would like to move him out of Section 2 and out of the BHU altogether. In her words, “he can never make it in the BHU. He’s too amped up by the other prisoners.” She has succeeded in arranging short-term stints in the Mental Health Infirmary (MHI), but due to the skewed balance of power between clinical and security staff, she lacks the authority to move him to a more clinically appropriate setting.

During his interview with DRO, Mr. Wynan described feeling desperate to get out of his cell. “I pace all day,” he said. “Sometimes I bang my head against the wall all day. I have to get my anger out.” He explained to us that he told his prescribing clinician, “No one can see when I am depressed because I am always so happy to get out of my cell. Back in, though, I just feel hopeless and want to die.”

Mr. Wynan’s records (and his own account) describe numerous, increasingly desperate attempts to get out of his small, stifling cell in Section 2: he threatens suicide, he threatens staff, he “sheets up,” he acts out, he harms himself by swallowing objects, he throws bodily fluids. He would prefer anything, even disciplinary segregation, over his seemingly eternal confinement in Section 2. These actions have sometimes resulted in cell extractions and temporary removal from the unit, but at a terrible cost to Mr. Wynan: his original release date of 2017 has been extended to 2035 because of convictions for offenses committed while in prison. After 3 ½ years in Section 2, he has finally been moved to another section of the BHU, but there is no indication that he will ever be allowed to leave the unit.

5. No limits on the length of confinement

The BHU was created to provide a more effective way to address the persistent behavioral problems of prisoners with serious mental illness than was available in punishment-based segregated housing units at OSP.¹⁷ Because those units are specifically operated to deliver concentrated measures of punishment and reduced privileges to curb and deter dangerous behavior, the time that a prisoner spends in those units is regulated and limited. In the BHU, where the ostensible focus is treatment rather than punishment, time is not limited.

Nevertheless, access to the mental health treatment that might equip a BHU prisoner to survive in a less restrictive unit of the prison has dwindled since the BHU opened. Compounding that effect, the level of restriction and isolation in the BHU has increased. Now, most prisoners and clinical staff report that conditions in the BHU are as harsh if not harsher than those in the disciplinary segregation units, especially for prisoners in Section 2 of the BHU. In fact, prisoners who are moved from general population to segregation and punishment units can also spend 23 hours a day in their cells, but most spend about four to six months under that level of restriction. In contrast, prisoners with serious mental illness often languish in solitary confinement for years at a time in the BHU. Even after completing the Dialectical Behavior Therapy (DBT) program, the major prerequisite for transition out of the BHU, many prisoners are subjected to isolation and sensory deprivation in the BHU for far longer than they would have been in the disciplinary segregation units.

6. Some effects of prolonged isolation

“[T]he record shows, what anyway seems pretty obvious, that isolating a human being from other human beings year after year or even month after month can cause substantial psychological damage, even if the isolation is not total.”

Davenport v. DeRobertis, 844 F.2d 1310, 1313 (7th Cir. 1988).

¹⁷ Those units are the Disciplinary Segregation Unit (DSU) and the Intensive Management Unit (IMU.)

“[The fact that] prolonged isolation from social and environmental stimulation increases the risk of developing mental illness does not strike this Court as rocket science.”

McClary v. Kelly, 4 F.Supp. 2d 195 208 (W.D.N.Y. 1998).



Inside a Section 2 BHU cell
Photo © Oregon Department of Corrections

Prisoners in the BHU experience an extreme form of isolation. That is not altogether surprising: the physical space occupied by BHU was originally designed as an Intensive Management Unit (IMU) where unmanageable prisoners were sent as a form of punishment to gain compliance and more controllable behavior. One of the principal components of that punishment was solitary confinement. Though it has been repurposed as a placement for prisoners with serious mental illness, BHU prisoners and MH staff report that the current BHU has retained or reintroduced many IMU practices.

Under the widely accepted definition of 22-23 hours of cell time per day, it is indisputable that prisoners in the BHU experience solitary confinement.¹⁸

There is a large body of scholarly articles, studies, court cases and settlement agreements that address the harmful effects of confining prisoners to their cells for long periods without any opportunity to socialize with other people.¹⁹ Clinical studies have established that confining a person to a cell for all but an hour or two each day can cause serious and lasting psychological harm and exacerbate already existing mental illness.²⁰ Summarizing the clinical research in an amicus brief to the U.S. Supreme Court, leading mental health experts concluded: “[n]o study of the effects of solitary or supermax-like confinement that lasted longer than 60 days failed to find evidence of negative psychological effects.”²¹

¹⁸ To its credit, ODOC has acknowledged the problem and has recently undertaken some initial steps to reduce the effect of excessive time that some ODOC prisoners spend in the cells. Thus far, those efforts have not reached the BHU.

¹⁹ See ABA STANDARDS FOR CRIMINAL JUSTICE: TREATMENT OF PRISONERS No. 23-2.8(a) (2010) (“No prisoner diagnosed with serious mental illness should be placed in long-term segregated housing”); American Psychiatric Association, *Position Statement on Segregation of Prisoners with Mental Illness* (2012) (“Prolonged segregation of adult inmates, with rare exception, should be avoided due to the potential for harm to such inmates. If an inmate with serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space and adequate unstructured out-of-cell time should be permitted.”); Interim Rep. of the Spec. Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment, U.N. Doc A/66/268 at 221 (Aug. 5, 2011) (“given their diminished capacity and that solitary confinement often results in severe exacerbation of a previously existing mental condition . . . its imposition, of any duration, on person with mental disabilities if cruel, inhuman or degrading treatment”).

²⁰ 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).

²¹ Brief of *Amici Curiae* Professors and Practitioners of Psychology and Psychiatry, *Wilkinson v. Austin*, 545 U.S. 209 (2005) (No. 04-4995)

The impact of isolation in the BHU is such that even the smallest simulations of normal social contacts are precious to the prisoners. We were surprised that many of the prisoners we spoke to complained that the QMHPs no longer sat in front of the tier to play word or card games with interested prisoners. This involved no more than a sympathetic person encouraging people serving long prison sentences to participate in children's games such as hangman. Its loss was nevertheless a serious degradation of life in the BHU.

D. No reliable access to mental health care

“MH is supposed to talk to inmates before the suit up thing, but usually MH doesn’t come. You have to do something extreme to get to see MH.” - BHU Prisoner

*“Now the guards are the ones who generally deal with a mental health crisis. Counselors are not available until hours or days later.”
- BHU Prisoner*

There is at least conflicting evidence to indicate that the BHU delivered a useful level of access to mental health services to prisoners during the initial year or two of operation. However, our investigation revealed that timely access to effective mental health care has not been available for BHU prisoners during subsequent years. Virtually every BHU prisoner who spoke with us cited an inability to access mental health services as a major and constant frustration. Inability to access mental services was also a near universal precipitating element in cell extractions and other incidents of force deployed against BHU prisoners. Tellingly, inadequate access to MH services was reported not only by the prisoners who had been the subjects of the incidents, but by other prisoners in the unit who witnessed and described incidents to us.

