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(NIC TA No. 23J1048)

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January 12, 2024

Sheriff Nicole Morrisey O'Donnell
Multnomah County Sheriff's Office
501 SE Hawthorne Blvd., Ste. 350
Portland, Oregon 97214

Re: Suicide Prevention and Mental Health Policy, Procedure, and Practice Review – Technical Assessment for the Multnomah County Detention System (NIC TA 23J1048)

Dear Sheriff Morrisey O'Donnell:

Attached to this email, please find the Technical Assistance Report detailing my review of the suicide prevention and related mental health services offered in the Multnomah County Detention Facilities. This report is based on my site visit to Multnomah County on November 29-December 1, 2023.

In our discussions before and during this site visit, I heard your commitment to learning more about how the security, suicide prevention and mental health intervention efforts in the detention facilities can be improved. I have strived to give you information to that end. While this is in some respects an incomplete report because I did not receive all the information needed to assess and address every area of your concern, I believe you'll find it is comprehensive in scope and detailed in both conclusions and recommendations.

I have found what I believe to be serious health care and operations issues in the Multnomah jail system. I believe, based on my knowledge, experience, and education in correctional settings and my experience serving as an investigation and litigation expert for the federal government and other agencies, that there are practices and omissions occurring in your jails that do not comport with constitutional standards, accreditation standards, and professional practice standards.

The scope of this technical assistance was about custody policies and protocols, suicide prevention efforts and the veracity of the health/mental health services offered in the MCDF system. Where I had sufficient information and documentation to substantiate what I believe are weak practices in those areas and in related security practices, I offer methods of addressing them.

My concerns also go beyond those I have with CH's separate administrative and operational structure: they relate to your detentions' staffing, which is not at full strength and made worse by the hiring delays that are occurring. These concerns also relate to your deputies' training and oversight, as well as to certain security practices, or lack thereof, that I suspect cause to be introduced or otherwise allow the possession of contraband inside the jails.

I believe in the promise of the partnership between justice and public health systems. At present, the structure, the process, and the outcomes of your and CH's operations seem to compromise your ability to exercise total oversight of the detentions system. My findings and recommendations detail what I believe is needed to begin to realize the promise of your partnership with CH.

Time is of the essence. I have included in this report prioritized and (relatively) quickly implementable recommendations. Perhaps you have already started or completed some of them which I mentioned in the exit briefing. Now, having read so many documents and having experienced the unwillingness of CH to fully participate in your efforts to head off additional inmate deaths, I urge you to consider a new structure for the MCSO/CH partnership – headed by an independent health services administrator. I believe that seeking the County's support in hiring or contracting with someone who is independent of CH, who understands the legal, ethical and health mandates of jail systems, and has a vision of what interdependent practice and mutual support can and should look like in your world, would be wise. In so many ways you have a great platform on which to build a solid, responsible health services program, but it will be difficult to realize that program if the structural barriers that exist now are not removed.

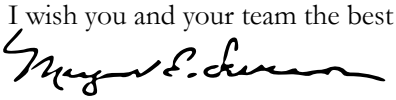
I also want to encourage you to make use of the NIC and of your colleagues around the country as you work to correct inadequacies that have the potential to cripple your system. At the same time, I feel strongly that your immediate focus needs to be on identifying who is in your jail and who needs urgent, potentially life-saving attention. I am providing recommendations to that end.

With that weighty backdrop to this report, I want to assure you that the information I am giving you in the many pages that follow and the changes and modifications I recommend, can be helpful to you in your efforts to reduce suicides and deaths related to drug ingestion, and in managing self-harm behaviors in the detentions' system.

In closing, I particularly want to acknowledge Deputy Chief Steve Reardon's help in getting me needed MCSO documents I thought were necessary to review, during and after the site visit. He managed all my many questions and requests in ways that allowed me to make the most of every minute of my work before, on site and after the visit to Multnomah County.

If I can be of further assistance to you as you review this report and as you consider implementing the recommendations made, please do not hesitate to contact me.

I wish you and your team the best as you move forward in this critical work.



Margaret Severson
Technical Resource Provider – Mental Health

c: Michael Jackson, Correctional Program Specialist, NIC Jails Division

DISCLAIMER

NIC TA No. 23J1048

This technical assistance activity was funded by the Jails Division of the National Institute of Corrections. The Institute is a federal agency established to provide assistance to strengthen state and local correctional agencies by creating more effective, humane, safe, and just correctional services.

The resource person, Margaret Severson, who provided the onsite technical assistance did so through a cooperative agreement, at the request of The Multnomah County Oregon Sheriff's Office, and through the coordination of the National Institute of Corrections. The direct onsite assistance and the subsequent report are intended to assist the agency in addressing issues outlined in the original request and in efforts to enhance the effectiveness of the agency.

The contents of this document reflect the views of Margaret Severson. The contents do not necessarily reflect the official views or policies of the National Institute of Corrections.

NIC TECHNICAL ASSISTANCE REPORT
(23J1048)

The Multnomah County Sheriff's Office
Portland, Oregon

Margaret Severson
Technical Assistance Provider

On Site: November 29 - December 1, 2023

I. INTRODUCTION AND BACKGROUND INFORMATION

This report contains the observations, conclusions and recommendations of Technical Assistance provider Margaret Severson following the provision of short-term technical assistance to the Multnomah County Sheriff's Office (MCSO) located in Portland, Oregon. These observations, conclusions, and recommendations are based on my 40 years of experience and clinical knowledge in assessing, developing, and managing the many components of jail health operations as they exist throughout the United States, and on an understanding of:

- The concerns of Sheriff Nicole Morrisey O'Donnell, Chief Deputy Reardon and other staff of the MCSO, especially those which relate to the care and custody of persons who appear to be at risk for suicide or self-injury, substance withdrawal, and/or who evidence acute mental health symptoms at the time of their arrest and/or during their incarceration.
- Applicable standards of practice set forth by recognized professional organizations involved with incarcerated persons'[1] health/mental health care.
- The relevant evidence-supported and best practice information available in the current literature; and
- An understanding of the constitutional mandates set out in caselaw and in legislation, that have shaped modern jail operations and management, and established the thresholds of care to be provided for all incarcerated persons.

Consistent with the Sheriff's resolve to seek an objective and transparent review of the suicide risk-reduction efforts underway in the detention facilities, Sheriff Nicole Morrisey O'Donnell contacted Michael Jackson, Correctional Program Specialist, NIC Jails Division, to request this technical assistance. This assistance, made possible through the sole financial support of the NIC, was defined as including:

- A review of materials relevant to an overall assessment of the Multnomah County Detention Facilities' (MCDF) suicide prevention and mental health programs, including intake screening documents, statistical data, procedures for incarcerated persons to access a range of health, crisis and ongoing mental health services, relevant policies, procedures and protocols, staff credentials, staff training materials, and more.
- An assessment of the operations of the MCDF as they relate to the care and custody of persons who have acute and chronic mental health and substance use challenges and who are at risk for suicide.
- Interviews of key staff and stakeholders including administrators, program staff, medical and mental health staffs, classification personnel and other contributing members of the organization who are responsible for or otherwise invested in the administration and success of various components of the health and mental health programs.

[1]In this report, I refer to incarcerated persons in a variety of ways, including as "incarcerated person(s)," "AICs" ("Adult in Custody" - the Correction Health's and MCSO's commonly spoken reference), "detainee(s)," "arrestee(s)," and "inmate(s)." In the context of this report, the reference is to those held on criminal charges and awaiting trial or sentencing or who are serving a sentence in the Multnomah County detention system.

- An assessment of the physical environment of the MCDF especially as it relates to the care and treatment of persons with behavioral health challenges, including those persons assessed as having a heightened propensity for self-harm.
- An exit presentation with key officials, including Sheriff Nicole Morrisey O'Donnell, Chief Deputy Reardon and invited MCSO and Corrections Health (CH) administrative and clinical staff working in the MCDF, to discuss my preliminary findings and recommendations.

Making scheduling the site visit a priority upon the approval of the NIC to provide this technical assistance, on August 18, 2023, I reached out to Sheriff Morrisey O'Donnell through Executive Administrator Melissa Froman, to make preliminary arrangements for my visit to Multnomah County. Once the tour dates were set, and acting quickly on my requests, Ms. Froman arranged for my secure electronic access to key documents I identified for review. This document review occurred simultaneously with their delivery, and again during and after the site visit, in preparation of this report.

The site visit took place November 29-December 1, 2023.

II. OVERVIEW OF TECHNICAL ASSISTANCE ACTIVITIES

PREPARATION AND ON-SITE ACTIVITIES

Prior to and while on-site in Portland, Oregon, I met and talked with Multnomah County Sheriff Nicole Morrisey O'Donnell and other Detention Facility (MCDF) and Corrections Health (CH) officials and staff. With the exception of the incarcerated persons I interviewed while in the detention facilities, the names and affiliations of the persons with whom I engaged while in the MCDF are found in Appendix A to this report.

Documents Reviewed

I requested many documents for review in advance of my arrival and again once on site. I am very thankful to Chief Reardon and other staff members working in the MCDF system for their cooperative and speedy response to my requests.

The list of documents reviewed before, during and after the site visit to Multnomah County, is found in Appendix B of this report. To assure their expectations of confidentiality and privacy, the identities of any incarcerated individuals named in the document titles are not disclosed in this itemized list.

A Note on Health Records

While I asked for access to review strategically selected health records while on site (the County uses an electronic medical record (EMR) system), in a response to a query posed to him by the CH Health Director, a Multnomah County attorney voiced concerns that my doing such a review would violate HIPAA standards. I was not aware of this attorney's concern until already at work in Portland. A confidential review of health records would no doubt have yielded additional information useful to this report and to the Sheriff's decisions after reviewing this report.

Should similar or related technical assistance be requested in the future, I hope that such HIPAA and other privacy concerns will be resolved in advance. Bound by a Code of Ethics and by my respect for privacy in consultations such as this one provided in Multnomah County, I regret not having the opportunity to complete a strategic health records review and to assure the county attorney of the safeguards of my doing so.

My post-visit request to CH for a review of a limited number of redacted, de-identified EMRs was not acknowledged.

MCDF SYSTEM (MCDC and MCIJ) Tours

In addition to the interview process and document review, at the start of the on-site visit I was provided a comprehensive tour of the MCDF system (MCDF) which consists of two adult detention facilities.

Exit Briefing

Prior to concluding this site visit on December 1, 2023, I met with Sheriff Nicole Morrisey O'Donnell and members of the MCSO/MCDF team, including Sheriff's employees and CH administrators and staff, to provide a summary of my initial impressions and recommendations, and to ensure their opportunity to engage in discussion. The roster of attendees at this meeting is also found in Appendix A.

III. ASSESSMENT OF THE MULTNOMAH COUNTY DETENTION SYSTEM

ASSESSMENT METHODOLOGY

This technical assistance was requested by Sheriff Nicole Morrisey O'Donnell for the purpose of securing "a review and evaluation of our corrections facilities specific to policy, services, and the physical plants. Specific areas of focus [were] contraband control and detection and suicide prevention and intervention." Further, Sheriff Morrisey O'Donnell requested assistance in identifying "any areas of physical plant weakness, service gaps, and/or policy and training needs within a report and to include recommendations for remedy." The Sheriff's requests formed the parameters of this technical assistance.

The National Institute of Corrections agreed to fund this Technical Assistance. I, Margaret Severson, served as the Technical Resource Provider (TRP) for the review of suicide prevention and related mental health practices in the MCDF and I am the sole author of this report. In an early planning meeting with the Sheriff, I asked for the involvement of the Corrections Health (CH) team, without whom any recommendations I might make about the development or modification of health protocols would lack informed consideration of CH's operations. Sheriff Morrisey O'Donnell secured the cooperation of the CH staff for this technical assistance. My appreciation of both the well-working elements of the CH program and of certain features of that program that should be developed or enhanced to serve the mission of both the MCSO and the CH, was clearly better for their joint participation in this consultation.

My objectives in providing this technical assistance were to gain a good understanding of the current operations of the detention center, to situate its operations within a broader correctional - public health framework, to consider the fit between current operational procedures and contemporary standards of best practices, including those articulated in caselaw and legislation, and to end this consultation with recommendations that would support the Sheriff's responsibility to provide safe, comprehensive, and responsive detention and care to those incarcerated in the MCDF system.

I am aware that seven (7) detainees died in MCDF custody since the start of 2023, at least three of these by suicide. An additional three (3) persons died in custody in 2022. A death in any jail shakes the system and the community in innumerable ways and should always be a catalyst for system review and where necessary, change. I did not look specifically at the documents associated with these deaths, given that my focus was and is on reviewing current services and forward progress, but my own years of correctional health practice has taught me many things, including that no death comes without considerable pain to the detentions and health staff, the family and the community. In-custody deaths cause significant turmoil inside every facility that experiences them, impacting most other incarcerated people and in general, provoking a period of greater-than-usual risk for the occurrence of similar critical incidents. That has certainly been the experience in Multnomah County.

In important and often invisible ways, the detentions and the CH staff are no doubt saving lives every day in this jail system. Recording visual observations, asking strategic questions at intake and beyond, housing incarcerated persons under different levels of security and safety surveillance, and providing treatment in the forms of verbal and pharmaceutical interventions all work together to keep those incarcerated in this jail system safe and alive. While recent deaths have shaken the system and the community and they may well do so again, it is important to acknowledge that an untold number of lives are saved every day because the processes and safeguards already in place were developed to support the safety, security, and health of all incarcerated persons.

Finally, at every opportunity in my work with Multnomah County, I made clear that my role is not an investigatory one. The focus of my assessment and this report is on the present and the future of MCDF operations, not on any one event or type of event that has already occurred, and my observations and recommendations are not related to any specific jail-related incident or person. The critical incidents that have

occurred in the MCDF, and the community's scrutiny of these incidents and their broader cultural meaning, are important to grapple with, but go beyond the scope of this technical assistance.

I am hopeful that the feedback delivered to the Sheriff and her staff, including CH staff, while on site, combined with my impressions and recommendations documented in this report, will be helpful in the ongoing efforts to see that the MCDF is a safe and secure system in which incarcerated people are well cared for, physically, mentally and environmentally.

THE STRUCTURE OF THIS REPORT.

In the following pages I provide descriptive information about the certain key elements and functions of this detention system that have a bearing on the operations and outcomes of the suicide prevention and mental health efforts expended in it. The MCDF shares the complexities of very large (mega) detention centers even if, in many respects, its total population falls at the low end of what is considered a very large jail system. Hiring and staffing challenges, environmental and design challenges, certain public policies and funding priorities, and the physical, mental, and behavioral health status of the jail population make the MCDF especially complex. In this report, I document important information gleaned from my interviews and tours on site, on my study of documents requested and received, and on my attempt to pull together data that hopefully present a clearer picture of this large jail system's day-to-day successes in light of the many significant operational threats it faces. This report should be read as intended: it serves as a platform for the conclusions and for the recommendations set out at the end of this report. It is not my intent to provide details of every aspect of the MCDF and CH's operations and services.

IV. THE MULTNOMAH COUNTY DETENTION SYSTEM.

A. FACILITIES. SITE INFORMATION. POPULATION AND TRENDS.

There are two adult detention facilities in Multnomah County: the downtown MCDC opened in 1983; the Inverness Jail (MCIJ) opened in 1987 and was expanded in 1991 and 1998. Both have undergone renovations, but like most detention centers of that era, the physical structures quickly show their age because of the type of use and constant wear and tear, and because advances in correctional thinking and practice favor different designs and ambient features than what were the norm in the mid-late 20th century.

The MCDC is a single cell modular facility. Deputies monitor the housing areas from pod control rooms and complete security checks in the housing units. In the MCIJ on the other hand, most housing areas are arranged as open dorms, and the supervision is designed to be direct, with a deputy posted in each dorm. In recent years and currently, staffing challenges have impacted the ability to provide sufficient security supervision in these facilities.

Over the past 40 years the total Multnomah County incarcerated population has ranged from nearly 750 persons to well more than 1000 detainees. In recent years, the number of people booked into the MCDC dropped, a trend that accelerated during the COVID era because of COVID itself and because of legislation modifying criminal justice practices in the state. While the jail system has a total capacity of 1,485 people, county funding currently limits the total incarcerated population to 1,130. Unlike many jail systems around the country, the MCDF houses an overwhelming majority of persons charged with felonies. This alone creates formidable management challenges, which is especially true when having to manage many persons with significant mental and behavioral health needs.

On November 29, 2023 there were 363 incarcerated persons housed in the MCDC, and 505 persons in the MCIJ. The MCIJ has a capacity of 1037 persons, but many fewer have been held in the MCIJ since the start of the pandemic. Like many detention centers around the country, the total population of the jail system is increasing, both in numbers and also reportedly, in severity of charges.[2]

On November 29, 2023, there were 868 persons incarcerated in the MCDF system. Of these, 98 were identified as female and 770 as male; 21 were sentenced, 3 of which were serving SB1145 sentenced time in the MCDF system and 10 persons were serving SB1145 sanction time in the MCDF. Persons sentenced to state time are usually transported to the state prison within a few days of their sentencing. Many of those incarcerated belong to race and/or ethnic minority groups (50%), and among them, most are Black/African American and Hispanic/Latino.

It is notable that the majority of those incarcerated in the MCDF are ages 21-29 (23.4%) and 30-39 (37.8%). I point this out at the start because the 21-39 age parameters are common among those who develop and evidence an acute presentation and worsening of serious psychiatric disorders (major mental illnesses), drug and alcohol addictions, and suicide. In essence, in every jail in the country – and Multnomah is no exception – on the basis of age alone, we receive into our jails individuals who are already at higher risk for debilitating illnesses and even for death. When viewing incarceration from a public health lens, considering conditions captured in what are conceptualized as the Social Determinants of Health (SDH),[3] there is no underestimating the level of risk that must be managed in detention centers like those of the MCDF.

