Behind the Eleventh Door One Year Later: DRO's First Annual Report – Progress to Improve Conditions at the Behavioral Health Unit of the Oregon State Penitentiary

Written by
Joel Greenberg, DRO Staff Attorney

Date of Release: April 2017

DISABILITY RIGHTS OREGON

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

Thank you to Esther Harlow, Jamie Jones, Bob Joondeph, Sarah Radcliffe, Elizabeth Seaberry, Tom Stenson, and Kathy Wilde for their valuable contributions to the development of this report.

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

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

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

Introduction: Why Conditions in the BHU Must Be Improved

On May 1, 2015, Disability Rights Oregon issued Behind the Eleventh Door, a report that documented its yearlong investigation of conditions in the Behavioral Health Unit (BHU) at the Oregon State Penitentiary. We concluded that the Unit had devolved into a hopeless and dysfunctional program where roughly 40 of the most severely mentally ill individuals who are incarcerated in Oregon prisons spent 23 hours a day (or more) in tiny, stifling, Lexan-covered cells.

In addition to describing the conditions that BHU residents endured, our report identified causes and made a number of recommendations for changes that would be necessary to restore the Unit to its intended purpose: to provide practically effective mental health treatment in a humane and safe environment. The Oregon Department of Corrections (ODOC) strenuously objected to our assessment that many of the problems in the BHU were attributable to a culture that marginalized the concerns of the Unit's clinicians in favor of overly over-zealous security measures. Nevertheless, the Department agreed with our central assessment that conditions in the Unit had reached a point that demanded change.

The MOU: DRO and ODOC Sign a Memorandum of Understanding to Avoid Litigation and Improve Conditions

Based on the shared conclusion and a belief that litigation would cost time and money that would be better used to improve the Unit, DRO and ODOC met and negotiated for many months before signing a Memorandum of Understanding (MOU) on January 8, 2016. The MOU was designed to implement a collaborative DRO/ODOC effort to improve the conditions in the BHU within the 4-year period of the agreement. DRO believed that improving BHU conditions would result in residents receiving more effective mental health care, a decrease in the use of force against residents, and a decrease in incidents of self-harm and attempted suicide. ODOC agreed to take a number of actions to reach specified goals and allowed DRO to effectively monitor progress toward those goals.

Key elements of the MOU:

1. BHU residents will spend an average of **20 hours per week out of their cells** in both treatment and educational activities and unstructured time that would encourage socialization and relationships with other residents and staff.
2. DOC will **better train and increase the numbers of clinical and correctional staff** to enable more clinically-informed and coordinated responses to the problem behaviors and learned isolation of BHU residents.
3. DOC will collect data on **the use of force** in the BHU and provide it to DRO on a quarterly basis**.**
4. DOC will collect data on the **incidents of self-harm and attempted suicide and provide it to DRO** a quarterly basis.
5. The **space available for clinical, educational, and treatment activities will be expanded and improved**.
6. ODOC will provide DRO with continued access to the Unit and **quarterly reports describing progress toward the goals of the MOU**.
7. **ODOC will hire an expert** to guide and oversee the Department's efforts to achieve the goals of the MOU. DRO will have extensive access to that expert and receive reports of his thoughts about the Department's progress.

DRO's Summary of Progress after Year One of the MOU

This report on progress toward the goals of the MOU is issued approximately one year after it was signed.[1] Our current assessment, in shortest form, is that ODOC and its retained expert, Dr. Dvoskin, have worked diligently to improve the leadership and operation of the Unit. They have been open to our suggestions and have partially achieved a number of the goals of the MOU. However, some of the most serious concerns that led to our investigation have resurfaced.

