Disability Rights Oregon

TO: Chair Bynum, Vice Chair Noble, Vice Chair Power, & Members of the House Committee on Judiciary
FROM: Disability Rights Oregon
DATE: February 25, 2021
RE: HB 2002, Testimony in Support of Converting Mandatory Minimum Sentences for Specified Felonies Other Than Murder to Presumptive Sentences

Chair, Vice Chairs, and Members of the Committee:

Disability Rights Oregon submits this testimony regarding HB 2002, legislation to convert mandatory minimum sentences for specified felonies other than murder to presumptive sentences.

The Problem: Jails are being used as behavioral health holding centers for people with disabilities.

Jails are the worst place for a person in a mental health crisis to be. Yet, due to a lack of robust community health services, housing, and diversion opportunities, Oregon jails are increasingly filled with people in need of medical, mental, and behavioral healthcare.

Most people in Oregon jails are facing low-level charges related to behavioral health needs, poverty, and difficult life circumstances. Disability Rights Oregon reports have recommended changes to stop the revolving door of people with mental health conditions being arrested for low-level, public nuisance offenses, cycling through the criminal justice system, and then being released without connection to community services. *See enclosures*. In particular low-level charges such as trespass, are a common reason that people with behavioral health conditions become caught in the criminal justice system. The Oregon Criminal Justice Commission asserts that "jails have become the default case management system for repeat, low-level offenders who are often houseless, often have substance abuse disorders, and often have mental health issues, traumatic brain injuries, or other chronic health issues."[1]

Prosecuting and incarcerating people on minor charges unnecessarily exposes them to harmful conditions in jails. No jail environment in Oregon is appropriate for people with mental health conditions. Jails were not meant to serve as hospitals or mental health crisis centers. After arrest, people's mental health often deteriorates. They may struggle to obey orders and conform to a jail's rigid requirements because of their disability. Jails will often punish them for failure to comply and often place the detainees in isolation. As a result, people with mental health conditions and other disabilities are likely to spend more time in jail and are much more likely to commit suicide while in jail. And once ensnared in the criminal legal system, people with disabilities face significant difficulty escaping the cycle of reincarceration. This cycle of failure is neither good for people

[1] Oregon Criminal Justice Commission, House Bill 3289 (2019) Report at 19, 21 (2020), available at https://www.oregon.gov/cjc/CJC%20Document%20Library/HB3289ReportSept2020.pdf.

caught in the cycle nor the jails which are unable to meet the high level of healthcare needs.

The Solution: **Require citation in lieu of arrest for certain crimes and close jails to people in acute need of medical or psychiatric care to reduce the number of people held in Oregon jails. Invest in community-based services to prevent criminalization.**

By enacting HB 2002, Oregon will enshrine in law proven methods for reducing jail populations. During the COVID-19 pandemic Oregon jails significantly reduced the number of people in custody by turning away arrestees who were charged with minor and/or non-person crimes as well as people who presented with serious medical needs. *See enclosure*. HB 2002 requirement for citation in lieu of arrest for certain crimes, including trespass, will help prevent people with disabilities from getting caught in the criminal justice cycle. Furthermore, preventing jails from booking individuals with serious medical or mental healthcare needs will allow people to receive the care they need in the community rather than the limited healthcare available to them in jail.

HB 2002 also invests in policies and programs that prevent the cycle of criminalization and incarceration such as culturally-specific programs, housing, crime survivor services, and addiction treatment.

Disability Rights Oregon strongly encourages the Committee to recommend HB 2002 do pass.

About Disability Rights Oregon

Disability Rights Oregon is a statewide nonprofit that upholds the civil rights of 950,000 people with disabilities in Oregon to live, work, and engage in the community. Disability Rights Oregon serves as a watchdog as we work to transform systems, policies, and practices to give more people the opportunity to reach their full potential. Since 1977, the organization has served as Oregon's federally authorized and mandated Protection & Advocacy System. Disability Rights Oregon is committed to ensuring the civil rights of all people are protected and enforced.

Grave Consequences: How the Criminalization of Disability Leads to Deaths in Jail

DRO | Disability Rights Oregon

Winter 2021

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The U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA), the Administration for Community Living (ACL), Rehabilitations Services Administration (RSA), Stanford University School of Law, and donors shared in the cost of funding this publication. The contents do not necessarily represent the official view of any funder.

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Executive Summary

Disability Rights Oregon (DRO) investigated ten deaths that occurred in eight Oregon jails between January 1, 2020 and October 31, 2020.[1] DRO examined the circumstances surrounding the deaths of these individuals and the failures contributing to the tragic loss of human life. Many of the deaths could have been prevented with adequate healthcare, jail oversight, and diversion to community health services in lieu of incarceration.

We have long known that jails have become the de facto mental health provider for many communities and yet are ill-equipped to provide the necessary care. The catastrophic loss of life detailed in this report demands better solutions. DRO's investigation found the following jail conditions put individuals with disabilities at risk of deadly harm:

- Jails use restraint practices banned in clinical settings: In April 2020, Clatsop County Jail deputies forcibly placed a man with mental illness face down on the ground. As many as six deputies held him down in the secure entrance to the jail until he stopped moving. He stopped moving within minutes and died within a few hours. This life-threatening restraint technique is called a "prone restraint" and is banned in many schools and clinical settings for the same reasons it should be banned in the criminal justice system—it contributes directly to the inability to breath and drastically increases the risk of death.[2]

- Jails inadequately assess medical conditions: Jail deputies and jail medical staff are unable to accurately assess medical conditions or complaints. This inability leads to death. In late January 2020, nurses and deputies at the NORCOR jail dismissed a woman's complaints of rib pain and denied her requests for hospital care. Eleven days after being booked in jail, she died there of pneumonia, a treatable disease the jail failed to timely recognize or treat. She was 26.

- Jails are unable to provide necessary treatment: Jails are not designed to provide treatment and often exacerbate symptoms of mental health conditions. For example, many jails place inmates with mental illness in segregation to keep them safe. However, this isolation can have devastating impacts on mental health symptoms. Some Oregon jails are unable to prescribe psychiatric medications, while other jails have wait-times to see a prescriber through telemedicine that exceed a month. Thirty-eight percent of Oregon jails report medical positions that are budgeted but unfilled.[3]

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[1] The deaths occurred in jails in Clatsop, Deschutes, Jackson, Klamath, Marion, and Polk counties, as well as the Springfield Municipal Jail and the NORCOR detention center in The Dalles.

[2] Nicole Bales, *Investigation into Warrenton Man's Death in Police Custody Finds No Excessive Force*, Astorian (Aug. 24, 2020) available at https://www.dailyastorian.com/news/local/investigation-into-warrenton-mans-1ea-8a0e-b7291152381e.html

[3] Oregon Criminal Justice Commission, House Bill 3289 (2019) Report at 5.

» Jails often failed to take measures to prevent suicide, even when detainees presented with known risks of suicide: Punitive jail culture rather than clinical best practices inform jail suicide precautions. Furthermore, jail staff did not perform required welfare checks to protect detainees, seriously ill detainees received wholly inadequate healthcare, or jails failed to mitigate ligature risks. Together, all of these factors contributed to the six suicide deaths identified in this report.

» Oregon lacks meaningful transparency and oversight of jail safety and healthcare: Oregon does not track data related to deaths in jails and no state agency is charged with overseeing jails' provision of healthcare. Oregon law only requires jails to provide for emergency medical healthcare, but does not offer guidance into treatment for non-emergent medical and mental health conditions.[4] This limited law was passed in 1973, decades prior to the era of mass incarceration during which Oregon jails have seen a 316 percent increase in population and an intensifying degree of physical and behavioral health needs.[5]

» Detainees cycle in and out of jail due to the lack of community treatment options: In previous reports, DRO has recommended changes to stop the revolving door of people with mental health conditions being arrested for low-level, public nuisance offenses, cycling through the criminal justice system, then being released without connection to community services.[6] When released without needed community services, individuals are left to repeat similar mental health-related conduct and re-arrest. Six of the ten individuals who died in Oregon jails in 2020 had been incarcerated many times for predominantly low-level offenses.

A Blueprint for Improving Health & Safety of People Held in Jails

DRO's investigation found both common failures and common solutions endorsed by a wide array of stakeholders. The following blueprint provides clear next steps to reduce the criminalization of people with disabilities and prevent deaths in jails.

[4] ORS 169.076

[5] Vera, *Incarceration Trends in Oregon*, available at https://www.vera.org/downloads/pdfdownloads/state-incarceration-trends-oregon.pdf

[6] Disability Rights Oregon, *A Merry Go Round That Never Stops: Mental Illness in the Multnomah County Detention Center* at 34 (2017) available at https://static1.squarespace.com/static/5d645da3cf8e4c000158e55a/t/5f050ad4e14f582e6f4f87aa/1594165986280/A_Merry_Go_Round_That_Never_Stops_Mental_Illness_in_the_Multnomah_County_Detention_Center.pdf; Disability Rights Oregon, *The "Unwanteds": Looking for Help, Landing in Jail* (Spring 2019), available at https://static1.squarespace.com/static/5d645da3cf8e4c000158e55a/t/5f0e37c36a6e4301c92d85d9/1594767330385/Report-The-Unwanteds-Looking-for-Help-Landing-in-Jail-2019-June18+%281%29.pdf.

Recommendation: Produce Adequate Healthcare Standards and Effective Suicide Protocols for Oregon Jails

- Revise Oregon law to produce enforceable minimum jail healthcare standards including: adequate healthcare staffing, access to medications, timely hospital transfer and continuity of care for individuals with acute care needs, and improved screening.
- Revise protocols used by Oregon jails to replace punitive suicide watch provisions with effective suicide protocols that keep detainees in mental health crises safe.
- Revise Oregon law to ban the use of dangerous restraint techniques that have contributed to the deaths of detainees, including prone restraint.

Recommendation: Strengthen Jail Oversight

- Establish an independent jail inspection process to provide adequate oversight of jails.
- Establish a transparent system for tracking deaths in Oregon jails using clear, uniform data, and make that data publicly available.

Recommendation: Prevent the Criminalization and Improper Incarceration of People with Disabilities

- Expand community support systems for individuals with disabilities who need healthcare, social support, and help with basic needs such as housing and treatment services.
- Revise Oregon law to ensure that detainees with acute medical and mental health conditions are taken to a healthcare facility, not booked in jail, including the right of jail commanders to refuse to book individuals whose acuity of health symptoms make them at risk of harm in a jail setting.

Introduction

Mass incarceration is a disability justice issue. Since 1970, Oregon jails have seen a 316 percent increase in population and detainees have an intensifying degree of physical and behavioral health needs.[7] In 2018, Oregon jail commanders estimated as much as 50 percent of their population would benefit from behavioral healthcare.[8] In some communities, jails are the largest providers of mental health services.[9]

Unlike prisons, which confine people who have been convicted of more serious crimes, jails hold people who have violated probation, are serving a short sentence on a less serious conviction, or who are being held pretrial and have not been convicted of anything.[10] The most common reasons for detention in Oregon jails are probation violations and low-level charges that are associated with homelessness and behavioral health needs, such as trespass, disorderly conduct, possession of controlled substances, and probation violations.[11]

After Oregon Public Broadcasting's (OPB) 2019 investigation of deaths in Oregon and Washington jails,[12] the Oregon legislature tasked the Criminal Justice Commission (CJC) with creating a report examining health, safety, and risk of death in Oregon jails.[13] Notably, the CJC's findings on jail deaths contained a warning that the jail data was "incomplete" and "not a sufficient description or explanation of deaths in Oregon's jails."[14]

Disability Rights Oregon (DRO) conducted this investigation into deaths in Oregon's jails in response to both OPB and CJC's findings. Over the course of the investigation, DRO found that at least ten individuals died in eight Oregon jails in 2020 for reasons unrelated to COVID-19. The deaths occurred in jails in Clatsop, Deschutes, Jackson, Klamath, Marion, and Polk counties, as well as the Springfield Municipal Jail and the NORCOR detention

[7] Vera, *Incarceration Trends in Oregon*, available at https://www.vera.org/downloads/pdfdownloads/state-incarceration-trends-oregon.pdf

[8] See also, *Police Executive Research Forum, Managing Mental Illness in Jails: Sheriffs are Finding Promising New Approaches* at 5 (September 2018) ("Among prison inmates, up to one quarter have severe mental illness only. By some other estimates, half or more of local jail inmates have some form of mental illness.") available at https://www.policeforum.org/assets/mentalillnessinjails.pdf

[9] *Id.* at 35.

[10] More than sixty percent of people held in Oregon jails are pretrial detainees. Vera, *Incarceration Trends in Oregon*.

[11] Oregon Criminal Justice Commission, House Bill 3289 (2019) Report at 21-22 (Sept. 15, 2020), available at https://www.oregon.gov/cjc/CJC%20Document%20Library/HB3289ReportSept2020.pdf.

[12] Conrad Wilson, et al, *Booked and Buried*, available at https://www.opb.org/news/article/jail-deaths-oregon-washington-data-tracking/

[13] House Bill 3289 (2019)

[14] Oregon Criminal Justice Commission, House Bill 3289 (2019) Report at 23.

center in The Dalles.[15] DRO's investigation found that while total jail populations have dramatically declined in 2020,[16] the percentage of people dying in jail or police custody has doubled.[17]

While this report does not tell the entire story of each person's death, each individual case is its own tragedy and speaks to the urgent need for action. Use of force, inadequate medical and mental healthcare, insufficient screening, and failure to follow safety protocols contributed to the deaths analyzed in this report. Criminalization of mental health conditions, lack of substantive healthcare standards, and lack of jail oversight were systemic issues uncovered through this investigation.