[2] The juvenile detention center (JDC) is part of the MCSO system but was not included in this technical assistance. No juveniles are housed in the MCDF system.

[3] https://health.gov/healthypeople/priority-areas/social-determinants-health

In the 12-month period, October 2022-September 2023, 15,756 persons were admitted to the MCDC and 15,737 persons were released. Bookings appeared to trend higher through that time, as did the number of releases. The average daily population (ADP) of the jail system during that period was 857 (range 805-912).

Thus far in 2023, the average length of stay (ALS) is approximately 20 days, with the median at 3.5 days. The ALS in the MCDF is by any measure long, and almost certainly foretells a growth in population to come, mirroring a phenomenon seen throughout the country.[4] Like many other detention systems, Multnomah County jail officials are faced with managing an increasing number of persons who have serious mental illnesses and serious substance abuse disorders and persons who are at risk for suicide. While these data are not currently tracked in the MCDF, growth in the ALS is thought related to the increased presence of incarcerated persons with mental illnesses, persons who are more likely to be spending a disproportionate amount of time in the MCDF when compared to other incarcerated persons with similar charges who do not have diagnosed mental illnesses. Again, these data are not collected and analyzed, and a recommendation to do so, along with the collection of other data and the measurement and implications of those data points, is found in the final section of this report.

Importantly, no one from the MCSO or from CH was able to provide an estimate of the percentage of currently incarcerated persons who have mental illness (SPMI, SMI, Acute, Chronic) and co-occurring disorders. There is no system to generate this information currently in place. The average number of persons housed each month between October 2022 – September 2023, in designated (and unspecified) mental health units, was 94 (range: 51-111). This average does not tell the whole story: there are persons who require mental health care housed throughout the MCDF system and the Classification and CH systems do not amass these data. Some CH staff believe that 100% of the jail population belong in one or more of these categories. While it may feel that way on more days than not, the consequence of that view is a skewed perception of what is needed in the system.

These data matter: they are important when thinking about and planning housing designations, staffing, deployment of staff, services to be offered inside the jails, outreach to the community, and for planning the County's future vis-à-vis the local justice system. Situating the jail system as one service provider in a community of service providers makes securing these data an imperative. The Sheriff can only articulate the reality of jail operations by sharing with the Multnomah community an evidence-supported narrative that accurately describes the health, and mental / behavioral health needs of the incarcerated population.

B. DETENTIONS' INFORMATION: STAFFING. HOUSING/CONDITIONS. CLASSIFICATION. TRAINING. CRITICAL INCIDENTS & DEBRIEFING.

Detention Staffing & Deployment.

Though recent recruitment efforts have been more successful than in the past, with the MCSO receiving 550 applications since January 1, 2023, the actual hiring and retention of detentions staff remains a significant problem. For example, on December 1, 2023, up to 47 of the 550 applicants remained viable for MCSO hire pending the completion of the county's hiring procedures. Many of the qualified applicants have likely been offered other employment since December 1, trumping the Sheriff's opportunity to extend an employment offer to them, and thwarting the Sheriff's efforts to operate a fully staffed jail system. It would be helpful for the county's Central Human Resource department to study and pinpoint where the hiring lag occurs and take steps to resolve the problems that result in hiring delays.

The Sheriff's and Chief Reardon's consultation with peers in the state and around the country who are also struggling with hiring delays is also encouraged.

[4] https://www.pewtrusts.org/en/research-and-analysis/articles/2020/06/23/small-but-growing-group-incarcerated-for-a-month-or-more-has-kept-jail-populations-high

Adding to and complicating the sluggish hiring process, the MCSO suffers staffing challenges that result from (1) retirements – those that have happened recently and anticipated retirements in the next 18 months; and (2) long term leaves that currently involve 20 people, most of whom are not expected to return to work.

On December 1, 2023, there were 314 deputies employed by the MCSO in detentions; 276 males and 74 females. Seventy (70) of these deputies are serving in special assignments. There are also 38 male sergeants and 6 female sergeants. MCSO administrators have identified that a total of 377 deputies are needed to staff the detention centers and perform other duties. Consequently, deputies work mandatory overtime hours: deputies and sergeants work regular eight (8) hour shifts and can also work up to another eight (8) hour shift in the same 24-hour period. At present, absenteeism is up.

There are no gender-specific posts in the jail system; deputies can be assigned to work in every area of the jail, regardless of sex. Although the presence of female deputies is often more robust, at a minimum, at least one (1) female deputy is on duty in the MCIJ and two (2) female deputies are on duty at the MCDC (1 in reception and 1 in housing) on every shift. At this minimal level, there is 1 female per shift available at the MCIJ to respond to 2 housing units that hold women (one a 50 and one a 10-person unit); and 2 females in the MCDC to respond to 7 housing units (of up to a total of 110 persons) plus the intake area.

Overall, the cadre of current deputies is described as young (experientially): 163 staff were hired up to and prior to 2016; 217 hired since 2017 and most of those were hired after 2020. Though fresh eyes and attitudes may compensate for the loss incurred as seasoned deputies retire, with those retirements both institutional knowledge and associated operational wisdom may be compromised.

Retention of newly hired deputies may be improving from past years. Of a group of 47 deputies hired in 2022, 35 (74%) are still on the job. Deputies serve their first year on probation thus some personnel loss occurs in that period. I do not have the gender breakdown of these personnel losses, but this is important data to monitor.

Deployment of officers – where they are posted and how many serve at each post – is an important administrative issue and in terms of suicide and related risk reduction, may be even (slightly) more operationally critical than the overall lack of staff. An example: On December 1, 2023, the Sergeant leading the morning briefing (the "huddle") announced a MCDC population of 358 persons and reported that some MCDC housing units would "close" early due to staff deficiencies. To "close" means to be without an officer assigned to the unit, and thus detainees would not be allowed out of their cells for their daily "walk" once the unit closed. On this date, the units affected by the staffing shortage were T2, 5B (disciplinary-male), 6C (acute mental close-male), and 8B (Acute Mental Close/Suicide Watch/ Disciplinary/ Ad-Seg-female), arguably the very same housing areas that require more deputy time and attention than do general population housing units.

MCDC Intake.

New detainees coming into the MCDF system are processed at the MCDC facility. The arresting officer will complete a portion of the MCDF's initial screening questionnaire. If the detainee's behavior is not an issue, initial screening of the detainee by a booking deputy takes place at one of four (4) interview spaces located along a counter. There is minimal privacy afforded in this area; if there are other detainees waiting to be processed, they can easily overhear the answers given to these screening questions.

A detainee may be refused at intake for several reasons: serious medical concerns, injuries, wounds, etc. I was told it is more difficult to refuse people for suspected mental health problems. Hospital emergency departments (ED) resist seeing the latter, and as is frequently the case across the country, even if seen in an ED, the person with mental health symptoms is quickly cleared and returned to the MCDC for processing.

If the detainee is uncooperative or disruptive, there are two (2) special purpose cells located in the booking area that can be used to house them until the booking process can proceed. Security checks are completed on persons in these cells twice per hour and depending on the detainee's behavior, detainees may stay in one of these cells for two or more days. Critical incidents such as self-harming behaviors have occurred in these cells.

When the booking process begins, the arresting officer reports whether the arrestee was assaultive or violent, had or consumed contraband (weapons/drugs), was treated recently at a hospital or by EMS, behaved in a way that suggested the presence of, or was recently evaluated for, mental illness, was incapable of understanding/following directions and if the arrestee's behavior suggested suicide or self-harming behavior.

The arrestee is then questioned, with the deputy using the "Booking Screening Questions." These questions seek both direct information from the detainee and the deputy's impressions. They include questions about current suicide thoughts, recent hospitalization for physical or mental health problems, or recent EMS care, belief that someone controls the detainee's mind and knows the detainee's thoughts, recent weight loss or increased energy and feelings of being "useless or sinful." Detainees are also asked if they have a physical disability, amputation or "other impairment." The deputy's observations include, e.g., whether the detainee appears to be "under the influence …" "(has) difficulty answering questions" and "(is) non-cooperative." Answers to these questions are "yes" and "no" and are marked on the form itself. I make recommendations for editing this form later in this report.

A copy of the completed Intake Screening is shared with the CH nurse and with the Classification deputy working in the intake area. In most cases, once this early screening and the booking is complete, detainees move into a larger section of the intake unit where they can be seated in gender-separated open seating areas. There are seven (7) single occupancy "side" cells located in this larger seating area, where disruptive people or people who require a suicide watch are held. There is a restraint chair available for use in one of the side cells, but there are no cameras in or focused on any of the side cells. There was one person on a suicide watch in a side cell when I toured. He had been in that cell for some time.

Ideally, absent disruptive and uncooperative behavior, the booking process is finished, and each detainee is then interviewed by court services-recognizance, classification, and a CH nurse. There is no set order for these interviews but in practice, the CH screening often occurs last – prior to movement into the classification or other initial housing unit. I review the CH screening process in the next major section of this report.

MCDC Housing

Housing units in the MCDC facility are located on floors 4-8. They are all single cell units, laid out in a modular design, with six modules on the 4th floor, and four modules per floor on floors 5-8. Adjacent modules share a pod control room, where an assigned deputy manages the doors and watches a 16-screen monitor of the common areas of the two housing modules. In the several control rooms I entered, I found the windows that allow the deputy's sight into the modules completely covered by blinds. Further, the control rooms are designed so that deputies viewing the monitors have their backs to the module windows. The control rooms were dark and, in my opinion, highly likely to negatively affect the level of awareness and vigilance desired among control room staff. Deputies assigned to the control rooms serve their entire shifts in those rooms with relief only for meals.

The 4th floor's modular unit houses special needs populations: medical, administrative segregation, acute severe psychiatric, and disciplinary. These are very restrictive housing pods: In the 4th floor units, out of cell time is limited to at most, 2 hours per day for all but those in the administrative segregation pods (4B&C), who may have outdoor or unit level recreation, 2 cells at a time, once per week. The "acute severe psychiatric" unit, 4D, in all ways, including lines of sight for security supervision, environment, lighting,

extreme isolation, and lack of out-of-cell time, is an undesirable unit in which to house persons suspected of or diagnosed with a serious mental illness, or who are assessed to be at high risk for suicide.

Cell-side interviews and security checks in the 4th floor units are often made with the food trap doors and the cell doors closed. In other words, the check or the interview must take place from outside of a thick steel door. The lighting is very poor inside these cells, made worse by their occupants covering the lights with whatever is available. In 4D and in other housing units, I saw graffiti, garbage, leftover food containers, multiple changes of clothing and other paraphernalia in the individually occupied cells.

Also, in 4D and elsewhere in the MCDC, officers make their security rounds every 30 minutes at staggered intervals unless a suicide watch is in effect, at which point the officer must make a safety check five (5) times per hour at staggered intervals not exceeding 15 minutes. The officer writes his/her observations at least once per hour on a specific suicide watch form. When there are more than 10 individuals on a suicide watch, or when there are suicide watches on two separate floors, another watch officer is assigned to complete watches (suicide checks). There are Active Suicide Watches (ASW) and Constant Suicide Watches (CSW), the latter of which requires the constant observation by a deputy. It is very staff intensive work and there is scant evidence to support the use of the CSW in detention facilities.

A designated "Mental Health Deputy" and a Sergeant spend a lot of time on 4D which is sometimes referred to as an "infirmary" (it is not an infirmary by definition or by CH's standards). The Mental Health Sergeant participates in a multidisciplinary team meeting each week. These mental health detentions' officers have not received any specific training related to managing persons with mental illness. An additional mental health deputy will be added to the team soon.

Floors 5-8 are comprised of 4 housing units, 16 or 32 cells in each unit. On these floors are acute mental health, suicide watch, and disciplinary units. Three of the units on floor 8 are female housing units, and 2 of these units are designed for those with acute mental health conditions, those on suicide watches and those in disciplinary or administrative segregation housing. Overall, I found the uses and names for the housing units in the MCDF confusing: there is a "Psychiatric Infirmary (mixed gender) (4D), Acute Mental Close (male) (6B, 6C), "Acute Mental Close/Suicide Watch/Disciplinary/ Ad-Seg (female) (8B) and Suicide Watch / Special Management (female) (8C).

The housing units on floors 5-8 are more spacious than those below, and the lighting is much better on floor 8 than anywhere else in the facility (probably due to skylights). However, staffing challenges are a reality in the units and on these floors. The control room on floor 7 serves also as the control room for floor 8, the ample day rooms on these 4 floors are not fully used, meals are always served through the food doors and in one's cell, and the cell lighting is overall poor, despite every cell having its own window to the outdoors.

In many units, out-of-cell time is very restricted, with 2-4 hours of "walk" time per day, often granted in segments by cell or one tier at a time, with additional recreation time in the protected open-air space on the 10th floor of the MCDC. That open-air recreation is offered by cell or by tier for 90 minutes per week in Mods 4B, 4C, 5C and 6C; and up to 180 minutes per week for other housing areas. Notably, 4D, the mental health unit, 5B, disciplinary and 7B, the medical unit – all with special populations, have no scheduled additional recreation. Units 8B and 5C have additional recreation scheduled only for those who are not serving disciplinary time, not on a suicide watch, not in special housing, or who do not require "walk alones." It appears that some AICs are never given out-of-cell "walk" time, and others get very little "walk" time. On days or on shifts when MCDF staffing is particularly low and units are closed, neither walk nor recreation time is provided. In short, while efforts to provide additional out-of-cell time were made this year, the hours of isolation in the entire MCDC facility are extensive. Eating, sleeping, and just being alone most of the 24 hours per day, every day, is unhealthy by any standard.

Years ago, at the recommendation of another NIC TRP, housing cells were retrofitted to reduce the mode of many jail suicides, e.g.., small hole vents were replaced and so-called breakaway hooks were removed to prevent ligatures being tied to them. However, these retrofits were not made in the showers and the shower areas inside many of the units are not clearly visible to the deputy inside the unit or on duty in the control room. One of the suicides that occurred in 2023 took place in such a shower.

The MCDC does not have "safety" cells or "time out" spaces, there are no cells in the MCDC equipped with working cameras, and in the medical unit, which does not have an officer present at all times and where retrofits are needed in its shower, the gurney-type beds are open to the floor, making hanging from the bed structure a viable method of suicide.

Deputies receive no additional, specialized training to work in specific units such as intake and the mental health units. Importantly, in most units, cell assignments are made by the unit deputy based on availability, not on location, and not on the detainee's assessed need for enhanced surveillance.

MCIJ Housing.
The design of the Inverness facility (MCIJ) is considerably different than that of the MCDC. The MCIJ has been expanded over the years, but it is essentially a single-story complex where housing units are dormitories which line a very long corridor. The dorms are generally characterized by sections of five (5) single bunks clustered inside of low walled surrounds. Every unit is to have at least one deputy assigned to it but there are 14 dorms, 2 with subunits, making round-the-clock staffing challenging. Dorm 6 and Dorm 15 and 15 sub-unit are designated as the MCIJ's acute mental health units. They have 50 and 75 bunks respectively; 11 of those bunks, located in the Dorm 15 sub-unit, are designated for those persons on suicide watches. This sub-unit in effect creates a remotely supervised unit inside of a direct supervision unit. In one cell in the sub-unit, an electrical plug is located right above the sink. When asked about this, I was told the electricity is usually off to that plug, but that someone needing a C-Pap for example, might be housed in this cell. It is of course possible for someone with a C-Pap to commit suicide with that equipment, and anyone can kill themselves with water and electricity. This sub-unit should not be used to house people assessed to be at risk for suicide. A recommendation to immediately stop doing so is made at the end of this report.

The disciplinary unit (17), both a close custody and a medical observation unit, is single celled as are other special needs units. I was told that persons serving disciplinary time in Unit 17 are given 15 minutes to 1 hour of "walk" time on each shift and, depending on staffing, may not always have walk time on the weekends. As in the MCDC, the extent of isolation here is likely deleterious to one's physical and mental health.

As with the MCDC, there is a medical clinic in the MCIJ. It appears to be designed as an infirmary, but it is not used as an infirmary. There is no full-time RN assigned to this 10-bed unit.

System Wide: Out-of-Cell Time.
Overall, in the single cell units in both the MCDC and the MCIJ, it appears that the incarcerated persons in these units are locked down and isolated for extended periods of the day and night. There is significant research evidence that such extensive lockdown periods have deleterious effects on physical and cognitive functioning as isolation itself can worsen the symptoms of physical and mental illnesses and contribute to the development of disruptive behaviors and poor impulse control – expressed commonly in acts of aggression and self-harm.[5]

[5] See, e.g., https://www.prisonpolicy.org/blog/2020/12/08/solitary_symposium/; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7546459/; https://www.vera.org/downloads/publications/the-impacts-of-solitary-confinement.pdf; https://www.nami.org/Blogs/NAMI-Blog/March-2023/How-Solitary-Confinement-Contributes-to-the-Mental-Health-Crisis

Classification. Pre-Trial Services. Programs.
Some members of the MCSO have had training in Objective Jail Classification (OJC), though the thrust of the classifying process seems largely related to assigning a custody level rather than as a review of institutional risk and program needs and suitability, and determination of appropriate housing. The classification of new detainees is done in a personal interview at the time of intake. After the first 48 hours of incarceration the detainee's file is reviewed, and permanent housing is assigned. The reclassification of detainees who have lengthy stays in the MCDF system is accomplished, if ever, via a review of paperwork.

Detainees are either assigned a classification status of "max" or "general." If initially assigned the status "max" – the designation is never reevaluated and changed, despite one's institutional behavior.