Both the BHU prisoners and the mental health staff who are assigned to help them would almost universally prefer to be in any other unit of the prison. When asked about the theory that prisoners might fake mental illness in order to be placed in the BHU, a member of the clinical staff who has worked with BHU prisoners scoffed: “Nobody would lie to stay in BHU; everyone wants out.” As another member of the mental health staff put it, “Everyone on the unit wants to leave.” Mental health staff on the unit have a high rate of turnover; most QMHPs work at the BHU for two years or less and transfer out as soon as there are other openings. BHU inmates do not have the same ability to change their situation and some have been in the BHU for more than three years even though they would prefer to be anywhere else, including Death Row or disciplinary segregation.

Case Study: Lincoln Stevens

An incident involving “Lincoln Stevens” in the spring of 2014 illustrates a set of events that were triggered by inability to access care during a mental health crisis. After repeated requests for crisis mental health care produced no response, Mr. Stevens sheeted up his cell and cut his arm so deeply that it bled unstoppably. Despite the fact that the continuing blood loss was potentially life threatening, what followed was an incredibly slow-moving ordeal that did not end until many hours later when Mr. Stevens was strapped into a restraint chair after being transported to a hospital and returned to the BHU without treatment.

During interviews, three neighboring prisoners confirmed that prior to cutting himself, Mr. Stevens had been calling repeatedly to staff. His tone was described as desperate and pleading. He said he was hearing voices, feeling panicked, and needed to talk to BHS staff. Officers told Mr. Stevens that there was no one available. (“Ain’t gonna happen.”) Mr. Stevens recalls saying that he felt like hurting himself and asking “Isn’t there anyone on call?”

Alone and escalating in his cell, Mr. Stevens eventually sliced his arm deeply in seven places. An officer was stationed outside Mr. Stevens’ cell but was unable to see inside because Mr. Stevens had sheeted up. The prisoner in the adjacent cell knew Mr. Stevens well and sensed that something was wrong. He eventually convinced Mr. Stevens to acknowledge being cut badly enough that the floor of his cell was covered in blood.

Mr. Stevens’ neighbor called to the officer on tier to radio for medical help. The officer did call for help, but according to his report, it took 35 more minutes for anyone else to arrive. At that point, Mr. Stevens submitted to handcuffs and a tether and was removed from his cell. Video footage shows seven very wide cuts across his forearm that were bleeding profusely. He was taken to the infirmary where nurses were not allowed to remove restraints that hindered their efforts to stop the bleeding. Over many minutes, they went through their entire supply of gauze pads but

could not “contain the blood.” After unsuccessful attempts to jerry-rig something to apply enough pressure to stop the bleeding, the nurses photographed the injuries and decided that there was no choice but to send him to an outside hospital.

Although Mr. Stevens was still bleeding uncontrollably and repeatedly soaked through the pads applied to his wounds, a great deal of time passed while security staff walked through a number of procedures associated with a transport out of the prison. These included tethering and escorting Mr. Stevens to a holding cell and then re-clothing him in a uniform that identified him as a prisoner in transport. More time passed while security staff tried to arrange for an escort vehicle to accompany the van that would transport Mr. Stevens to the hospital. The tape also recorded a discussion of who was next in line to receive the overtime pay that was attached to the assignment of accompanying Mr. Stevens to the hospital. Another recorded exchange explored who was authorized to handle a taser during transport.

Long before the van actually left for the hospital, Mr. Stevens’ agitation and distress had risen to the point that he was resistant to every element of the transport process. What transpired at the hospital is not recorded on the videotape, but according to reports of the security staff who took Mr. Stevens to the hospital, he refused to cooperate with hospital staff. On that basis, the accompanying officers determined that he was too volatile to receive treatment. They brought Mr. Stevens back to the prison where his wounds were finally bandaged at 11pm, approximately 3 ½ hours after he had cut himself. According to the ODOC incident report, after his wounds were attended to well enough to stop the bleeding, Mr. Stevens said, “If you put me in a smock I am going to bite myself.” The report continues, “I [Lieutenant] informed Prisoner Stevens that he was placed on Suicide Watch and that he was going to be in a smock. Prisoner Stevens responded, ‘You better just put me in the restraint chair.’”

Interviews with staff and prisoners, and review of ODOC mental health treatment logs reveal ongoing problems with access to routine and crisis mental health care. The most commonly raised explanations for inadequate access to MH care in the BHU are explained below.

1. Physical and logistical issues

a) Lack of office space for Mental Health staff

The physical layout of the unit creates a huge and persistent access problem for MH staff. QMHPs do not have office space within the BHU building even though they are the front line MH staff who are expected to deal with mental health crises. Clinical staff cannot enter the building that houses the BHU without radioing a control officer who remotely unlocks the doors. Once inside the building, they must again be electronically passed by the tower officer through locked gates to reach the cell tiers. They are thus unable to see or hear what is happening on the unit during large parts of their workdays when they do an ever-expanding amount of paperwork in their remote office cubicles.

b) Confidentiality

Another problem related to the limitations of the physical layout of the unit is that there is no confidential space in which MH staff can meet or speak with BHU prisoners. This means that prisoners who are in crisis must discuss their problems within earshot of officers and/or other prisoners. The lack of a confidential space exacerbates the prevalent fears among BHU prisoners that officers and other prisoners are conspiring against them. A number of the prisoners we spoke to reported an understandable fear that officers would use their confidential mental health information to tease or extort them.

c) Staffing

QMHPs and other MH staff told us consistently that there were not enough of them to respond to full blown crises, let alone act proactively to recognize and defuse escalating situations. Current rules require that all BHU prisoners are transported by two officers. Most are also required to be tethered (hands cuffed behind their backs and attached to a kind of leash) and additionally controlled by a third officer before they can be moved out of their cells. There are many times when the number of officers on the unit is simply not adequate to escort prisoners to scheduled activities. For instance, (and as discussed elsewhere in this report,) ODOC has explained to us that it is physically impossible to escort every BHU prisoner to scheduled showers and rec periods and that the maximum number of showers available on any given day is twelve. The problem is presumably worse when there is a crisis that creates additional demands for escorts.

Lower staffing levels at night and over the weekends²² means that prisoners who experience MH crises during those periods are not seen by MH staff in time to defuse problems that then escalate into cell extractions or other incidents of force. One of the few long-term mental health clinicians on the BHU reported a belief that violence-prone officers seek out a weekend schedule so that they can control the unit with less interference from clinical staff.

2. Balance of power

“If you protest about CO treatment of inmates, you can wait for 30 minutes in the rain to get into the unit. It’s a hostile work environment.” - BHU Clinician

²² No MH staff member is scheduled to be on duty between 8:30 pm and 6:30 am on any day of the week. On weekdays and depending on the time of day, one or two of the four QMHPs who cover the BHU is on duty. Individual 9 and 10 hour shifts start as early as 6:30 am and end between 5 p.m. and 8 p.m. The BHU’s prescribing provider is available three days a week between 10 a.m. and 8:30 p.m.. The MH unit director is on duty between 7:30 a.m. and 4 p.m. on weekdays. A contractor who teaches DBT skills is in the BHU on two weekdays from 7 a.m. to 5 p.m. and 7 a.m. to 8 p.m.