No one should die in jail. This report advocates for agreed-upon interventions that would make Oregon jails safer. Ultimately, the recommendations call for increased jail oversight, reducing jail populations, and protecting the lives of people with disabilities in our jails.

Investigation Methodology

There is no centralized entity or source of reliable data that tracks jail deaths in Oregon. Early in its investigation, DRO used a variety of methods—including researching news coverage, reviewing requests for DRO assistance, and reports from public defenders—to identify ten individuals who died in Oregon jails between January 1 and October 31, 2020.

As the federally-designated protection and advocacy system for the state, DRO has unique authority to access confidential records from institutions that confine people with disabilities. Using this authority, DRO requested records related to these ten jail deaths from eight jails.[18] The records requested included incident reports, medical and behavioral health records, cell-check logs, suicide risk assessments, and jail policies related to intake and suicide watch. When available, DRO also reviewed video footage and hospital records. DRO also discussed some specific cases with jail commanders to garner additional details not available in the records. The jail commanders and sheriffs from the facilities provided

[15] Nationally, jails death rates have increased 35 percent over the past ten years. Peter Eisler et al, Dying Inside: The Hidden Crisis in America's Jails Part One, Reuters (Oct. 16, 2020) available at https://www.reuters.com/investigates/special-report/usa-jails-deaths/.

[16] The COVID-19 pandemic has prompted jails to significantly reduce their populations. In the Spring of 2020, Disability Rights Oregon found counties have reduced jail populations by roughly half, with reductions as large as seventy-five percent in some jails. *Oregon Jails during COVID-19: A Look Inside 29 County Jails* available at https://static1.squarespace.com/static/5d645da3cf8e4c000158e55a/t/5f0ce118b798024382bf8697/1594679577329/DRO-Report-Oregon+Jails+during+COVID-19-A+Look+Inside+29+County+Jails+%28Updated+05-01-2020%29.pdf

[17] Oregon jails reported nine deaths in 2018, seven deaths in 2019, and ten deaths between January and October of 2020. It is unknown if additional deaths have occurred in November and December of 2020.

[18] Record requests were made under DRO's authority as the Protection and Advocacy System. See the Developmental Disabilities Assistance and Bill of Rights ("DD") Act, 42 U.S.C. § 15041, et seq., the Protection and Advocacy for Individuals with Mental Illnesses ("PAIMI") Act, 42 U.S.C. § 10801, et seq., the Protection and Advocacy for Individual Rights ("PAIR") Act, 29 U.S.C. § 794e, and the regulations promulgated thereto, and ORS 192.517.

extensive records in a forthcoming and timely manner. DRO reviewed the records and tracked information related to causes of death, jail compliance with safety protocols, physical and mental health treatment provided in the jail, and past bookings. DRO's investigation focused on identifying issues in individual cases and patterns between cases.

DRO's federal mandates also require that we maintain the confidentiality of our clients and their records. This report includes two detailed accounts of those who died. We were able to share these details as the family or representative of the deceased authorized the release of this information. DRO made efforts to locate family members or authorized representatives of all of the deceased. In cases where DRO was not able to locate such individuals, the confidentiality of the deceased has been protected by removing all identifying information.

Client Stories

Alex Jimenez

Alexander Jimenez was a proud U.S. army veteran and identified as Black, Native American, and Hispanic. His friends call him Alex. Alex experienced significant trauma in his life. He grew up in the foster care system, had been to prison, and had been homeless for a long period of time. He had a mental illness and struggled with addiction.

Alex ended up in the small town of Warrenton, where his veteran's fiduciary program helped him secure housing. He was feeling hopeful for the first time in a long time. He loved the local library and the Seaside Aquarium. He remained terrified of the police, to the extent that he refused to enter the DMV in order to get an ID. This fear was probably rooted in his trauma history and magnified by his mental illness. His advocate and representative through The Thom-Boy Project, Tami Herman, remembers him as a "very private person who sought nothing more than to feel safe and secure. Alex tried very hard to become comfortable with living in a home after years on the street, learning to cook and do laundry for himself; the little things others may take for granted. He enjoyed the small town feel of Warrenton, but felt oddly out of place at the same time. His skin color, his manner of self-expression in dress, and his mental illness did not invite inclusion from many of the small townspeople."

Alex was arrested for walking in the middle of the street. Local officers were acquainted with him. They had interacted with Alex approximately eight times between fall 2019 and his death in April 2020. When Alex did not respond to officers' requests to get out of the street, they arrested him and used a taser.

Due to the tasing and his mental health symptoms, officers brought Alex to the local hospital for a medical assessment of whether he was healthy enough to be safely booked in jail.

> A doctor's medical assessment consisted of looking at Alex as he sat in the back of a police car yelling and moving around. The hospital did not measure Alex's vitals, examine the area where he was tased, or assess his mental health needs. Based on a cursory observation, the doctor cleared him for jail, saying "I guess you're ready to go to jail".

When officers arrived at the jail with Alex, several deputies were in the sally port[19] and tried to assist with removing him from the car. DRO reviewed sally port video footage of Alex's arrival at the Clatsop County Jail, including law enforcement body cameras. In the footage, Alex struggled against police officers when they took him out of the car. They kicked his legs out from under him, forced him to the ground, and used their hands, arms, upper bodies, and knees to hold him face down on the concrete floor. At times, there were as many as six people holding him down until eventually he stopped moving.

After he lay still for several minutes, someone checked his pulse. A deputy realized he wasn't breathing, turned him over, and began chest compressions until paramedics with the fire department arrived. The paramedics took him to the hospital where they briefly revived him, but Alex Jimenez never regained consciousness and died later that day. The medical examiner's report categorized his death as "accidental due to toxic effects of methamphetamine" with fatty liver and "recent application of conductive electrical devices" noted as additional contributing factors.

Clatsop County Sheriff Matthew Phillips noted that Alex Jimenez's death "shook my staff deeply and resulted in employees seeking counseling." Sheriff Phillips has already instituted some of the reforms called for in DRO's recommendations with the Clatsop County Jail.

[19] The sally port is the secured, controlled entry into the jail.

Jennifer McLaren

Jennifer McLaren was 26 years old when she died from a severe case of undiagnosed pneumonia in a jail in The Dalles. She had a history of drug possession charges and was arrested for a probation violation on January 24, 2020.

At jail booking, she began complaining of rib pain and her cellmate asked to be moved because Jennifer seemed sick and her cellmate didn't want to catch it. Eight days after her arrest, Jennifer asked to be brought to the hospital, but instead was moved to a booking cell where she could be observed more closely.

> Both nurses and deputies believed she was faking her pain and difficulty moving until the day she died.

The day before her death, Jennifer became very dehydrated. This concerned medical staff, so they ordered her to drink a gallon of juice but did not attempt to have her hospitalized.

Immediately before Jennifer fell unconscious due to her illness, jail staff called emergency medical services. Emergency medical staff responded quickly, but it was too late for them to save her. Jennifer died at the jail. The medical examiner listed her cause of death as pneumonia in both lungs with blood-borne bacteria that had spread throughout her body. In most cases pneumonia is treatable, especially in a young person.

Factual Findings and Trends

The Majority of People Who Died in Oregon Jails in 2020 Had a Disability

Over half of the ten people who died in Oregon jails between January 1, 2020 and October 31, 2020 had mental illness or substance abuse disorder:

- five had documented mental health conditions;
- six committed suicide;
- eight had documented substance use disorder and six were incarcerated for charges related to their substance use when they died in custody;
- six had been in and out of jail many times for predominantly low-level offenses; and
- at least four were houseless or had a history of housing insecurity.

Suicide Was the Leading Cause of Death in Oregon Jails and Is Preventable

Jail suicide rates in Oregon are a persistent problem. Oregon Public Broadcasting reported in 2019 that the suicide rate in Oregon and Washington jails exceeded the national average,[20] and the rates in jails are significantly higher than those in the community. In September 2020, Oregon jails reported 212 in-facility suicide attempts over the previous year. [21]

Jails Failed to Identify and Prevent Suicide

Six of the ten individuals who died in Oregon jails in the first ten months of 2020 died by suicide. The records revealed a lack of safe jail conditions or procedures to mitigate the risk.

[20] Conrad Wilson, *Suicide Is the Leading Cause of Death in Oregon and Washington Jails*, OPB (April 4, 2019) available at https://www.opb.org/news/article/suicide-oregon-washington-jails-death-investigation/

[21] Oregon Criminal Justice Commission, House Bill 3289 (2019) Report at 8.

None of the individuals were on suicide watch, though in some cases there were indications that the person was at risk, including a recent hospitalization for attempted suicide.

Many Jails Are Rife with Ligature Risks

All of those who committed suicide died by hanging: Each person was left unsupervised in cells with unmitigated ligature risks. Unlike hospital licensing which requires eliminating all furnishings or fixtures that a patient could use to hang themselves, there is no oversight or licensing body in Oregon that proactively requires jails to address ligature risks. Federal law, however, does require that jails remove ligature risks from their facilities.[22]

Jails' Suicide Watch Protocols Increase Risk of Harm

Most jails have limited options to keep inmates who pose a suicide risk safe. Jail protocols include segregation, denying phone calls and showers, or putting inmates in suicide smocks stripping them of all other clothing and belongings. These protocols treat suicide risk punitively which deters people in jail custody from alerting jail staff of their suicidal ideation.

DRO's review of jail policies reveals that the most common suicide watch precautions are largely punitive. For example, policies dictate the removal of clothing, bedding, and personal belongings from cells or placing detainees in restrictive settings such as segregation or isolation. These restrictive measures make detainees less safe for three reasons: The extreme degree of deprivation and isolation imposed exacerbates feelings of despair; fear of a punitive response discourages detainees who feel suicidal from coming forward; and, enforcing unnecessarily harsh conditions on suicide watch creates countless reasons to impose force against individuals in psychiatric crisis.[23]

Oregon law requires hourly welfare checks in correctional facilities for all inmates.[24] For inmates on suicide watch, welfare checks may increase to fifteen-minute intervals. In two deaths investigated by DRO, jail staff failed to conduct adequate welfare checks. Adequate welfare checks can save lives by preventing or mitigating the time inmates spend with ligatures around their necks.

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[22] In DOJ enforcement of the Civil Rights of Institutionalized Persons Act, unmitigated ligature risks in jails are a common violation covered. See, Special Litigation Case Summaries, US Department of Justice, https://www.justice.gov/crt/special-litigation-section-case-summaries/download#corrections-summ.

[23] Disability Rights Oregon, *A Merry Go Round That Never Stops: Mental Illness in the Multnomah County Detention Center* at 34 (2017) available at https://static1.squarespace.com/static/5d645da3cf8e4c000158e55a/t/5f050ad4e14f582e6f4f87aa/1594165986280/A_Merry_Go_Round_That_Never_Stops_Mental_Illness_in_the_Multnomah_County_Detention_Center.pdf.

[24] ORS 169.076(1)

People in Oregon Jails Were Not Afforded Adequate Medical Care during and after Their Bookings

Hospitals Cleared Still-Sick Patients, Leaving Jails with Few Safe Options to Care for These Individuals

Through this investigation, DRO found evidence that hospitals cleared individuals for jail transport without adequate examination. Under federal law,[25] hospitals have a statutory duty to provide stabilizing emergency care to people in medical and behavioral health crises,[26] which extends to individuals brought to hospitals by law enforcement prior to booking or during a crisis that began in jail custody.

Over the course of this investigation, Oregon sheriffs and jail commanders reported that local hospitals regularly clear patients for jail transport, regardless of the severity of their medical or mental health condition. In two cases reviewed for this report, hospital staff quickly released the individuals with conditions that ultimately contributed to their death.

Inappropriate and Unsafe Restraint

The risk of harm jailing people with acute mental illness is exacerbated by unsafe restraint practices to control behavior related to their disability. Alex Jimenez died after being restrained face down, also known as a "prone restraint," by at least six deputies for several minutes.[27] The use of prone restraints can impair the subject's ability to breathe, causing positional asphyxia and potential death.[28] Risks are elevated when combined with other factors that are prevalent in jails, such as intoxication, mental health symptoms, agitation, obesity, and respiratory distress.[29] Schools and clinical settings have long barred prone, or

[25] Emergency Medical Treatment and Labor Act (EMTALA) 42 U.S.C. § 1395dd (2020)

[26] For a discussion of emergency departments' failures to treat psychiatric patients, see Alexander M. Martell, EMTALA and Psychiatric Patients, 21 DePaul J. Health Care L. 1 (2019); see also Disability Rights Oregon, *The "Unwanteds": Looking for Help, Landing in Jail* (Spring 2019), available at https://static1.squarespace.com/static/5d645da3cf8e4c000158e55a/t/5f0e37c36a6e4301c92d85d9/1594767330385/Report-The-Unwanteds-Looking-for-Help-Landing-in-Jail-2019-June18+%281%29.pdf.

[27] DRO's 2017 investigative report on conditions in the Multnomah County Detention Center – *A Merry Go Round that Never Stops* - describes multiple instances in which detainees were restrained in a prone position for prolonged periods, often pinned underneath multiple deputies. In one case described in that report, a young woman lost consciousness and suffered brain damage as a result of prone restraints.

[28] Lawrence Heiskell, *How to Prevent Positional Asphyxia*, Police Magazine (September 9, 2019) available at https://www.policemag.com/524139/how-to-prevent-positional-asphyxia

[29] *Id.*

face down, restraint practices due to concerns about safety.[30]

Jails Do not Provide Quality Medical Care and Are Ill-Equipped to Monitor Serious Medical and Mental Health Conditions

DRO's investigation also found that detainees reporting symptoms were often seen as drug-seeking or otherwise faking their symptoms. Requests for medical care were dismissed. Warning signs of life-threatening medical conditions went unnoticed and unaddressed.