There is a cadre of counselors, non-sworn personnel, who work for the MCSO in the jail facilities. While a staff of 15 counselors is sought, there are currently 13 counselors employed, 7 at MCIJ and 6 at MCDC. They provide routine support to the incarcerated persons in the system, facilitate programs, coordinate the work of the chaplains, and they may also work on release planning. They are in cell housing areas daily. If they notice someone who may need mental health services, they make an entry into the JCS with the hope that it will be read by someone from CH. However, they "typically receive no feedback from CH" staff, with CH staff citing "HIPAA concerns." I address this lack of communication in sections below.

The counselors report that there is at least a three (3) month wait for mental health services in the community when an individual is released from the MCDF. There is an urgent care clinic in the Portland area where same day assistance can be had, but it can be used only one time. After being seen in that community clinic, even if a referral is made, a provider visit might not occur for another six (6) months. This service delay no doubt compromises reentry efforts.

Training.
When first hired into the MCSO, new deputies participate in a 2.5-week county training schedule. This training includes a suicide risk identification and risk reduction, an 8-hour course, Crisis Intervention Training (CIT) including de-escalation strategies in a 4-hour block, Use of Force training and Diversity, Equity, and Inclusion (DEI) training. The identification of mental health signs, symptoms, and interventions is <u>not</u> offered at all, and there is reportedly very little specific time spent on identifying and mitigating the introduction of contraband in the jail facilities. Trauma informed care was offered in the past, as late as 2018, but that is no longer the case. Training that integrates trauma-informed behavior management strategies is always advisable for the staff of correctional facilities.

Annual MCSO training is also offered and required of all sworn personnel. In 2023, deputies are scheduled to receive a total of 40.5 hours of training. At present, deputies are paid for off-duty time to complete on-line training. Next year, deputies will have to complete training while on duty. Having to split their attention between performing job tasks and completing training requirements is likely to further accentuate the consequences of an already critical staffing situation. In 2024, required training hours will be reduced to 34 hours for deputies and 38 hours for Sergeants. I note with concern that suicide prevention training will be offered online in a one-hour Lexipol (contracted) segment.

Every deputy is sent to the state law enforcement academy after being on the job for a number of months. This six (6) week course takes a maximum of 12 officers out of the MCDF system during the "off" season; and 4-6 officers during the summer months.

Deputies assigned to intake, the intake-housing unit and to other higher risk units such as the mental health unit, the infirmary, the women's unit, and the disciplinary / segregation units, do not receive additional or specialized training related to supervising and managing higher-risk populations.

Some amount of training is required for all CH and other external and non-sworn personnel working in the detentions system, but there is no system to ensure and document that all those new to the detention systems go through the training.

Suicide Watches. Critical Incidents. Deaths in Custody.
On November 29, there were 4 Active Suicide Watches and 2 Constant Suicide Watches underway in the MCDF system. One of those on a watch had been on this watch for approximately one month. At the time, I asked if there was a formal system to review the case, talk with the AIC, and create a case plan to end the watch and move him out of the unit into general population. There is not a system to do so in the MCDF. I asked also to see this person's EMR and that request was denied. I address the issue of lengthy suicide watches – which take up enormous staff time if not thoughtfully started and strategically ended within a reasonable time – in the recommendations section of this report.

Wanting to explore the procedures for managing persons on suicide watches, I asked for all suicide incident reports written on 3 days of each of 6 months, the 1st, 12th, and 22nd of May through October, 2023. Incident reports are generated only if there is a use of force or placement in a restraint chair, not necessarily when a suicide watch is started. The watch materials I received consist of a summary page of the watches on those dates, and the officers' logs on each person on a watch. Table 1 provides an overall view of the number of people on watches on these chosen dates, their gender and race. A review of relevant EMRs associated with these watches would help explain why someone might be on a watch for 30 days or more, but I was denied access to the EMRs. Race and gender are also important to note in these kinds of explorations. There is a significant body of research related to the intended and unintended, unconscious diagnostic and treatment bias that plays out in mental health practice. Over time, looking at the treatment intervention data vis-à-vis gender and race can help inform training protocols, interventions and practice outcomes.

Table 1. Sample: Suicide Watch Data

Watch Date	Number of Persons & Reports	Gender M=Male; F=Female	Race: W=White; B=Black; A=Asian H=Hispanic; I=Indian; P= Pacific Islander incl/ Hawaiian
05/01/23	6	6 M	2W - 4B
05/12/23	4	4 M	1W – 3B
05/12/23	4	4 M	1W – 3B
06/01/23	3	2F; 1M	1W – 2B
06/12/23	7	1F; 6M	4W – 2B
06/22/23	1	1M	1B
07/01/23	8	8M	4W - 4B
07/12/23	6	6M	6B
07/22/23	6	1F; 5M	1W - 3B - 2H
08/01/23	9	1F; 8M	3W - 7B
08/12/23	7	7M	4W - 1B - 1A
08/22/23	6	1F; 5M	5W - 1B
09/01/23	6	6M	2W - 4B
09/12/23	7	2F; 5M	6W - 1B
09/22/23	4	4M	3W - 1H
10/01/23	6	6M	4W - 1B - 1I
10/12/23	7	7M	3W- 2B - 1H - 1P
10/22/23	6	6M	1W - 3B - 2H

As can be seen in Table 1, on each of the 18 randomly selected days, there was at least one suicide watch in effect (Table 1, above). Browsing through a randomly selected number of these watches, I noted the same names on watch forms during these multiple suicide watch periods. One form listed the day and time the watch started and the day and time the watch was discontinued. There was no notation on any of the official watch forms as to why the watch was started, i.e., a threat or an actual physical attempt of suicide. Some AICs on were left on a suicide watch for 30 or more days. There were no notes to the deputies from the

mental health clinician or provider about what to give the AIC on the watch, and what to withhold. There was also no indication of the signs and symptoms the deputy should be aware of specific to each AIC on a watch, during his/her suicide checks. There were many days when most or all descriptions of the AICs' activities were "sleeping, eating, laying down." There were also few notes that documented the AICs' time out of cell, time to recreation, the condition of the cell, and the demeanor of the AIC being watched. Across the files reviewed, there were few notations of mental health visits, though by policy there is to be a CH visit once every 24 hours while on watch. On forms marked "constant suicide watch" – the notations of the deputies did not differ from the notations about those on "active suicide watch" even though they are different levels of watch which have different requirements of the officer.

My scan of these documents suggests that more than 50% of this sample are on a watch for one-two days. They were housed in different units in the MCDF. I wonder if some of those on watch were placed on the watch because of a flag placed in a prior custody record, rather than because of a clinical interview that assessed current suicide risk.

In-Custody Deaths; Investigation and Debriefing Procedures.

As mentioned earlier, in the last two years there have been a total of 10 deaths in the MCDF system. I did not review any documents related to the specific persons and their deaths. I did ask for certain objective data about these deaths as they are part of the total jail system and data have the potential to yield a small but meaningful perspective when looking at the complexities of jail operations. I received data on 9 of the 10 deaths. Two of the 3 deaths in 2022 occurred in the MCDC, 1 in reception and 1 in housing. The third person, booked into jail at the MCDC, died at the hospital. Among the 7 deaths in 2023, 3 occurred in the MCIJ and 4 in the MCDC.

The three deaths in 2022 occurred in May, July and November. The seven deaths in 2023 occurred in May (2 deaths, 11 days apart), June (2 deaths, 5 days apart), July and August (2 deaths, 12 days apart) and October. The timing of these deaths lends support to the need for this (and all) jail systems to increase the frequency of security checks during at minimum, the first two weeks after the event. Death commonly moves people to think about their own mortality. There is no reason to believe that incarcerated people would not do the same, thus the need for heightened awareness, i.e. checks, during the period immediately following a death in custody.

I do not know how long each of the deceased was in custody prior to their death, nor do I know the age of the deceased, but the toxicology findings on every one of the 9 persons whose data I reviewed, revealed drugs in their system. Primary among those drugs was Fentanyl, which appeared in four of the autopsy reports, but there was often a mix of prescription drugs (some of which have a high "street" value in jails and on the street, such as the antidepressants Bupropion (Wellbutrin), Celexa, Lexapro, Prozac, and Trazadone; and antipsychotics such as Zyprexa and Seroquel, and non-prescription street drugs (meth, cocaine, hydroxyzine (an antihistamine) amphetamines, cough suppressants with codeine, and cannabis). Two deaths, both suicides but with cause of death ruled to be something other than ingestion of substances, revealed the presence of only one (Gabapentin) or two similar (Wellbutrin) prescribed medications.

These toxicology findings are especially important to consider and should spur a full review of prescriptive practices in the jail system. Certain antidepressants and antipsychotics are so common in jail bartering that some facilities no longer list them on their drug formularies and in fact, outright ban their use. Some of those types of medications are also highly lethal in small quantities. In total, they are generally all medications that when hoarded, create a serious risk of intentional and unintentional overdose, and death.[6]

[6] It is challenging to find robust research literature about concerns of misuse of prescription medications in correctional facilities. There are many reasons why resistance to talking about these concerns exist, thus in addition to these citations – which include research, opinion, and news articles - informal dialogue about prescriptive practices with other jails and corrections' agencies in Oregon and around the country, are encouraged. See, for a glimpse of the investigations

The increase in deaths in 2023 and the fact that at least 9 of the 10 persons who died in custody in the last 2 years had ingested one or more substances, should raise an alarm for the MCSO, and immediate measures should be taken to reduce access to unnecessary and/or dangerous drugs either through prescriptive means or through an attack on the introduction of contraband. Depending on the timing of these deaths, i.e., how long each person was in custody before the death, one must question how the drugs in their systems were obtained. If not by prescription, by whom and by what means? I understand that contraband has been introduced into the system through the mail. It is also likely that staff are introducing contraband into this system.

At the exit briefing and again in this report, I suggested that the MCSO should brace itself for additional deaths in custody. My review of the very limited data about these deaths reinforces my concern that there will be additional deaths, and especially so if security and prescriptive practices are not updated thoughtfully and quickly. Recommendations for reviewing both security (heightened watches) and the prescriptive practices (commonly abused medications) in the MCDF are given in the final section of this report.

After a death in the MCDF system, an investigation and debriefing take place. This is true for both the MCSO and the CH, though apart from the initial review of the critical incident, those processes are generally managed separately. When there is a critical incident in the MCDF, I understand that as part of the psychological autopsy everything in the person's custody record for the prior six years, including grievances, is reviewed. The health record is only reviewed by CH.

The MCSO also contracts with a local agency to assist with a critical incident debriefing (CID) process. Personnel from the MCSO and from CH may participate in this process.

Security Practices.
At the outset of this brief section, I acknowledge that I am not an expert in security procedures. However, I share here several observations about the MCDF security practices as they may impact suicide and death risk reduction and mental health interdiction efforts in the detention centers.

When I entered the secure confines of the MDCD for the first time and every time thereafter, I was not once asked for identification, I was not asked to walk through a security scanner, my backpack was never searched, and not one deputy asked me what I was doing in the jail before I introduced myself and my purpose there. It would be easy to say this might be because I was accompanied by jail command staff when in the secure areas. As it turns out, I saw many people walk in and out of the secure areas of the jails without being stopped, without their bags being searched, without walking through a metal detector, etc. I watched countless CH staff do so. I also watched deputies do the same.

Particularly when looking at the toxicology reports of the deaths that have occurred in the MCDF system, the likelihood of contraband being introduced into the jails by staff cannot be underestimated. It is a reality in many detention systems.

Further, as I witnessed and later reviewed the amount of lockdown that occurs in the MCDC, not only is the isolation that results from lockdown detrimental to one's mental and physical health, it also sends a message of fear. Especially for people struggling with mental illness and significant depression, which is isolating in

currently in the literature, the following sites: https://www.capl-acpd.org/wp-content/uploads/2020/03/CAPL-Rx-Guide-Corrections-FIN-EN-Web.pdf; https://pubmed.ncbi.nlm.nih.gov/23233472/; https://www.ccjm.org/content/88/5/286; https://www.mercurynews.com/2009/04/05/santa-clara-county-jails-cut-off-prescription-drug-pipeline/; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10104426/#:~:text=There%20are%20also%20reports%20of,or%20insufflated%20nasally%20%5B19%5D;

and of itself, fear can be debilitating and provoke feelings of helplessness and hopelessness, feelings long associated with suicide.

It seems important that the MCSO consider the reason(s) for the extensive lock down in both detention centers: why the day room spaces are not being used to their fullest, why meals must be eaten in isolation, and why walk times are in some cases, limited to two cells or a tier at a time. I wonder if the people – staff and incarcerated alike – in this secure facility actually feel safe, feel assured of back up, and know the people around them? If not, how might that be affecting the delivery of health and mental health, recreation, inmate classification, and educational services? And, how might those factors be impacting suicide behavior in the system?

V. HEATH, BEHAVIORAL HEALTH and RELATED SERVICES

A. HEALTH SERVICES. STAFFING. SCREENING. CARE. MEDICATIONS.

The shared mission of the Sheriff's Office and of the County Public Health Department through Corrections Health (CH), is an ideal point of partnership. The population served by both agencies is often the same: people who are poor and socially and politically marginalized, under or uninsured, who present with histories of trauma, and who may be members of race, culture, and/or economically disadvantaged groups. These are people who may fare poorly when assessed along the touchstones of the Social Determinations of Health (SDH) and the markers of trauma measured by Adverse Childhood Experiences.[7] In Multnomah County and arguably in every county across the country, having a mission to serve nearly (not entirely) identical populations and each being governmental agencies should easily translate to a mission driven commitment in the jail environment. And in fact, when interviewing both detentions and CH personnel in Multnomah County, I heard a lot about their embracing the same mission: Safety, security, good practices, quality of care. These are the values and goals that drive each system and there is always work to do to ensure policies and protocols are designed to move the total system along those common lines.

While both the Sheriff's Office and the Health Department are county funded agencies, the heads of both departments report separately to the county. In practice, this arrangement has the logical but unfortunate consequence of creating operational and informational silos when what is most needed is a spirit of cooperation and plan of action marked by recognition of the interdependence of their roles. There are many examples of how this siloed system plays out in suboptimal ways in Multnomah County: in the one-way communications pattern - where corrections provides health and behavioral information on those in custody to CH, but CH shares almost no information with the MCSO and its staff, even in matters of life and death in the jail facilities; and in the reporting of data, when only at the request of the Sheriff's administrative staff is information shared about the number of detainees being served.

While CH plans to offer services delivered by health/behavioral health staff consisting of physicians, registered nurses, mid-level providers, dentists, psychiatrists, psychiatric fellows, and a cadre of master's level clinical providers, it currently operates, in the words of its Medical Director, as "nurse heavy." This term was used by the Medical Director to summarize CH's approach to delivering total health care in this detention system.

Access To Heath/Mental Health Care

At the MCDF, as in all correctional settings, access to care begins at intake. The MCDF system provides access to CH care through written requests from detainees, the use of the call button in their cells, or verbally, during interactions with staff. Incarcerated persons must rely on the staff of the detention facility for both routine and emergency health/behavioral health services. The power of staff to grant or deny access to services is relevant to the heightened legal and ethical standards of care that must be exercised in detentions.

CH Staffing

Adequate health staffing is necessary to fulfill the promise of access to health care, and for the delivery of safe and effective total person health care. Detention systems often struggle to hire and retain staff, in part because staff must undergo and then pass certain law enforcement standards for working in the system, in part because the jobs of clinical staff are demanding and stressful, and in part because the jail environment is unlike that of other healthcare settings. Certainly, the COVID pandemic made hiring and retaining staff more challenging in Multnomah County, but even in its aftermath, staffing challenges for corrections-based work continue. Consequently, nurses are working a lot of overtime in the MC jails; there are currently a number of vacancies in nursing – filled by both overtime and contract staff, there are no internal medicine and

[7]Respectively, https://health.gov/healthypeople/priority-areas/social-determinants-health; and https://www.cdc.gov/violenceprevention/aces/index.html

psychiatric physicians working in the jails at this time, and there are vacancies in clinical-behavioral staff (see the following section).

Registered Nurses (RNs) are on duty in the MCDF system round-the-clock and there are two (2) RNs posted to the intake section of the MCDC on every shift. RNs are the primary providers of health services: they complete the intake health screening, they respond to health and mental health emergencies, they confirm and ensure prescribed medications are ordered and administered, respond to grievances, serve as first (and sometimes the only) responders to crises, and monitor incarcerated persons when placed in restraints and when housed in the medical housing areas.

Curiously, the medical offices are located on the 4th floor of the MCDC and the mental health offices are located on the 2nd floor of an adjacent building – not in the MCDC at all. The physical separation of health care staff is often counterproductive: In the jail setting, as in any inter- and multi-disciplinary operation, physical proximity builds the capacity for good communications, collective problem solving, and constructive planning.

Health Intake

One of the most critical health positions in the jail is in the facility's intake unit. In the Multnomah system, all detainees are initially processed at the MCDC facility and their initial contact with the medical staff generally occurs shortly after their admission. As is the expectation of all detention centers, in the MCDC, certain key activities occur at intake, where access to health/behavioral health care begins. Health screening by an RN generally takes place within hours of a detainee's entry into the system though there are exceptions, particularly when a detainee is uncooperative. On average, between 10-25 intake health screenings are completed during each 8-hour shift.

The screening nurse sits in one of the four medical interview spaces that are separated by side partitions. These are not areas that afford privacy. After obtaining a new detainee's consent, I watched a health screening process completed by the RN who on that day, was working an overtime shift. Even though the nurse spoke quietly and calmly, her questions and the detainee's answers could be heard in the two adjacent medical screening spaces

The initial health screening, or "General Medical Screen" used by CH, has both subjective and objective assessment elements which yield information about an individual's physical and mental health and cognitive status shortly after admission. In terms of mental health information, detainees are asked if they have a "mental health diagnosis," "a history of mental health treatment, past medications, or psychiatric hospitalization," a "history of suicide attempts," whether the detainee is "thinking about killing one's self," whether they want "mental health to check in with you while … here," and whether this is the person's "first incarceration." The nurse then notes whether there is "collateral information" that suggests a risk for suicide, whether the "client" expressed "extreme shame, guilt, humiliation or hopelessness," and whether the detainee "appears to have significant mental health and/or coping concerns." On the basis of these questions the nurse determines whether a suicide watch will be started. The initiation or not of a suicide watch also appears to be related to "flags" active on this health screen.