The Positive Ledger

On the plus side of the ledger, there has been significant progress toward the reduction of uses of force, reduction of self-harm, and an expanded and improved

[1] DRO intends to issue subsequent reports at end of each of the years during which the MOU is in effect.

capacity for some BHU residents to engage in meaningful activity and socialization.[2] The Unit, although still dark and foreboding, is not the loud, foul smelling place that it was in 2015. Residents have at least some opportunity to see the sky and breathe outside air[3] and some of the air-blocking Lexan cell fronts are gone.[4] Most BHU residents now have working TVs in their cells. Those TVs are not a substitute for the effective programming and activities that are needed to fully reform the program into one that meets the objectives of the MOU, but they do provide a welcome measure of relief from the boredom and despair that permeated the Unit when we first saw it in 2015.[5] Some long-term BHU residents who never expected to leave the BHU have reached a level of mental health improvement that allowed them to transfer to less restrictive settings. Although DRO continues to receive reports about security staff behavior that seems at odds with the specialized mission of the BHU, OSP's new superintendent has made some promising and responsive changes in security leadership. In addition, the BHU will soon implement a system of behavioral management that will empower security staff to issue bankable rewards for positive behavior (or failure to engage in frequently seen negative behaviors) in the form of "BHU Bucks." It is hoped that this system will improve the behavioral tool kits of Correctional Officers (COs) by allowing them to positively reinforce good behavior.

These are impressive and meaningful improvements.

In addition, with DRO's support, ODOC successfully secured legislative allocations of approximately 8 million dollars that will be used to erect a new treatment building that is expected to be ready for use between January and April of 2018. When completed, BHU clinicians and contractors will have greatly expanded space for confidential therapy, office work, education, and other treatment

[2] Although DRO has learned of one recent alarming use of force, reports seem to indicate that ODOC has moved aggressively to review the incident and consider its implications for training and assignment of correctional staff who work in the unit. DRO may address this incident and ODOC's response to it more fully in DRO's next annual report.

[3] Although the rec areas have been significantly improved, 6 BHU residents who have been determined to pose a high risk of staff injury have not been allowed to use the rec areas (in 3 cases, for many months) without being shackled.

[4] However, ODOC reports that there are now 13 Lexan-fronted cells in the BHU. We believe that ODOC has recently increased the number of Lexan-fronted cell after removing the Lexan sheets from almost all BHU cells shortly after the MOU was signed.

[5] One indication of problems and frustration that persist in the BHU despite the installation of 42 individual TVs in the BHU is provided by the following fact: as of 4/14/17, twelve TVs had been destroyed by residents. In cases where DRO has spoken to those residents, they reported extreme frustration and loss of control that negatively affected their own welfare.

activities. More importantly, from our perspective, the new building should mean that BHU residents will spend much of their day out of their cells and in the new building where they will be meaningfully engaged.

The Negative Ledger

Although the above-noted progress is certainly commendable and significant, the Department has made little progress toward getting BHU residents out of their cells for the MOU's target average of 20 hours per week. This is a deeply concerning failure because DRO and ODOC have agreed that out-of-cell time is probably the key measurable indicator of progress toward the substantive goal of reforming the BHU to an effective program.

Unfortunately, after one year of effort, the current average time out of cell for BHU residents is <u>less than five hours per week</u>. Although this is about twice the average time out of cell when the MOU was signed, progress since the first quarterly report has been erratic.[6]

We share ODOC's expectation and hope for a significant increase in structured out-of-cell time (such as therapy or groups) when the new treatment building is completed. However, we do not believe that it is reasonable or necessary to delay other actions that will lead to some increase in the unstructured time that is provided to BHU residents before the new building is completed. Despite many other improvements, it seems that BHU residents are still either unable or unwilling to leave their cells for more than a few hours a week.[7]

One Explanation for ODOC's Poor Progress toward the Target Average of 20 Hours/Week Out-of-Cell

To address the current disappointing result of ODOC's efforts to bring BHU residents out of their cells for more hours of useful treatment and human interactions, Dr. Dvoskin has suggested measures designed to create a more graduated, clearer, and simpler set of rules that direct when BHU residents are

[6] See the attached graph at the end of this report (Appendix A)

[7] The attached graph does not include out-of-cell data received from ODOC on 4/14/17. That data was accompanied by ODOC' suggestion that some well-intended reforms may have resulted in unintended negative impacts on out-of-cell time in the BHU. Nevertheless, the data, although slightly improved from the previous quarters, indicates that the average out-of-cell time for the unit was still <u>less than 5 hours per week</u> as of 4/14/17.