Jennifer McLaren was sent to jail for violating the terms of her probation. When she arrived, she complained of rib pain. Her concerns were dismissed by jail staff. Eight days later, Jennifer asked to be taken to the hospital. Jail staff denied her request for care. Jennifer died inside the jail of pneumonia a few days later. Similar circumstances—jail medical staff doubting and downplaying symptoms—led to another detainee dying in a different Oregon jail in 2020.

Jail Deputies Neglected Legally Required Hourly Welfare Checks that May Have Saved Lives

Oregon law requires hourly welfare checks in correctional facilities.[31] In two deaths investigated by DRO, jail staff failed to conduct adequate welfare checks. As a result, the individuals laid dead for hours before being discovered by deputies. In one case, a detainee had left their bunk to commit suicide in the night and was not found until the next morning. In the second case, so much time had passed between death and discovery by deputies that rigor mortis set in, leading DRO to conclude that no welfare check had been conducted in several hours.[32]

[30] *See e.g.*, Equip for Equality, *National Review of Restraint Related Deaths of Children and Adults with Disabilities: The Lethal Consequences of Restraint* at 9 (2011) available at https://www.equipforequality.org/wp-content/uploads/2014/04/National-Review-of-Restraint-Related-Deaths-of-Adults-and-Children-with-Disabilities-The-Lethal-Consequences-of-Restraint.pdf.

[31] ORS 169.076(1)

[32] Rigor mortis https://www.sciencedirect.com/topics/medicine-and-dentistry/rigor-mortis

Discussion

Data Regarding Deaths in Jails Are Flawed but Point toward Rising Death Rates and a Dire Need for Oversight

Data Regarding Deaths in Jails Is Inconsistent and Opaque

As a result of Oregon Public Broadcasting (OPB)'s 2019 investigation of deaths in Oregon and Washington jails, the legislature tasked the Oregon Criminal Justice Commission (CJC) with creating a report examining health, safety, and risk of death in Oregon jails. The CJC's findings on jail deaths, however, contained the caveat that the data CJC received from jails was "incomplete" and "not a sufficient description or explanation of deaths in Oregon's jails."

Because there is no statutory requirement that jails track or report in-custody deaths, neither the CJC nor DRO were able to ascertain definitive answers to basic questions about how many people are dying in jails and why. The CJC concluded that accurate tracking of deaths in jail would require "regular, jail-by-jail, qualitative investigation."

The Number of Deaths of People Held in Oregon Jails Is Increasing

Data, albeit limited, indicate rising jail death rates in Oregon and across the country. OPB's investigation found that seven people died in Oregon jails in 2019 and nine died in custody in 2018. DRO's investigation of jail deaths during the first ten months of 2020 found that at least ten people had died in eight Oregon jails.

Jails Are Shielded from Public Scrutiny and Lack Meaningful Oversight

In a study of national media reports of people killed by police, as many as half of the people of color killed by police were also people with disabilities. This risk of harm follows Black, Indigenous, and other People of Color (BIPOC) and people with disabilities when they move from police custody to jail, but the cameras do not follow from the street into the jailhouse. As soon as an officer hands control over to a jail commander, the public can no longer use camera phones to record brutality and there are no bystanders or family to intervene or bear witness.

As a result, jails are subject only to voluntary oversight through the Oregon State Sheriffs' Association (OSSA). Currently, OSSA conducts inspections through deploying jail and sheriff's staff from other counties. Inspections are currently planned well in advance, results are not publicly available or tracked by any centralized agency, and there is no mechanism to enforce compliance with the OSSA standards.

Jails Are Not Well-Equipped to Provide Adequate Medical Care

Lack of Legal Standard for Medical Care

Oregon statutes on jail requirements have not been updated since the 1970s and require nothing beyond emergency medical treatment and delegates the responsibility for producing its own standards of medical care to each individual jail. Lack of consensus or standards regarding access to healthcare in jails creates drastic disparities across the state. People in custody in many counties are left without access to basic healthcare and life-saving treatment. Similarly, OSSA standards require jails to provide adequate healthcare, but leave the term undefined, stating that "the local medical director must determine what adequate healthcare is." The fact that there is little consensus or guidance about what "adequate" means in the jail context confounds the structural difficulties to ensuring adequate healthcare in jail.

Jails Were not Built for Healthcare Delivery

Jails lack the physical space to treat health conditions. Historically jails have been designed, built, and staffed as facilities meant for short-term stays for pretrial detainees, not de facto healthcare facilities for people in crisis. Smaller jails may lack a clinic space to provide healthcare services and most jails do not have confidential spaces available for mental health care visits. Other jails have labyrinth-like floor plans that make it time-consuming for deputies to escort inmates to and from their healthcare appointments. In recognition of the limitations of jail healthcare, OSSA published a jail standard which allows jails to request that an arresting officer bring an arrestee in mental health crisis to a hospital for evaluation prior to booking. However, some hospitals and law enforcement agencies have resisted implementing this standard.

Recruitment and Retention Challenges Impede Adequate Clinical Staffing

DRO has visited jails that have no capacity to prescribe psychiatric medications or where wait-times to see a prescriber through telemedicine can exceed a month. Thirty-eight percent of Oregon jails report medical positions that are budgeted but unfilled because the jails are unable to recruit and retain qualified medical staff. Homer Venters, an expert in correctional healthcare, points out that "correctional health has sometimes been thought of as a career of last resort, and correctional health professionals provide care in extremely difficult settings, where their decisions are often questioned by patients and security staff alike."[33]

[33] Homer Venters, *A Three-Dimensional Action Plan to Raise the Quality of Care of US Correctional Health and Promote Alternatives to Incarceration*, Am J. Pub. Health 613 (April 2016) available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4816015/

The Criminalization of Mental Health Conditions Exposes People with Disabilities to Increased Risks of Dying in Jail

The ten people who died in Oregon jails in 2020 affirm what DRO knows generally about the population of people confined in county jails: Most are facing low-level charges related to behavioral health needs, poverty, and difficult life circumstances. The Oregon Criminal Justice Commission asserts that "jails have become the default case management system for repeat, low-level offenders who are often houseless, often have substance abuse disorders, and often have mental health issues, traumatic brain injuries, or other chronic health issues."[34]

Prosecuting and incarcerating people on minor charges unnecessarily exposes them to harmful conditions in jails. This is especially true for people with disabilities or complex healthcare needs. Criminalizing behavioral health conditions exacerbates existing symptoms, adds additional trauma, and further disrupts progress towards housing, services, and other stabilizing benefits in the community. The failure to adequately fund effective community-based mental health systems has directly contributed to people with disabilities in need of treatment being met with jail and prison rather than recovery and care.

[34] Oregon Criminal Justice Commission, House Bill 3289 (2019) Report at 19, 21.

Blueprint for Improving Jail Health & Safety

While this report highlights system failures and failures in individual facilities, there are clear solutions to these problems. Perhaps most promisingly, there is already a broad-based consensus regarding the need for change, including from the people who run jails. In 2019, jail commanders from almost every jail in Oregon shared with the Criminal Justice Commission (CJC) detailed feedback on ways to improve the health and safety of detainees in Oregon jails. CJC used the jail commanders' feedback, along with input from stakeholders, to craft a blueprint for health and safety in jails.

On September 15, 2020, the CJC's Jail Advisory Committee submitted a report with nine policy recommendations based on a survey of Oregon's local correctional facilities and a collection of data from jails' records management system during early 2019:[35]

- Reduce community reliance on jails for management of individuals committing frequent, low level infractions. Increase resources for community services for these individuals.
- Reform the process by which individuals with serious mental illness or who are experiencing a mental health crisis encounter local correctional facilities. Increase diversion from jail, especially for individuals experiencing a mental health crisis.
- Ensure that qualified staff conduct each screening.
- Ensure Oregon Health Plan (and other insurance coverage) remains intact upon booking, during jail stays, and after re-entry.
- Adopt minimum healthcare standards for jails.
- Provide additional resources to recruit and retain medical staff in jails, especially for small and rural jails.
- Consider jails and prisons as separate entities in all future policy development.
- Facilitate continuation of treatment upon booking and ensure "warm handoffs" upon re-entry.
- Develop a standardized jail inspection process that includes objective inspectors, a randomized inspection schedule, and reports inspection findings to the state.
- Develop a standardized method and data format for jails to submit data to the CJC.

[35] Oregon Criminal Justice Commission, House Bill 3289 (2020). Report available at https://www.oregon.gov/cjc/CJC%20Document%20Library/HB3289ReportSept2020.pdf.

Based on Disability Rights Oregon's (DRO) investigation into jail deaths, DRO supports each of the CJC's recommendations. Based on our investigation into how and why inmates die while in custody, DRO makes seven further recommendations to increase the health and safety of inmates with disabilities. Taken together, these recommendations will improve healthcare standards and suicide protocols by strengthening jail oversight and preventing improper incarceration people with disabilities.

Recommendation: Produce Adequate Healthcare Standards and Effective Suicide Protocols for Oregon Jails

- Revise Oregon law to produce enforceable minimum jail healthcare standards including: adequate healthcare staffing, access to medications, timely hospital transfer and continuity of care for individuals with acute care needs, and improved screening.
- Revise protocols used by Oregon jails to replace punitive suicide watch provisions with effective suicide protocols that keep detainees in mental health crises safe.
- Revise Oregon law to ban the use of dangerous restraint techniques that have contributed to the deaths of detainees, including prone restraint.

Recommendation: Strengthen Jail Oversight

- Establish an independent jail inspection process to provide adequate oversight of jails.
- Establish a transparent system for tracking deaths in Oregon jails using clear, uniform data, and make that data publicly available.

Recommendation: Prevent the Criminalization and Improper Incarceration of People with Disabilities

- Expand community support systems for individuals with disabilities who need healthcare, social support, and help with basic needs such as housing and treatment services.
- Revise Oregon law to ensure that detainees with acute medical and mental health conditions are taken to a healthcare facility, not booked in jail, including the right of jail commanders to refuse to book individuals whose acuity of health symptoms make them at risk of harm in a jail setting.

Conclusion

State leaders, sheriffs, and jail commanders have the difficult obligation to ensure jails are healthy and safe for both jail staff and the individuals confined to their care. This obligation has only become more difficult in recent years as jail rosters continue to increase due in part to a lack of robust community health services, housing, and diversion opportunities. For now, these individuals are being warehoused in jails that are ill-equipped to recognize the humanity of the people in jail custody. Robust mental and physical healthcare standards are necessary given the high levels of need in Oregon jails. Oversight systems must be in place to guarantee that jails meet those standards. Both are central to protecting the lives of people held in Oregon's jails.

The most powerful method for preventing deaths in Oregon jails is to end the overuse or misuse of incarceration. In the absence of community-based support for people with mental health conditions, jails will continue to act as de facto treatment centers, crisis centers, and hospitals. And once ensnared in the criminal legal system, people with mental health conditions and other disabilities face significant difficulty escaping the never-ending cycle of re-incarceration.

> All ten of the tragic deaths documented in this report are the result of a long-standing public health crisis worsened by steep barriers to social support.

Judges, law enforcement, advocates, and people with lived experience in the criminal legal system agree that Oregon must stop criminalizing low-level, mental health driven behaviors. We can and must do better.

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The "Unwanteds": Looking for help, landing in jail

An analysis of how trespass arrests at Portland-area hospitals criminalize mental illness

Spring 2019

Dedicated to Jessica Sharp

1984 - 2019

"Our lives and our dignity have inherent value and we deserve to be treated like anyone else and to receive medical treatment when we need it."

Jessica Sharp

The "Unwanteds"

In recent years, Disability Rights Oregon has worked hard to improve the experiences of people with mental health conditions who were ensnared in the criminal justice system. We have visited jails across the state and interviewed hundreds of people who are incarcerated. Conditions in Oregon jails are dire and each of these conversations affirmed the urgent need to improve the treatment people receive in custody. The long-term solution, however, must involve preventing people with mental illness from needlessly ending up in criminal justice settings.

Many of the people who suffer most profoundly in jail have serious mental health concerns and are arrested on low-level charges related to their disability—trespass, disorderly conduct, misuse of 911, or violation of probation terms that they were never equipped to meet. Jails are the worst place for people with serious mental illness to be. Behavioral health resources in jail are sparse, risk of suicide is heightened, solitary confinement is often the default placement for people whose behavior does not conform, and mental health crisis is routinely met with force, discipline, lock-down, and the use of restraints. Law enforcement officials agree that jails are not equipped to serve as mental health treatment facilities and that public safety may be better served by connecting individuals to treatment and supports in the community.

> "Mentally ill persons do not belong in a jail, they deserve to be humanely housed in a therapeutic environment where they can be appropriately treated by medical professionals."
>
> Washington County Sheriff Pat Garrett[1]

At a glance, the solution appears to be simply connecting individuals in need to the healthcare system rather than making an arrest. But it turns out that people who are frequently arrested on low-level behavioral health-related charges are often frequent visitors to emergency departments. A recent study looked at Oregonians who had been booked in jail four or more times in the past year. Those individuals were 150 times more likely to have visited an emergency department as compared to other adults enrolled in the Oregon Health Plan.[2] They visit the hospitals to look for help, but sometimes it is the hospital who sends them to jail.

The basic concept of mental health diversion is to offer treatment as a possibility instead of jail. Beyond missed opportunities to divert, the cases described in The "Unwanteds" point to pressures in our system

[1] Declaration of Washington County Sheriff Pat Garrett, Disability Rights Oregon, Metropolitan Public Defender Services, Inc. v. Allen, Case No.:02-00339 (D. Or), May 29, 2019.