Finally, the nurse records her behavioral observations, for example, the detainee's level of consciousness, appearance, eye contact, mental status (limited to orientation and affect), breathing, and gait, on the initial screening form. The nurse ultimately writes a brief summary, codifies her/his assessment in accord with the diagnoses found in the International Classification of Diseases 10 (ICD 10) and creates a treatment plan. At the same time, the detainee is given information about how to access care while incarcerated. Housing recommendations can be made if the detainee's condition suggests special housing is advisable, but the final decision on housing rests with the MCDC classification and security staff.

Many correctional institutions around the country now use a universal, multi-agency release of information form (ROI) so that need-to-know information can be exchanged between health services and corrections and other agencies that may have provided or will provide the detainee with health services at release. The CH does not use this kind of ROI and instead assumes the position that the detainee/AIC's health information is private and totally confidential, even in the case of suicide risk and risks of physical and mental health decompensation. This stance is inconsistent with good health practice in a corrections agency, it is contrary to the NCCHC's instructions,[8] and it literally places every detainee who enters into this system in a position of jeopardy. I have already provided CH and MCSO officials with sample multi-agency ROIs and documents that support their use as being compliant with HIPAA standards. I address this further in the conclusions and recommendations sections of this report.

14 Day Health Assessment

The NCCHC requires a full health evaluation within the first 14 days of incarceration. Although I have provided technical assistance in many NCCHC accredited jails over the last 35 years and given access to health records, I requested but was not given the opportunity to review CH EMRs and 14-day Health Assessments. I am unsure whether the CH's 14-day assessment is different from the other health assessments that are done. Any symptoms of mental illness, suicide ideation, and substance abuse requires a focused evaluation by a provider who has special training in the area. In the MCDF system, this should be the mental health professionals. I do not see reference to a 14-day evaluation by either health or mental health staff in the documents I have reviewed. I also was unable to substantiate a formal role for the CH mental health clinicians in participating in a 14-day evaluation process.[9] This is a gap in services that can have significant consequences.

Sick Call; Medication Administration; Emergency Reponses; Payment for Services.

When admitted to the MCDC, if the detainee reports taking medication, attempts are made to verify and initiate the medication(s), and the detainee will be scheduled for sick call. I did not witness or evaluate a formal nursing or medical sick call during my visit to Multnomah County. Sick calls are important performance markers and data points (especially with regard to backlogs for nursing and physician sick calls) that should be shared at minimum, at every quarterly meeting (see, NCCHC standard J-A-04) between MCDF and CH administrators. I also did not view a medication pass in the housing units, though I inquired about medication administration times and procedures especially in the MCDC. Medication rounds in the housing units seem to happen at least five times per day; I was told that they begin at 0100, 0500, 0630, 1300, and 2100.

Though requested, I was not provided information about how many incarcerated people receive daily medications, the number of people prescribed psychiatric medications and the types of psychiatric medications prescribed, and the number of medications being administered on a daily basis. Medications are administered in the housing units at both detention facilities. In the MCDC, the nurse or trained certified medical assistant (CMA) enters each housing unit with medications and is assisted by a deputy during the pill call process. Either the deputy calls for a pill line, where those expecting medications line up and approach the nurse for their medications, or the nurse gives the medications to the incarcerated person through the

[8] For example, in its helpful "frequent questions" online @ www.NCCHC.org, this was underscored: "The right to confidentiality is not absolute and may be breached when there's risk of serious injury or death to the patient, other inmates or staff. … often state laws or regulations govern confidentiality of health information and the circumstances under which disclosure of certain information is permitted." … "Most disciplines, including those affiliated with mental health, also require that such specific information be taken to the appropriate authority. Finally, it is good practice for the mental health clinician to tell the patient in their first encounter that certain issues cannot be kept confidential: "If you tell me that you are going to harm or kill yourself or someone else, or engage in behavior that jeopardizes the safety or security of the facility, I will need to tell the appropriate authorities." *From CorrectCare Volume 17, Issue 1, Winter 2003*

[9] The National Institute on Correctional Health Care (NCCHC) recently awarded accreditation to CH after a period of probation assigned when CH did not meet 13 of the NCCHC's essential standards and 5 of its applicable "important" standards in 2021.[9]

cell's food/trap door. It is easy to "cheek" medications when they are administered from a trap door, even if the AIC is told to drink water after putting the medication in his/her mouth. Asked about their knowledge of the extent of hoarding and trading of medications, CH does not believe this is a major problem, though occasionally medications are found during shakedowns.

I did not have access to CH provider sick call lists and other documents that track the on-site availability of physicians and mid-level providers, time between referrals and being seen by a provider or clinician, and the number of rescheduled appointments with providers and clinical staff, but in both the physical and psychiatric realms of health services provided, the jails are either understaffed or staff is deployed in ways that do not maximize their time and skills. At present, incarcerated persons must wait up to 10 days to have contact with a mental health clinician, and three weeks or more to see a prescriptive provider, thus I am inclined to believe that it is the latter, deployment of staff, which is a matter of policy and protocols, that is the culprit. I speak to this and provide more information about the type and extent of psychiatric services offered, in the section that follows.

Chronic Care

As a matter of NCCHC essential standards (J-F-01) and good health policy, in corrections' settings, chronic care conditions are to be identified and managed (i.e., through protocols that would include periodic blood tests and screening in specialty clinics) on a regular basis. Chronic care is not limited to physical conditions; indeed, substance use disorders (SUD) and serious mental illness (SMI) are also considered as chronic care conditions.[10] The CH team reported that there are no formal chronic care services offered in the MDCF to persons with these conditions.[11]

Medication and Pharmacy Services

I requested but was not given access to the Medication Administration Records (MARs) while on site in Multnomah County. Reviewing the MARs can provide a birds-eye view of the health of the institution, and it can highlight problems with medication compliance, the overuse of certain medications, and the housing areas where medications may be abused (traded, sold, or hoarded). Continual reviews of the MARs can also provide a rough point-in-time estimate of the number of people in the jail system who may have a mental illness or who are withdrawing from substance(s).

The County uses its own pharmacy contract to provide all the medications prescribed in the detention centers, and I was told that medication options are not excluded simply as a matter of cost.

Individuals on medications who are released from custody, when their release date is known, are provided 90 days of medications, obtainable in part (30-day supply) at discharge with the remainder obtainable by prescriptions already written.

Withdrawal and Detox Care

This is an important area of correctional and corrections health services. Aside from learning about the MCSO's efforts to improve the use of its body scanning equipment to find concealed drugs and other contraband especially at the time of intake, and the widespread use of Narcan in the MCDC, the protocols for withdrawal and detox care were beyond the scope of this report. I noted earlier that autopsies of 9 of the

[10] Standard F-01 of NCCHC's 2018 Health Standards indicates that Chronic Disease Services and Other Special Needs includes categories of major mental illnesses, including mood disorders and psychotic disorders. (see https://www.ncchc.org/2018-standards-for-health-services-whats-new/)

[11] https://www.ncchc.org/q-a/chronic-disease-services/

Standard F-01 Patients with Chronic Disease Services and Other Special Needs includes major mental illnesses; therefore, the responsible physician should establish and annually approve clinical protocols consistent with national clinical practice guidelines for management of major mental illnesses (Compliance Indicators 2 and 3).

10 deaths that have occurred in the MCDF since 2022 revealed some level of (street and prescription) drug(s) ingestion.

Access to Care
The CH, consistent with its NCCHC's accreditation as the MCDF's health care provider, is responsible for identifying and eliminating unreasonable barriers to care (J-A-01). The 2021 NCCHC report notes that "the facility does not have a co-payment for health services." Indeed, a Medical Request Form dated 8/12/21 (sent to me in a file entitled "Screening Information Content-Part 5") that detainees must fill out when reporting a health concern, reads: "You will not be charged for any care or treatment provided by Corrections Health (including) Medical care, mental health care, and dental care and also outside appointments scheduled by Corrections Health." However, another version of the Medical Request Form dated 5/31/18 (sent to me in a separate file entitled "Medical Request Form") reads "you will only be charged if your evaluation results in an on-site Corrections Health doctor/dentist/nurse practitioner visit." This contradiction needs to be resolved. If one form and policy no longer applies, it should be removed from the system.

CH Staff Training
Maintaining a well-trained health care workforce is essential in any setting but especially so in the detentions' world where health and mental health care is delivered by what I refer to as "invited guests," those invited by the host to offer their knowledge, skills, and expertise to further the host's objectives. These invited guests are, by education, licensure, and ethical standards, defined by a mission usually pursued in a primary health care setting. While it may feel at times that health care is the driver of the detention's world, their mission is importantly interdependent with that of custody staff, who work for the host and in this joint venture, one cannot be successful without the other.

The CH policy statement on training of CH staff reads "staff should receive initial suicide prevention training upon hire and a refresher annually at minimum. The specific training offered and timelines for completion may vary based on availability. All MHCs should receive annual, clinically focused training on suicide prevention in addition to the all-staff training." I am unable to tell from this policy – because it is not documented in the policy - whether CH arranges for training, whether and how the training is determined to be appropriate, and how such training is reported, documented, tracked, and evaluated. Further, clinical staff, including the nurses who are working in this "nurse heavy" environment, should receive training in delivering evidence-supported crisis intervention and mental health care services to the incarcerated population.

I note that the 2021 NCCHC accreditation report indicates that correctional officers receive training about "signs and symptoms of mental illness" at least every two years. The training unit at the MCDC told me that it does not offer any such mental health training to its officers on either an annual or bi-annual basis. This is an essential NCCHC standard (J-C-04-3f); I do not understand how this important standard was missed by the NCCHC auditors even if, as recorded, the CH Health Administrator approved the corrections training program on August 26, 2021.[12]

B. MENTAL/BEHAVIORAL HEALTH POPULATION, STAFFING & ASSIGNMENTS. SCREENINGS & CLINICAL SERVICES.

The Population with Mental Health Conditions & Needs
When looking at recent population demographics across the country and certainly in Multnomah County, certain dangers lurk. Notable among those dangers are the increasing numbers of people booked into the jail who are identified as having significant health, mental health and substance use challenges, and their suspected increased average lengths of stay when compared to those who are incarcerated but who do not

[12] The training the CH Health Administrator was referring to may have been the initial training that all new deputies receive before they begin work in the detention facilities. That is the only time mental health training is given and the curriculum, which I reviewed, is insufficient.

have similar types of mental health challenges. For many people incarcerated in the MCDF, their earliest and arguably most significant encounter with the jail system happens soon after their arrest, at a moment when they are at high risk that those health, mental health, and/or substance use challenges will be exacerbated.

Although I received some information about the number of provider and clinician visits by month, more detail is needed about those visits to be useful. For example, I asked how many detainees currently incarcerated in the MCDF system have an acute or chronic (SMI; SPMI) mental illness, and no CH (and no MCDF) person had an answer. I asked about the percentage of the total jail population being seen by a mental health provider (a clinician and/or someone with prescriptive authority). Again, no one had the answer to this question. Not knowing these very fundamental data points, upon which programs are usually developed and evaluated, is surprising. The collection and analysis of these kind of data can lend support to the CH's goal to provide comprehensive care in the jails, and also can and should be used to set the narrative for the larger Multnomah County community, who very well may not understand the myriad and extent of challenges facing both the MCSO and CH.

I used one data source to generate a very rough idea of the numbers of persons perceived to have a mental health need in the MCDF system as of November 30, 2023. This is admittedly an entirely inadequate, rudimentary attempt to put numbers on the table for the MCSO's consideration. Table 2, Appendix C, is a detailed unit-by-unit look at the numbers of the persons housed in each unit of the MCDC and MCIJ, the number of those persons in each unit whose record contains some (undefined) mental health markers, such as a flag, a code, a level of acuity, and/or an assigned custody designation. Table 2a, below, provides a summary of the data.

Table 2a. Summary: Classification Data (717 List)

Total Pop MCDC 385	Total Mental Health (MH) 159	Classification of MH Pop TOTAL MAX 94 TOTAL GEN 67 TOTAL "MH" CODE 154 TOTAL UNK 1	Custody Level / Housing TOTAL ACUTE MC 40 TOTAL MC 44 TOTAL PSYCH 2 TOTAL CLOSE 18 TOTAL DISC 12 TOTAL AD SEG 12 TOTAL GEN 7 TOTAL TRANS 2 TOTAL PC VULNBLE 1 BLANK 1
Total Pop MCIJ 512 TOTAL 428 @ MCIJ 78 @ MTSI 6 @ UNKN	 122 TOTAL 117 TOTAL 5 0	 TOTAL MAX 91 TOTAL GEN 57 TOTAL "MH" CODE 81 TOTAL UNK	 TOTAL ACUTE MC 0 TOTAL MC 40 TOTAL PSYCH 0 TOTAL MC 44 TOTAL DISC 7 TOTAL AD SEG 0 TOTAL GEN 0 TOTAL TRANS 5 TOTAL PC VULNBLE 1 BLANK 5

My analysis revealed the following. On November 30, 2023, 159 persons or 41% of the MCDC population, and 122 persons or 24% of the MCIJ population had some sort of mental health designation attached to it. In the total MCDF system, of the 897 persons incarcerated, 281 or 31% of the population was identified by a mental health custody-related code. Those with codes that included the words "acute" "mental close" "psych" and "close," when added together, comprised 67% (188 persons) of all those with a mental health code of any sort. Most (84% or 235 persons) with one of these codes also had a "flag" for mental health on their booking or classification record. My understanding is that these flags are unreliable. It is possible that a

flag was attached to a person during prior incarcerations and never reevaluated and updated or removed. Without a more exacting and regulated flag system, it is an unreliable data measure and any conclusions relying on these codes lack validity.

The 31% figure, based on the housing classification assigned, may be a more useful one. It is certainly within the range of likely percentages when one looks at the number of persons in detention systems nationwide who present with some heightened level of mental health needs. It is a helpful percentage to use to debunk the notion that 100% of the jail population has a significant mental health condition, and it can be helpful in the deployment of available custody and mental health staff. Where should staff attention be maximized? The simple answer: In those housing units where acuity is the greatest and in the receiving area of the MCDC. Then, the questions are, in part: What, if anything, can be done about housing that would help manage this population? What could be done with this population that would help meet housing needs? Consolidate units? Increase staff in these units? Increase the services delivered in these units? Streamline services and treatment tasks?

More work must be done to determine whether this 31% is at all accurate. Looking at the medication records is one source of data and is not just data about population numbers, but also about prescriptive practices. Point-in-time sampling can also provide estimates of defined segments of the population. Data mining and triangulation of findings is likely to give a much better idea of the actual numbers of AICs that have a certain level of mental instability and where they are clustered in the MCDF. Ideas for these methods and recommendations for sharing data and more, are provided at the end of this report.

Policies

The CH *Mental Health Services* policy, revised last in April 2023, speaks to a variety of services offered to incarcerated persons in the MCDF system, including making housing recommendations, delivering "basic mental health services" which are "clinically indicated," treating dual diagnosis and chronic disease conditions, and providing crisis intervention services. In a list of "outpatient services," individual and group counseling are listed, as is coordination of "mental health, medical and substance abuse services" through informal discussions and multidisciplinary team meetings.

In this "nurse heavy" system, however, the RN staff are the primary evaluators and first responders to mental health needs at intake, in screenings/assessments, and in response to staff when an "urgent mental health need" is identified and mental health staff are not available. There is no official on call system for accessing a mental health professional. Nurses and medical staff are the only staff who officially provide on call availability.

As to the CH suicide prevention policy (revised May, 2023), protocols call for the prompt evaluation of suicidal persons, the development of treatment plans, clinical follow-up and monitoring by facility staff. The CH suicide prevention policy does not reference the MCSO's suicide prevention policy and should. Anyone can initiate a suicide watch, and mental health staff can direct the level of watch (active or constant) and are the only ones authorized to reduce the level of or discontinue a suicide watch. Persons on constant suicide watch (CSW) who are by policy under the continuous supervision of a deputy, are seen at least once every 24 hours, but it is not clear whether this follow-up is done by a mental health consultant (MHC) or by someone else at the direction of the MHC. In the case of those on active suicide watches (ASW), the same is true except the clinical follow-up may be accomplished as little as once every seven (7) days.

Intake Process & Intake, 14-Day, and Mid-Stay Screenings

As noted earlier, when first transported to the MCDC, detainees enter the booking area and the law enforcement officer who has escorted the detainee is asked to report certain known information and impressions about the detainee's physical and mental health condition. In addition, the intake deputies ask detainees questions about their recent ingestion of drugs and alcohol, thoughts of self-harm, and mental and

physical health status. While mental health staff have access to these documents, how they inform clinical action and judgment is unknown.

Notably, while refusing admission for acute medical conditions at least until the detainee is seen in a local emergency department (ED), the MCDF does not generally refuse admission of detainees suffering from what may be an acute mental health crisis or drug ingestion.

It appears that the "Columbia Suicide Severity Rating (LR Screener)" assessment tool is used to screen some but not all persons detained in the MCDF system, but I see no reference in the policies and protocols of it being used for persons thought to be at risk for self-harm at some point during their incarceration. In addition, it is unclear whether the CH is using the version of this tool that has been validated with the correctional population. A copy of this screening tool is found in Appendix D of this report. There are other excellent validated screening tools available as well. One source for this is the National Institute of Justice; the other is the NCCHC, who collaborated with the American Foundation for Suicide Prevention to produce a corrections specific strategy to reduce institutional deaths. This is recommended to both CH and MCSO personnel and could be helpful in future training.[13]

When deemed necessary, an intake nurse can make a referral for a CH mental health consultation using the "MCDC Mental Health Referral Form." This form is used for CH staff referrals no matter where they originate in the MCDF system. A note at the top of the form reads "*This form is to be used for MHC referrals** -MHCs provide behavioral health assessment, safety planning, and verbal therapy. -MHPs do not prescribe or directly connect AICs to medications."* I do not know why this italicized language is included on this form. At the bottom of the form, the referring CH person must indicate the detainee's "Acuity" level, presumably to be used as an aid in the triage process.