allowed out of their cells. In an additional effort to discourage the reduction of out-of-cell time as a way to punish rule violations, Superintendent Kelly recently informed hearings officers that out-of-cell time (including recreation time) is more of a necessity or need than it is a "privilege" for BHU residents. He encouraged hearings officers to consider that perspective, along with the recommendations of the BHU Treatment Team, when deciding whether to impose Loss of Privilege (LOP) or other sanctions that would reduce out-of-cell time. ODOC is also considering Dr. Dvoskin's recent suggestion to urgently repurpose some newly available space rather than wait for the completion of the new building before increasing staff levels.

DRO agrees that ODOC's progress toward more time out of cells for BHU residents could be accelerated by more aggressively increasing mental health staffing rates rather than delaying those increases on the theory that there will not be adequate room for additional staff to operate until the new building is completed. We endorse his suggestion that a recently emptied unit in the building that houses the BHU, although far from ideal treatment or office space, could have been quickly repurposed to accommodate a much-needed staffing increase. ODOC's failure to do this has unnecessarily delayed critically needed increases in BHU staffing that will be needed to improve progress toward the central goals of the MOU.

An Alternative Explanation for ODOC's Poor Progress toward the Target Average of 20 Hours/Week Out of Cell

DRO supports the above recommendations and hopes that they will achieve the desired result, but we question their sufficiency as a way to adequately improve a thus far unsuccessful effort to increase the time that BHU residents spend out of their cells. Our doubt is based on consistent unsolicited communication from inmates and clinical staff (former and current). Those reports lead us to primarily attribute the problem to another cause: the same **imbalance of power between the security and clinical staff** that triggered our 2015 investigation.[8]

[8] One of the former or current members of the BHU clinical staff told us that, "I understand that some changes have taken place, however, inmates still spend much of their time in solitary confinement, and counselors continue facing opposition in trying to meet with inmates, as well as trying to advocate for clients to move forward in the level system." The same individual further explained, "I believe this imbalance of power is what lends to their reluctance in addressing these issues. Painting some walls, adding a few televisions and a few programs to the BHU is like painting a house with dry rot and mold."

Then and now, clinical staff and BHU residents contacted us (privately, and with fear of being exposed) to report that daily decisions by security hindered the efficacy and delivery of clinical support to an extent that many clinicians were frustrated about their jobs and in some instances, actually fearful for their safety. According to these reports, the situation is especially dire for clinicians who work alone during weekends and evenings when Behavioral Health Service (BHS) administrators are not present. These reports and other sources of information support the idea that the BHU's operation is being negatively affected by an overemphasis on security concerns.

Need to Support BHU Clinical Staff

DRO has received reports that some BHU clinical staff have been subject to retaliation by security staff members. We will continue to investigate these reports in order to determine if needed mental health services are being blocked due to the desire of some staff to assert authority rather than to further the mission of the BHU.

DRO understands that, in a prison, security staff members may see even minor disrespect or non-compliant behavior as a threat to the maintenance of control and safety. Clinical staff members are more likely to see the same behaviors as symptoms of a serious mental illness that require analysis and treatment rather than punishment. In the BHU where the entire population consists of individuals with serious mental illness, these different perspectives can be expected to rub against each other. In addition, BHU clinical staff members are very dependent on security staff. Clinicians depend on COs to open and close doors, ensure their safety, and provide access to their clients.[9] This imbalance of power can result, in some instances, to an inappropriate submission of clinical perspectives to security perspectives. Reports of this sort of friction from BHU residents and clinical staff members who have confidentially contacted DRO provide the basis for our suspicion that the above-described power dynamic continues to be a significant obstacle to the goal of getting BHU residents out of their cells to access a mixture of engaging and useful activities.

[9] In a secure forensic hospital setting, this is less true because these facilities are overseen by clinicians who hire security staff as a necessary support.