[2] Justice Center, The Council of State Governments, "Oregon's Behavioral Health Justice Reinvestment Initiative: Improving Public Safety and Health Outcomes for People Who Are High Utilizers of Jail and Hospital Resources" (2019).

which fuel the opposite of diversion—an active removal of willing patients from the healthcare system and transfer of those individuals to the criminal justice system.

The "Unwanteds'" was prompted by a deepening understanding that decriminalizing mental illness requires more than simply transporting people in crisis to a hospital instead of jail. Rather, it will require fundamental shifts in how we deliver healthcare—ensuring that we have a system that is accessible to navigate, trauma-informed, with resources that are ample and diverse enough to meet the need. At a minimum, a doctor's commitment to doing no harm to a patient must be reflected in a commitment by the hospital system not to needlessly worsen the known social determinants of their patients' health.[3] Jail is traumatizing and harmful to people with people with serious mental health concerns and hospitals must end the practice of dumping their "unwanteds" into jail.

"Betty"

Around 10 p.m. on a fall night in 2018, the Portland Police Bureau received a call from Legacy Good Samaritan Hospital for "an unwanted woman." An officer responded to the call around midnight, and hospital staff directed him to a woman in the waiting area who, they reported, had no medical need to be there, and refused to leave.

The police report describes "Betty" as 76 years old, partially blind, experiencing pain due to "lingering injuries" sustained during an assault at a homeless shelter, hardly able to walk, and "most likely suffering from the onset of Dementia." She had been seen at the emergency department of Oregon Health & Science University earlier that day.

"Betty" admitted to refusing to leave the hospital, which would justify an arrest for trespass. But the officer was reluctant to take her to jail. He called Adult Protective Services who reported that the woman was known to them, but they could not provide a motel voucher because she had history of hoarding and property damage, which could result in county vouchers no longer being accepted by a particular motel. The officer looked into whether she could stay at the police precinct for the night. After consulting with the sergeant they "determined that the precinct lobby may be too be unsafe for [her]."

The officer completed the police bureau's "Mental Health Template" (indicating that a likely mental health condition was identified,) but none of the mental health-related techniques were used (such as de-escalation, disengagement with a plan, or delayed custody). No mental health professional responded or was present at the scene. Instead, this 76-year-old woman with multiple disabilities and health problems, was arrested, and booked at the Multnomah County jail.

[3] There is a growing public health consensus that health outcomes are heavily impacted by the conditions in the places where people live. Living on the streets or living in jail can exact a heavy toll on a person's physical and emotional well-being. See, Office of Disease Prevention and Health Promotion, "Social Determinants of Health," https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

This single story raises so many questions about the nexus between our healthcare system, housing system, and our criminal justice system. Why would jail be the only available place of shelter for a woman who is older, homeless, in need of medical care, and has done nothing wrong? How could seeking help at a hospital be a crime?

In many instances, hospitals make tremendous efforts to reach beyond the immediate healthcare needs of their patients and to address the life circumstances that are impacting their health. Portland-area hospitals have invested in recuperative care for patients whose post-hospitalization recovery would otherwise be thwarted by the harsh conditions of homelessness, and hospitals are even pooling resources to fund affordable housing development. People who work as social workers or medical providers in hospital emergency departments are driven to this career path by a desire and commitment to providing compassionate and competent care to patients in dire circumstances. But in the cases described in The "Unwanteds", patients in the toughest of circumstances are pushed out of the healthcare system and re-routed to a place where they are highly unlikely to get the help they need—jail.

In the policy debates around mental health diversion (providing healthcare, services, and supports instead of incarceration), one counterargument that is often raised is the notion that people with mental health conditions refuse treatment. That is certainly true in some cases, and people have important rights to make autonomous, informed decisions about their own healthcare. The cases examined in The '"Unwanteds" are telling, however, in that they involve people who wanted help, who sought help, and who refused to leave the place where they thought they could get help.

What The "Unwanteds" uncovers is that privilege, not need, far too often is the determining factor in who receives treatment and who is dumped into jail.

Collision Course: Increasing Housing Costs and Inadequate Supply of Behavioral Healthcare

Across the state, two crises—rising housing costs and the vast unmet need for behavioral healthcare—are driving people into homelessness and into emergency departments. Use of trespass notices and reliance on law enforcement to arrest trespassed patients has arisen as one of the tools deployed by hospitals in the face of unprecedented need in our community.

Homelessness, Behavioral Health, and Arrests

Homelessness has hit crisis levels in Multnomah County and across the state,[4] and hospital emergency departments are at the forefront of that crisis. A comprehensive report was released this past fall by a local independent consulting firm ECONorthwest, which explained that most people experiencing homelessness in the Portland-area experience episodic, or short-term, homelessness driven by drastically increasing rents and an inadequate housing supply.[5] Tens of thousands of households are either homeless or at risk due to the housing affordability crisis and the region's most recent count identified 4,300 episodically homeless on a given night last winter.[6] A second, smaller population (fewer than 2,000 individuals) experiences long-term homelessness, which is related to personal challenges—mental illness, addiction, or serious physical health conditions.[7]

Healthcare Challenges and the Long-Term Homeless

For people experiencing long-term homelessness, their healthcare needs may have led to their homelessness and those needs are inevitably exacerbated by the hardship and instability of living on the streets. The Oregonian described Portland's homeless population as "especially sickly," citing a 2009 survey of 646 people sleeping outside, which found nearly half had asthma, hepatitis, heart disease, or other conditions that made them "medically vulnerable."

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4 https://www.pdxmonthly.com/articles/2019/4/23/the-numbers-behind-oregons-homelessness-crisis
5 ECONorthwest, "Homelessness in the Portland Region: A Review of Trends, Causes, and the Outlook Ahead," prepared for the Oregon Community Foundation, October 10, 2018, https://www.oregoncf.org/news-resources/press-releases/current/homelessness-and-housing-in-portland?noredirect=true
6 Id., see also, John Tapogna and Madeline Baron, "Addressing Portland's two homeless crises," The Oregonian, November 16, 2018, https://www.oregonlive.com/opinion/2018/11/opinion_addressing_portlands_t.html
7 Id.

Drug use, particularly meth, is prevalent, [8] and treatment is hard to access.[9]

Multnomah County's mental health system has been described as overburdened and inaccessible, especially for people who do not fit neatly into a provider-driven model.[10] In 2018, Multnomah County hired the Human Services Research Institute ("HSRI") to analyze its publicly funded mental health system. One of the most common themes in HSRI's stakeholder interviews and community input sessions was "a lack of predictable pathways for individuals to access services."[11]

For people with additional challenges related to homelessness or poverty, finding a provider, applying for services, comparing waitlist times, finding transportation, and making it to appointments at a specific time, can prove to be significant barriers to care. In 2017, less than one third of the 6,808 Medicaid enrollees in Multnomah County with diagnosed mental health conditions were enrolled with one of the agencies providing specialty mental health services.[12]

High Rates of Arrest

The Oregonian conducted its own survey of arrests in Multnomah County and found that 4,437 homeless people were arrested by Portland Police in 2017 —260 more homeless people than the federal survey counted.[13] The staggering number of arrests has grown in part from calls from Portland-area businesses and neighborhood leaders for police to stop street-level crime such as disorderly conduct and drug use.[14] Police also increased searches at homeless encampments for people with outstanding warrants.[15]

Enforcing criminal laws is the legitimate and necessary role for the police. But, disparate arrest rates for homeless people appear to be driven by their circumstances as opposed to serious criminal behaviors. The Oregonian survey found that 1,200 arrests were for procedural offenses such as missing court or violating probation or parole.[16] The second leading cause of arrest was trespass; with homeless people constituting 72% of all trespass arrests in 2017. The study found that officers themselves cited social problems as key predictors of arrests. Officers reported that "a lack of housing, mental health, and addiction treatment drive the arrests up."[17]

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[8] Thacher Shmid, "What's the Drug of Choice for Portland's Homeless?," Willamette Week, August 16, 2017, https://www.wweek.com/news/city/2017/08/16/whats-the-drug-of-choice-for-portlands-homeless/ (last accessed on Jan. 20, 2019)
[9] Emily Green, "Bill would force Oregon addiction-services commission to 'do something,'" Street Roots, February 9, 2018, https://news.streetroots.org/2018/02/09/bill-would-force-oregon-addiction-services-commission-do-something
[10] Human Services Research Institute (HSRI), "Multnomah County Mental Health System Analysis," June 2018, https://multco.us/multnomah-county-mental-health-system-analysis-0
[11] Id.
[12] Id. at 59.
[13] Rebecca Woolington and Melissa Lewis, "Portland homeless accounted for majority of police arrests in 2017, analysis finds," Oregonlive, June 27, 2018, https://www.oregonlive.com/portland/index.ssf/2018/06/portland_homeless_accounted_fo.html
[14] Id.
[15] Id.
[16] Id.
[17] Id.

A grave cyclical effect is occurring: 440 homeless people who were arrested in 2017 were arrested more than 20 times since 1996.[18] The survey found 80% of homeless people arrested in 2017 had been arrested at least once before in the past twenty years.[19]

In short, we know that more and more people are homeless on the streets of Portland, Oregon and that they are both more likely to experience poor physical and mental health, and more likely to be frequently arrested. No one is in favor of a system that criminalizes homelessness and healthcare needs, including law enforcement.

> You can't arrest your way out of that issue – of homelessness, or behavioral health, or addiction. It just doesn't work. Where I've seen the work is with an intervention, with treatment, and wrap-around services in the community. That's where lives are changed.
>
> Marion County Sheriff Jason Myers[20]

Despite our shared views, however, the number of people with the combined risk factors of homelessness and mental illness funneling into the criminal justice system has drastically increased in recent years. The number of patients ordered to the state psychiatric hospital (the Oregon State Hospital or "OSH") because they were charged with a crime for which they are not competent to stand trial has more than doubled in the past seven years.[21] According to the state hospital's analysis, 66% of these patients reported being homeless immediately prior to their arrest.[22] Criminalization is, by default, our statewide strategy; utilizing the most expensive and most restrictive intervention as a short-term "fix" that only makes the long-term challenges worse.

Portland: An Example of a Statewide Problem

The "Unwanteds" looks at arrests occurring at six Portland-area hospitals, but the issues discussed have statewide relevance. DRO visits jails and hospitals across the state, and we've learned about the degree to which hospitals and jails are intertwined. The people who are frequently arrested are often the same people who frequently present at the emergency department. In our interviews with multiple jail commanders across the state, a common theme is frustration with the lack of a healthcare and social services safety net

[18] Id.
[19] Id.
[20] "Decriminalize Mental Illness" video, Disability Rights Oregon, https://www.youtube.com/watch?time_continue=434&v=xfLfdU8Nu9s
[21] Derek Wehr, email, 5/7/2019; the average daily population was 109 in January of 2012, and 258 in January 2019.
[22] Derek Wehr, email, 5/7/2019;

to prevent vulnerable people from ending up in jail on low-level charges. Often, jail commanders report a tension with their local hospital over a high need population that neither system is eager to serve.

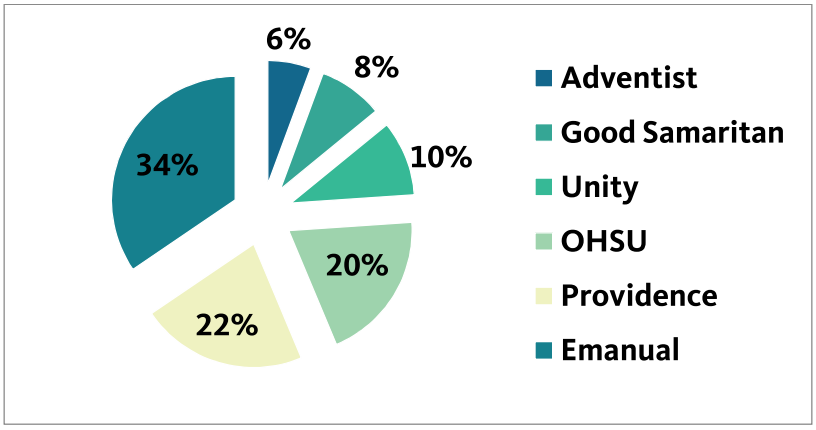
Methods

Based on the reports we heard from our clients, from jails, and public defenders, DRO and the Criminal Justice Reform Clinic at Lewis & Clark Law School sought to answer the question: do hospitals play a role in displacing people, especially those who are homeless and have behavioral health needs, from the healthcare system into the criminal justice system?

In the summer of 2018, DRO submitted a public records request to the Portland Police Bureau requesting reports generated from calls from six Portland-area hospitals in which the primary offense was trespass. Our request covered a one-year period from summer 2017 through summer 2018.The hospitals included in the request are those that have emergency departments: Oregon Health & Science University (OHSU), Legacy Good Samaritan Hospital ("Good Samaritan"), Legacy Emanuel Hospital ("Legacy"), Unity Center for Behavioral Health ("Unity"), Providence Portland Medical Center ("Providence Portland"), and Adventist Medical Center ("Adventist").

OHSU is unique among Portland-area hospitals in that it has its own internal police force of sworn officers who are empowered to make arrests. The other hospitals have security staff who can detain people, but call on outside law enforcement to effectuate arrests. Because of this distinction, DRO also submitted a public records request to OHSU, for trespass arrests within the same period.

In total, we received 142 reports. Some of the reports provided, generated in fall 2018, postdate the period subject to our request. Below is a chart that breaks down the percentage of the 142 reports by hospital.