An unhealthy shift in the balance of power between correctional staff and mental health staff was one of the primary concerns raised by the individuals who triggered our investigation. Nearly all of the staff and prisoners we spoke to during the course of our investigation saw changes in the balance of power between security and treatment perspectives as a strong and troubling factor in the overall operation and culture of the unit. We encountered a wide spectrum of opinions about how, when, or why this balance had shifted; but there was broad agreement that it had indeed shifted. There was also broad agreement that security and correctional concerns had become the dominant drivers of practices at the BHU and that this was a change from earlier times when treatment issues played a more substantive role.

One result of the architectural deficiencies and staffing constraints described above is that security staff have become gatekeepers; they control clinical staff's access to their clients. One clinician told us that his supervisor had warned: "Don't upset security. If you do, you can't do your job."

a) "Slow-Playing"

A number of current and past MH staff reported to us that security staff purposely impeded access to their clients as a way to communicate their authority. One clinician described the implicit message of correctional staff to the mental health staff as "you are guests and you are lucky to even be here," and "if you want some cooperation and get let in doors or get to see your people, you should not be speaking up about this sort of thing."

Mental health staff reported that their requests to have clients brought to appointments were often met with a series of excuses such as "we don't have a second officer," or "he was acting out today." MH staff believe that officers employ stalling tactics and excuses when they are unhappy about complaints by clinical staff or perceive clinical staff as too soft-hearted. Another clinician reported that officers have slowly (and intentionally) increased the duration of daily count and meal periods as a way to decrease the amount of time during which patients can be seen for

treatment needs. The prevalence of this sort of activity by officers was such that the MH staff have adopted the term “slow-playing” as a universally understood and short-hand way of referring to it.

b) Security staff dominate treatment team decisions

Clinical staff consistently complained that security concerns were given precedence at treatment team meetings. Clinical input was sometimes ignored or suppressed. It was more often the case, however, that treatment concerns were given a polite hearing before being subordinated to the concerns of the correctional staff. Several past or present members of the BHU MH staff told us that this change in the power dynamics of the unit’s operation created an atmosphere in which they became reluctant to express their true feelings. Every member of MH staff who spoke with us clearly understood the risks of working in a prison with dangerous individuals and considered safety and order first priorities. However, at some point within the last two years, they told us that the reach of those primary security concerns was extended beyond the point where there was any real possibility of individualized treatment decisions or consideration of patients’ clinical needs.

For instance, prisoners in the BHU can theoretically move through a system of graduated privileges as incentives for good behavior and progress in treatment. One of the primary privileges that is awarded once a prisoner has graduated from levels A and B to C, is “day room.” Day room privileges entitle a prisoner to stand in front of his cell, walk on the tier, or sit in a plastic chair outside of his cell for one hour per week. Entitlement to this minimal luxury is a frequent point of contention between security and clinical staff. Clinical staff reported invariable pushback from officers regarding moving prisoners through the level system and noted that even when officers consented to a level C designation, they often successfully objected to the “day room” privilege that should have accompanied that transition.

Another example that was raised by both prisoners and MH staff was a decision to prohibit anyone housed in Section 2 from possessing batteries. This change was adopted after a Section 2 prisoner was able start a fire in

his cell with a battery. Without batteries, prisoners cannot listen to music or hear the audio feed of the TV that some had previously watched for eight or more hours a day. The loss of TV and music had real impact on the already precarious mental health of many BHU prisoners who use them to help drown out internal voices that are common symptoms of some forms of mental illness (e.g. bi polar disorder and many forms of schizophrenia). An ODOC psychiatrist made the same point to us by stating that “the worst thing you could do to a psychotic person is have TV with no sound.” The unit’s MH staff saw the decision to remove all batteries from the entire section as an unnecessarily harsh solution that caused new problems. They believed that battery problem could be addressed by other means with little risk of another fire, but were overruled by security staff with little concern for the problems that this action would create for the most troubled prisoners in the BHU.

Finally, clinical staff no longer have a role in determining the level of restraint and supervision that a particular prisoner requires when out of his cell. During the earlier history of the BHU, treatment teams made these decisions on an individualized basis. After security staff assumed increased control over the operation of the unit, clinical staff lost any power to raise individual circumstances and treatment needs when determining the level of security during escort. Now, the majority of BHU prisoners (those with A or B security designations) are required to be cuffed, tethered, and escorted by a three-person team of officers whenever they are moved out of their cells. The tethers and three-person escort teams are humiliating and impair an individual’s ability to envision any potential for normal human interactions.²³

3. Corrections Officers lack the tools to handle mental health crises

In the absence of a consistent clinical staff presence on the unit, the BHU’s primary strategy for responding to mental health crises depends on the decisions of corrections officers who rely on a limited set of security tools.

²³ The impact of these requirements on access to care is discussed elsewhere in this report.

That strategy is in stark contrast to the verbal de-escalation strategies that are now widely recognized as more effective interventions to ensure safety while avoiding potentially traumatizing forms of restraint. In the BHU, crisis intervention still means riot gear, tasers, pepper spray, and a restraint chair.

E. A culture of violence and retaliation

*"I don't give a f**k. Just shut up. I'm not here to serve you man. Shut up and do your time."* - BHU Correction Officer (as reported by a prisoner)

"Every time. They tell you if you don't take your meds, we're gonna' suit up, tase you, mace you, take away your property, and then put you back in your room butt naked."- BHU Prisoner

Our investigation revealed consistent evidence that prisoners in the unit are routinely subjected to physical and psychological violence by correctional staff. In some instances, these measures were employed to reduce what seemed to be relatively remote risks. In others, it seemed that excessive force and forms of psychological torment were used by correctional staff to repay prisoners for what the officers saw as unnecessary work and/or threats to their own safety and dignity. We also saw convincing evidence that some BHU officers had become adept at using procedures that were designed to protect prisoners (such as suicide prevention precautions) as implements of punishment and retaliation.

The question of how much force can be legitimately deployed against prisoners in the BHU is not a simple one. Although the unit houses prisoners with serious mental illness who need and are entitled to humane conditions and treatment, it is also true that many BHU prisoners have committed violent acts before and during their incarceration. Sometimes force is required to prevent a prisoner from harming himself or someone else.

