IN THE CIRCUIT COURT OF THE STATE OF OREGON
FOR THE COUNTY OF WASHINGTON

State of Oregon, Plaintiff; v. Carlos Zamora-Skaar, Defendant.	Cases No. 18CR79052, 18CR84154 Hon. Charles D. Bailey
State of Oregon, Plaintiff; v. Dustin Lee Wood Defendant.	Cases No. 19CR01852, 18CR79575, 17CR75655 Hon. Charles D. Bailey
State of Oregon, Plaintiff; v. Gale Merrill Defendant.	Case No. 18CR65775 Hon. Charles D. Bailey
State of Oregon, Plaintiff; v. Jay Mendoza, Defendant.	Case No. 18CR65775 Hon. Charles D. Bailey

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AMICUS CURIAE DISABILITY RIGHTS OREGON'S MEMORANDUM REGARDING CONTEMPT MOTIONS

In 2002, Disability Rights Oregon (then "Oregon Advocacy Center") filed a lawsuit against the Oregon Department of Human Services and the head of the Oregon State Hospital. The lawsuit alleged that the Oregon State Hospital wrongly delayed for "weeks and months" the admission of defendants in criminal cases found unable to aid and assist in their defense. *Oregon Advocacy Ctr. v. Mink*, No. CV 02-339-PA, 2002 WL 35578910, at *1 (D. Or. May 10, 2002) [*Mink I*]. The federal district court held a trial in the matter and found that Oregon detainees unable to aid and assist their counsel waited in jail an average of roughly 32 days for transport to the state hospital. *Mink I*, at *3. One prisoner waited 166 days for transport. *Id.*

The court held that detaining people in psychiatric crisis indefinitely was "unjust and inhumane" and that protracted jail detention "increases the likelihood that they may decompensate and suffer unduly." *Mink I*, at *4. The district court also held that "[t]he *lack of funds, staff or facilities* cannot justify defendants' failure to provide persons found unfit with the treatment that is necessary to attempt restoration of competency." *Mink I*, at *6 (emphasis added).

The district court then ordered the Department of Human Services (which later split its behavioral health function into the Oregon Health Authority) to provide "full admission of such persons into a state mental hospital or other treatment facility so designated by the" agency, "in a reasonably timely manner, and completed not later than seven days" after the determination of

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incapacity. *Oregon Advocacy Ctr. v. Mink*, No. CV 02-339-PA, 2002 WL 35578888, at *1 (D. Or. May 15, 2002) [*Mink II*].

The *Mink* defendants appealed the case to the Ninth Circuit on several points, each of which the Ninth Circuit rejected. *Oregon Advocacy Ctr. v. Mink*, 322 F.3d 1101, 1123 (9th Cir. 2003) [*Mink III*]. Of chief concern to the above-captioned proceedings, the State argued that the district court erred because its failures to achieve timely care of detainees with mental illnesses should have been determined individually and under a "deliberate indifference" standard. *Id.* at 1121.

The Ninth Circuit rejected this argument and held that a less strict "balancing of interests" standard should apply and that the general untimeliness of assessments could be addressed as a whole. *Id.* Since the state could not advance any legitimate interest in keeping detainees with serious mental illness in jails, the substantial liberty interests of the detainees weighed in favor of the verdict against the state. *Id.* The Ninth Circuit reiterated the district court's admonition that "lack of funds, staff or facilities" cannot defend the unnecessary delay of services to aid and assist detainees. *Id.*

The Ninth Circuit also observed that "OSH is solely responsible for the timely treatment of incapacitated criminal defendants" under Oregon law. *Id.* at 1119-20. It also recognized the "undisputed harms" of protracted detention of people with serious mental illnesses: that the continued lack of treatment would impair their defense, that county jail disciplinary processes,

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often including protracted isolation 22-23 hours a day, were unhelpful and often harmful to detainees, and that protracted detention tended to increase the risk of suicide and decompensation. *Id.* at 1120.

The holdings of the district court and the Ninth Circuit are just as valid today as when determined. If anything, a greater body of knowledge and expertise underlines and accentuates the extreme harms done to people with serious mental illness who remain unnecessarily detained in jail.[1]

Unlike the state's posture prior to the filing of the *Mink* complaint in 2002, , the state has now been on specific notice of the need to provide treatment within seven days and has remained under court order to that effect since 2002. The population of aid-and-assist patients at OSH has been regularly monitored. Since 2010, that population has grown precipitously. The daily population of aid-and-assist patients at OSH rose from 76 in March 2010, to 150 in December 2013, to 263 in March 2019, with 40 detainees on the waiting list.[2] While that population growth

[1] Jeffrey Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, 38 J. Amer. Acad. Psych. & Law 104 (2010) (describing the isolation of people with mental illnesses as akin to "torture" in its clinical effects, as well as exacerbating the risk of suicide). "[P]rolonged segregation of inmates with serious mental illness violates basic tenets of mental health treatment." *Id.*

[2] Oregon State Hospital, Aid and Assist Presentation to the Oregon Legislature (2014), *at* https://olis.leg.state.or.us/liz/2013I1/Downloads/CommitteeMeetingDocument/31877 ; OSH statistics, e-mail communication from OHA, March 22, 2019.