Clinical Staff Turnover

Another warning indicator is a vexingly high rate of turnover in the clinical team. The BHU's current clinical staffing level is set at five QMHP FTE (Qualified Mental Health Professional Full-Time Equivalent) positions and two contractors who are expected to provide approximately 50 hours of DBT (Dialectical Behavior Therapy) and other class activities to BHU residents each week. This is an expected and much needed increase in clinical staffing from the four QMHP FTE and 15 hours week of contracted DBT and other classroom activities that were the clinical staffing levels in effect when the MOU was signed.

However, despite ODOC's attempts to train and implement the above-noted increase in clinical staffing levels, that increase remains elusive due to turnover and/or resignations by clinical staff and contractors. Since the signing of the MOU when the BHU was staffed by four QMHPs, three have resigned and one has transferred to other duties elsewhere in OSP. In addition, one DBT provider whose contract ended has not continued.

Although there could be many reasons for this high rate of turnover, we believe that that at least some of the problem is the product of frustration with a unit atmosphere that is influenced too strongly by a security perspective.

Disciplinary Referral Rates

An additional sign of problems between the clinical and security staff is a reportedly disproportionate high frequency of disciplinary referrals that are lodged against residents by the BHU security team.[10] This is another potential source of friction between clinical and security staff members because many of these referrals may be based on minor rule violations such as swearing or disrespecting an officer. This is a significant problem because these sorts of security complaints frequently result in counterproductive LOPs that cancel or restrict a resident's ability to leave his cell. Such restrictions diminish the ability of clinical staff to make progress with their angry and unavailable clients. DRO hopes that the change in the use of LOPs in the BHU (described on page 6 of this report) will greatly improve this problem.

[10] DRO is not fully able to gauge the accuracy of these reports at this time because ODOC has not completed its collection of the relevant data.

The central focus of the MOU to decrease the time that BHU residents spend out of their cells is impossible to reconcile with a high rate of cell-ins. In addition, because Conduct Orders and resulting cell-ins do not create an easily followed or tracked paper record, they do not allow ODOC to know about problematic COs or understand when a particular BHU resident might have been subjected to a succession of cell-ins that would be the functional equivalent of punctuated solitary confinement.

ODOC can track Minor Misconduct Disciplinary Reports because of the paper trail that is associated with them. They may be less problematic than cell-ins because they typically result in LOPs (Loss of Privilege) such as a clothing or commissary restriction rather than cell ins.[11] DRO does not discount the significant impact that LOPs may have on the atmosphere of the BHU, but the impact is likely much smaller than the one that occurs when residents are confined to their cells for days at a time without a record.

ODOC was able to provide DRO with some data about the number of rule violations that are sanctioned in one way or another within the BHU.[12] That data is mostly comprised of violations that are classified as Minor Misconduct Disciplinary Reports.[13] It strongly confirms that the roughly 40 BHU residents are disproportionately sanctioned for disciplinary infractions when compared to the overall population (approximately 2000) at Oregon State Penitentiary (OSP).

Although BHU residents represent only about 2% of the OSP population, in 2016, they received more than 11% of the recorded disciplinary sanctions that ODOC. The data also indicate that the rate of tracked disciplinary reports has actually increased since January of 2016, when the MOU was signed. Moreover, because ODOC has a limited data collection structure in place to capture the two sorts of disciplinary sanctions that are most commonly imposed on BHU residents, the disproportional rate of sanctions in the BHU may be far higher. Many of those sanctions are imposed via Conduct Orders, disciplinary actions that are not easily

[11] ODOC's data for the period between the roughly one year between signing of the MOU and February of 2017 indicate that Minor Misconducts, which are much more easily tracked than Conduct Orders, have not been used frequently in the BHU or OSP.

[12] See the BHU Discipline Data at the end of this report (Appendix B)

[13] Conduct Orders and Minor Misconduct Disciplinary Reports are typically imposed for relatively low-seriousness rule violations such as Disrespect III, Disobedience II, and Property (Destruction) II.

collected or tracked. Conduct Orders typically result in confinement of an individual to his cell for up to 72 hours.

