



April 7, 2015

TO: Senator Sara Gelsler, Chair
Senate Human Services and Early Childhood Committee
FR: Bob Joondeph, Sarah Radcliffe and Joel Greenberg
RE: SB 739

Disability Rights Oregon (DRO) is Oregon's federally-funded *Protection and Advocacy* office that provides legal-based advocacy services to Oregonians with disabilities. These services include investigating complaints of abuse and neglect.

In the spring of 2014, DRO received several complaints of abuse and neglect of prisoners with serious mental illness in the Behavioral Health Unit (BHU) at the Oregon State Penitentiary. The BHU was originally designed to provide intensive mental health treatment to individuals who, due to serious mental illness, are not able to conform their behavior to prison rules and are not responsive to the system of graduated privileges and deterrents employed in disciplinary segregation units. DRO investigated these complaints, and what we learned prompted SB 739.

DRO's Investigation of the Oregon State Penitentiary Behavioral Health Unit

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

- interviews of 19 BHU prisoners,
- approximately 4,500 pages medical, mental health and disciplinary records,
- video footage of seven "suit ups" or cell extractions involving anticipated use of force,
- Unusual Incident Reports (UIRs),
- written DOC policies, emails and memoranda relating to BHU procedures,
- records and logs that document BHU practices,
- confidential interviews with 8 current and former members of the BHU mental health staff.

Our investigation revealed that prisoners in the BHU spend months and sometimes years in 6 x 10 foot cells, with no natural light, no access to the outdoors or fresh air, and only rare opportunities to speak with other people. Most are in their cells for 23 hours a day and very few regularly shower or take recreation even though DOC policies require that they be offered those opportunities daily.

Other out-of-cell activities that ODC policies direct to be provided to BHU inmates include:

- o one hour per week of Dialectical Behavior Therapy, during which prisoners are lined up in cages the size of telephone booths,
- o one session per week with a counselor, and
- o for the few who have graduated to a “level C,” one hour per week of “day room,” during which the prisoner is allowed to sit on a plastic chair outside his cell. DRO learned that usually only one or two prisoners access “day room” in any given week.

Other than these possibilities, the men in the BHU have literally nothing to do. Personal property, such as books, radios, or art supplies is very tightly regulated. For example, DRO reviewed emails from BHU management apparently responding to officer concerns about whether a prisoner should be allowed to possess a single crayon.

Despite the BHU’s original purpose of providing robust mental health treatment, in recent years, access to crisis and routine mental health care has dwindled in recent years.

Former and current mental health staff complained to us that corrections staff dominate treatment team decisions and impede their access to clients, sometimes through excuses and feet dragging (a practice universally referred to as “slow-playing”) and sometimes by refusing to buzz them into the building.

In the absence of mental health staff influence and presence, corrections officers more readily respond to BHU prisoners’ mental health needs with riot gear, tasers, pepper spray, and a restraint chair. DRO reviewed numerous incidents in which there was no crisis counseling available to prevent inmate self-harm. Once the harm occurred – often by swallowing a dangerous item, cutting oneself, or head-banging - the response is often to pepper spray the person, strip him and place him in a restraint chair, sometimes for long periods of time, and then impose suicide precautions. Mental health staff reported pressure from officers to impose these precautions punitively, rather than protectively.

DRO found instances in which medications were administered under threat of tasing and that forcible cell extractions are a regular occurrence. We understand that these violent interactions may cause lasting damage to prisoners, and create a cycle of escalation and lashing out that exposes correctional officers to considerable risks. Life for an inmate in the BHU is like other prisons in which individuals with Serious Mental Illness live in solitary confinement: men in cages pace incessantly; they pound the walls, mutter to themselves, and scream incessantly; horrific levels of self-harm are a regular occurrence.

National Opposition to Solitary Confinement for Individuals with SMI

For individuals with Serious Mental Illness (SMI), solitary confinement is now understood as a sure way to promote decompensation and in many cases, cause or exacerbate dangerous behavior. This is why the American Bar Association , the American Psychiatric

Association, and the United Nations all oppose solitary confinement for people with mental illness.*

U.S. courts have noted the profound impact of solitary confinement on mental health in a long line of cases that begins with a 1890 U.S. Supreme Court decision. When applied to prisoners who already suffer from serious mental illness, one judge compared solitary confinement to putting an asthmatic in place with little air to breathe.

The problems we discovered are not unique to Oregon. In fact, Senate Bill 739 is modeled after a recent consent decree entered into by the state of Arizona in federal court.

Senate Bill 739

Senate Bill 739 will help break the destructive cycle of punishment and psychological decompensation through two key provisions:

- SB 739 mandates that prisoners with serious mental illness receive **five hours of structured therapeutic activities** and **two hours of unstructured activities per day**; and
- In non-emergency situations, SB 739 requires a **“cooling off” period**, during which a trained mental health professional has an opportunity to verbally deescalate the prisoner or gain compliance, prior to use of force against a prisoner with SMI. This provision prevents pepper spray, tasers, and the restraint chair from being the default tools that DOC uses to handle mental health crises or difficult behavior related to a prisoner’s mental illness.

Thank you for this opportunity to testify and to provide you with the preliminary findings of our investigation.

* **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 is cruel, inhuman or degrading treatment”).