There is no formal feedback system built into this referral process. The person referred may or may not be seen in a timely manner. I was present in intake when a very loud, nonsensical male detainee, in a single holding cell with the cell window covered by a heavy "curtain," and pounding on the cell door, came to my attention. This new detainee had been in this side cell for more than three (3) hours. The classification staff talked with him briefly. The nurse had neither talked with him nor examined him from a verbal or observational point of view. Three hours prior, she had sent a referral to mental health staff who have 24 hours to triage requests but may not actually see him at all. Though CH administrators denied this, the nurse informed me that if mental health did not respond within 24 hours, this detainee would be sent to a hospital emergency department (ED) for an evaluation. Even if mental health triages this individual on paper, I was told it could be 10 days before he is seen; and perhaps longer. By any standard this is simply not in keeping with best practices. I address the triage process, what constitutes "adequate" time-to-be-seen, and options to manage these types of intakes and similar referrals, in the recommendations found at the end of this report.

When the CH mental health staff see detainees for the first time, a "Mental Health Screen, Initial Visit" is completed. It is a substantial form which begins with a recap of entries into the JCS (the jail information system) – which appears to be the mental health record to date. There are sections for recording subjective, historical, and objective impressions, as well as psychiatric history (trauma, mediation and substance use history), mental status, a concluding "assessment" summary which includes provisional diagnosis(es), suicide risk assessment, and risk of harm to others assessment. At the end, a plan is devised – the elements of which appear to be generated from a drop-down list. If the detainee is on a suicide watch, a "Mental Health Screen, Suicide Watch" form is completed. This form reviews the incarcerated person's signs and symptoms, the impressions of the interviewer, and a plan for moving forward. It is a lengthy form, more akin to what might be used in psychiatric settings than in correctional settings.

[13] https://www.ncchc.org/wp-content/uploads/Suicide_Prevention_Resource_Guide.pdf

As to the timing of additional clinical visits with mental health staff, the CH procedures read: "MHCs and MH leadership direct the timeliness of risk assessment and treatment as needed" and that other staff "do not directly assign the timing of interventions." This is just not workable in a jail – where the crisis-prone milieu demands immediate responses from staff that are competent to know what to do, when, and with whom.

Other areas of practice protocols are also unhelpful. If a person is placed on a suicide watch, the policy is that they should be seen "promptly" and "by the next day at the latest…" These are really two different instructions. When a person is placed on a suicide watch, it means there is some urgency for clinical attention and "next day" is too far off. For some reason, the procedures also read that the incarcerated person should not be seen "more than once per day" unless being seen pending release. I cannot think of a rationale for this limitation on clinical judgement. Further, persons on constant suicide watch (CSW) are to be seen at least every 24 hours by a mental health professional (per NCCHC standards); but those on CSW and those on active suicide watch (ASW) "who are suicidal, or expressing suicidal ideation, will typically be seen once a day outside of unavoidable/unexpected coverage issues." And, those on ASW who are deemed not actively suicidal but who are not removed from the ASW because they will not agree to a safety plan, may be seen 2, 3 or 5 times per week. What could possibly override daily reevaluation of someone on a suicide watch of any sort? Again, there is no clinical justification for these protocols. CH's suicide response procedures, in short, are not necessarily clinically informed ones.

Staffing - Clinical Services - Behavioral Health Care

CH Staffing

Understanding the CH mental health staffing levels is challenging, but the one point on which everyone agrees is that in the MCDF system they are short of their desired number and of type of staff. There is currently no on-site psychiatrist providing services in the MCDF system. There is a full-time psychiatric nurse practitioner (PNP) working in the MCDC and a .75 PNP in the MCIJ facility. There are psychiatric Fellows present in the jails who provide evaluation and prescriptive services during their 5-6 month rotations. I am not sure who provides supervision to these Fellows. CH reported having 6 filled FTE clinical positions in the MCDC and 3 FTE positions in the MCIJ. It appears from the CH's mental health team report that many of the clinical positions are less than full time. This likely has a bearing on assigning specific responsibilities to clinical staff and on measuring productivity and accountability.

Reports of inadequate numbers of CH health and mental health staff have emerged over at least the last several years. Most recently, in September 2023, the annual inspection of the MCDF system by the Corrections Grand Jury (CGJ) revealed concerns about the CH staffing levels. As to mental health, the CGJ also found "a shortage" of mental health staff and recommended "a study be conducted examining the emerging acute mental and acute physical health needs" of the jail population.

Notably, there are no psychiatric nurses and clinical psychologists on the CH staff, nor are there discharge planners, peer-support workers, or case managers, though a yet-to-be defined case manager position is currently being filled.

There used to be mental health coverage overnight; now it is a struggle to have sufficient evening and weekend coverage. Deputies with whom I spoke commented on the especially difficult absence of clinical staff during the swing shift. As noted earlier, there is no formal on call system for mental health crises. The nurses are the first responders and often the decision makers and while they may informally call a CH mental health manager for input, there is not a documented procedure – by policy or practice – for consultation.

Treatment Services

The COVID years took its toll in the MCDF system by altering where and how and how much clinical work is done. CH and MCSO staff agreed that even when the total detentions' population decreased during the COVID years, the population of those with significant mental health challenges remained the same and likely has increased in the last two years.

Neither the CH staff nor the detentions staff would or perhaps could provide actual or estimated data of the number of incarcerated persons presenting a mental health condition requiring staff attention. As noted earlier, there has been no effort to identify the number of people (or percentage of the whole population) who have a Serious Mental Illness (SMI), a Serious and Persistent Mental Illness (SPMI),[14] a Substance Use Disorder, a Co-occurring Disorder, and a Developmental Disorder. Further, while the average length of stay (LOS) in the MCDF system has doubled in recent years to 20 days (the median LOS is 3.5 days), what the LOS looks like among persons with mental illness remains unknown. I address this in the recommendations section of this report.

As to suicide and self-injurious behaviors, it appears that there are no analyses of the relationship between those behaviors and the presence of a diagnosable mental health/substance use condition. While most people in society with mental illness do not die from suicide, "(M)ost suicides are related to psychiatric disease, with depression, substance use disorders and psychosis being the most relevant risk factors",[15] making these kinds of relationships in jails particularly important to understand. That understanding helps shape housing designations and assignments, deployment of staff and triage and treatment priorities.

As mentioned earlier in this report, detainees coming into the MCDC who present with signs of a significant mental illness, should be but are not refused admission pending an evaluation in a hospital or crisis center. This is an important albeit difficult-to-initiate best practice and recommendations are made toward this end.

The mental health staff have little unobstructed contact with the incarcerated population. I am unaware whether this is a matter of choice or policy. It may well be due to not feeling safe in the housing units. On rounds of the mental health units, the mental health professionals generally check in on the persons on watches and in on all persons housed in 4D by interviewing them from outside of the cell doors. Sometimes the food trap doors are open, but often not. The cell doors have windows that are often difficult to see through, either because of items hanging from the windows or smudging of the window from the inside. In only doing these cell-side interviews, privacy is compromised (e.g., the question "Are you thinking of suicide" is asked of each person and the answers are easily overheard by others in the unit) and the mental health professional is unable to fully and adequately appraise the behavioral cues that often signal the presence or emergence of a significant mental health condition (depression, mania, schizophrenia, anxiety, etc.).

I accompanied mental health clinicians on two separate rounds in the MCDC. Communicating through the heavy steel doors was very difficult – with no privacy at all. In some cases, the AIC was asked if they were ready to leave the unit, no longer suicidal. If the AIC said no, there was no further discussion about the purpose of the unit and the need for the AIC to be transferred. Suicide risk assessments were incomplete in that some important assessment questions were not asked, and behavioral assessments were impossible to do. However, the critical question "Are you thinking about suicide now" was always asked and the demeanor of the mental health clinician was calm, respectful and professional. When done with rounds in both cases, the clinician left the unit without talking with the deputy assigned to it except to say whether the person would continue on suicide watch or not.

Prescriptive Practices and Consequences

Not having data on the number of incarcerated persons in the MCDF system who are prescribed psychotropic medications, given the extent of mental health problems described by staff, the closure of state hospitals and the capacity of community health systems in Multnomah County, and the purportedly very high substance-using population in the county, it would not be a surprise to learn that a high percentage of incarcerated persons in the Multnomah County system is prescribed such medication. Many may be

[14] Definitions are found @: https://oregon.public.law/rules/oar_309-036-0105
[15] See, for example, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6165520/

prescribed more than one psychotropic medication. When CH looks at these data, it would be helpful to compare their findings with those of other jurisdictions.[16]

The CH does not currently have a psychiatrist working in the MCDF. It is a matter of some urgency to contract with an experienced psychiatrist who can review CH's diagnostic and prescriptive practices, the latter especially for recommendations about medications that should not be routinely prescribed in the detention center. A recommendation to this effect is provided at the end of this report.

Even with the many medication administration rounds completed each day, CH staff are sensitive to the times when medication administration can be particularly unproductive for persons with psychiatric problems, who not only need undisrupted sleep, but whose medications may induce sleep and thus exacerbate any resistance to taking their medications when administered in the early hours of the morning. I was unable to verify through the medication administration records the extent to which medication refusals occur in the jails.

Watches; Crisis Housing

Referrals and requests for mental health services can be generated by anyone, including the incarcerated person, who is informed how to access health care at the time of the intake health screening. At present, requests for health/mental health care are made in writing. Oddly, the request form is directed to the medical staff. There should be an option to send this to a mental health clinical manager for direct triaging. In situations where a deputy identifies an emergent crisis, the deputy can directly request a CH service.

The initiation of a suicide watch always results in a referral to mental health staff. Incarcerated persons placed on a suicide watch are usually moved to a designated mental health unit, though exactly how the unit assignment is made is unclear. Once on a suicide watch, the incarcerated person's possessions and clothing are removed and a suicide-resistant smock and blanket is provided. These watches can go on indefinitely. I saw and heard about people who had been on active suicide watch for more than one month. That points to a problem in the risk assessment methods being used in the jail system.

In any correctional facility, the length of time a person spends on a watch triggers many problems, including long periods of isolation. This is definitely the case in the MCDF, where the use of lockdown is extreme and current interviewing strategies (through a closed door or a trap door) offer no relief from the isolation. There can be no thorough evaluations done under these circumstances. I am unsure how cell confinement developed into the default housing option in this jail system, but it works only to the detriment of those subject to it – and a large part of the jail population is in fact subject to it. I wonder if such extreme isolation is related to the staffing deficiencies and to fears of interviewing incarcerated persons in open spaces that can afford privacy, such as in day room areas.

I note with concern that at the MCIJ, dorm 15, a large open, well lighted single cell direct supervision unit, contains a sub-unit where people who are on suicide watches are held. This sub-unit is not designed for direct supervision and should not be used for actively suicidal detainees. A recommendation is made to that end. But dorm 15 itself might be a good unit for people who struggle with suicide thoughts and / or who have some mental health challenges. It offers plenty of day room space in which clinical contacts can be had in private, but still under the direct supervision of a deputy assigned to that dorm. More on this in the recommendations that follow.

Finally, as mentioned earlier, the conditions of the special housing units – particularly unit 4D at the MCDC – are abysmal. They are poorly lighted in and outside of the cells and sight into the cells, for suicide checks and for clinical contact, is severely compromised. The day rooms are unused. There is no guarantee of time out of one's cell. None of the cells in the MCDF system are equipped with cameras; if a person is on a constant

[16] See, for example, https://calhps.com/reports/PolicyBrief_PsychotropicMedications_CalHPS.pdf

suicide check, the deputy is stationed directly outside of the cell and monitors the AIC's behavior through the trap door. It cannot be pleasant for the AIC or the mental health clinician to try to do clinical work under these conditions, nor can it be helpful to the deputy who is assigned to work this unit. In all, those conditions, in terms of both physical and operational conditions, are of grave concern.

Treatment Programs

There is no formalized substance use program active in the MCDF system. Prior to COVID, self-help groups such as Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) were offered, and there is hope to reinstate those programs in the near future. Dorm 10 in the MCIJ holds up to 75 persons and offers what was described to be a pre-treatment readiness program sponsored by the Volunteers of America. The unit itself and the treatment leanings of it resemble a "therapeutic community" experience. I am unaware of the actual curriculum if there is one and I did not receive information about outcomes for those who have been exposed to or completed it.

There really are no other defined treatment programs offered in the MCDF system, but CH clinical staff expressed interest in developing and providing therapeutic groups for the incarcerated population. This is an excellent idea!

Triage

It is difficult for me to identify a coherent CH mental health triage protocol. Triage is done by the mental health managers every morning, and clinicians' appointments are "scheduled." The CH protocols suggest recommended numbers of clinical contacts on any given day; these look to be based on an outpatient appointment protocol and not on the nature of crises that emerge every day all day in the jail system. I make recommendations about staff deployment and the responsibilities that come with their assignments to particular high risk/high volume areas of the MCDF at the end of this report. At present, the CH protocols seem like an odd fit for a detentions' environment.

Access to Hospitalization

I was not provided any data about persons waiting in the jail for transfer to a state institution for either a competency evaluation or restoration to competency process. Anecdotally, however, it appears that there are such people being housed in the jail for long period (months and longer) of time.

Summary

In sum, there are improvements needed in CH staffing, in its deployment of staff, in its policies and protocols, and most importantly, in its communications with its corrections partners. While the CH clinicians seem to be trusted by the MCDF deputies and administration, their work is hampered by the model of services provided (which might be viewed as a community mental health center model rather than as a supportive partner model), and in their actual collaborations with other MCDF staff. Misunderstandings about HIPAA hamper the work of the CH staff and impact the mission of the MCSO in operating a safe and secure detentions system.

The past two years, marked by crisis and deaths in the MCDF system, have no doubt been quite stressful for the CH staff and indeed, for all the staff of the MCDF system. Fears of additional suicide behaviors and deaths may be yielding an overestimation of risk, the overuse of suicide watches, and placement of incarcerated persons into housing that puts them at greater risk.

V. ALLIED JUSTICE & COMMUNITY SERVICES

Time did not allow for my inquiry into the allied justice services available in Multnomah County. At some point in the future, after the demands of the current staffing and response crises abate and what I consider to be urgently needed modifications of jail practices are made, the County should explore a formal systems evaluation that can help it manage the jail population, particularly those with serious mental health needs, by exploring diversion opportunities before and after arrest and sentencing. The *Sequential Intercepts for Change: Criminal Justice-Behavioral Healthcare Partnerships*[17] initiative is one resource to explore.

[17] For a quick overview, see: https://www.prainc.com/sim/ Also see this seminal publication for an overview of the SIM: Munetz, M. and P. Griffin, *Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness.* Psychiatric Services, 2006. **57**(4): p. 544-549.

VI. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

As a technical assistance provider for the NIC, my focus is on identifying areas of practice that, if modified, will work to support the Sheriff's goal of operating a responsible and responsive detention system that satisfies the mandate to keep people safe and secure and well cared for while in custody. My approach is a systems-based, jail centered one; practical in that that I am mindful of the need for both short- and long-term ideas and recommendations. My work with Multnomah County, documented in this Report, is especially focused on devising recommendations that will help all staff feel more confident about their ability to work as a team, pooling needed expertise in ways that maximize the objectives of the system and its many parts.

There are positive things happening in Multnomah County and there are certain unique features about the MCDF system and its operations. Principal among those features is the potential of the partnership with the CH system. Both serve a common mission which I heard clearly articulated while on site: the achievement of a safe environment, bolstered by good practice, and by the delivery of quality care. In addition, from entry into the MCDF through one's incarceration, there are environmental supports that help move toward realization of that mission. The design of the open seating in the MCDC intake area offers a very good space for setting and reinforcing expectations for detainees' behavior. The range of housing options in the jail facilities – some with direct supervision – can also serve the common mission. And the presence of a skilled health and mental health team working in collaboration with custody staff can help set the tone for a system that wants to operate in accord with best practices.

There are also housing areas that offer design and ambient features that should not be underestimated for their contribution to supporting good security, and good physical, mental health, and behavior management practices. In most of those units – and even in the small, celled units on the 4th floor of the MCDC, the dayroom areas are large and most could easily accommodate individual and group programs and interventions: educational classes, crisis groups, psychoeducational groups, and individual interviews.

Finally, when looking at an incarcerated population that comes into the jail already disadvantaged in impactful ways – histories of significant physical and mental illness, of poverty and hunger, poor nutrition and disrupted social support systems, and of oppression and disenfranchisement – it cannot and should not be overlooked or underappreciated that every day the MCSO deputies and the CH medical and behavioral health staff working in the MCDF system are saving lives, through their people management and their clinical skills, through the use of screening protocols and assessments, and through their responses to people in crisis.

The unfortunate truth in detentions is that we can more easily quantify where we fall short in our efforts than where we have success. In the last 2 years, the MCDF has experienced 10 inmate deaths, including at least 3 suicides. The death of an incarcerated person serves trauma on the institution, on those who work and who are detained in it, and on the community that strives to understand what happened and yet is left with questions. At this moment and likely for some period to come, both internal and external challenges stress the MCDF system. Internally, because even while early screening processes are intended to identify and highlight detainees' immediate health, mental health, substance use and safety needs, the efficacy of these processes is hindered by a lack of privacy, inexact protocols, staffing challenges, and communication gaps. Externally, underfunded mental health resources in the community, and the frightening and deadly drug culture that has developed in this area has put the detentions system in the untenable position of having to save people from untreated diseases and from self-destruction, conditions much better managed outside of a jail cell.