Cell Ins

On 4/17/17, ODOC responded to a DRO request with compiled data that recorded the number of BHU cell-ins that occurred between during the roughly three months between 1/1/17 and 4/13/17. That data indicates that at least 31 cell ins were imposed on BHU residents during the same period. At least[14] 17 of those were for the maximum allowable 72 hours and the approximate number of hours that BHU residents spent celled in during this period was at least 1468, the equivalent of 61 full days.

Although most of the above cell ins were triggered by behaviors that were undoubtedly frustrating for the officers who experienced them, many of those behaviors were exactly what might be expected in a unit that houses residents with serious mental illness, behavioral dysregulation, and impulsivity. At least twelve of the 31 cell-ins were responses to verbal disrespect. Others followed incidents during which residents threw toilet water and sheets, refused to get off of a phone, or exposed themselves to a CO.[15]

DRO believes that many of these incidents could have been more effectively addressed through the BHU treatment team process in conjunction with better selection and training of security staff who work on the unit. Whether or not ODOC shares that belief, it is hard to reconcile a goal of increased time out of cells with continued use of cell ins as a primary response to expected behaviors.

DRO and ODOC Do Not Assess the Significance of Confidential Complaints to DRO in the Same Way

Dr. Dvoskin has spoken confidentially to clinicians and inmates who contacted us about the above concerns despite the fear of retaliation by security staff. He has concluded that the concerns conveyed to us were not specific enough to be

[14] ODOC's data did not include the duration of 4 of the 31 cell ins.

[15] The possibility of inappropriate use of cell ins and other issues relevant to this report is well illustrated by the following record entry of a Conduct Order from February of 2014: "48 hours. Extortion. Inmate threatened to hurt himself unless BHS staff agreed to see him right away. Inmate later told BHS staff that he had no intentions of hurting himself, it was just a way to get to see them."

actionable or a cause of major concern in the context of his own observation that the interaction between security and clinical staff at treatment meetings seems healthy, open, and positive. The gulf between our assessment and his may be partially attributable to the fact that he has not yet observed or met with the evening and weekend staff of the BHU during his on-site visits. We hope that he will take that step during his next trip to the BHU.

It is also possible that his positive observations of the way that clinical and security staff interact during the day shift may have missed the fear and frustration that clinicians have expressed to us because it is not the result of discrete and easily investigated incidents. Instead, they complain about an atmosphere of subtle intimidation and dismissal of clinical issues. As reported to us, this atmosphere is played out in many ways such as when clinicians cannot get their clients to a scheduled activity or gain access to the Unit because of long waits at locked gates between their offices and the cells.

