DISABILITY RIGHTS OREGON

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

Executive Summary

Written by
Sarah Radcliffe, PAIMI Managing Attorney

When a community fails to invest in behavioral healthcare, social safety net services, and affordable supportive housing, its jails fill with people who are held because of behaviors driven by their psychiatric disabilities. In an environment of such scarcity, judges, law enforcement agents, or family members may sometimes believe that an arrest is the only ticket to services and safety for a person in crisis. Disability Rights Oregon has found that, in fact, the experience of arrest and jail can be profoundly harmful for people with mental illnesses. Arrest is not a ticket to treatment or services. Instead, it leads to an environment of severe social and sensory deprivation where mental health crisis is responded to with tasers, spit socks, and a restraint chair. Jail is the antithesis to a trauma-informed response.

This report examines what happens in Multnomah County when a person with a severe mental illness gets caught in the criminal justice trap. It makes recommendations on how the County can use its jails more efficiently and effectively to improve the lives of those in its custody and better protect public safety. Most importantly, this report brings to light individual experiences of people who are surviving in the jail despite serious mental health concerns and a distinctly counter-therapeutic environment. We hope these stories will convey a deeper understanding of the profound suffering that is a constant reality behind the walls of the Justice Center–right in our midst and yet invisible to the public eye.

Disability Rights Oregon used our access and monitoring authority as the federally designated *Protection and Advocacy System* for Oregon to visit the jail on multiple occasions and speak directly with people incarcerated there, to inspect thousands of

pages of medical and security records, and to interview staff. Our investigation revealed a climate in which well-intentioned staff have become accustomed to responding to behavioral healthcare needs with force and deprivation, and in which "rogue" violence by a handful of ill-intentioned staff is not effectively reined in.

"Routinized" violence occurs because, in the absence of a clinically-staffed therapeutic environment, deputies respond to problematic behaviors with the tools and training that they have been given. Despite the high volume of people in custody with serious mental health concerns, deputies in the jail receive no mental health or crisis intervention training. Hence, risk of self-harm is addressed by strapping the individual into a restraint chair, sometimes for hours at a time, or stripping the person naked (aside from a suicide smock), removing all personal items and privileges, and leaving him or her alone in a cell. Mental health crisis is considered as behavior that must be controlled, with force if necessary. People with symptoms of mental illness are regularly deemed "too unstable" to come out of their cells to access showers, fresh air, or human contact. As the following examples illustrate, these tactics are both traumatic and dangerous for the individuals involved.

- A person in crisis who reached out to deputies to say he was hearing voices and needed his medication ended up being tased five times. When back-up arrived, they found him being held face-down breathing heavily and repeating "don't hurt me."

- A person in custody in the midst of a medical emergency had her medical care delayed so deputies could forcefully restrain her. Even after she had apparently stopped breathing and lost consciousness, they fastened her in to a restraint chair. Meanwhile, she spent a critical period of time without oxygen.

- One person in custody spent almost a year in MCDC's psychiatric infirmary where patients often receive less than an hour per day out of their cells. He lost a dangerous amount of weight, pulled out a tooth, and was terrified by hallucinations of monsters. The alleged reason for his arrest was a non-violent refusal to leave a psychiatric inpatient hospital, which resulted in a trespass charge.

These conditions undermine the humanity of people who are spending time in jail, and in doing so, contribute to a sense of impunity for staff that may be tempted to abuse their power. DRO discovered rare, but shockingly egregious accounts of violence against detainees with mental illness. These assaults and the resulting injuries were met

with lackadaisical responses from both medical staff and jail administration. Supervisory reviews often cite the victim's mental illness as a factor *justifying* the use of force. Several examples follow:

- An individual with serious mental illness was subjected to physical force by a deputy that resulted in a shattered hip socket. He waited over 6 hours before the jail x-rayed his hip and finally took him to the hospital, where he required surgery and insertion of screws to secure the bone fragments into place. He was returned to the jail to recover from his injury, but his fear of staff and untreated psychosis made him reluctant to accept necessary medical care. When released 6 months later, he was still unable to walk.

- A deputy tased an individual in the jail's psychiatric infirmary, then straddled him and delivered multiple "focused blows" to the patient's face. This assault resulted in extensive, bone shattering facial fractures.

- Following his seemingly unprovoked use of force, one deputy was described by multiple supervisors as a "bully" on "a power trip" with a pattern of misusing force and instigating confrontation that had persisted unchecked for years. Jail leadership referred the most recent case to the District Attorney's office, but the DA declined to prosecute, noting that the alleged victim had a history of cursing and had given the deputy a "what the fuck dude/come on kind of look." This deputy was still working in direct contact with detainees until DRO discovered this information and requested his removal pending investigation.

Jail has become our community's default behavioral health hospital, a role for which is it under-resourced, understaffed, and undertrained. This dynamic is particularly pronounced for Black community members with mental illness, who are drastically overrepresented in the jail's population and are more likely to be disciplined, restrained, and subjected to force or violence in jail.

DRO's report recommends investments to bring jail conditions up to constitutional standards, including steps to:

- End solitary confinement for people with serious mental illness;
- Strengthen supports for people with mental health issues in custody;
- Create a new protocol for responding to mental health related behavior in jail; and
- Improve oversight and accountability to remedy systemic race and disability disparities, and prevent staff misconduct.

It is important to bear in mind, however, that there is no amount of funding, staffing, or policy changes that can transform the jail into a safe, therapeutic environment for people whose primary need is behavioral healthcare. Our community must focus on ending the jail's role as a dumping ground for people who lack a welcoming destination. The long-term solution is a city and county in which people with disabilities are integrated into the fabric of daily life through supports such as affordable, supportive housing and robust community mental health services, rather than being locked behind closed doors.

610 SW Broadway, Suite 200, Portland OR 97205
Voice: 503-243-2081 or 1-800-452-1694
TTY: 503-323-9161 or 1-800-556-5351
Fax: 503-243-1738 or 1-800-513-2321
E-mail: welcome@droregon.org
Website: www.droregon.org