Emanuel: 49 (34.50%) Providence: 31 (21.83%) OHSU: 28 (19.71%) Unity: 14 (9.85%) Good Samaritan: 12 (8.45%) Adventist: 8 (5.63%)

A law student with the Criminal Justice Reform Clinic (CJRC) at Lewis & Clark Law School entered information from these 142 reports into a spreadsheet, which allowed us to gather data regarding who is arrested for trespass at hospitals and why. The name and date of each arrest was matched with court records to determine whether the case was prosecuted and the outcome.

What Is Trespass and How Is It Operationalized at Hospitals?

Under Oregon law, a person commits the crime of criminal trespass in the second degree if the person "enters or remains unlawfully in a motor vehicle or in or upon premises."[23] In practice, "remaining unlawfully" occurs when a person remains on the premises after being asked to leave. Trespass enforcement is a way of policing who is present in a particular space. When a person is asked to leave a hospital, and does not, they are eligible for arrest under Oregon's criminal trespass statute. Hospitals and law enforcement often code these calls as "unwanteds."

Each hospital sets its own policies regarding trespass or exclusion. Sometimes the exclusion order is permanent (and can last for the individual's entire lifetime), and some orders are short-term (i.e., 30 days). Hospitals may or may not have a system for periodic review of exclusion orders, and may or may not have a formal appeal process through which a trespassed individual can object. Often times, exclusion or trespass orders appear to be a tool used by security staff, which may be divorced from any clinical input.

Importantly, the Emergency Medical Treatment and Labor Act (EMTALA),[24] requires emergency departments to screen all patients who come to the facility and to stabilize emergent medical conditions, including behavioral health emergencies. People who have been trespassed from a hospital retain their right to access the emergency department under EMTALA, although it's not guaranteed that they are made aware of that right. Individuals have contacted DRO to report access to their primary care or specialty care provider was compromised due to a trespass notice, even occasionally over the objection of the clinician.

[23] ORS 164.245

Who is "Unwanted" at Hospitals?

People experiencing homelessness, people of color, and people with mental health concerns are disproportionately represented among those arrested for trespass at hospitals. The disposition of these calls almost always ends with the person in the custody of the jail, despite the fact that only a quarter appeared to present a risk of violence.

How Many People Are Impacted?

DRO asked hospitals to report the number of people currently subject to an exclusion notice or trespass from their facilities. As of April 2, 2019:

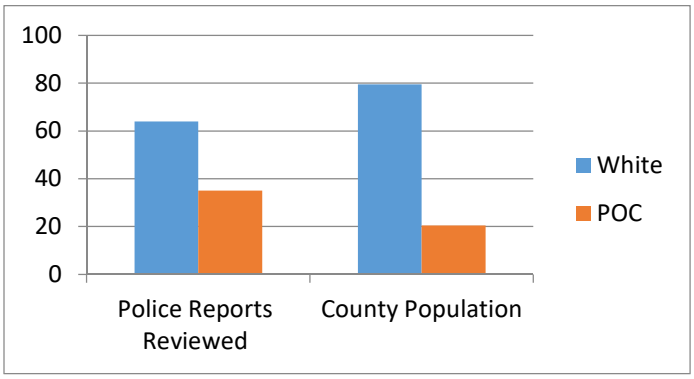
- OHSU: reported that 16 people were subject to a 30 day exclusion and 52 people had been permanently excluded.[25]
- Legacy Health Systems: reported that 146 people were trespassed from all Legacy premises (including Emanuel, Good Samaritan, and Unity). Some of those orders are permanent and others are short term, but Legacy was not able to provide further detail on their duration.[26]
- Providence: reported that Providence Portland Medical Center issued an estimated 114 trespasses of indefinite duration in the past three years. When DRO raised concerns about hospital trespass practices as part of our preliminary research for The "Unwanteds", Providence implemented a new security and clinical review process and rescinded 75 trespasses; leaving 39 trespass notices in place at this time.[27]
- Adventist: did not respond to requests for information and provided no explanation for failing to respond.

Presumably, there is some overlap between the trespass lists maintained by different hospitals, and some individuals may be effectively quite limited in where they can access healthcare.

[25] Melanie Maurice, emails, April 10 and 12, 2019.
[26] Gregory Chaimov, email, April 19, 2019.
[27] Jennifer Erwin, email, April 19, 2019.

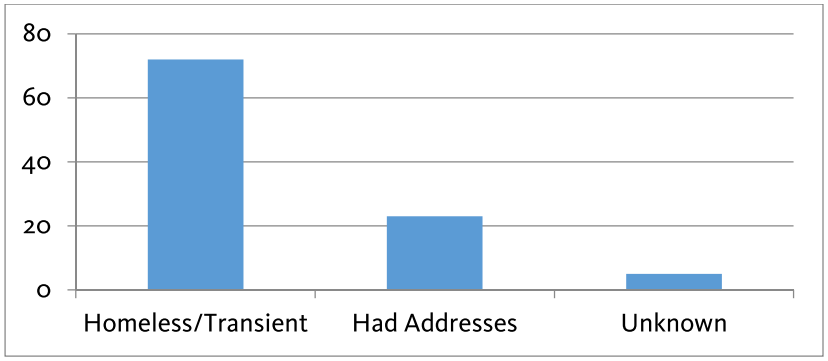
Disproportionate Representation: People of Color and People Experiencing Homelessness

People of color are over-represented among individuals arrested for trespass at hospitals: 64% of the reports involved white subjects (91 reports); 35% were people of color (50).[28]



According to 2010 U.S. Census data, 79.5% of people in Multnomah County are white.

72% of the reports involved people who were identified as homeless or transient (102); 23% had identified addresses (33); and 5% were marked as unknown (7).



According to the latest point in time count for homelessness, Multnomah County's homeless population was 4,177 in 2017.[29] The portion of the county's overall population experiencing homelessness is less than 3%.[30] Hence, homeless people are grossly overrepresented among the trespass arrests.

[28] U.S. Census Bureau, "Quick Facts," https://www.census.gov/quickfacts/fact/table/portlandcityoregon,multnomahcountyoregon,US/RHI125217

[29] Oregon Housing and Community Services, "Point-in-Time Count," 2017 https://public.tableau.com/profile/oregon.housing.and.community.services#!/vizhome/InformationDashboardPITCount_1/Point-in-TimeCount

[30] U.S. Census Bureau, "Quick Facts," https://www.census.gov/quickfacts/fact/table/portlandcityoregon,multnomahcountyoregon,US; United States Interagency Council on Homelessness, "Oregon Homelessness Statistics," https://www.usich.gov/homelessness-statistics/or/

Of the 142 arrests, 109 involved patients who were either seeking care or being discharged from care[31] – mostly people who had been seen in the emergency department and refused to leave. Of the 94 people who were arrested at discharge, 71 were identified as homeless or transient.

Only 26% of the reports (37) included facts indicating that the subject may have been violent or threatening. The remaining 104 reports did not include any facts suggesting a risk of violence.

30% of the reports contained facts that indicating that the individual had a mental health related concern. The majority of these individuals (32 out of 42) were either seeking care or had been discharged from care immediately prior to their arrest.

[31] The other cases mostly involved people loitering in different parts of the hospital or on hospital grounds.

The Outcome Is Almost Always Jail

Despite the fact that the vast majority of these cases involved non-violent, passive resistance to leaving a hospital, almost every one of these individuals ended up in jail. In 94% (133) of the cases, the resolution of the call involved booking the subject in jail.[32]

There were only a handful of exceptions; instances in which an officer took steps to arrange some alternative to jail. Two of those rare situations are described below.

In one case, the officer determined that the subject appeared so sickly that it was highly unlikely that the jail would accept her.[33] Plus, she had been discharged from the hospital with a bag of uncapped syringes, which he thought would be unsafe to handle. So, the officer just dropped her (and her bag of sharps) off in the middle of the night at a transit station.

"Tammy"

In September 2018, police responded to a call from Providence. Security explained that the individual had been treated in the emergency department and discharged at 2:30 a.m.

According to the report, she did not want to leave the hospital and lingered in the bathroom, where she allegedly tried to use drugs. When security attempted to physically escort her off the property, she kicked and spat.

According to the responding officer, "She also appeared to be extremely sick. I did not see the point of risking my safety trying to inventory her bags [which were full of uncapped syringes], and it seemed highly unlikely that MCDC [the jail] would accept her as sick as she was. She assured me that she had no intention of returning to Providence Hospital, and understood that she was trespassed. Upon her request, I gave her a ride to the Hollywood Transit station where I released her."

[32] In one case, Providence security told the arresting officer that the DA's office had agreed to prosecute all cases involving the hospital. The discharging patient requested to be taken to jail, stating that he had "no place else to go." Hospital security informed the officer that he wanted to pursue criminal charges and that "the hospital has an agreement with the Multnomah County DA that no cases would be declined for 'no complaint.'"

In a phone call, the Multnomah County DA's office said that there is no such agreement and clarified what the security personnel may have been referring to. The DA's office maintains a list of entities who have requested that all charges arising out of incidents on their property be prosecuted. The DA's office still makes a case-by-case decision as to whether to proceed, but the additional step of contacting the victim is eliminated. The list was last updated on April 16, 2019, and Legacy Emanuel, Legacy Good Samaritan, Unity, Providence, and OHSU were all included on that list.

[33] If a person who presents at booking appears to require hospital care, the jail may require medical clearance by a hospital prior to booking.

Another case triggered a special response. Consistent with the vast majority of hospital trespass calls, the person at issue here was homeless. But she had only recently become homeless, had little prior law enforcement contact, and had history of professional employment.

"Karen"

In September of 2017, police responded to 1:30 a.m. call from Good Samaritan Hospital. The officer reported:

"Upon speaking with [Karen], she denied trying to strike, but said she did indeed stay in the hospital trying to get a referral for social services. She said the hospital said it was too late at night and suggested she stay across the street on NW 23rd Ave.

We spoke further and it became apparent that [Karen's] actions were not the result of blatant criminal activity, but more likely from her being homeless and being very upset with her situation. Also, a records check showed very limited police contact, most recently being a mental hold in August.

I learned she had only been transient for three months, and before that had been a certified [professional] living in Bend. Based on our conversation, it appeared that [Karen] was dealing with some mental health issues and substance abuse."

The officer called the Sergeant to get approval to issue a citation rather than arrest, and gave "Karen" a ride to a homeless shelter, where she had a bed reserved.

What is the Impact of an Arrest?

In many of these cases, hospital security is enticed by the promise that a call to law enforcement will provide a quick resolution to the immediate situation with which they're presented (person will not leave, call law enforcement, law enforcement takes them away, done). But hospital staff and administration are likely unaware of what happens after that person is arrested. They may not have imagined the fallout that flows from an arrest.

Serious Harms

Some of the cases we reviewed involve people who are frequently arrested. In those cases, a hospital-based arrest represents a potential missed opportunity to change the person's trajectory by making a connection to services that would interrupt their cycle of bouncing between emergency departments, jail, service providers, and homelessness. This cycle comes at tremendous cost to all of these systems. Yet, those trapped in the cycle never actually receive the help they need. In other cases, the hospital might arrest a person who has never had contact with the criminal justice system before.

One of these individuals was a young woman with schizophrenia named Jessica Sharp, who asked DRO to share her name and her story. Jessica was arrested for trespass at Providence Milwaukie Hospital.[34]

> "I just want people to know that people with schizophrenia lives have value; that we are valuable people and we are worthy. Not just because of the contributions that we can make and the fact that we can be productive members of society, but because our lives and our dignity have inherent value and we deserve to be treated like anyone else and to receive medical treatment when we need it."
>
> -Jessica Sharp, a patient who was arrested at a hospital

According to Jessica, she failed to rouse and leave the emergency department when directed to do so. Police accused her of pretending to sleep. Jessica reported that she experienced catatonia, a psychiatric condition which can render a person involuntarily immobile. She recalled briefly regaining consciousness and asking for food. At that point, she thought hospital staff may have suspected her of being homeless, which was (presumably) when the police were called. Jessica was not homeless. Her video interview, available on DRO's website: www.droregon.org, describes both the arrest and the fall-out she experienced.

[34] Jessica's arrest was outside the scope of DRO's records request to PPB. She reached out to us independently to share her story.

Following her arrest, Jessica spent a frightening week in jail. She had no access mental healthcare. After her release from jail, she found herself stranded with no phone, transportation, or the keys to her apartment. She hitched a ride with another discharging inmate, who hoisted her onto her balcony so that she could break in to her own apartment. An eviction notice was posted on the door and her dog had been impounded. By the time we met Jessica, she was in a new apartment and had reunited with her dog, but her relationship to the healthcare system was permanently impacted by the fact that an ambulance ride to the hospital had so quickly and inexplicably triggered a negative encounter with the criminal justice system, a week in jail, and an eviction notice.

We are deeply saddened to note that, this past winter, Jessica Sharp passed away from cancer. She was 34 years old.

Systemic Problems Triggered by Mass-Criminalization of Mental Illness

Prosecuting even a minor crime against a person with serious mental illness comes at a great financial and human cost. The charge may trigger an exceedingly long and expensive period of confinement, in jail and then at the state psychiatric hospital. Afterwards, the individual is often discharged to homelessness and whatever they had before—whether that was a job, low-rent apartment, government benefits, or simply a tent and a companion animal—is gone.

A Statewide "Aid and Assist" Crisis

Foundational to the criminal justice system in the United States is the concept that any person charged with a crime must be able to understand what they are being accused of doing wrong, and be able to work with their attorney to defend themselves in court. This concept is referred to as the ability to "aid and assist" in their defense. If the person accused of a crime is unable to aid and assist due to their disability, mental illness, or another reason, then the person is not competent to stand trial.