That said, we discovered that force is the default response to many recurring problem behaviors in the BHU. The violent culture of the unit allows and promotes physical and psychological force in response to minimal or contrived provocations by mentally ill prisoners. It disguises subtle forms of retaliation and verbal aggression as accountability and is so pervasive and consistent that it has engendered a specialized vocabulary that is shared by everyone who lives or works there. Specialized rituals, rules, and language have evolved to trigger and describe violence against

the prisoners who live in the BHU. For example, BHU prisoners who are unable to elicit a timely response to requests for MH attention have been taught that they can achieve that objective through a variety of actions that have been described elsewhere in this report. They can “sheet up” their cells by covering them with bedding; refuse a direct order (e.g. refuse to pass back a food tray through the cell slot); refuse to take ordered medications; directly harm themselves enough to require medical attention; throw bodily fluids at an officer, state a desire to commit suicide, or “pop a sprinkler.” Almost every recorded use of force that we reviewed began with a refusal to “back up to the cuff port and submit to restraints.”

Any of these actions produces a reaction by correctional staff, usually a “suit up” in which a team of 4-6 officers comes to a prisoner’s cell to threaten and/or use force to remove the prisoner from his cell. This sort of scenario allows prisoners to force a response by their jailers, but at an obvious and high cost that many BHU prisoners seem willing to accept. This prisoner-triggered suit up process therefore threatens to reverse the power dynamic of guard and prisoner, unless the officers can further elevate the cost to the prisoner who has forced them to act in response to his demands. The officers who are required to man these suit-up teams are undoubtedly and understandably frustrated at the inconvenience and demands of the process. It is therefore perhaps no surprise that various hidden forms of retaliation against prisoners often follow these incidents. The ability of frustrated officers to use excessive force is theoretically limited because the suit-ups are videotaped, but we have learned that the prison environment provides almost limitless ways for officers to exact a price for challenging their control.²⁴

The videotapes of cell extractions and related planned use of force incidents are, just like the actions of the prisoners who are their subjects, heavily ritualized. The tapes begin with on-camera jargon-laced explanations of the reason for the suit-up (e.g. “inmate X is refusing a direct order to submit to restraints,”) a statement on whether use of the taser or

²⁴ We learned that these videotapes are not reviewed by mental health staff. None of the MH staff we spoke with had seen one, although all agreed that joint security/mental health staff review would be a good idea.

OC spray (another name for pepper spray) has been authorized, and introductions of each team member that resemble the pre-game portion of an NFL football game. The officers are dressed in face shields, black riot gear, plastic gloves, and towels that are wrapped around their necks and stuffed into a semi-rigid vest. They wear full gas masks when there is a possibility of using OC spray.²⁵

Due to the regularity of these events, both officers and prisoners seem to accept the use of tasers and OC spray as routine precursors to cell extractions. In the videos we reviewed, tasers were used both prior to entry and during the time that the team worked to apply restraints.²⁶ Despite violence and risk suggested by the gear and weapons, the tone of the videos is flat and mundane. They consistently convey a sense that each of the incidents we saw was a type of event that had become a routine part of life for BHU correctional staff and prisoners. In fact, in one of the videos we reviewed, another cell extraction can be heard occurring simultaneously. BHU prisoners have actually developed a practice of counting to track the number of seconds that they can hear the clicking of a taser or the hiss of OC spray. They keep records.

²⁵ The teams typically include one CO who is responsible for each of the following duties: restraints, taser or OC spray, shield, control 1, and control 2. The shield is a torso-sized rectangular plastic shield with two handles that is used as a sort of battering ram as the team enters a cell. The shield officer pushes a prisoner backwards into a wall or onto the floor with his own weight and that of others behind him if necessary. In this way, a prisoner is flattened against a hard surface and so left unable to extend arms to strike at the team. Control officers follow to quickly grab and hold the arms and legs of prisoners after they are flattened or knocked down by the shield. The restraint officer then puts on handcuffs and/or shackles.

²⁶ OC spray was used only before entry to reduce its secondary effect on the extraction team.

Case Study: Ryan Hays

The videotape of “Ryan Hays” forced removal from his cell is a good example of the BHU culture. The videotaped explanation for the July 2014 planned use of force against Mr. Hays is that he has refused to leave his cell to be electronically scanned for weapons or contraband that might be hidden in his body. The scanning procedure is effected by placing a prisoner in a \$9,700 apparatus called a BOSS chair that resembles a large boxy throne. The leader of the extraction team explains that all prisoners who are placed in Section 2 are scanned in the BOSS chair, a requirement that had been purportedly delayed for Mr. Hays because “he had become agitated.”

Rather than consent to restraints for a second time in one day, Mr. Hays “sheeted up” his cell to force a suit-up. However, when the team arrived, he agreed to pull down his mattress and submit to restraints, but only at the last possible moment as the red dot of the taser guide light was visible on his body. The tape makes it clear that he has forced the suit up and successfully removed any justification for using the taser. He is laughing, and his pleasure at having achieved this result is evident.

As the incident continues, the audio description of the camera operator notes that “inmate is beginning to resist,” as Mr. Hays is being cuffed through the slot in his Lexan™ covered cell. Despite many viewings of the tape, we can see no sign of resistance by Mr. Hays. His expression is calm, his shoulders are relaxed and his hands are invisible behind the bodies of the officers. Nevertheless, as soon as he clears the cell door and is within reach of the team members gathered around the door, he is immediately slammed to the floor by someone who grabs his head and pushes down hard. His body is then obscured by the bodies of the officers who repeat “stop resisting” over and over until he is brought up to his knees and his head is covered with a spit sock.

Mr. Hays is then placed on the BOSS chair and finally returned to his cell, still naked except for the spit sock over his head. The tape resumes when

the team leader reviews the incident in the hallway and confirms that no one was injured. He explains that Mr. Hays “was getting a little frisky and has really long fingernails” before “he started resisting and assumed a fighting stance and we took him to the ground.”

Nearly every incident that we heard about from BHU prisoners or were subsequently able to review contained similar vignettes during which multiple officers yelled at immobilized prisoners to stop resisting while they (the prisoners) were under a swarm of armored bodies and/or a plastic shield designed to pin them to the floor.