Indeed, the number of persons with mental illness and co-occurring disorders that are brought to the jail combined with what are likely longer lengths-of-stay than other non-mentally ill persons, make detentions' work more difficult. A collaborative and communicative relationship between the CH nursing and mental

health staff, and between them and the detentions staff will go a long way toward streamlining protocols, identification and early intervention needs.

The long periods of lockdown and the extent of isolation experienced in many of the housing units is likely working against the MCSO's safety, security, and healthy people goals. While staffing deficiencies are no doubt a culprit, deployment and unmet training needs may be more so. Asking people to manage behavior they do not understand and that is perhaps personally threatening is antithetical to the MCSO's mission. And overuse of lockdown always suggests the possibility that at least part of what is happening is that key staff members doubt their own skills to manage the population safely. They may be fearful of not having back up when it is most needed and rely on lockdown to ease that discomfort.

In short, how this shared MCSO and CH mission meets or doesn't meet its objectives, and what can further the MCSO's detention system's success is a central part of this report and the recommendations that follow. I hope these recommendations might help reset the MCSO's approach to both inmate behavior management and the operational rules that may no longer be functional. And I hope that CH will reconsider its relationship with the MCSO, fully understanding and embracing its role as partner and invited guest in the MCDF system; lives depend on it.

I believe the many recommendations provided in the pages that follow will help guide the Sheriff and her staff as they examine the detention system and modify procedures and practices in ways that offer renewed support to the mission of maximizing safety and security and the outlay of beneficial health services. Many of these recommendations can be implemented alone but some benefits will be enhanced if implemented alongside others. Further, these recommendations should be viewed through a public health lens:[18] the incarcerated person enters the jail with a lifetime of health, and mental and behavioral health strengths and challenges. The responsibility of the detentions system is to treat people where they are, and for the conditions they have when they enter the system. This cannot be an "appointment only" health delivery system; nor can it be a health system that operates with secrecy, independently of its host. While the following list of recommendations may seem daunting, they are all designed to further a public health agenda that by its very nature, supports and enhances the safety and security mission of the detention system.

I am confident that the combination of staff knowledge and experience, and the ideas set out in this report for movement forward, will further existing efforts to save lives, mitigate suffering, and promote good health. I also know that with change comes anxiety, and thus a thoughtful organized implementation of whatever changes are to be made is necessary to lessen the sense of disorganization or chaos that naturally accompanies system change.

In detentions, I understand that a change in the protocols of one division will necessitate adaptations in other divisions. Clearly, some of my recommendations will require a more robust joint effort than others and must be led and supported by the Sheriff and the MCSO administrative staff.

[18] The 2012 Surgeon General's report *National Strategy for Suicide Prevention: Goals and Objectives for Action*, available at http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html, speaks to the public health approach in suicide prevention. Also see, the 2001 publication: *Mental Health: Culture, Race, and Ethnicity A Supplement to Mental Health: A Report of the Surgeon General* available at: http://www.ncbi.nlm.nih.gov/books/NBK44243/.

RECOMMENDATIONS

On site, I promised to highlight certain recommendations that, if implemented thoughtfully but more quickly than others, might yield in the short term immediate impactful benefits. I believe there are at least 12 quickly implementable changes. They are listed here as items 2-13. Recommendation #1, however, requires a structural change that I believe is key to the success of the MCSO and CH partnership.

(1) Hire or contract with an independent, knowledgeable health services administrator, someone with extensive experience in the delivery of health/mental health services in the correctional environment, to guide the collaboration and coordination efforts of the MCSO and Corrections Health going forward. This person, an employee or independent contractor who reports to Sheriff Nicole Morrisey O'Donnell, should serve as the CEO (my term) of health services, overseeing the development of revised healthcare policies and related protocols, personnel decisions including hiring and deployment, and guiding the relationship between Corrections and Health in accord with contemporary legal and ethical standards. Those standards are known by the Bill of Rights, by legislation, and by caselaw.

Again, recommendations #2-13, which can be (relatively) quickly implemented, are those from which immediate benefits can be derived.

(2) Screenings undertaken at all levels should be completed in a setting that affords the detainee privacy and respect for the personal nature of their health information.

- If more than one person is brought into the initial intake area, the screening should not start until only one person to be screened is present. The other detainees should be placed in a holding cell or should remain in the sallyport until each individual is screened in private.

- New detainees whose answers indicate the presence of a serious mental or health condition, must have their "Jail Booking Screening" reviewed by the CH RN, and if clinically indicated, by CH mental health staff, before being cleared for housing in the MCDF. Options for housing until the person can be fully screened include management in the open seating area of booking, and assignment to a booking cell under security supervision, with documented welfare checks of the detainee's behavior at intervals not to exceed 15 minutes.

- If unstable medically or psychiatrically, the detainee should be sent to a local hospital for investigation of their health conditions, clearance for incarceration, or diversion to another setting, and if cleared for the jail, for recommendations for health/mental health care in the MCDF.

(3) Keeping in mind that the first 3-24 hours of incarceration is a high risk/high lethality period for suicide and for critical health incidents, the frequency of cell checks for all occupied "side" cells should be increased to checks staggered at intervals not exceeding 15 minutes.

- These checks should be thorough. Lighting and cell windows must allow a clear visual of the detainee. If the detainee appears to be sleeping, the deputy must document that breathing is seen; if the deputy is unable to confirm breathing, the door should be opened and the detainee engaged in verbal communication – enough to determine that the detainee is aware of his/her surroundings and how to access assistance if needed.

(4) Place signs at the MCDC and the MCIJ check in areas and in the visiting areas (video rooms; window visiting rooms, and attorney visiting rooms) that ask that all visitors alert _____ (e.g., an identifiable deputy at the visiting desk; the officer in charge; the captain's office …) if they have any concerns about the mental or physical health of the person they are seeing or have knowledge that the person has ingested a harmful substance. (This can be highlighted with something like a "Help Us Save Lives …" banner.)

(5) Retrofit the showers in every applicable shower unit (I observed the need in the showers in the modules on the 4th floor; and in the "infirmary" area – but they may be in other areas I did not visit) in the MCDC and in the MCIJ, including replacing vent screens with small hole covers, and replacing sprinkler heads and shower heads from which one can tie a ligature.

(6) Redeploy custody staff in accord with the classification of your population. Prohibit the early "close" (i.e., which leaves the unit without an assigned officer and cancels opportunities for "walks" and recreation) of all initial classification units, and, if different, of the following specific units: any unit housing a person on a suicide watch, any unit that houses persons labeled "acute mental close" and "mental close" and "psychiatric" (at the MCDC those units are: R, 4A, 4D, 5C, 6A, 6B, 6C, 7A, 7C, 7D, 8A, 8B. At the MCIJ, those units currently include: 06, 15, 18.) In sum, when short of staff, assign staff in accordance with your highest risk populations (determined by health assessments and behavior; not solely by charges).

(7) Immediately stop the practice of assigning persons on suicide watches to subunit 15 at the MCIJ. Those cells are inherently dangerous because they are isolated from staff sight and in an emergency, the unit officer must open at minimum two (2) doors to respond. As an alternative, assuming that at least one deputy is located in Unit 15 at all times, identify the cells in 15 that are in the direct sight of the deputy and assign persons at risk for self-injury to those cells. If on a suicide watch, the deputy (or a rover), should continue documented checks at staggered intervals not exceeding 15 minutes.

(8) Immediately remove the blinds and window coverings from all control rooms. Investigate and if possible, move the computer and the screens to the side of the control room that faces the housing units, enhancing security supervision.

(9) When seen, immediately remove objects from cells that are intended to obscure light and sight into the cell. The key here to remove these objects right away, every time they obscure sight into the cell. When and if possible, replace the lighting (especially in the high-risk housing areas – which include any unit designated for persons with acute health and mental health conditions) with more ambient and softer lighting.

(10) Develop and implement the use of a multi-agency release of information form at intake. Ideally, this initiative should be led by CH, but if there is resistance to doing so, the MCSO should take the lead in making the sharing of need-to-know information a standard in the MCDF system. I have already provided sample copies of standard multi-agency ROI forms to the CH and to Deputy Chief Reardon, MCSO, along with an article that discusses how HIPAA standards should be interpreted in communications that occur in corrections agencies. If needed, the Multnomah County Attorney's office should be consulted.

(11) When there is a critical incident – particularly a death of any type - in the MCDF system, immediately increase system-wide security checks so that they occur 3-4 times in every 60 minute period, and continue these increased checks for at least 2 weeks following the incident. I realize this will be challenging, given current staffing levels, but the MCDF's recent deaths and anecdotal evidence from other jurisdictions underscore the risk of more deaths occurring within a very short period of time.

- It is not too late to use shift briefings to remind staff that deaths are a reality in the MCDF and provide methods to reduce their incidence. CH staff should help deliver this message by quickly and accurately reviewing the signs and symptoms of suicide ideation, mental illness, and substance withdrawal, and by emphasizing the availability of CH staff to help with this identification process when alerted by an officer who has concerns. Start now!

(12) Resist the urge to lock people down rather than perform these additional checks. In corrections, the data are indisputable: The overwhelming majority of deaths occur in isolation.

(13) CH clinical staff should document on the suicide check form the reason for initiating a suicide check and the signs and symptoms deputies should be aware of that signal an increased risk of self-harm or mental decompensation. Even if documented elsewhere, e.g., in the medical record (EMR) (and it should be), this information should also be documented on the suicide watch form and should be discussed with the unit deputy at every opportunity to do so. When CH clinicians make rounds in the unit(s), they should inquire about the deputy's observations and concerns, and respond to them.

NOTE: The remaining list of recommendations, and there are many, will require more time to implement and of course, will need to be prioritized by those staff directly impacted by them. I am deliberately not separating these recommendations by what might be viewed as either MCSO or CH responsibilities. Consideration of these ideas should be joint, and the discussions that ensue should focus on how collaboration and cooperation should and will look in undertaking this truly systems work and on accomplishing mutual goals for a safe, secure environment marked by the knowledge and exercise of best practices.

(14) Staffing must be increased across the board: MCSO and CH. I support the Sheriff's efforts to ease hiring delays and recommend that the assistance of the Multnomah Central Human Resource Department be sought for a review of hiring processes and delays. Time is of the essence. Staffing shortages put AICs and the staff in danger, they clearly result in unacceptable periods of lockdown, and they directly contribute to the critical incidents happening in the jail system.

- While a hiring study is recommended, it is my opinion that the MCSO does not have time to wait for it in order to cover its highest risk housing units. Custody staff at all levels, needs to be increased in the high-risk units (mental health, disciplinary, administrative segregation, protective custody, intake and women).

- CH staff must also increase its staff, including the hiring of a .5 - 1.0 FTE psychiatrist and case managers who can be assigned to the same high risk units to provide (1) better medication management and oversight of the medication protocols in the MCDF system, (2) more direct face-to-face contact with the AIC population, (3) more frequent and varied therapeutic encounters, (4) more direct exchange of written and verbal information with deputies assigned to these high risk units, and (5) the creation of more specific case management, treatment, and discharge plans.

- Given what is known about imprisoned women and their almost universal histories of trauma, and particularly of sexual trauma, the hiring of additional women deputies is particularly important. Both recruitment and retention challenges should be examined and where needed, modified in this effort.

(15) As soon as possible, the CH should assign a full-time experienced CH clinician / diagnostician to the intake unit to provide CH consultation coverage during its busiest intake hours, which I understand to be from 1PM-9PM daily (a quick study of your intake data will yield better data on this). While on duty in the intake section, the CH clinician should (1) see and assess every detainee housed in a side cell on a daily basis and might do so several times during an 8-hour shift depending on the detainee's level and type of acuity; and (2) working with classification and the intake RN, devise an appropriate transition plan from intake into longer-term housing. In addition, (3) the intake clinician should complete mental health evaluations on detainees coming into the facility who appear to be symptomatic when the CH nurse completes the initial health screening, and (4) should spend time evaluating the need for the existing mental health code placed in a detainee's record in the past, and when clinically indicated, remove the code if a clinical exam generates no or solely sub-clinical indicators for suicide risk and/or mental decompensation.

(16) Working with the classification, housing, and custody staff and as soon as possible, the CH should assign full-time experienced mental health clinicians to the units where the persons with significant mental health challenges are housed. This will take certain steps. First, a sound way of identifying who should be included in this category, i.e., who requires special housing, must be developed. Second, a discussion about the types of housing that would be both more secure and therapeutically advantageous for this population is needed and designated. Third, adequate staffing for these units and the use of non-

sworn staff to support therapeutic efforts should be determined. The CH mental health staff should be a central part of this reassignment process.

- Housing may be needed for persons who are experiencing an acute psychotic episode and for those whose primary condition, psychosis or substance-induced, requires heightened security, nursing and mental health presence, medications, a calm, well-lighted environment, and the opportunity for daily cognitive and behavioral assessment. This "acute" population may range from 6%-10% of the population. That is a rough guess, data mining efforts will help generate a more exact estimate.
- There is always a "sub-acute" population in the jail system as well. Those in this category require heightened supervision and treatment attention, including a specific case management plan, but once stable, can and should be moved into a less intensive housing unit. Movement into a less intensive unit is a clinical decision, not a matter of AIC's choice or preference.
- In detention centers, there is often a need for a transition/chronic care unit. Some of those who are housed here may be in this unit indefinitely. Others, who came into the unit to stay until stable, can be moved to general population with an ongoing case management plan that provides periodic contact with members of the CH team; and perhaps with the interdisciplinary team described in recommendation #18, below.
- If feasible, an initial housing/intake classification unit – a unit that should have enhanced security and health staff involvement – can also be used as a transfer point for people transitioning out of the transition/chronic care unit and headed into general population.
- The dayroom of initial housing units provides a good opportunity to offer an early group geared to assessing new and reclassified incarcerated persons. This is intended to be an eyes-on (to assess behavioral clues), information-giving experience where the primary objective is to assess how new detainees and recently reassigned incarcerated persons are managing the change in their housing statuses. This group, an "orientation" or "information" group, can preferably and easily be co-facilitated by CH and Inmate Services/Inmate Classification staff.
- On a totally subjective level – I like the light and open areas of the mods on the 8th floor (and perhaps those on the 7th floor as well?) for the sub-acute, transition, and initial housing units. In these housing areas, with a little planning, direct supervision of at least some AICs can be accomplished. For example, with a deputy in the unit at all times, AICs can be assigned to specific cells more in the direct sightline of the unit deputy. If necessary, an AIC's cell door can be left open to reduce the isolation and increase the deputy's surveillance. Further, the presence of a round-the-clock deputy should assure the AICs of their safety and security, while treatment interventions delivered inside the mods, in the dayrooms and in interview spaces, can bolster personal feelings of safety and security (often thought of in terms of internal locus of control).
    - Obviously, brainstorming is needed for this recommendation and some jurisdictions find it helpful to ask outsiders – i.e., jail staff from other counties – to help them reimagine spaces and services by considering "What would it look like if we could start all over …?"
    - In the spirit of a whole-system approach to suicide prevention and management of persons with mental health challenges in this detention system, consider who else can assist in this effort. Classification staff, specifically, the counselors, as well as the chaplain staff can be great partners in these efforts.

(17) Devise a plan to get AICs housed in single cells (with the exception of those in disciplinary confinement) out of their cells for longer periods of time, and for activities such as meals, in-unit education and therapeutic services, and leisure time. Be ready to implement this plan as staffing increases by doing so unit by unit. This is particularly applicable to those housed in the MCDC. Ideally, except for unit counts and periodic security reasons, and assuming a valid classification level has been assigned, AICs should be out of their cells for the majority of any 24-hour day.

(18) While it is possible for one to continuously think about suicide, the very high-risk period of suicide generally lasts 48-72 hours and is often discernable by a skilled interview. Active and Chronic Suicide Watches that are extended beyond this time frame must be reviewed, and extensions for reasons other than risk (i.e., because someone will not create a safety plan) should not be allowed. If in fact, someone is actively at high risk for suicide for longer than 5 days, that person requires hospitalization. Often, behavior challenges and chronic thoughts of self-harm can be managed in other housing by alternative strategies, including more out-of-cell time, strategic cell assignments (in direct sight of a deputy), and more frequent contact with mental health staff.

- Create/assign a team to meet on a set day each week to assess and devise a case plan for any person still on suicide watch at day 5. This team should consist of a mental health clinician, a representative of the medical staff, a classification representative – perhaps an inmate counselor, and a Sergeant. The AICs' behavior and mental status should be reviewed during the team meeting, followed by the team making rounds, interviewing each AIC to both assess and plan for a successful transition off the watch and into population.

- While this sounds time consuming, it should not be. This team should replace the current weekly multidisciplinary team meeting, which seems more about housing than full case management, and involves many staff who could be otherwise more usefully deployed.

- A key in this recommendation to halt the practice of leaving AICs on suicide watch when they do not want to return to population. Whether an AIC remains on a suicide watch should always be a matter of clinical assessment and judgment. The AIC should be invited to contribute to the case plan but does not have control of it nor over where he/she is housed.

- The content of the team's discussions should be inmate-specific, need-to-know information only. The team needs to know about the person's mental health status, risk for self-harm, current and historical behavior in the institution, and vulnerabilities – and that knowledge should be used to build the case management plan. This involves no insults to privacy – it is part of the system's work to keep people alive.