Once this determination is made by a judge, there are two paths. First, the State could choose to drop their charges against the person. Second, if the State wishes to continue to prosecute the person for a crime, then the court must order "competency restoration services." Competency restoration services include mental health treatment and a class about the legal system. Typically, those services are provided at the state psychiatric hospital (the Oregon State Hospital or "OSH").

On average, people spend between 70-80 days at the state hospital on what's often referred to as an "aid and assist" order, but they can spend up to a year on a misdemeanor charge.[35] The cost of State Hospital is

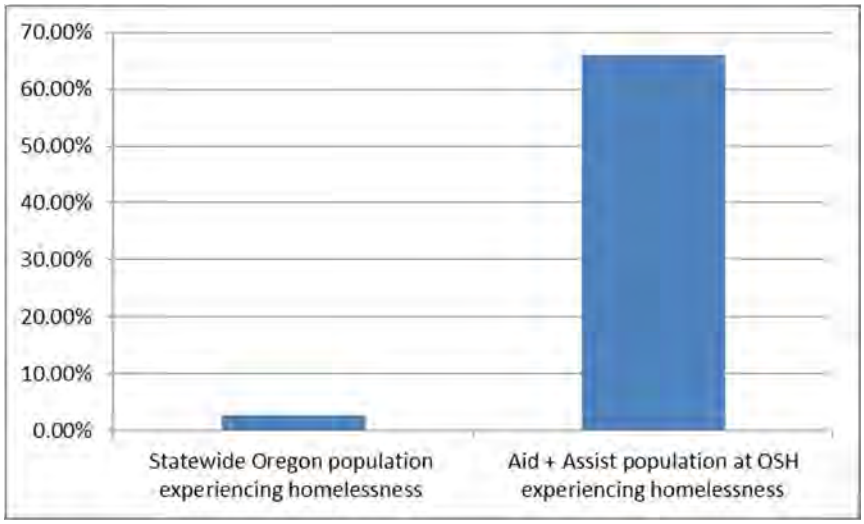
[35] Derek Wehr, email, 5/7/2019; The median length of stay for an aid and assist order was 77 days in 2018. See also https://www.oregon.gov/oha/Budget/OHA-2019-WM-Presentation-OSH.pdf

approximately $1,300 per person per day from Oregon's general fund.[36] These costs are paid for by the people of Oregon.

After competency is restored, the case can be resolved. If the charges are not serious, the person often receives credit for the time they've served in jail awaiting restoration and at the hospital, and they are discharged. The road to discharge, however, generally involves multiple hearings, multiple professional evaluations, weeks or months in jail, and approximately $100,000 in state hospital treatment costs (depending on the length of stay). [37]

The number of people of with serious mental health concerns who are reeled into Oregon's criminal justice system has more than doubled in the past seven years.[38] According to state officials, the backlog of individuals languishing in jail awaiting competency restoration services at the state hospital has become a statewide crisis.[39]

The statewide homeless population is 2.62%.[40] The State Hospital has found that 66% of "aid and assist" patients reported being homeless immediately prior to their arrest.[41] The Oregon Health Authority, which operates the State Hospital, has described it as "the world's most expensive homeless shelter."[42]



[36] Gordon Friedman, "Costly, ineffective, cruel: Ways to lower costs, improve outcomes for Oregon's mentally ill, The Oregonian/Oregonlive, January 27, 2019, https://www.oregonlive.com/news/2019/01/costly-ineffective-cruel-ways-to-lower-costs-improve-outcomes-for-oregons-mentally-ill.html (citing a cost of $1,300 per person per day for care at the Oregon State Hospital)

[37] The per person cost of treatment depends on many factors, including the length of stay. Using the average length of stay of 70 to 80 days and a $1,300 per person per day rate, the average cost to taxpayers is $91,000 to $104,000 per person.

[38] Derek Wehr, email, 5/7/2019; the average daily population was 109 in January of 2012, and 258 in January 2019.

[39] Gordon Friedman, "Citing 'moral emergency,' attorneys seek contempt as Oregon defies mentally ill defendants' rights," The Oregonian/Oregonlive, May 10, 2019, https://www.oregonlive.com/pacific-northwest-news/2019/05/citing-moral-emergency-attorneys-seek-contempt-as-oregon-defies-mentally-ill-defendants-rights.html

[40] United States Interagency Council on Homelessness, "Oregon Homelessness Statistics," https://www.usich.gov/homelessness-statistics/or/

[41] Derek Wehr, email, 5/7/2019;

[42] Gordon Friedman, "Oregon mental hospital is 'world's most expensive homeless shelter,' state health director says," The Oregonian/Oregonlive, May 1, 2019, https://www.oregonlive.com/pacific-northwest-news/2019/05/oregon-mental-hospital-is-worlds-most-expensive-homeless-shelter-state-health-director-says.html

Stories of People Arrested at Hospitals who were not Competent to Face their Charges Due to Mental Illness

Some of the people arrested at hospitals had mental health symptoms serious enough to render them unable to aid and assist in order to defend against the charge. Ironically, they were deemed insufficiently ill for clinical care, but too ill to face charges in the criminal justice system.

The stories below provide examples of people who were seeking healthcare at a hospital, who were arrested for trespass instead of treated, and whose competency to stand trial (or "aid and assist") on the trespass charge was called into question.

"Carla"

In the following story, jail clinical staff made an effort to change the trajectory of a young woman with serious mental health concerns. According to court records, "Carla" has been arrested 52 times in the past six years in Multnomah County. Almost all of the charges against her are misdemeanors and violations for things such as sidewalk obstruction, camping, littering, interfering with a peace officer, trespass, disorderly conduct, theft, and public transportation fare violations. Many of these cases were not prosecuted. Some cases required an evaluation of her competency to determine whether she could understand the charge and aid and assist in her defense. She has had at least one admission to the state psychiatric hospital.

She returned from the State Hospital to jail and then, rather than discharge her to the street, jail clinical staff took the somewhat extraordinary step of having her released directly to Providence Hospital on a mental health hold. However, the hospital refused to let her stay. Records indicated that she wanted to remain at the hospital voluntarily and had even received approval for a continued stay from the on-call doctor. Instead, the hospital discharged her and sent her right back to jail on a new charge—trespass.

Carla's mental health condition was not in dispute, nor was her willingness to receive healthcare. Her jail records described a history of psychosis and she was "making no sense" at the time of her arrest.

When police arrived, Providence hospital security informed them that the woman had been "brought to the location on a mental health hold." She was cleared for discharge, but she refused to leave, repeating "I am not discharged!"

Police found her handcuffed in the security office. The officer wrote that she "attempted to speak to [the patient], however, she was talking to herself and making no sense." She was arrested and taken to back to jail – only a few days after she was released from jail to the hospital.

The officer completed the police bureau's "mental health template" indicating that they identified a mental health concern, but none of the interventions identified on the template (such as de-escalation or contact with a mental health professional) were used.

"Leonard"

The hospital security report stated that the patient lay on the floor of a hallway in the emergency department in a gown and adult diaper, and refused to leave the hallway until he spoke to a police officer "to report his supposed rape." An officer came to speak with him, but afterwards, the patient still refused to leave.

Police were called back to the scene and found "Leonard" handcuffed and in a wheelchair. Hospital security reported that he was "given the opportunity to leave the premises of his own accord, he refused to do so." The police officer's report states that "Leonard" suffers from leukemia, neuropathy, and gangrene, which had resulted in the amputation of his leg.

He was taken to jail and booked for trespass. A month after his arrest, a hearing was held to determine whether he was competent to proceed, or whether mental illness prevented him from understanding the charge and working with his attorney. At that point, the charge was dismissed.

"Richard"

A homeless man was discharged from the hospital but continued to linger on the premises. Hospital security reported that the individual was "pretending to talk on the phone." When they asked him to leave he spoke nonsensically about his sovereignty and divine rights.

The officer asked security what condition "Richard" had been treated for in the hospital, but they did not know. The officer completed the police bureau's "mental health template" indicating that they identified a mental health concern, but none of the interventions identified on the template (such as de-escalation or contact with a mental health professional) were used. Instead, he was arrested and booked in jail.

5 days after his arrest, a hearing was held to determine whether "Richard" was competent to proceed. At that point, the charge was dismissed.

The fact that these individuals' competency to face their charges was doubted by the court provides confirmation of their legitimate mental health concerns and reaffirms the nonsensicality of arresting people for seeking healthcare; an arrest in such cases only harms the individual and creates huge costs in other systems.

Arrests Are Driven by Mental Health Needs and Homelessness

Most of the cases we reviewed appeared driven by a reticence to leave the hospital due to homelessness or disruptive behaviors related to a behavioral health condition. In all of these instances, treatment, diversion, or discharge planning could have offered a resolution that was both more humane and more effective than jail.

Arrested for Seeking Mental Healthcare

In our review, we identified 42 of the 142 reports as indicating an apparent connection to mental health related behaviors. It is possible that many other individuals had behavioral health needs, but that the officer did not observe or record any indicators. The 42 reports we identified contained clear indicators such as speaking "nonsensically," erratic behavior, disclosing a diagnosis of schizophrenia and saying that he had been off his medications for three weeks, "making no sense," or having been on a mental health hold or discharged from the inpatient psychiatric unit immediately prior to the police response.

Of these 42 individuals, 32 were either seeking care or had been discharged from care immediately prior to their arrest. This is a critical point, because the assumption is often made that people with mental illness end up in the justice system because they refuse healthcare interventions. In these cases, the opposite was true; the healthcare system refused them.

"Charles"

The individual was assessed in the Emergency Department at Providence for suicidal thoughts. He was disruptive at the time of discharge, engaging in "a fit," and making threats. Security handcuffed him and almost tasered him, wrapped him in a blanket and brought him back to a room in the emergency department to await the police response. He fell asleep and was sleeping when police arrived.

He was arrested and brought to jail. The mental health template was completed, but there were no attempts at de-escalation and no contact with a mental health professional was provided.

During the booking, he accused the officer of being "the anti-Christ," and said that he was schizophrenic and had been off his medications for three weeks. He told the officer that he hadn't threatened anyone and that he was talking to the voices in his head.

Reports involving police response to mental health-related behaviors at a hospital point to two areas of concern. First, law enforcement has failed to offer diversion in lieu of jail, even for non-violent, low-level

offenders whose behavior appears to be mental health driven. Second, some reports raise serious questions about hospital compliance with their mandates regarding discharge planning.

Police Failure to Divert

In Oregon and across the country, there is a growing consensus that people should not be sent to jail for low-level behaviors related to a mental health concern. [43] Jail is known to be a harmful environment for people with mental illness; solitary confinement, increased suicide rates, and limited access to healthcare present heightened risks when combined with pre-existing mental health concerns. If the underlying cause for a person's objectionable behavior indicates a need for behavioral healthcare, then time in jail is bound to make the problem worse, not better. When people are released from jail traumatized and in psychiatric distress without housing, healthcare, or any support system, the cycle of repeat arrests is cemented rather than interrupted. A more proactive solution is to connect people to needed services in lieu of arrest.

Portland Police written policy on response to mental health crisis encourages a non-criminal disposition if the behavior of the individual and the governmental interests at stake allow.[44] Presumably, this policy would favor a non-criminal disposition if the person is not dangerous and the potential charge is not serious. Non-criminal outcomes suggested in the policy include referring the person to a mental health provider, calling an ambulance to bring the person to a mental health or medical facility, or providing police transport to a mental health or medical facility.

But what are police supposed to do if the call originates from a mental health/medical facility? Police should not respond to calls for mental-health related behaviors at a mental health treatment facility. Further, mental health treatment facilities should not call the police to respond to mental health related behavior. These are precisely the types of situations that hospital clinicians and social workers are trained to handle; and the kinds of situations that may inevitably be escalated or criminalized through police presence.

Of the hospital trespass reports reviewed, 36 included the Portland Police "Mental Health Template," indicating the police identified a potential mental health nexus. Our review identified a threat of violence in only 12 of the 36 cases. A non-violent person with an identified mental health concern, whose only crime is their presence at a medical facility, would appear to be the most likely candidate for pre-arrest diversion. Yet, all but 2 of the 36 people whose reports included the Mental Health Template were arrested and booked in jail.[45]

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[43] In November 2017, Sheriff Mike Reese led the initiative to launch a new mental health diversion program. The program gave law enforcement officers the option of bringing people from Central Precinct who would otherwise be incarcerated on charges of trespass or disorderly conduct to the Cascadia Behavioral Health Walk-In Clinic. The officer would issue a citation, but if the person connected with the mental health provider, Cascadia would notify the district attorney, and the citation would be dropped. By all accounts, this initiative was not successful. The project was championed by the Multnomah County Sheriff's Office, but was not implemented by the Portland Police Bureau. Six months after its launch, law enforcement transported only three individuals to the Cascadia Walk-In Clinic through this program and the effort was discontinued.

[44] Police Response to Mental Health Crisis (850.20), Portland Police Bureau, https://www.portlandoregon.gov/police/article/701129

[45] The Mental Health Template requires officers to consider alternative techniques to resolve a situation that appears to be mental health driven. Officers can choose:

[ ]De-escalation

[ ]Disengagement with a plan

"Tiffany"

Police identified the subject of the call as a "woman wouldn't leave hospital." When the officer arrived, he found the subject seated and handcuffed. She reported that "she did not leave because she didn't have anywhere else to go, and someone at the hospital told her that they were going to give her breakfast burrito."

Hospital security report indicates that she engaged in erratic behavior at the time of her discharge from the Emergency Department, such as walking down the middle of the road and impeding traffic, throwing her belongings, and shaking her "buttocks" at the security staff. After these behaviors, she was told to leave the property two more times. She refused and was placed in handcuffs and police were called.