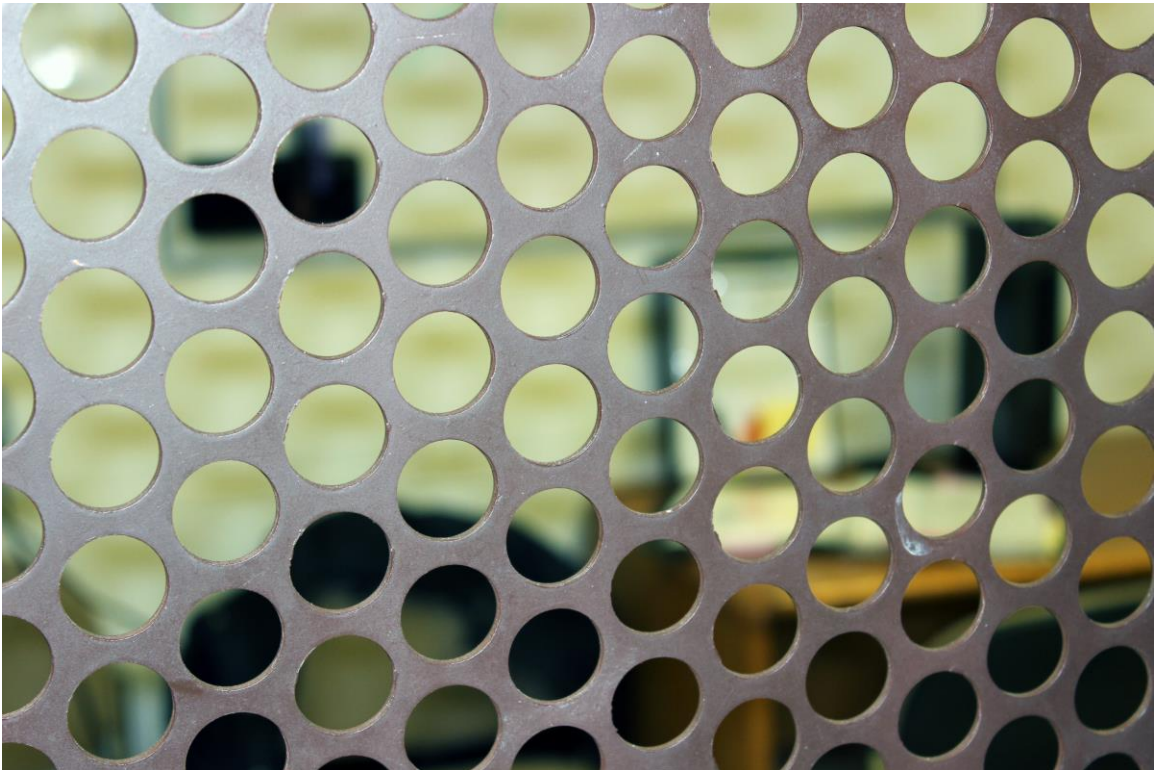
1. Suicide Precautions have become a form of punishment in the BHU

The correctional officers have developed other ritualized actions that are used to “educate” prisoners about the cost of continually requesting MH attention or showing disrespect for their authority over every aspect of life in the BHU. One of those tools is the punitive use of suicide precautions. Although suicide prevention precautions on the BHU were presumably crafted to ensure the safety of prisoners, those “protections” now strongly resemble other forms of deprivation that are imposed on prisoners for disciplinary reasons.

ODOC rules require officers and mental health staff to implement precautions if a prisoner presents a risk of suicide.²⁷ These precautions require removal of items that “pose a threat to self-harm. . . based on the instruction from a mental health provider or a registered nurse . . . in consultation with a mental health provider.” In the BHU, that assessment has been replaced by a near universal removal of all items regardless of their potential to be harmful. Our review indicates that BHU security does not consult in a meaningful way with mental health staff about whether particular items could pose a danger. Instead, they generally deprive a prisoner on suicide watch of clothing, bedding and all personal belongings

²⁷ Suicide Watch is for high risk situations and requires constant monitoring. Suicide Close Observation (SCO) is for moderate risks and requires observation at least every 15 minutes. OAR 291-076-0030.

including items such photographs and letters from family. He is then issued a Teflon® smock and a Teflon® blanket. Mattresses are frequently removed as well. Reports by staff and prisoners and review of seven individual medical records confirm that this extreme and unthinking level of deprivation is the norm in the BHU and that BHU prisoners view it as punishment.



View from inside cell in education room

Photo © Oregon Department of Corrections

Our investigation also revealed that suicide restrictions are sometimes imposed where there is no suspected risk of suicide. Several current and former BHU mental health counselors reported to DRO that security staff have pressured clinicians to impose Suicide Close Observation (SCO) as a consequence for prisoner behavior that inconveniences security. One counselor said that MH staff would benefit from “coaching” about how to explain to security officers that SCO should not be used as a punishment. Another clinician reported that pressure to use suicide watch punitively was “the final straw” that prompted a decision to seek another job out of the BHU. This occurred when the clinician was able to successfully calm

down a prisoner experiencing a mental health crisis so that the prisoner no longer presented a risk of suicide or self-harm. Nevertheless, the officer who had brought the prisoner to the clinician insisted that the clinician place the prisoner on suicide watch. The officer told the clinician that if this did not happen, the prisoner would receive a “write up” for a disciplinary infraction. The clear implication was that the prisoner’s behavior had inconvenienced the officer and would therefore have to result in a consequence.

2. Forced medications

“They do shots on Monday and Friday and meds by pill every day. When they come to do shots, it’s a goon squad. A lady comes around. ‘You’re not going to take meds? OK, I’m going to make you. If you don’t take your meds we’re going to come back and taser you.’ This happens all the time.” - BHU Prisoner

The Department of Corrections has adopted an administrative process that (after receiving a second opinion and offering an opportunity for a hearing) allows a treating psychiatrist to place a patient on an involuntary medication order.²⁸ Under such an order, ODOC staff can use force to compel the prisoner to take medications. The prisoners we interviewed, however, reported a disturbing degree of violence used in administering forced medications. It is a common practice in the BHU to taser or pepper spray a “non-compliant patient,” drag him onto the tier or into a hallway and pull down his pants so that a shot can be administered. On at least one occasion, this was done to a prisoner who was determined to be “refusing medications” while he was asleep or too medicated to respond.

²⁸ OAR 291-064-0070 through OAR 291-064-0140.

Case Study: Caleb Freeman

“Caleb Freeman” was transferred to the BHU in 2011 and has been there with the exception of brief periods in the Mental Health Infirmary (MHI) and Disciplinary Segregation Unit (DSU) ever since. Like most BHU prisoners, Mr. Freeman has taken a number of medications to control symptoms of mental illness for the entire time he has been in the unit.

During the two times that we spoke with Mr. Freeman, he seemed groggy and confused and his hair and clothing were littered with tiny gray bits of bedding or paper. He recalled an incident during which he had been tased and extracted from his cell by a riot-suited security team. He could not clearly remember whether he had been sleeping or was partially asleep with a blanket over his head when this happened, but he did tell us that he spent most of his days with his head under a blanket to partially block out the constant noise and chaos that is life in the BHU. (This was also how we found him at about 10 a.m. on the first morning that we spoke to him during a tier walk and how other prisoners described him to us.)

When trying to describe an incident that occurred in the fall of 2013,²⁹ Mr. Freeman remembered only that he was startled by what turned out to be a taser strike while under his blanket. He could not recall many details other than someone may have said “time for a shot,” although he was not able to be sure that this did not occur during some other incident. He remembers falling off of his bed and being crushed under the shield and the weight of an unknown number of officers. The taser did not hurt him badly (it apparently did not fully penetrate his blanket to embed in his skin), but it did startle and frighten him awake. He remembers that officers kept yelling “Stop Resisting” while he repeated that he was not resisting. They eventually flipped him over on his stomach and he was choked from behind until lifted and walked out onto tier where he got a shot and was then returned to his cell.