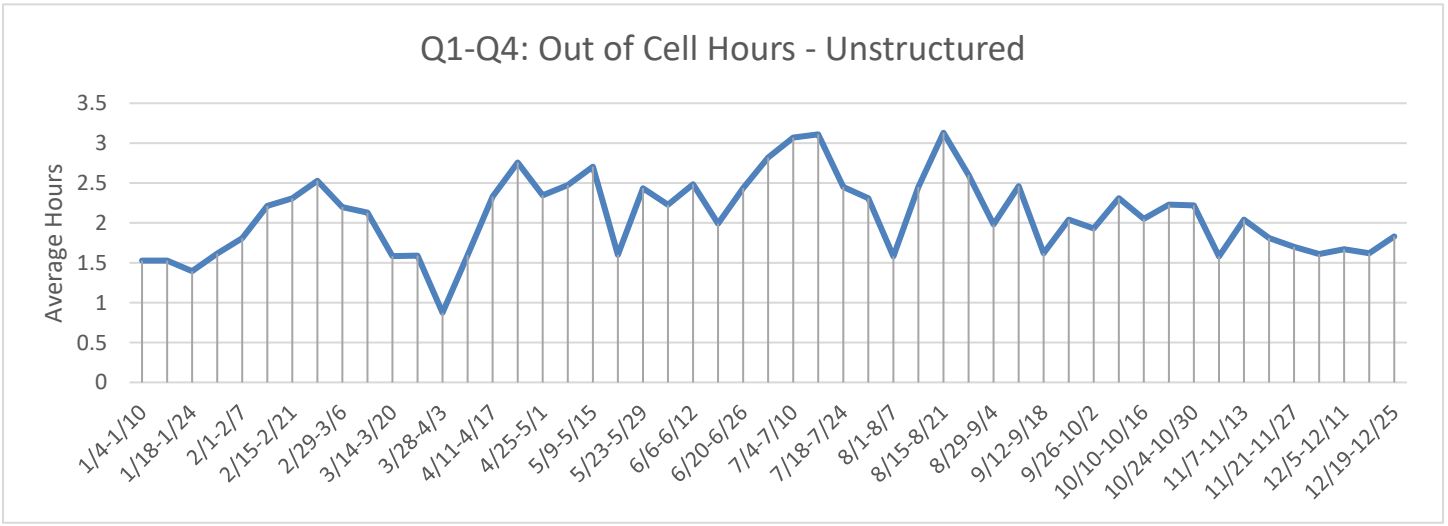
Conclusion

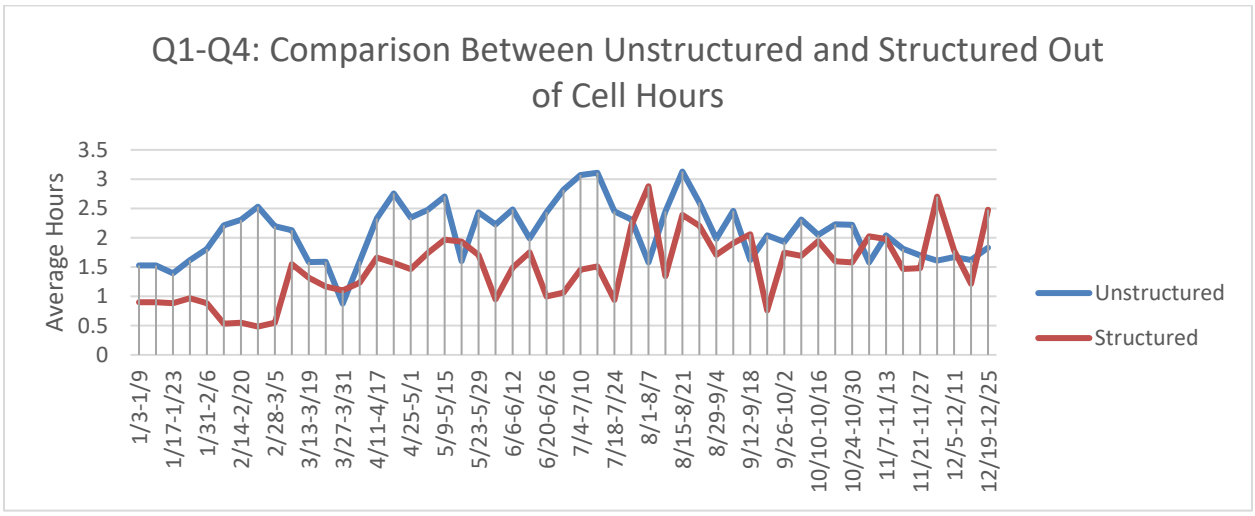
DRO continues to believe that it is both possible and practical to achieve the goals of the MOU, but we are concerned at the lack of progress toward increasing the hours that residents spend out of their cells while engaged in meaningful activity, the agreement's central goal. We trust that ODOC's planned and current efforts to improve its rate of progress toward that goal are sincere and well-intended. We also share ODOC's hope that these new efforts will prove to be successful in the near future. However, we are concerned that the Department's understanding of the power dynamics in the BHU is incomplete. The test of that proposition will be the measure of progress toward the target of providing BHU residents with an average of 20 hours per week out of their cells.