Hospital security described her as "unremorseful and insulting" while she was held pending the police response. She continued to try to get out of her chair. Then, security reports that she "became more remorseful of her actions and apologized. "She began to cry and said she had experienced domestic violence.

She was then arrested and booked in jail.

The police bureau's Mental Health Template was completed, but none of the interventions suggested in the template (such as de-escalation or contact with a mental health professional) were utilized.

The basic concept of mental health diversion is to offer treatment as a possibility instead of jail. Beyond missed opportunities to divert, these cases point to an active removal of willing patients from the healthcare system and transfer of those individuals to the criminal justice system—which fuel the opposite of diversion. This is how mental health disability is criminalized.

Failure to Provide Discharge Planning

More than half of reports we reviewed (64%) involved discharged or discharging patients—mostly people who had been seen in the emergency department and refused to leave. Of the 94 who were arrested at discharge, 71 were identified as homeless or transient. Not surprisingly, patients are reluctant to return to homelessness and there are insufficient recuperative care and shelter beds to meet the need.[46]

[ ]Delayed Custody
[X]Not Applicable; circumstances did not warrant any of the above
Officers must also indicate whether a mental health professional responded to or was present at the scene.

[46] Amy Reifenrath, "Portland's post-hospital care for homeless falls short of meeting needs," OregonLive, https://www.oregonlive.com/health/index.ssf/2009/03/portlands_posthospital_care_fo.html (last accessed on Jan. 20, 2019)

"Janice"

In September 2018, police were called to assist with a patient who was discharging from the inpatient behavioral health unit at Providence Portland. She was described as transient and in her early 40s.

According to hospital security, nurses on the inpatient psychiatric unit called security to report that a discharged patient was "stalling." When security arrived, the patient began to yell, "I DON'T WANT TO GO BACK OUT THERE! I'M SCARED!"

As security escorted her out of the building, she began saying "'PLEASE LET ME GO THE OTHER WAY! I CAN'T GO OUT THOSE DOORS!"

The security officers' plan was to walk her to the bus stop, but she began trying to push against the four security officers, in an attempt to force her way back into the building. They handcuffed her and put her in a wheelchair to await a police response.

A bystander video-recorded the incident and was told by security that he would be trespassed as well.

Police responded, the subject refused to speak to them, and she was transported directly to jail.

"Ronald"

In December 2017, police were called to apprehend a patient who had been discharged from the emergency department but refused to leave. Security wheeled him to the sidewalk, but he refused to get out of the wheelchair. They finally got him seated on a ledge, but soon found he had stumbled back into the lobby and was sleeping on a bench. When asked to leave again, he said he couldn't. So, the police were called.

The responding officer recognized "Ronald" because he had dropped him off at a drug and alcohol detox facility earlier that same day.

The officer woke him up and "Ronald" the individual "crumbled down on the floor." The officer told him that he "needed to leave or he was going to be arrested for trespass" and he volunteered to go back to jail.

His belongings exceeded what would fit into the jail locker, so the officer had to take them to Central Precinct. The property receipt notes that his belongings were all wet.

Hospitals have legal obligations to provide discharge planning, both from inpatient units and from emergency departments. The thoroughness of the discharge planning is often as important as the quality of the care itself. Especially for behavioral health conditions, several hours in an emergency department or seven days in an inpatient unit may only have value if the patient discharges with the supports in place to sustain their wellbeing. Transition planning matters as much as the healthcare services because it is the opportunity to invest in long-term stability and to prevent readmission.

The examples above describe security officers attempting to forcibly wrangle a discharging psychiatric patient to the bus stop, or wheeling a groggy and intoxicated man to the curb. These examples, along with stories throughout The "Unwanteds", raise doubts about whether hospitals are meeting their obligations around discharge planning.

FEDERAL LAW

Hospital discharge planning duties are set forth under federal law, as a condition of participation in the Medicare program. All hospitals in The "Unwanteds" voluntarily participate in Medicare.

Federal regulations require hospitals participating in the Medicare program to create adequate discharge plans for patients upon discharge from an inpatient setting. Hospitals are required to identify "all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning."[47] Such patients, and any others who request discharge planning, must receive a discharge planning evaluation by qualified staff. That evaluation must address any need for post-hospitalization services and the availability of those services, and must include an assessment of the patient's capacity for self-care in the environment from which they came.

OREGON LAW

State law also imposes discharge planning requirements, including new provisions that apply to behavioral health visits to emergency departments.

In 2017, the Oregon legislature passed House Bill 3090, a law that extended psychiatric inpatient discharge planning requirements to include patients who presented with behavioral health crisis in the emergency department.[48] The Oregon Health Authority (OHA) promulgated administrative rules that operationalize the statutory language, and hospitals were required to comply as of December 1, 2018.

Now, patients discharging from inpatient units and emergency departments, if seen for behavioral health crisis, have the right to:

- Involve a "lay caregiver" (usually a friend or family member)
- Receive a behavioral health assessment and a long-term needs assessment, which addresses the patient's income, housing situation, insurance, and aftercare support

47 42 C.F.R. § 482.43
48 2017, HB 3090, ORS 441.053 Release of patient presenting with behavioral health crisis

- Access care coordination in order to facilitate a transition to outpatient treatment, community-based providers, peer support, lay caregivers or others who can implement the patient's plan of care
- Have a follow-up appointment scheduled to occur within 7 days of discharge.

Patients discharging from an emergency department after a behavioral health crisis also have the right to receive "caring contacts" post discharge, which are brief communications to assist with care transition and to case management to assist with accessing "medical and behavioral health care, social and educational services, public assistance and medical assistance and other needed community services identified in the individual's patient-centered care plan."[49] In the 142 reports we reviewed, it is unclear whether any discharge planning occurred. Instead, it appears they these patients were simply labeled "unwanted" and the police were called to remove them from the hospital.

49 OAR 836-053-1403

Arrested for Lack of Shelter

Of the reports reviewed, 72% identify the subject as homeless or transient.[50] In many cases it is apparent that the individual had overstayed their welcome at the hospital because they had nowhere else to go. As an indication of the dearth of shelter options, a number of the subjects requested to be taken to jail. The following quotes are all from separate police reports.

- "I have no medication, food or even shoes. Take me back to f[@#!]g jail."
- The subject refused to provide his name to staff at the emergency department. The report makes note of his altered mental status/paranoia. He stated to the officer: "I'm not leaving. I guess you will have to take me to jail."
- Police interviewed the patient in a Providence emergency department exam room. He admitted to refusing to leave the hospital and said he wanted to be taken to jail.
- "I asked [him] if he was warned that he would be arrested if he did not leave. [He] said 'Yes, I want to go to jail.' I asked [him] why he wanted to go to jail. He responded, 'I have no place else to go.'"
- "I'm not leaving, I'm not going out to the cold."
- "[He] had been previously trespassed numerous times as he frequently seeks hospitals as places of refuge during the cold."

In other reports, the subjects explain that they thought they would be allowed to sit in the waiting room until the buses started running, or they were hoping to talk to a social worker, or someone had promised food or a bus pass. Sometimes discharged patients fell asleep in a waiting room or the chapel. One 21-year-old was described as "confused and looking for his shoes."

All of these scenarios ended with arrest.

In one case, a recently discharged patient was lingering in the lobby at Emanuel Hospital. He told police that he was waiting to speak to a social worker. Nursing staff advised that he was discharged and that social work staff would not speak with him any further. She said the social worker "had explained this to [him] already and even had offered him a bus pass to encourage him to move along." At this point, the patient "became angry and started demanding a bus pass." The officer stated that they would not be "offering that courtesy to him again today." He was arrested and booked in jail.

[50] 23% had identified addresses (33); and 5% were marked as unknown (7).

"Jennifer"

In the fall of 2017, police were called to Adventist Hospital to respond to an "unwanted" who had refused to leave after being cleared by medical personnel. Police arrived at about 10:45 p.m. and found a 49-year-old-woman who said she didn't want to leave because she did not have anywhere to go.

The officer reported that she "attempted to provide solutions and assistance with her current lack of housing." "Jennifer" declined an offer of a ride to a shelter or MAX stop, and did not have a friend who could pick her up.

The officer informed her that "if she continued to refuse to leave the hospital, I would have to arrest her for Criminal Trespassing. She then told me to arrest her. I then took her into custody without incident."

The report continued: "[Jennifer] began crying and said she didn't know why she was being arrested. I told her she was being arrested for trespassing because she refused to leave and told me I would have to arrest her. She said she didn't think I would actually arrest her."

"Jennifer" was booked in jail. The officer concluded; "[s]he was advised to not return to Portland Adventist or she would be arrested again."

Recommendations

The following recommendations will prevent people with disabilities from being arrested for seeking help and promote upstream solutions to reduce the churn of people with intense needs through emergency departments and jails. Our recommendations include:

- overhauling hospital trespass policies,
- enforcement of hospital discharge planning requirements,
- creating non-law enforcement street response teams, and
- increasing targeted investments in housing and community-based behavioral healthcare.

Solution: Overhaul of Hospital Trespass Policies

Patients who do not present a threat of violence should not be excluded or trespassed from a hospital. Hospitals are a critically important part of our healthcare infrastructure. Banning an individual should be recognized as a serious, temporary, last-resort option. The decision to ban a person from a hospital should not be a reactionary one as part of the security response at the site of a disturbance. Rather, it should be a multi-disciplinary decision that involves a clinical review. The trespass should be of limited duration and any trespassed individual should receive notice of how to appeal the decision. Even in the absence of an appeal, trespasses should be periodically reviewed for continued appropriateness.

Hospital security staff should be trained in de-escalation techniques and crisis intervention. They should utilize those skills or call on clinical staff to assist, rather than relying on law enforcement to take a disruptive patient away. Hospitals should not pass a challenging patient off to security staff in lieu of providing discharge planning or behavioral healthcare. Hospital security staff practices should align with the mission of the healthcare system that they serve.

Hospitals should track and make publicly available their data regarding use of trespass notices, including the number of notices issued and whether homeless people, people of color, and people with behavioral health needs are disproportionately impacted. Hospitals should also coordinate to ensure that an individual is not barred from multiple locations and effectively unable to access medical care in the area where they live.

Solution: Enforcement of Hospital Inpatient and Emergency Department Discharge Planning Requirements

The Oregon Health Authority (OHA) is charged with ensuring hospital compliance with state regulatory requirements. The concerns identified in The "Unwanteds" point to a need for more comprehensive enforcement of hospital discharge planning obligations.

Earlier this year, the Oregon Health Authority sent a survey to hospitals to assess their compliance with the new law that expands discharge planning requirements for patients who visit emergency departments in behavioral health crisis.[51]Twenty-one of the 59 Oregon hospitals responded to the survey. Most of the hospital that responded indicated that they had updated (or begun updating) their emergency department discharge protocols to comply with the new law, but 8 of the 21 responding hospitals indicated that they did not know whether their policy had been updated or that their policy was more than three years old.

Robust and aggressive enforcement is needed. New legislation may be required in order to compel hospitals to report to OHA regarding whether they are complying with their legal obligations to provide discharge planning. In fact, such legislation was requested by OHA this legislative session.[52]

If patients (or friends, family, or professionals who are involved) are aware of violations of hospital discharge planning requirements, they may consider filing a complaint with Oregon Health Authority.[53]

[51] In 2017, House Bill 3090 modified ORS 441.053 (Release of patient presenting with behavioral health crisis.) DRO obtained an embargoed draft of the Oregon Health Authority's report on its survey of hospital policies pursuant to House Bill 3090. A public copy will be forthcoming from the OHA.

[52] Senate Bill 23A

[53]Information about how to file a Health Care Facility Complaint is available here: https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/HEALTHCAREPROVIDERSFACILITIES/HEALTHCAREHEALTHCAREREGULATIONQUALITYIMPROVEMENT/Pages/complaint.aspx

Solution: Creation of Non-Law Enforcement Street Response Teams; Police Commitment to Diversion Rather than Arrest

Law enforcement should not be called and should not respond to complaints from hospitals regarding "unwanted" patients. Oregon statute may broadly define the crime of trespass, but law enforcement agencies have discretion to reject trespass enforcement against patients at hospitals as a law enforcement priority. For example, the Portland Police Bureau policy sets an expectation that "mental health facilities will not request police assistance with behavior management, such as gaining physical control of a person who is aggressive, resistive, or refuses to go with facility-arranged transportation."[54] The same expectation should apply to hospitals who rely on police to remove a patient who refuses to discharge. Police should simply refuse to use the jail as a shelter option or a mental health treatment center; the jail is ill equipped to meet either of those needs.

The first step is to remove arrest as the default option for a patient who, due to homelessness, medical need, or behavioral health needs, refuses to leave the hospital. The second step is to create the capacity for a non-law enforcement response and triage. Hospitals have an obligation to provide discharge planning, but it is not realistic for hospital social workers to serve as a bridge to ongoing supports for such a high volume of high need individuals. Instead, hospitals, health insurance companies, and Coordinated Care Organizations should help fund a non-law enforcement crisis/street response.

Street Roots has set forth a comprehensive plan for a new model of street response in Portland; six vans staffed by a medic and a peer support specialist, both with additional de-escalation and behavioral health training.[55] This proposal is modeled after the Cahoots program, which has been successfully de-escalating and diverting in Lane County for more than 20 years.

Hospitals and healthcare systems are on the frontlines of the housing and behavioral health crises, and one of the tools currently relied upon—calls to law enforcement—is making these problems worse. Hospitals and healthcare systems have a stake in creating a softer landing for patients exiting care; when people's basic needs are met, they are much less likely to continually present at the emergency department.