An ODOC video tracks well with Mr. Freeman’s unsure account in most

²⁹ Mr. Freeman, like many BHU prisoners, finds it very difficult to accurately remember when events occurred, but his records clarified the timing of the incident that he described to us.

respects. The extraction team leader's explanation of the reason for assembling the team fails to note whether Mr. Freeman had actively refused medication or simply failed to respond to commands while in the sort of stupor that appears to be his usual state. Instead, the team leader stated that "the Inmate is refusing to submit to restraints to receive his involuntary medication injection," that health service had been notified and were on scene to administer an injection, and that the team had received authorization to use a taser.

The video shows clearly that Mr. Freeman was wrapped tightly in a blanket with his head scrunched underneath it when the team arrived at his cell. There was no sign that he was awake or aware of his surroundings while one of the team members opened the cuff port and repeated loudly through it, "You will be tased if you do not back up to the port and submit to restraints." The laser guide light of the taser fell on the blanket at approximately Mr. Freeman's neck or shoulder, and the discharge of the taser cartridge was audible as he yelled and rolled back and forth before falling off his mattress. Taser clicking sounds indicated that it was discharged for about seven seconds while Mr. Freeman was crushed against the floor and officers yelled, "Stop resisting, or you'll get it again." His response is not clear enough to make out. The officers then asked for the shield to be removed from Mr. Freeman's chest so that they could get at his arms.

After being taken out of his cell, his pants were pulled down and he was given a shot in the buttock. Another nearby laughing prisoner can be heard cackling that, "I thought there wasn't gonna be a full moon today." During this incident, officers from another cell extraction team elsewhere on the tier can be heard yelling to another prisoner that, "You will be tased if you do not submit to restraints."

Medical records suggest that Mr. Freeman's bouts of agitation, psychosis, and lethargy may have well been the result of overmedication. For much of the time he has been in the BHU, Mr. Freeman's medications have included

varying dosages of as many as eight powerful psychotropic medications at a time.³⁰

That theory is supported by records that show Mr. Freeman's mental health and behavior both deteriorated following the 2013 incident. Records from approximately one month later indicate that he had expressed a desire to hit his head on the wall and was claiming that "he is God, able to breathe fire, read minds." The acuity level of his mental illness was raised to severe. He stopped showering or cleaning anything in his cell. By February of 2014, Mr. Freeman was described as lethargic and it was noted that he slept underneath a blanket for much of every day.

3. Retaliation

Prisoners reported to us that a handful of BHU officers have found a myriad of ways to punish prisoners who are seen as litigious or troublesome. One prisoner reported that his complaints about an officer resulted in threats to put him in the rec yard with another prisoner who was widely known to be extremely dangerous. Another reported that his hand was pinned in the cuff-port while an officer repeatedly smashed his fingers with his shield because he (the prisoner) had complained about the unfair confiscation of his coffee stash. That assault was confirmed by two neighboring prisoners. Others complained that officers would "sneak by" their cells during early morning rounds to deny shower opportunities. Frequent and unjustified searches of cells were cited as another retaliatory tool.

³⁰ For instance, records indicate that on 3/6/14, Mr. Freeman's medication regimen included Prolixin, Geodon, Paxil, Trazadone, Amitriptyline, Tegretol, Propanalol, and Benadryl. In the period surrounding the 9/27/13 incident, he was receiving Prolixin, Geodon, Zyprexa, Celexa, Thorazine, Lithium, Propanalol, and Benadryl. Some of these may be unsafe when taken in combination.

Case Study: Franklin Smith

“Franklin Smith’s” story illustrates how hidden forms of retaliation can set the stage for escalation and excessive force. Records indicate that Mr. Smith was housed in a number of locations in OSP since his arrival there in early 2009 and that he lived in the BHU continuously between September 2013 and early 2015.³¹ BHU mental health staff described him as highly impacted by the conditions there, writing that he reported hearing voices behind the walls of his cell and that he was particularly troubled by the Lexan™ covering his cell front. Mr. Smith dealt with his angst at the BHU conditions by persistently filing complaints.

According to Mr. Smith, one of the COs who had been a subject of his complaints had repeatedly punished him in a number of unofficial ways that included scrambling his meals. This was accomplished by turning his plastic-wrapped covered food trays upside down and shaking them so that the food in the divided compartments would mix together into a disgusting mess. The officer would then smile, turn the tray right side up, and slide his work through the slot of the cell.

Records indicate that by May 27, 2014, the day of the incident, Mr. Smith had been complaining about this problem for more than a month. When he received another scrambled meal on that day, he broke from the usual sequence of events and refused to slide the tray containing his ruined meal back through the slot at the end of mealtime. Mr. Smith said he would not return his tray until the lieutenant came to the cell to see what had been done to his meal. Following a number of direct orders to return the tray, an extraction team was assembled to remove the Mr. Smith from his cell and recover the tray.

As was the case in each of the videotaped incidents that we viewed, the team leader’s explanation of the reason for the cell extraction is extremely brief and does not refer to any of the setting events or history behind Mr.

³¹ Mr. Smith was transferred to another ODOC prison a few months after we began our investigation.

Smith's final refusal to obey an order: "This will be a forced move with force authorized after inmate refused a direct order to back up and submit to cuffs for a move to cell 10."

The video records Mr. Smith telling the team leader that he was willing to return his tray and would do so as soon as the lieutenant came to see what had been done to his food. He can also be heard to say that he did not want to be forcibly extracted by the seven-man team that was at his cell for that purpose, but was resigned to that outcome. He states:

"I understand that the taser will be deployed and would love to back up as soon as the lieutenant comes and looks at this tray. As soon as that happens I'll back up and cuff up. I would love to cuff up. I'm a 52 year old fat man with injuries. I don't want this."

He ends by saying "Do what you gotta do." He then raises his mattress as a temporary shield against the taser barbs that are coming. The door is opened and Mr. Smith is instantly smashed into the back wall of the cell by the shield and then dropped to the floor. He is then under a pile of bodies and is presumably grabbed by the control officers. Although it is hard to see much of what is happening on the floor, the video records multiple CO commands to "Stop Resisting." During this time, the almost continuous clicking of a taser is heard for approximately 40 seconds.

Mr. Smith eventually is heard to say, "I stopped. What do you want me to do?" As he is led out of his cell, he can be heard yelling to a neighbor to find out how long he "rode the lightning." His neighbor reports that his 40-second ride was the record.

During the ensuing minutes, Mr. Smith is taken to hallway, stripped naked and placed face down on the floor. He is cursorily examined by a nurse who asks him if he's OK while the taser barbs are removed. His obesity and obvious poor physical condition require him to be assisted to sit up when he is ordered to do so. The casual tone of conversation between a man who had just been tased for the better part of a minute before being crushed to the floor by a squad of heavily armored men confirms that the BHU has become a place in which force and violence are the accepted and

expected responses to any non-conforming behavior.

The Unusual Incident Report (UIR) that documents the incident notes that Mr. Smith was charged \$22.95 for the cost of the taser cartridge, \$12.00 for a pair of red shorts, and \$1.01 for the underwear that officers cut from his body.³²

³² See Appendix, Exhibit 3.