(19) There is momentum across the country for detention facilities to use empirically validated instruments to assess mental health and substance use conditions. One of those instruments is the Columbia Suicide Severity Rating Scale, which has been validated on/for corrections' populations. The CSSR is a form designed to be used by anyone; a mental health professional is not needed. While it is a risk assessment tool, one does not have to be an expert in risk assessment and risk reduction to use it. I have included a copy of the CSSRS in Appendix D of this report. There are other validated screening tools available for use as well – and CH and MCSO staff should review these tools together and make decisions about their adoption.[19]

- In the case of the CSSRS, intake deputies can be quickly trained by a CH mental health clinician in how to complete this form, i.e., how to ask these questions and what to note as the detainee answers. I recommend adding this screen to the booking officer's screening protocol. It only takes a few minutes to complete. This form should also be made available to deputies working in classification and in housing units, to use any time they suspect a detainee is considering self-harm. Findings, of course, should be immediately shared with supervisory and CH staff.

[19] The excellent NIJ *Research for Practice* publication "Screens for Corrections," is available @ https://nij.ojp.gov/library/publications/mental-health-screens-corrections and should be reviewed for valid screening options. There are also gender-specific screening instruments to be considered.

(20) Either by adopting a kiosk system or when implementing the planned distribution of electronic tablets to the incarcerated population, prioritize placing the "Medical Request Form" on that platform so that AICs can make requests to be seen without having to verbally ask a deputy or a nurse for, and then return a paper request slip. Separate requests can be created and directed to the medical, mental health, inmate services/classification, and security sections, and responded to by personnel in those units (and/or forwarded as needed). (As noted in the body of this report, I was given two versions of the Medical Request Form, one that referred to charges for health care, one that did not. This needs to be corrected).

(21) CH mental health (and medical) staff should make use of the ample space available in the housing units to see AICs in person, without resorting to interviews hampered by structural barriers such as doors. If custody staff believe that an incarcerated person poses a threat to safety, with the door open and the incarcerated person directed to sit on their bunk, the CH clinician should interview the person from the doorway, out of good earshot of other incarcerated persons. If that option is also deemed too unsafe, the incarcerated person to be interviewed can be seen in the dayroom area, secured, under the watch of the deputy assigned to the unit. Concerns about HIPAA mandates and professional ethics have been addressed in many publications and forums.[20] Acting as invited guests in the MCDF, clinical staff must not fail to share need-to-know information that is needed to inform and direct adequate treatment.

(22) The MCSO is currently updating its classification procedures. If feasible, implementation of in-person interviews at the 48-72 hour point in one's stay helps to gauge how the incarcerated person is adjusting to the environment, and how that person's mental health status may have changed during his/her short stay in the detention facility. These interviews could be done in the initial housing units, using dayroom or interview spaces.

(23) Initiate Chronic Care protocols for persons diagnosed with or suspected to meet the criteria for SMI and SPMI, and for substance use/dependency. This list can and should be expanded to include other chronic mental health conditions as the Chronic Care program is fully developed.

(24) The available jail suicide research suggests that 50% of jail suicides occur sometime after the seventh day of incarceration, and often well into a jail stay. Consequently, at intake or at any time an incarcerated person has mental health needs identified, a plan should be made for near-term, early stay (7 days), longer stay (14 days), and mid-stay (30, 60, 90 days) reevaluations by CH staff. For example, when removed from a suicide watch, CH staff should follow-up to appraise the incarcerated person's current status within 48 hours, again at one week, two weeks, and one month time frames. If the incarcerated person is likely to stay for months or longer, the DHS clinician should set appointments for ongoing mid-stay check-ins with the incarcerated person.

(25) Once adequate CH staffing is accomplished, the clinical expertise that CH provides in MCDF system opens the door for rethinking how and what services are and should be offered in the MCDF, with a particular focus on creating a refined triage system, devising a new schedule for more comprehensive staff coverage, including on-call services, and offering on-site services that are potentially more efficient and collaborative in the jail setting. Constitutional standards, caselaw, and standards of good clinical practice tell us that the essential services in jails are these: screening, evaluation, crisis response, treatment planning (including a schedule (not appointments!) of follow up visits), case management while incarcerated, and a discharge plan at release that is started at intake. These essential services and the staff needed to attend to them should be considered in this rethinking process. It will be useful for the MCDF and CH to seek technical assistance to facilitate a collaborative redesign process.

[20] This is admittedly a murky area of law, however, these sources may be useful to browse and discuss with a county attorney: https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/CSG_CJMH_Info_Sharing.pdf; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3987588/

- Scheduling appointments for AICs is neither useful nor responsive. Instead, if CH moves to a system of assigned and targeted responsibilities (intake, mental health units, general population, women, and on-call/crisis services), the clinician(s) should be empowered to set their own schedules, documenting in the EMR when AICs will be reevaluated and a plan for ongoing contact or termination of contact. The overlay of a community mental health operation onto the jail is largely unworkable when one considers the crisis prone drivers of the system (e.g., arrest, detention, personal crises, fears – rational or not, mental decompensation, family crises, interpersonal crises, trauma histories, and sentencing).

- Triage and service priorities should be defined. The following are <u>suggestions</u> for consideration, i.e., starting points when devising a triage protocol. Flowcharts of certain service priorities and offerings might be helpful. A simple example of an intake/screening flowchart is provided in Appendix E.

    - <u>Priority assessments and reassessments</u>. Review of referrals from custody and the CH RN staff, and from self-referrals, prioritized by what might be categorized as crises. Crises in the jail are not unlike crises in the community: (1) suicide ideation and factors indicating elevated risk (a feasible plan for suicide, suicide talk, a history of suicide attempts, a history of suicide among family and close friends, verbalizations of having no hope; (2) presence of an acute mental disorder (Axis I); (3) victimization - sexual and/or physical, recent and historical; (4) intoxication and withdrawal from substances; and (5) situational catalysts: death of a loved one; divorce papers received; unexpected sentence to prison; loss of social support, etc.

        1. The protocols for the triage scheme should answer the questions: What needs to be done and in what order should they be done when a crisis occurs? Who authorizes a crisis response? Who needs to know when a crisis occurs and what do they need to know? What options and people (housing, follow up, custody staff, chaplains, medications, hospitalization) are available to manage the crisis? What must be documented about the crisis from start to finish? With whom must and should that documentation be shared?

        2. Triage can and often should also be prioritized by the location of the incarcerated person – since incarcerated persons who may have self-injured or who are uncooperative would likely have been moved to the very locations that create additional risk, especially those that isolate the individual by sight, sounds, and human contact: crisis cells, highly restrictive units, single cells in intake, the women's unit, etc.

        3. Triage should always include a review of the completed intake screening forms – those done at pre-booking and by the CH RN assigned to intake.

    - <u>Routine, but necessary tasks and services, prioritized</u>. Protocols for this step should define services and corresponding tasks, with detail as to how they are prioritized and delivered. These include everything from scheduled follow-up contacts with incarcerated persons, case management tasks, communications between staff and the sharing of need-to-know information, communication about potential competency issues, roll-call training, CQI audits, outreach to community services, etc. An intake housing group, as suggested in recommendation #6, would fit well in this category.

    - <u>Additional desired but not essential services</u>. These might include longer term individual counseling, structured support groups, periodic walk-throughs of general housing areas, and routine (no agenda) check ins with RN and MCDF staff and administrators.

(26) CH clinical presence in the MCDF should be expanded to include some evening hours and weekends. This presence can be accomplished through staggered "shifts," with limited hours and types of services provided, and the expansion of coverage can be tested for efficiencies. For example, in consultation with the MCDF administrative staff, expand coverage to include times when CH can be present at shift change/shift briefings, and when access to incarcerated persons is maximized by avoiding restrictions that occur because of medication rounds, meal delivery and lockdowns. Weekend hours of service can

be limited to satisfying triage priorities (crisis and follow-up risk assessments, crisis cell / special housing reassessments).

(27) There is a point of diminishing returns when many incarcerated persons with mental health challenges are housed on special watches. There are incentives to being placed in these special areas, i.e., privacy, security, and attention, but there are also major risks, including the risk of worsening symptoms and self-injury, that result from the isolation (nearly 100% of jail suicides occur in single cells). When many special watches are in effect, it is challenging for deputies to complete their rounds in the time prescribed by policy, and the direct contact with the CH clinician may be hampered by structural (doors, small food trap openings, lack of privacy) issues. This is a matter to be addressed in related DHS and MCDF policy and protocols. Consider the following:

- Every person placed in restrictive housing under a mental health/suicide watch should be reevaluated by a CH mental health clinician at least once every 24 hours, daily, no exceptions. The reevaluation should include a suicide risk assessment (which entails more than just asking if someone is thinking of self-injury), and a plan for moving the person to a housing unit. Crisis cells should be used sparingly as should cells in housing areas where lockdown is extensive. Almost all jail suicides occur in isolation. The goal is to be able to see people moved to regular housing as soon as possible.

- It may be helpful to be guided by uniform definitions of "suicide attempts" and "suicide gestures." The Centers for Disease Control and the Veteran's Administration are two sources for such definitions. Then can be found at these sites: http://www.cdc.gov/violenceprevention/suicide/definitions.html and http://www.healthquality.va.gov/guidelines/MH/srb, respectively.

  In addition, as suggested earlier, the Columbia Suicide Severity Rating Scale (with Triage Points for Corrections) (C-SSRS) is an excellent validated scale to use to assess risk and referral points, (See Appendix D for a link and a copy) and could be used by deputies as well as the clinical staff.

- Deputies should document their checks at staggered intervals not exceeding 15 minutes and note behaviors (talking, pacing, eating, sleeping-but moving), what is heard (content of speech and/or verbal sounds) and what is seen (how the incarcerated person appears and the condition of the cell). CH staff should check the deputies' logs for this information, daily. MCSO command staff should review suicide logs at least weekly to ensure important information such as time-out-of-cell, showers, and mental health visits are documented on those forms.

- At the time of placement in a special cell, the CH staff should assure (inform) the incarcerated person that the placement is time limited. Further, the CH staff should be clear that the decision to move the person from any unit is that of Sheriff's personnel, with CH input.

(28) Working together, reducing the opportunities for inmate death and especially for the purpose of suicide risk reduction efforts, should be data-driven as opposed to crisis driven. Examples of data needed for overall prevention and treatment purposes include prevalence data (for mental illness and other conditions of interest), data on the length of stay (LOS) of persons with mental disorders vis-à-vis LOS for those who do not have mental disorders, data on the number of suicide threats, gestures, and attempts, data about the amount of stockpiled medication found in housing units, the kinds of medications found, and the locations where they are found. In addition, collect and analyze data about the medication administration process: how much medication is administered, the locations where the CH staff feel most vulnerable during medication passes, and the security problems associated medication passes. The locations where suicide incidents, overdoses, and medical crises occur most frequently (single cells, disciplinary or segregation units, mental health units) should be constantly monitored, and options for alterations in the environments where they occur should be generated. Additional helpful data might relate to the types and details of communication breakdowns that occur, and options for their resolution; where more staff is needed the most and where more staff can have the

most impact on reducing suicide behaviors. These are problems that cross disciplines and require concerted thinking and action to solve.

- Until a regular system of data collection is determined, some organized way of understanding the numbers of people with mental illness, who are intoxicated at intake, who are in withdrawal during their stay, and who are at risk for suicide and self-harm is important to devise. Consider the data obtainable from existing records and periodic point-in-time population reviews:
  - Diagnoses made in the EMR (MCDC based or from CH system-wide EMRs)
  - Referrals to mental health staff found in the EMR or on separate referral forms
  - Current prescriptions that include psychotropic medications (antipsychotics, antidepressants, mood regulators, anti-anxiety medications, withdrawal medications). The CH pharmacy should be able to regularly deliver an organized (by type) list of the number of medications prescribed in the facility, the number of AICs who are receiving medications, the number of AICs receiving multiple types of the same category of medications, etc.
  - Admission of a physical or mental disability, evidenced by enrollment in a government program (SSI, SS, Oregon disability program)

(29) The MCDF does not have a "cool down" cell/space, i.e., a soft cell that can be used to help detainees/ incarcerated persons calm after a behavior crisis. Instead, restraint chairs and side cells are used. These latter options should be reconsidered, at least in terms of duration. A visit with state hospital administrators and with jail administrators of facilities that no longer use mechanical restraints should be considered in order to learn more about viable alternatives for behavior management. Calming cells are one option and the quick arrival of a crisis responder should always be part of crisis intervention efforts.

(30) Currently, women confined in the MCDF system experience a lot of lockdown hours. The classification of these women and the actual need for such restrictive housing should be reexamined. Women are social – they fare better, physically and emotionally, in a social environment. This is especially true for women with significant mental illnesses, particularly depression and anxiety. Therapeutic groups (e.g., Dialectical Behavior Therapy (DBT)[21] and trauma-specific interventions) and psychoeducational groups focused on health and mental health issues, would be especially useful and could be co-facilitated by the CH clinical staff and the IC counselor staff in the housing pod itself.

(31) It is highly recommended that the Sheriff request technical assistance from the National Institute of Corrections (NIC) for both inmate behavior management and inmate classification (which go hand-in-hand). Assistance under the NIC's Strategic Inmate Management initiative may be helpful in this regard.

(32) The CH protocols, which are lacking relationship to jail procedures, should be revised to be compatible with and reference the MCSO policies and procedures.

(33) Special mental health training for officers assigned to intake/release, the intake housing unit(s), the women's units, the mental health units and in the segregation units (PC, Disciplinary, AdSeg) should be developed and delivered and offered on an ongoing basis. These are the areas in the jail system where persons with serious mental illnesses and those who are at risk for suicide are likely to be first identified. Permanently assigned and well-trained officers can make all the difference in a jail system when managing these at-risk populations.

- Training materials should include case-based instruction. The NIC Information Center (www.nicic.org) can provide lesson plans with "advanced" mental health content. It is also strongly recommended that some of the circumstances around recent critical incidents be used to further the discussion about identifying and intervening for suicide risk reduction.

[21] See, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2963469/

- Consistent with enhanced training, when possible (when the MCDF is more robustly staffed), handpick officers to work the intake, intake housing, segregation, and mental health units. These officers should have a good sensitivity towards persons with mental health challenges, good communication skills, be willing to assist in the decision process when various alternatives are considered in the effort to manage an incarcerated person's behavior and be willing to participate in "grand rounds" - or periodic walk-throughs of these special needs units with other staff – especially with CH staff.

(34) At present, eight (8) hours of suicide prevention training is offered in the initial training provided to new deputies and then one (1) hour of on-line suicide prevention training in the following yearly training curriculum. There is no mental health-specific training offered in the annual training curricula. All staff should receive ongoing suicide prevention training, which can, if necessary, take place in shift briefings (the huddle) over time. In addition, all staff should be exposed to training that helps them identify the symptoms and signs of mental illness. These are in large part, behavioral signs – some reported by the incarcerated person and others observed by the detentions' staff. CH staff are encouraged to make use of shift-briefings/roll call to provide mental health updates, quick skill lessons, and tips (behavioral clues) that will aid deputies and other MCSO staff in identifying persons who are at risk for mental health challenges and decompensation while incarcerated. Further, while it can be difficult to distinguish between the two, helping staff understand the symptoms and presentations of substance use and of mental illness will help them more readily identify early signs of impending health risks, and feel competent in doing so.

- Shift-briefing sessions can be particularly useful forums for discussion and debriefing after a critical incident has occurred, when staff may feel especially unequipped to manage crises (a normal reaction to stress). At such times, the mental health staff should attend the briefings, provide information, answer questions, and deliver tips for ways to manage the population safely post-crisis. And, while there, CH staff can use their trauma-informed approach to identify and help any staff struggling in the aftermath of a critical incident.

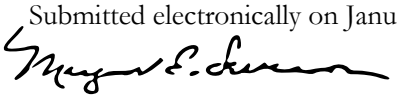
- Also consider looking to the community for training. Opportunities to take a "Mental Health First Aid" class, for example, which was offered in the MCDF system in the past, should be explored. The NIC also offers this class.

(35) The MCDC should require that all CH staff receive training in working in a secure detention center, including safety information, definitions and methods of introducing contraband, and security practices. This training should be documented and records maintained by the MCSO for each CH employee who has attended the training.

(36) Over time, the MCSO and Multnomah County justice services may want to secure a systems' review to identify the various points of interface where strategic interventions can serve to divert persons from justice involvement (i.e., sequential intercepts).

In conclusion, I am aware that there is a lot of information in this report to digest. As Sheriff Nicole Morrisey O'Donnell and her administrators and staff move forward with efforts to enhance the health and mental health services in the MCDF, should clarification be needed on any of the recommendations presented in this report, please do not hesitate to contact me with your questions.

Submitted electronically on January 12, 2024.



Margaret E Severson
Technical Resource Provider

APPENDIX A: ON SITE MEETING ATTENDEES

Attendees @ The Initial Meeting: Wednesday, Nov 29, 2023 @ 8:00 A.M.