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has complex origins, the Oregon Health Authority has the ultimate authority to manage behavioral health care throughout the state.

The Oregon Health Authority manages the Oregon State Hospital, but also manages a complex array of community-based behavioral health services, operates the state Medicaid program, administers the grant of behavioral health funding to county authorities, and regulates all Oregon behavioral health placements, both public and private. No other entity in the state has such a substantial role in determining the course of behavioral health care in Oregon.

As part of a dispute resolution with the United States Department of Justice, the state of Oregon promised in 2016 to make changes to improve services to people with mental illnesses, in a document called the Oregon Performance Plan.[3] The Oregon Health Authority promised in that plan to meet certain benchmarks for performance in providing mental health care, many of which it has not met. For instance, OHA was to serve 2,000 individuals with a specific community-based service, Assertive Community Treatment, by June 30, 2018. *Id.* at 5. By that date, OHA had only gotten 1,248 people into that service.[4] OHA also promised in its plan that,

[3] State of Oregon, Oregon's Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness (2016) [Oregon Performance Plan] *available at* https://www.oregon.gov/oha/HSD/BHP/Oregon%20Performance%20Plan/Oregon-Performance-Plan.pdf

[4] Oregon Health Authority, Oregon Performance Plan Semi-Annual Narrative Report, January 2019, at 2, [Jan. 2019 OHA Report] *available at* https://www.oregon.gov/oha/HSD/BHP/Oregon%20Performance%20Plan/January%202019-Narrative-Report-with-Data-Report.pdf

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as of June 30, 2018, it would get 1,355 people into supportive housing, a type of independent housing with on-site supports. Or. Performance Plan, at 8. By June 30, 2018, only 1,036 had found supportive housing. Jan. 2019 OHA Report, at 7.

OHA further promised that it would get 85% of patients at the Oregon State Hospital out of the hospital within 25 days of them being determined ready for placement in the community. Or. Performance Plan, at 9. Not only did OHA not meet this goal, its performance on this metric actually got worse, dropping from 54% in early 2017 to 48% in early 2018. Jan. 2019 OHA Report, at 9. It promised to get 90% of patients out of the hospital in 120 days from admission by mid-2017. Or. Performance Plan, at 10. Even by mid-2018, OHA still only managed to release 54% of its patients within 120 days. Jan. 2019 OHA Report, at 10.

Without fully recapitulating the state's performance on the goals it set for itself (some of which it has met), the state's overall performance has been poor, especially on those relating to moving patients quickly through the hospital and into community placements. This backlog of patients creates a glut in the hospital, including many patients who, by OHA's own reckoning, do not need to be in the hospital.

The origins of this problem are complex, but many of the solutions are within OHA's capacity to address. Avoiding psychiatric crises that result in hospitalization or criminal charges requires adequate community-based resources, but OHA controls the community-based funding for those services. Fostering an adequate supply of community-based post-hospital care services

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and supported housing so that patients can leave the hospital promptly and reenter the community is likewise part of OHA's responsibility. Operating the hospital in a manner that promptly and appropriately admits, treats, and steps patients down to community sites is also within OHA's capacity.

Some factors behind this problem are outside OHA's capacity to control. County-level and municipal-level officials determine which individuals to arrest, choose which individuals to charge with crimes, and administer the local behavioral health systems. Some District Attorneys decline to proceed on low-level charges against defendants who lack competency, especially if the behavior at issue is driven by behavioral health concerns. Judges play a role in these decisions, as well. Community-based competency restoration services require collaboration between OHA, the Community Mental Health Program, and the court. OAR 309-088-0105 *et seq.* The availability of community-based restoration varies widely depending on the county in which the defendant happens to be confined. These factors, while significant, do not place the whole problem of hospital crowding outside OHA's control.

A constitutional right must be protected, even when protecting it is difficult or expensive. Providing appropriate, timely mental health care to individuals taken into custody under state law is not an optional service, nor is it a right that can be relaxed when resources are tight. A state can no more say it will prolong the detention of incapacitated individuals because the state hospital is crowded than it could say that it will only provide jury trials to some defendants

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because the court system is crowded, or that it will only seek search warrants before searching some homes because the police are too busy.

This Court is not charged with enforcing the Mink order or determining the extent of OHA's compliance with its own announced goals described the Oregon Performance Plan. This background, however, may be helpful to the Court in understanding the backdrop of the hospital crowding and in assessing whether any disobedience to this Court's orders was conducted willfully, since by tradition the contempt power should be used to protect a "recognized statutory, procedural, or constitutional right." *United States v. Woodley*, 9 F.3d 774, 782 (9th Cir. 1993). This Court can likewise consider whether OHA's noncompliance with its order constitutes "undue interference" with the judiciary's "core function." *Oregonians for Sound Econ. Policy, Inc. v. State Accident Ins. Fund Corp.*, 218 Or. App. 31, 49, as modified, 219 Or. App. 310 (2008).

Submitted this 30th day of April, 2019,

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