IV. CONCLUSION

Our investigation revealed that the BHU may have once provided constitutionally adequate mental health care for the seriously mental ill prisoners who live there, but that it no longer does. For some time, BHU prisoners have not been provided with any practical possibility of being out of their cells for more than one hour a day. They are thus forced to live in solitary confinement for months or years without adequate access to the care that would allow them to avoid repeated cycles of psychological isolation, decompensation, and punishment. Those repeated cycles endanger everyone who lives or works in the unit.

Although the causal history of this state of affairs may be quite complex, our investigation made it clear to us that three interrelated and fundamental elements drive avoidable cycles of punishment and psychological decompensations in the BHU. They are:

1. **Excessive isolation,**
2. **Inadequate access to timely mental health care, and**
3. **A pervasive culture of violence and retribution that exacerbates the harm of the inadequate access to mental health care and isolation.**

The reasons for these problems are beyond the scope of our investigation, although they may be relevant in discussions about how to return the BHU to its original mission. DRO has begun those discussions with ODOC and we remain hopeful that further negotiations will be productive for all concerned parties. We believe that our investigation has contributed to that process by exposing and confirming serious problems that must be solved if the BHU is to serve a useful purpose. To reach that result, ODOC will need to implement the following reforms:

BHU prisoners must be allowed to spend more hours out of their cells in an environment where they can relate to other human beings face to face.

The BHU must be reconfigured (or moved to a new building) to ensure that mental health professionals are on site with the capacity to see prisoners proactively, confidentially, and as needed.

Finally, the BHU's operating culture must be rebalanced to end the routine use of unnecessary force and retaliation against prisoners with serious mental illness. This can only be accomplished if therapeutic concerns are permanently accorded a significant role in decisions about prisoner care and conditions in the BHU.

V. OTHER ISSUES

Our investigation revealed a number of concerns that are beyond its scope. Those issues suggest the need for additional investigation by DRO, ODOC, or another entity. They are:

A. Minimal cooperation between MH staff and medical staff in the BHU and other special housing units.

We learned about several cases in which serious written and oral reports of medical concerns about a BHU prisoner were brushed off by medical staff. One clinician reported that her requests for medical attention for BHU prisoners invariably produced little or no medical response beyond notes indicating that each of the prisoners had refused treatment. Medical staff take the position that MH clinicians should not be concerned with medical problems and should leave the diagnosis and treatment of medical problems to the medical staff. Multiple sources reported to us that in at least one case, a prisoner died because a mental health clinician was unable to convince medical staff of the need to examine and treat the prisoner's deteriorating physical condition. These alarms were ignored for approximately four months before medical staff finally realized the seriousness of the situation and ordered hospitalization. The prisoner died within hours of reaching the hospital.

B. Poorly trained nurses in special housing units

Clinicians reported to us that the nurses who are assigned to BHU and other special housing units have minimal expertise in the care and treatment of individuals with serious mental illness. This problem is compounded by a rotation system that moves nurses out of the BHU before they are able to develop specialized knowledge and skills needed for the effective treatment of individuals with serious mental illness. A mental health provider who treats special housing prisoners told us that she cannot use normal prescribing protocols (such as an "as needed" or "PRN" order) because the nurses who are responsible for administering medications are not able to understand or make basic decisions about

dosage. This means that prescriptions continue to be administered even when there are obvious signs of dosage or side effect problems.

C. Important services and opportunities that are available elsewhere in the prison are not available in the BHU.

We spoke to a BHU prisoner who speaks Spanish and very limited English. He has not been provided an interpreter or language-appropriate services. This means that he cannot understand DBT discussions or written materials, and therefore cannot complete the program to access a higher level of privileges or improve his deteriorating mental health. He is similarly unable to benefit from meetings with his doctor or counselor who do not speak Spanish.

Legal research is an important prisoner activity throughout the prison and prisoners in general population normally have access to a law library. Legal research in the BHU is available for only one prisoner at a time and scheduled appointments are often cancelled because of inadequate staffing for escorts. When BHU prisoners are able to do legal research, it is in a tiny room where they have to ask an officer to print requested materials and hand them through a slot.

D. Confidentiality

Officers who sometimes bear ill will toward individual BHU prisoners frequently participate in treatment team meetings where they learn confidential information that can then be used to retaliate against those prisoners. Similarly, multiple MH providers told us that the cramped space of the BHU means that officers who are not part of a meeting can easily overhear treatment team discussions. It should be noted that these



BHU staff office
Photo © Oregon Department of
Corrections

meetings can involve discussions of topics such as known triggers of anger or details of sexual history. More than one BHU prisoner reported to us that confidential information about his psychological condition and history had been used against him by an officer. Even if these beliefs are inaccurate, there is little attention paid to the issue of confidentiality in the BHU and it appears that no one has weighed the benefits of openly shared clinical information and its potential for harm.

APPENDIX

BHU REC LOG

6/4/2014

Cell	Name	SID	Level	Clip	Raz	Shr	Yard #1	Yard #2	Comments	Init.
B81			C	2	2	2	2	2	RA / CI- DSU	
B82			B	2	2	2	2	2	Ad-Seg From SRCI	
B83			B	2	2	2	2	2	RA	
B84			B	2	2	2	2	2	RA	
B85			C	2	2	2	2	2	DSU SO	
B86			C	2	2	2	2	2	DSU SO	
B87			C	2	2	2	2	2	SG / DSU	
B88			B	2	2	2	2	2	RA	
B25										
B26			B	2	2	2	2	2	Ad hold SO	
B27										
B28			B	2	2	2	2	2	From EOCI	
B29			C	2	2	2	2	2	RA DSU	
B30			B	2	2	2	2	2	FROM DSU	
B31										
B82			IMU3	2	2	2	2	2	IMU	
B89			B	2	2	2	2	2	SO	
B90			A-1	2	2	2	2	2	DSU	
B91			A-2	2	2	2	2	2		
B92			A-2	2	2	2	2	2		
B93			A-1	2	2	2	2	2	SO	
B94			A-1	2	2	2	2	2	DSU until 08/27/14	
B95									SO	
B96			B	2	2	2	2	2	From EOCI	
B97									RA	
B98			IMU	2	2	2	2	2	IMU FROM SRCI	
B99			IMU	2	2	2	2	2	IMU FROM SRCI SO	
B100									IMU FROM SRCI	
B101			IMU	2	2	2	2	2	IMU FROM SRCI	
B102									0/1	
B103			B	2	2	2	2	2	RA	
B104										
B105			B	2	2	2	2	2		