Multnomah County Sheriff's Office (MCSO)

- Sheriff Nicole Morrisey-O'Donnell
- Chief Deputy Steve Alexander – Chief of Agency Services
- Chief Deputy Steve Reardon – Chief of Corrections Facilities
- Katie Burgard – Chief of Staff
- Jon Harms-Mahlandt – Chief of Business Services
- Chris Liedle – Communications Director

Corrections Health

- Valdez Bravo – Deputy Director of Operations – Corrections Health
- Myque Obiero – Corrections Health Director
- Doctor Eleazar Lawson – Medical Director
- Michelle Cannavino – Mental Health Program Manager
- Casey Jones – Transition Planner
- Brittanie Shauna – Nursing Supervisor
- Deidre Bond – Nurse Manager
- Mariana Orellana – Nurse Supervisor
- Kelsey Ufford RN
- Rachel Lee, Sr. Operations Manager
- Halcyon Dodd – DC Nurse Manager
- Kristina Bode RN
- Signe Soderberg RN
- Patty Bare MHC
- Mare Cox RN
- John Muench, MD, MPH
- Tim Victorella - Quality Manager

National Institute of Corrections

- Michael Jackson, Correctional Program Specialist
- Katie Reich, Correctional Program Specialist

Attendees, November 30, afternoon meeting:

- Captain Rian Hakala – Training Captain
- Sergeant Ray SeVilla – Training Sergeant
- Deputy Alexandra Qualls – Training Deputy
- Patrick Hewitt – Training
- Stephanie LaCarrubba – Facility Services Director (Programs, Pre-Trial, Classification, MH Sworn Staff)
- Sergeant William Maxwell – Classification Unit

Attendees at the Exit Briefing, December 1, 2023:

Multnomah County Sheriff's Office (MCSO)

- Sheriff Nicole Morrisey-O'Donnell
- Chief Deputy Steve Alexander – Chief of Agency Services
- Chief Deputy Steve Reardon – Chief of Corrections Facilities
- Katie Burgard – Chief of Staff
- Chris Liedle – Communications Director

Corrections Health

- Valdez Bravo – Deputy Director of Operations – Corrections Health
- Myque Obiero – Corrections Health Director
- Doctor Elezar Lawson – Medical Director
- Rachael Lee – Senior Operations Manager
- Michelle Cannavino – Mental Health Program Manager
- Trinity DeMoulin – Mental Health Supervisor

National Institute of Corrections

- Michael Jackson, Correctional Program Specialist

APPENDIX B: DOCUMENTS REVIEID

The following documents, listed in random order, were reviewed in preparation of the site-visit, while on-site and otherwise in preparation for writing this report:

- NIC 2022: Acknowledgement of Request for Technical Assistance (February 18, 2022)

Corrections Health (CH) Documents

- Corrections Health (CH) Staff Information
  - CH Organization Chart
  - CH Staff Roster
  - Mental Health (MH) MH Staff Roster
  - MH Staff Work Schedule
  - MH Job Descriptions
- Corrections Health (CH) Screening Documents
  - CH mental health EPIC staff dot phrase references
  - CH General Medical Screening
  - CH Nursing Assessment Medical Backup
  - CH Medical Request Form
  - CH MH Initial Visit
  - CH MH Suicide Screen
- Corrections Health (CH) Policy and Procedures
  - CH MH Services Policy
  - CH Suicide Prevention (SP) and Intervention Policy
  - CH Transport of Adults in Custody on Suicide Watch (SW)
  - CH Safety Planning Upon Release Policy
  - CH Grievance Process for Health Care Complaints
  - CH Discharge Planning (D/P) Policy
  - CH Grievance Policy
  - CH Credential Policy
  - CH CQI Policy
  - CH MH Process Information
  - CH Restraint and Seclusion Policy
- Corrections Health (CH) Data Information
  - CH Medical, MH, and Dental Clinic Data (2023)
  - Grievance Data (2023)
  - Overdose Data (FY 2022 and 23)
  - Pregnancy and Outcome Data
- Corrections Health (CH) CQI Study Information
  - Three CQI CH Studies Completed 2021, 2022, 2023
- Corrections Health (CH) Orientation Information
  - All Staff Orientation Checklist
  - MH Orientation Material
  - Nursing and CMA Orientation Material
  - Orientation Packet
    - MH SP Self Care
- Medical Request Form (MRF)
- Death in Custody Notification and Review Process

Multnomah County Sheriff's Office (MCSO) Documents

- Chapter 16: Health Care for Adults in Custody
- Conditions Audit – Sheriff's October 6, 2022 and April 2023 Status Updates (002) (Response with Updates to Multnomah County Auditor, Jennifer McGuirk re the 2022 Jail Conditions Audit)
- Copy of 2023 in-custody deaths (de-identified)
- Corrections Grand Jury 2021 Report: Review of Correctional Facilities in Multnomah County, Oregon
- Corrections Grand Jury 2022 Report: Review of Correctional Facilities in Multnomah County, Oregon
- Current 717 Lists
- Forms
  - AIC Grievance Form
  - JCS (Jail Booking Screening Questions)
  - JCS Classification Triage
  - Service Request Form
  - MCSO Jail Intake Booking Screening Questions
  - MC Corrections Suicide Watch Form
  - Notice of Application of Protective Restraints
  - Service Request Form
  - Medical Request Form
  - Observation Check Sheet
  - Current Suicide Watch Form
- Jail Report October 2023
- LE Peer Support Members (Lieutenant, Sergeants, Deputies, Detectives, Civilians)
- MCDC Module Designation (classification / housing designations)
- MCDC Recreation Schedule
- MCIJ Dorm Designation (classification / housing designations)
- Memorandum of Understanding: A Collaboration between Call to Safety and the Multnomah County Sheriff's Office (MCSO)
- Memorandum of Understanding. Worksystems, Oregon Employment Dept. SE Works, and Multnomah County Sheriff's Office. (undated)
- Memorandum of Understanding. Pathway Home. Mental Health Association of Oregon and Multnomah County Sheriff's Office.
- Memorandum of Understanding. Sexual Assault Nurse Examiner Access to Multnomah County Correctional Facilities. A collaboration between Rapid Save Investigations (RSI) Sexual Assault Nurse Examiners (SANE), MCSO Corrections Health and the Multnomah County Sheriff's Office (MCSO).
- Mink Final Term Sheet (Oregon Advocacy Center et al. v. Mink et al. (June 2023)
- Multnomah County Detention Center (MCDC) Organization Chart
- Multnomah County Detention Center 2018 Post Orders
- Multnomah County Jail Conditions. Circumstances Ire worse for adults in custody who are black and/or have mental health conditions. Multnomah County Auditor's Office, April 2022.
- Multnomah County Jail Inverness (MCIJ) Organizational Chart
- National Commission on Correctional Health Care. Health Services Accreditation Reports. October-December, 2021. (MCDC and Inverness Jails)
- Neutral Expert Seventh Report Regarding the Consolidated *Mink* and *Bowman* Cases, authored by Debra Pinals M.D., Court Appted Expert.
- Nov. 7, 2019 Letter: U.S. Dept. of Justice, U.S. Marshal's Service re: "Intergovernmental Agreement for Multnomah County Detention Center."
- Observation Check Sheet

- Oregon State Sheriffs' Association, Multnomah County Jail (Inverness) Inspection, November 2022
- Oregon State Sheriffs' Association, Multnomah County Jail (Justice Center) Inspection, November 2021
- LE Peer Support Members' List
- Suicide Watch Deputy Responsibilities
- Suicide Watch Utility Deputy (MCJ Post Orders 2022)
- Training Documents
    - Communication about Suicide Risk (Course Details and Quiz)
    - MH Suicide Prevention Self Care (Training)
    - Suicide Prevention – Preserving Life and Saving Safe (screen shot)
    - Suicide Prevention (Course Details)
    - Suicide Prevention Trauma Support Resources (Course Details and Quiz)
    - Suicide Statistics and legal Implications (Course Details and Quiz)
    - Suicide Watch Documentation (quiz)
    - Suicide Watch Observation (quiz)
    - Suicide Watch Process (Course Details and Quiz)
    - Understanding Suicidality (Course Details and Quiz)
    - Understanding Trauma (Course Details and Quiz)

- Multnomah County Corrections Grand Jury 2023 Report. Review of the Correctional Facilities in Multnomah County, Oregon

APPENDIX C. CLASSIFICATION DATA

Table 2. Classification Data (717 List, 11/30/2023)

DORM	TOTAL UNIT POP	# PERSONS w/ MH CODE + GENDER M/F	CLASSIFICATION OF MENTAL HEALTH POPULATION	CUSTODY LEVEL/HOUSING
R	27	5 M	2 Max; 2 Gen; 1 Unknown 4 w/ "MH" code	1 -Acute MH 2- Mental close 1 - psychiatric 1 – blank
4A	5	2 M	1 Max; 1 Gen; 2 w/ MH code	1 – close 1-mental close
4B	8	5 M	5 Max; 5 w/ MH code	5 – AdSeg
4C	8	3 M	3 Max; 3 w/ MH code	3 – AdSeg
4D	7	4 M + 2 F + 1 M (disc only)	3 Max; 3 Gen; 6 w/ MH code	5 – Psychiatric 1 – Acute Mental Close
4E	5	1 M	1 Max & w/ MH code	1 – Discipline
4F	5	3 M	1 Max; 2 Gen; 3 w/ MH code	3 – Discipline
5A	31	6 M	6 Max 6 w/ MH code	6 - Close
5B	11	3 M	1 Max; 2 Gen; 3w/MH code	3 – Discipline
5C	14	7M	3 Max; 4 Gen 7 w/ MH code	4 – Discipline 1 – Mental Close 2 - AdSeg
5D	29	5 M	4 Max; 1 Gen; 5 w/ MH code	5 – Close
6A	26	5M	2 Max; 3 Gen 5 w/ MH code	2 – Acute Mental Close 1 – Mental. Close 1 – Close 1 – General MCDC
6B	16	16M	8 Max; 8 Gen 14 w/ MH code	11- Acute Mental Close 5 – Mental Close
6C	16	16 M	10 Max; 6 Gen 16 w/ MH code	10 Acute Mental Close 6 Mental Close
6D	30	6 M	6 Max 6 w/ MH code	5 General MCDC 1 Close
7A	30	10M	7 Max; 3 Gen 10 w/ MH code	8 – Mental Close 1 – Close 1 - Transitional
7B	2	1M	1 Max w/ MH code	1 - Vulnerable
7C	15	8M	6 Max; 2 Gen 8 w/ MH code	5 – Mental Close 2 Acute Mental Close 1 PC Vulnerable
7D	29	9M	5 Max; 8 Gen; 9 w/ MH code	6 – Mental Close 1 Acute Mental Close 2 – Transitional
8A	29	21Female	7 Max; 14 Gen 20 w/ MH code	14 – Mental Close 5 Acute Mental Close 1 – General 1 Discipline
8B	15	12 Female	5 Max; 7 Gen 12 MH code	1 – Mental Close 7 Acute Mental Close

				3 Discipline 1 Ad Seg
8C	8	3 Male	2 Max; 1 Gen; 3 MH code	1 – Close 1 Ad Seg 1 Discipline
8D	19	5 Female	5 Max; 5 MH code	3 – Gen MCDC 1 Transitional 1 Close
	TOTAL POP MCDC: 385	TOTAL MH: 159	TOTAL MAX 94 TOTAL GEN 67 TOTAL "MH" CODE 154 TOTAL UNK 1	TOTAL ACUTE MC 40 TOTAL MC 44 TOTAL PSYCH 2 TOTAL CLOSE 18 TOTAL DISC 12 TOTAL AD SEG 12 TOTAL GEN 7 TOTAL TRANS 2 TOTAL PC VULNBLE 1 BLANK 1
06	40	40M	24 Max; 16 Gen 40 w/ MH code	39 Mental Health 1 MCIJ
07	29	3 Female	2 Max; 1 Gen 3 w/ MH code	3 - MCIJ
08	31	0 Male	28 Max; 3 Gen	PC Vulnerable
09	29	2 Male	2 Gen 2 w/ MH code	2 MCIJ
10	56	8 Male	3 Max 5 Gen 8 w/ MH code	All MCIJ
11	65	0 Male	-	-
12	65	5 Male	4 Max; 1 Gen 4 w/MH code	3 MCIJ 2 Facility Worker
13	59	1 Male	1 Max 1 w/ MH code	MCIJ
14	45	6 Male	3 Max; 3 Gen 6 w/ MH code	5 Transitional 1 MCIJ
15	45	45 Male	22 Max; 23 Gen 45 w/ MH code	44 Mental Close 1 Discipline
16	24	5 Male	2 Max; 3 Gen 5 w/ MH code	5 Discipline
18	5	2 Male	2 Max 2 w/ MH code	1 Mental Health 1 Discipline
MTSI	78	5 Male	5 w/ MH code	?
--	4 + 2 Males	0 MH	--	--
	TOTAL POP MCIJ 512 TOTAL 428 @ MCIJ 78 @ MTSI 6 @ UNKN	TOTAL MH POP 122 TOTAL 117 TOTAL 5 0	TOTAL MAX 91 TOTAL GEN 57 TOTAL "MH" CODE 81 TOTAL UNK	TOTAL ACUTE MC 0 TOTAL MH 40 TOTAL PSYCH 0 TOTAL MC 44 TOTAL DISC 7 TOTAL AD SEG 0 TOTAL GEN 0 TOTAL TRANS 5 TOTAL PC VULNBLE 1 BLANK 5

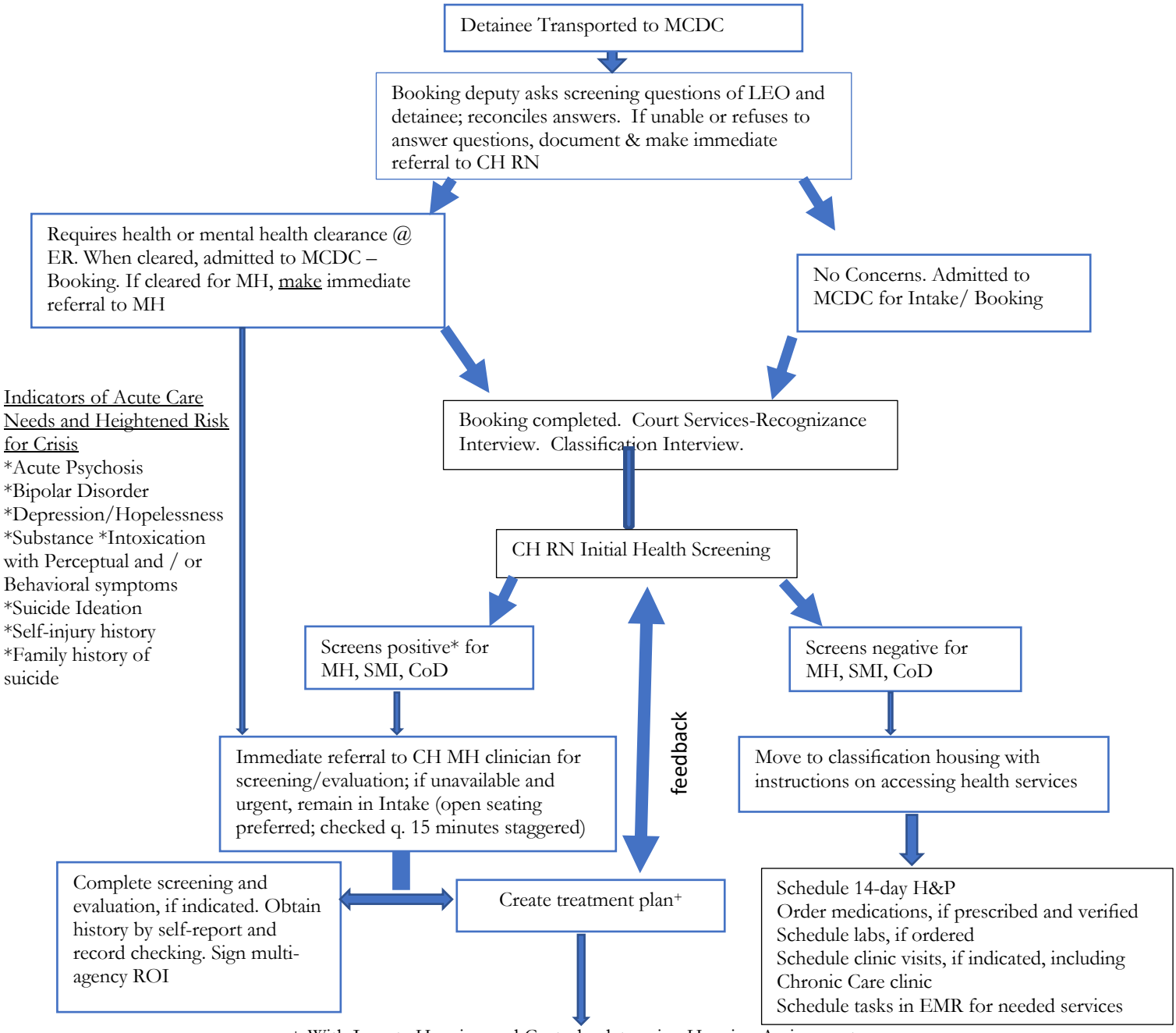
APPENDIX D. COLUMBIA SUICIDE SEVERITY RATING SCALE (WITH TRIAGE POINTS FOR CORRECTIONS) (from https://cssrs.columbia.edu)

SUICIDE IDEATION DEFINITIONS AND PROMPTS:	**Past month**	
Ask questions that are in bold and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up? ***Have you wished you Ire dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "*I've thought about killing ourself" without general thoughts of ways to kill oneself/ associated methods, intent, or plan.*" ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*" ***Have you been thinking about how you might do this?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, Int to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past 3 months?***	**Lifetime** **Past 3 Months**	

Response Protocol to C-SSRS Screening

Item 1 Behavioral Health Referral
Item 2 Behavioral Health Referral
Item 3 Same Day Behavioral Health Evaluation, Consider Suicide Precautions
Item 4 Immediate Suicide Precautions
Item 5 Immediate Suicide Precautions
Item 6 Over 3 months ago: Same Day Behavioral Health Evaluation, Consider Suicide Precautions
Item 6 3 months ago or less: Immediate Suicide Precautions

APPENDIX E: PROPOSED INTERNAL TRIAGE SYSTEM (admissions flowchart)



+ With Inmate Housing and Custody, determine Housing Assignment
+ Referral to Others (counselors; discharge planners, if indicated
+ Consult with Psychiatrist (emergency or scheduled), if indicated
+ Share risk & safety information with deputies, verbally and in writing
+ Schedule follow-up CH MH reassessments/contacts (24, 48, 72 hours; 1-2 weeks)
+ Initiate case management plan, including timing of follow up contacts
+ Refer for MAT, if appropriate
+ Refer for community services
+ Share information with referral agencies
+ Share information / findings/ recommendations with CH health staff
+ Medications @ release

RNs and CH Professionals Document Referrals and Related Information in EMR
RNs and CH Professionals Document Assessments and Plans in EMR