[54] Portland Police Bureau Policy 850.25 Police Response to Mental Health Facilities, https://www.portlandoregon.gov/police/article/701147

[55] Emily Green, "Portland Street Response: A Street Roots special report," Street Roots, March 15, 2019, https://news.streetroots.org/2019/03/15/portland-street-response-street-roots-special-report

Solution: Investments in Housing and Community-Based Behavioral Healthcare

Several promising programs in Oregon are demonstrating that addressing the social determinants of health can reduce emergency department utilization and law enforcement contact, and help people stay healthy and stable. The primary barrier to building upon these efforts in order to adequately meet the need is funding. That is why the investment of healthcare system dollars could make a critical difference. Healthcare systems can take a proactive approach by investing in broadly accessible community-based behavioral healthcare, post-hospitalization recuperative care programs, and supportive housing programs that prioritize housing people who frequently visit emergency departments and jails.

Expanded Access to Community-Based Behavioral Healthcare

One of the recommendations that arose from the 2018 HSRI study of the publicly funded mental health system in Multnomah County was expanded services for people with complex needs. This included expanded access to Assertive Community Treatment (especially for people without Medicaid coverage), flexible service delivery models that are permissive of no-shows or problematic behaviors, enhanced walk-in services, and peer-run services that reach people who are not engaged with the traditional mental health system.[56]Except for in the most emergent crises, these resources would serve people's needs more appropriately than emergency departments and would lessen the burden of non-emergent walk-in patients at hospitals.

DRO, along with multiple other stakeholders, has long called for a shelter and services hub that would serve as an alternative to both hospitals and jails. Options for such a center are currently being explored by county leadership and an investment of healthcare system dollars could be instrumental in bringing plans to fruition.[57]

FREQUENT USER SYSTEM ENGAGEMENT (FUSE)

In Lane County, law enforcement, healthcare, and county stakeholders collaborated to identify 100 people who most frequently visit emergency departments and are most frequently arrested.[58] Through a partnership between Lane County and Sheltercare, the Frequent User System Engagement (FUSE) program aims to house and support these individuals. The numbers are small, but the results are significant. In its pilot year, 10 individuals were housed and those participants saw a 50% decrease in average healthcare

[56] Human Services Research Institute (HSRI), "Multnomah County Mental Health System Analysis," June 2018, https://multco.us/multnomah-county-mental-health-system-analysis-0

[57] Ericka Cruz Geuvarra, "Multnomah County Takes First Step Toward Mental Health Resource Center," Oregon Public Broadcasting, January 16, 2019, https://www.opb.org/news/article/multnomah-county-mental-health-resource-center/

[58] Lane County, Frequent User System Engagement, https://www.lanecounty.org/UserFiles/Servers/Server_3585797/File/Government/County%20Departments/Health%20and%20Human%20Services/Human%20Services/HMIS%20ServicePoint/Fight%20Homeless%20wth%20Data%20handout%201.pdf

costs, fewer emergency room visits and hospitalizations, and an 82% decrease in average number Eugene Police Department arrests.

The FUSE model was developed by the Corporation for Supportive Housing and has been implemented in communities across the country with demonstrable cost savings across systems and improved outcomes for people with intensive needs and challenges.[59]

HOSPITAL-FUNDED RECUPERATIVE CARE

Recuperative care is a model that provides temporary housing and post-hospitalization healthcare to people discharging from the hospital whose recovery would otherwise be impacted by homelessness. In Portland, Central City Concern has partnered with area hospitals and CareOregon to provide recuperative care to more than 1,000 patients since the program began in 2005.[60]This program has demonstrated significant savings in healthcare costs, and good outcomes for individuals. The stories in The "Unwanteds" and the visible healthcare needs of the homeless that we all witness point to a need for more recuperative care placements.

HOSPITAL-FUNDED SUPPORTIVE HOUSING DEVELOPMENT

Across the country, hospitals are increasingly investing in housing programs to help homeless people. [61] In 2016, Providence, Adventist, OHSU, Kaiser, Legacy Health, and CareOregon invested in a $21.5 million project through Central City Concern to build 382 supportive housing units for individuals and families who have experienced homelessness in the Portland-area.[62] Propelled by the concept that "housing is health," these housing units will offer medical stabilization beds, addiction treatment, behavioral health services, palliative and advanced illness care, and an integrated persistent pain program.[63]

[59] https://www.csh.org/fuse/ Implementation of FUSE is currently being explored as a possible approach for Multnomah County. See https://multco.us/csh-frequent-users-systems-engagement-fuse-model
[60] https://www.centralcityconcern.org/services/health-recovery/recuperative-care-program/index.html
[61] Pauline Bartolone, "Hospitals Make Housing the Homeless Part of Their Job," Kaiser Health News, October 12, 2017, http://www.governing.com/topics/health-human-services/khn-hospitals-homeless.html
[62] Central City Concern, "Housing Is Health," https://www.centralcityconcern.org/housingishealth
[63] Id.

Conclusion

Across Oregon, judges, law enforcement, advocates, and people with lived experience in the criminal justice system agree that low-level, mental-health driven behaviors should be decriminalized. Yet, The "Unwanteds" documents that people with identified mental health concerns are regularly arrested simply for being present at a hospital where they are unwanted. Their only crime is their presence in the space where they thought they could get help.

If our healthcare system criminalizes people who are non-violent and seeking care, we will never make progress on reducing the growing influx of people who are funneled into jail due to behavioral health needs, and the cycle of crisis, criminalization, and homelessness will persist. The healthcare system's ethical mandate to do no harm encompasses an obligation not to needlessly sabotage the social determinants (poverty, homelessness, criminal justice involvement), which have such profound health consequences.

Closing jail doors will require opening doors elsewhere—to a system of community-based care and services that is accessible and welcoming, trauma-informed, focused on reducing harm (vs. enforcing compliance), and with ample resources and diverse interventions that address the spectrum of healthcare needs and the life circumstances that drive those needs. Some of these changes recommended in The "Unwanteds" fit squarely within a hospital's obligation to its patients; other changes will require collaboration and resources beyond the walls of the hospital. Critical to implementing community-wide solutions is bringing hospitals into the consensus that jail is not the answer.

Acknowledgements

Written by Sarah Radcliffe, Managing Attorney for the Mental Health Rights Project at Disability Rights Oregon.

Much gratitude to Professor Aliza Kaplan, Director of the Criminal Justice Reform Clinic at Lewis & Clark Law School, who assisted with the design of this project, research, and editing.

Thanks to Lewis + Clark law student Brittany Hill for her exhaustive and detail-oriented work in entering the police reports into a comprehensive spreadsheet, and researching the outcomes of the cases. Thanks to DRO staff Lisa Rose Gagnon for assistance in analyzing the data.

Finally, DRO appreciates the full cooperation of the Portland Police Bureau. Tammi Weiss spent an untold number of hours retrieving and redacting reports subject to DRO's public records request.

This publication was funded in part by grants from Substance Abuse and Mental Health Services Administration (SAMHSA), the Administration for Community Living (ACL), and Rehabilitations Services Administration (RSA)

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Oregon Jails during COVID-19

A Look Inside 29 County Jails

Updated: May 1, 2020

Jails in Oregon Slashed Population during Pandemic

Jails across Oregon have drastically reduced their populations. On average, jails have nearly 50% fewer people in custody as compared to their pre-pandemic population. This is true in both urban and rural settings. For example, three jails have reduced a pre-pandemic population:

- From 120 to a Current Population of 29
- From 45 to a Current Population of 13
- From 466 to a Current Population of 152

Reducing the jail population has made jail conditions safer for those left in custody and the employees who work at jails, allowing for improved social distancing in a high-density setting that is ripe for an outbreak. To date, there have been no confirmed cases of COVID-19 among the inmate population in Oregon county jails.

Basic Needs in County Jails to Respond to COVID-19

Jails told Disability Rights Oregon what their needs are. These include soap and sanitizer, tests for COVID-19 to use on staff, and tests for COVID-19 to use on inmates, and medical or security relief staff.

13 jails need more soap and/or hand sanitizer

- Benton
- Crook
- Grant
- Jackson
- Klamath
- Lake
- Linn
- Malheur
- Polk
- Tillamook
- Umatilla
- Washington
- Yamhill

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droregon.org/covid-19

14 jails need tests for COVID for staff or inmates

- Baker
- Clatsop
- Curry
- Columbia
- Douglas
- Grant
- Josephine
- Klamath
- Lane
- Malheur
- Tillamook
- Union
- Washington
- Jackson (staff only)
- Marion (staff only)

4 jails need medical and/or security relief staff

- Grant
- Harney
- Lincoln
- Yamhill

Reduced Jail Population by County

County	Pre-COVID-19 Jail Population	Current Jail Population	Reduction
Baker	30	13	56.7%
Benton	32	19	40.6%
Clackamas	466	152	67.4%
Clatsop	60	39	35.0%
Crook	56	25	55.4%
Curry	26	8	69.2%
Columbia	175	95	45.7%
Deschutes	290	150	48.3%
Douglas	194	73	62.4%
Grant	20	11	45.0%
Harney	9	3	66.7%
Jackson	315	210	33.3%
Josephine	195	95	51.3%
Klamath	129	76	41.1%
Lake	18	13	27.8%
Lane	400	225	43.8%
Lincoln	161	84	47.8%

County	Pre-COVID-19 Jail Population	Current Jail Population	Reduction
Linn	207	115	44.4%
Malheur	82	34	58.5%
Marion	415	281	32.3%
Multnomah	1112	775	30.3%
NORCOR	160	83	48.13%
Polk	120	29	75.8%
Springfield	45	13	71.1%
Tillamook	56	32	42.9%
Umatilla	210	163	22.4%
Union	32	16	50.0%
Washington	572	272	52.4%
Yamhill	143	57	60.1%

What This Data Means

Disability Rights Oregon, along with allies in law enforcement and government, has long called for decriminalizing mental illness and reducing the high rates of pretrial incarceration.

> So many people are held in custody, not because they pose a risk to public safety, but because they have no money for bail or because, often due to homelessness or behavioral health concerns, they appear at risk of no-showing for their court date.

Jail commanders see the cost of unnecessary pre-trial incarceration first-hand, whether that's deprivation of healthcare, the trauma of solitary confinement, loss of contact with loved ones, losing health insurance or other public benefits, losing a job, or losing a spot on a wait-list for affordable housing or addiction treatment.

But generally, jails are not empowered to release people, even if they should not be in custody. Judges, law enforcement, and advocates agree that incarcerating people on low-level charges related to difficult life circumstances, disabilities, and behavioral health needs does more harm than good. Yet, the growing number of people in local jails has appeared, until now, to be an intractable problem.

Local Approaches to Reducing the Population

The dramatic drop in jail populations in response to the pandemic was achieved through a variety of locally-driven solutions.

- Most jails worked with courts and law enforcement to significantly curtail their admissions criteria, turning away arrestees who are charged with minor and/or non-person crimes, or who show signs of illness.
- Jails also worked collaboratively with the courts and attorneys to release people with a short time left to serve or who could be safely supervised in the community.
- Twenty-four jails reported that they involved medical staff in identifying inmates at risk of serious illness due to age or preexisting medical condition, and worked with the courts and attorneys to release these vulnerable individuals, where feasible.

Recommendations: Charting a Path to Change

We can sustain this progress.

- New legislation should give Sheriffs or Jail Commanders greater discretion to release people with minor pending charges, especially if they have health conditions that are difficult to care for in jail.
- Courts should reassess their recognizance release criteria to prevent penalizing people who are homeless, unemployed, or have unmet behavioral healthcare needs.
- District Attorneys should decline to proceed on low-level cases, especially where there is a nexus to disability.
- Law enforcement should continue to operate with the expectation that jail is only an option if a risk to public safety is present.

These steps led to a statewide 50% reduction in jail population that appeared impossible prior to the pandemic.

> Now that Oregon communities have recalibrated our assessment of what charges and circumstances should trigger pretrial jail time, we have a unique opportunity not to revert back to the status quo of harmful and unnecessary incarceration.

Why this Survey was Conducted

On March 17, 2020, Disability Rights Oregon, ACLU of Oregon, Oregon Justice Resource Center, Partnership for Safety & Justice, Oregon Criminal Defense Lawyers Association, and Sponsors Justice Reimagined wrote to the Oregon State Sheriffs' Association seeking information about how Jail Commanders in Oregon are responding the COVID-19 public health crisis. Disability Rights Oregon and our partners also urged County Sheriffs to:

- Reduce Jail Populations
- Provide for Adequate Cell and Personal Hygiene for Inmates and Staff
- Educate Staff and Inmates about the Importance of Good Hygiene
- Ensure Routine Assessment of Inmate Condition
- Collect Data about the Impact of COVID-19 in Jails

After sending this letter, Disability Rights Oregon worked with the Oregon State Sheriffs' Association to distribute an online survey, sent to all Jail Commanders, to gauge whether jails are adhering to COVID-19 public health recommendations and to solicit input from jails about what support is needed in order to protect the health of inmates and staff during this pandemic.

About the Survey Method

The survey was sent to all County Jail Commanders in Oregon. The survey was also sent separately to Springfield Municipal Jail, which has a capacity of 100 inmates and is comparable in size to many County jails. Responses were received between April 14 and May 1, 2020. Twenty-nine jails responded to the survey.

The following federal authorities share in the cost of funding this publication: the U.S. Department of Health and Human Services, Administration for Community Living (ACL), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the U.S. Department of Education, Rehabilitation Services Administration (RSA). The contents do not necessarily represent the official views of ACL, SAMHSA or RSA.