Exhibit 1

APPENDIX

BHU REC LOG

6/4/2014

Cell	Name	SID	Level	Clip	Raz	Shr	Yard #1	Yard #2	Comments	Init.
B17	[REDACTED]	[REDACTED]	B	2	2	2	2	2	C1	[Signature]
B18	[REDACTED]	[REDACTED]	B	2	2	2	2	2	RA	[Signature]
B19	[REDACTED]	[REDACTED]	C	2	2	2	2	2	RA	[Signature]
B20	[REDACTED]	[REDACTED]	B	2	2	2	2	2	RA	[Signature]
B21	[REDACTED]	[REDACTED]							RA	[Signature]
B22	[REDACTED]	[REDACTED]	C	2	2	2	2	2	RA	[Signature]
B23	[REDACTED]	[REDACTED]	B	2	2	2	2	2	RA	[Signature]
B24	[REDACTED]	[REDACTED]							RA	
B25	[REDACTED]	[REDACTED]	C	2	2	2	2	2	RA	[Signature]
B26	[REDACTED]	[REDACTED]	B	2	2	2	2	2	RA	[Signature]
B27	[REDACTED]	[REDACTED]	C	2	2	2	2	2	RA	[Signature]
B28	[REDACTED]	[REDACTED]	B	2	2	2	2	2	RA	[Signature]
B29	[REDACTED]	[REDACTED]	B	2	2	2	2	2	RA	[Signature]
B30	[REDACTED]	[REDACTED]	B	2	2	2	2	2	IMU BHU inmate RA	[Signature]
B31	[REDACTED]	[REDACTED]	B	2	2	2	2	2	RA	[Signature]
B32	[REDACTED]	[REDACTED]	C	2	2	2	2	2	RA	[Signature]
B33	[REDACTED]	[REDACTED]	C	2	2	2	2	2	RA	[Signature]

Exhibit 1

APPENDIX

BHU REC LOG

4/12/2014

Cell	Name	SID	Level	Clip	Raz	Shr	Yard #1	Yard #2	Comments	Init.
B01										
B02			C			R	R	R		
B03			C			I/O	R	R		
B04			B				R			
B05			C			I/O	R	R		
B06			C			I/O	R	R	Rec with Cross	
B07			B			R	R	R		
B08										
B25										
B26										
B27			B			I/O	610/635	R		
B28			C				CELL 10	—		
B29			C				CELL 10	—		
B30			C				CELL 10	—	Rec with Johnson	
B31										
B32			IMU3			I/O	645/730	—	IMU	
B09										
B10			A-1			R	R	—		
B11			A-1			R	R	—	4/6/2014	
B12			A-2			R	R	—	From EOCI	
B13			B			R	R	—		
B14			A-2			R	—	—		
B15			A-1			R	—	—		
B16			A-1			R	—	—		
B33										
B34										
B35										
B36										
B37			A-1			R	—	—	IMU BHU inmate	
B38										
B39										
B40										
B41			B			R	R	R		

Exhibit 2

APPENDIX

BHU REC LOG

4/12/2014

Cell	Name	SID	Level	Clip	Raz	Shr	Yard #1	Yard #2	Comments	Init.
B17			B				I / R	710 / 750		
B18			C				R	R		
B19			C				R	R		
B20										
B21			B				R	R		
B22										
B23			B				R	R		
B24										
B42			C				R	R		
B43			A-1				R	R	Ad hold	
B44			B				R	R		
B45			B				R	R		
B46			B				I / R	625 / 705	FROM DSU	
B47			B				R	R		
B48			C				R	R		
B49			C				R	R		

Exhibit 2

APPENDIX

Misconduct Report Price List
6/29/2012

Clothing	Cost	Clothing	Cost	De-Con	Cost	Housing	Cost
T-Shirt (1X)	3.81	Coat (1X)	30.77	Gloves, pair	.14	Elect. Outlet	5.39
T-Shirt (2X)	4.55	Coat (2X)	32.47	Red Bag (sm)	.14	Toilet Brush	1.50
T-Shirt (3X)	5.37	Coat (3X)	32.17	Red Bag (med)	.18	Tier Broom	7.30
T-Shirt (4X)	6.15	Coat (4X)	32.12	Clear Bag (sm)	.14	Blanket	5.49
T-Shirt (5X)	5.87	Coat (5X)	32.19	Clear Bag (lg)	.22	Mattress 24"	123.88
T-Shirt (6X)	5.24	Coat (6X)	32.50	Paper Towel	.05	Mattress 30"	146.36
Dress Shirt (1X)	13.75	Coat (7X)	35.25	Scratch Pad	.76	Sheet	5.64
Dress Shirt (2X)	14.25	Coat (8X)	34.60	Virustat Tbg	.14 oz	Sheet Set	12.92
Dress Shirt (3X)	14.25	Underwear (M)	.78	Enzyme Plus	.14 oz	Pillowcase	1.64
Dress Shirt (4X)	14.25	Underwear (L)	.84	Pine DC	.13 oz	Light Fixture	5.62
Dress Shirt (5X)	15.90	Underwear (1X)	.85	PH Neutral	.10 oz	Mirror	2.50
Sweatshirt (1X)	4.68	Underwear (2X)	.91	Bleach	.40 oz	Bulletin Board	5.07
Sweatshirt (2X)	6.08	Underwear (3X)	1.01	Germicide Handwipes	.07	Storage Drawer	28.50
Sweatshirt (3X)	6.08	Underwear (4X)	1.01			Toilet	349.57
Sweatshirt (4X)	8.58	Socks	.47	Janitorial	Cost	Sink	255.32
Sweatshirt (5X)	8.75	Shoes (6)	3.91	Red Pad	4.10	Sprinkler Head	39.00
Sweatshirt (6X)	8.95	Shoes (7)	3.99	White Pad	4.16	Paint Cell	100.00
Pants (32"-40")	17.50	Shoes (8)	3.99	Natural Pad	4.69	Window Pain 12"	9.00
Pants (42"-48")	20.00	Shoes (9)	4.63	Scrub Pad blue	4.04	Window Pain 17X14"	14.00
Pants (50"-60")	22.50	Shoes (10)	4.80	Strip Pad black	4.15	Window Pain 19x15"	15.00
Red Shorts (M)	8.62	Shoes (11)	4.95	Counter Brush	9.34		
Red Shorts (L)	5.43	Shoes (12)	4.94	Push Broom	9.64		
Red Shorts (1X)	9.64	Shoes (13)	4.93	Broom Handle, tapered	4.33		
Red Shorts (2X)	9.96	Shoes (14)	4.85	Broom Handle, threaded	2.95		
Red Shorts (3X)	10.00	Workboots (6-8)	31.50	Whisk Broom	2.75	Use of Force Tools	
Red Shorts (4X)	12.00	Workboots (9)	31.45	Dust Mop Handle	7.32	MK3 1.5 oz	10.50
		Workboots (10-12)	31.50	Dust Mop Frame 24"	4.48	MK4 3.0 oz	11.50
		Workboots (13)	31.41	Dust Mod Hea 24"	9.41	MK9 16 oz	34.10
		Workboots (14)	28.62	Dust Mop Head 30"	14.93	Deep Freeze	19.95
		Belt	1.60	Wet Mop Handle	7.23	Tazer	22.95
		Stocking Cap	.91	Mop Bucket	54.08		

Miscellaneous	Cost

Exhibit 3