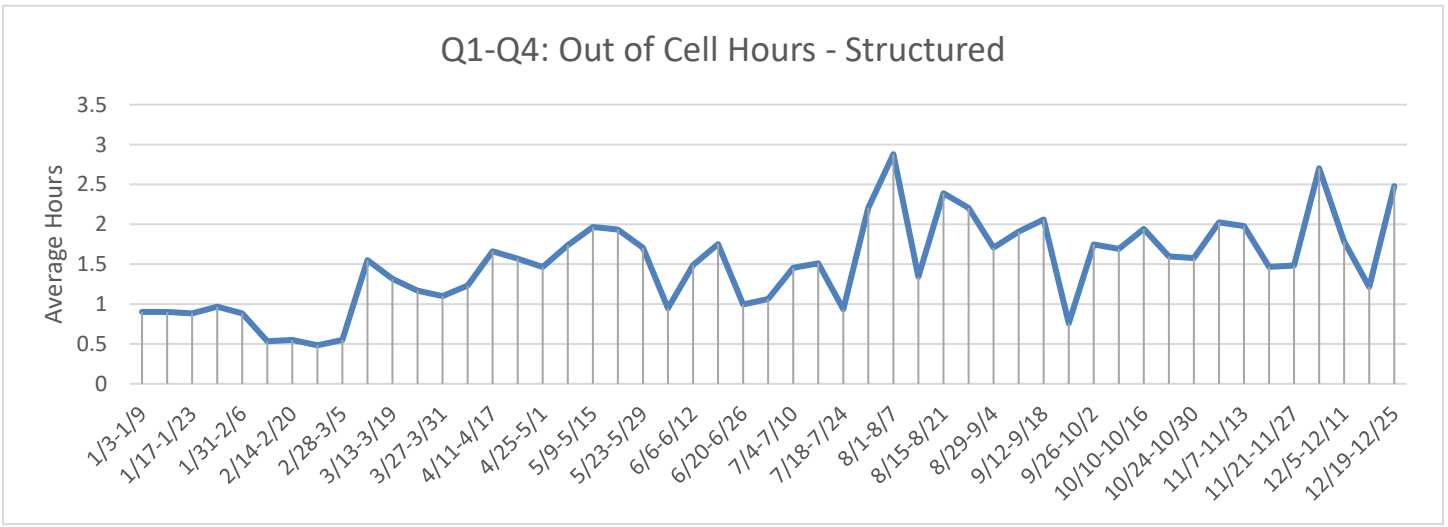
Recommendations

- Security staff who work in the BHU will not be effective absent a desire to work in a unit where the clinical perspective is valued and coordinated with security function whenever possible. Behavioral Health Services should, therefore, be charged with interviewing officers who wish to work in the BHU.
- Additional cross-disciplinary training should be an initial and ongoing requirement for all ODOC employees and contractors who work in the Unit. Dr. Dvoskin should interview night and weekend staff (including clinical, security, and contractors) in a confidential setting to better understand the relationship between the players and the current operation of the Unit. His interviews should be conducted in a way that invites opinion regardless of whether or not the respondents can provide concrete evidence for their thoughts.
- 12-hour security shifts for security staff who work in the BHU should be eliminated. They disproportionately attract security officers based on scheduling concerns rather than an affinity for the population.
- ODOC should create a process that allows BHS to track and review incidents in which clinical staff are unable to access their BHU clients for more than 15 minutes.

Appendix A – Out of Cell Time Graph







Appendix B – BHU Discipline Data

2016

Month	Total OSP DRs	Total SMH DRs	BHU DRs	MHI DRs	ICH DRs	GP DRs
January	109	11	6	3	0	2
February	120	13	2	4	1	6
March	117	11	6	2	0	3
April	168	11	8	1	2	0
May	125	14	5	1	2	6
June	164	22	12	5	1	4
July	187	24	15	4	4	1
August	259	17	8	7	1	1
September	138	20	10	3	0	7
October	134	15	11	1	0	3
November	146	21	10	4	5	2
December	163	28	13	5	2	8
Totals for 2016	1830	207	106	40	18	43

2017

Month	Total OSP DRs	Total SMH DRs	BHU DRs	MHI DRs	ICH DRs	GP DRs
January 2017	141	24	16	4	3	1

DR = Disciplinary Report

SMH = Special Management Housing or all of the three specialized housing units at OSP

BHU = Behavioral Health Unit

MHI = Mental Health Infirmary

ICH = Intermediate Care Housing

GP = General Population