Final Report of Review of Due Process Procedures in Special Management Units at the Maine State Prison and the Maine Correctional Center

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EXECUTIVE SUMMARY

In the summer of 2010, the Legislatures' Public Safety Committee charged the Mental Health/Substance Abuse Focus Group with assisting the Commissioner of the Department of Corrections in reviewing the due process procedures and the policies regarding the placement of special management prisoners within it facilities. The focus group does have some additional members but due to schedules not all could attend every meeting. This report is based upon the consensus of opinion of the above mentioned members who were able to attend the majority of meetings. The "group" took its task very seriously and has spent 100's of hours doing the ground work necessary to develop this report.

Numerous members of the Department of Corrections were invaluable in supporting our work and responding to our many questions/inquires and visits to the facilities. They are named in the addendum to this report. Additionally the "group" would like to thank Deputy Commissioner Denise Lord and Commissioner Marty Magnusson for their openness, support and willingness to allow us to move well beyond the initial scope of the intended review and because they are already implementing many of the recommendations.

The “group” is also appreciative to the thoughtful and caring input of several advocacy groups. These groups, also named in the addendum, offered valuable insights, guidance and a needed perspective. We attempted to get a wide cross section of various groups who it was thought would bring a unique perspective. Written materials were also offered by several members of these groups that were felt to be invaluable.

The “group” has utilized a number of procedures to be certain we could obtain a clear understanding of the current policies and practices in the various facilities and units. A complete list of what we have reviewed and the procedures utilized is attached. While we have attempted an exhaustive review and selected procedures designed to give us an honest and realistic picture, we realize that some readers will never be satisfied with any product that continues to recognize the need for some type of special management unit in the facilities. We approached the task with an extreme amount of diligence and desire to complete our work and offer our unfettered opinions in an independent fashion. The “group” was insistent on an open exchange, independence and a candid report. We have not doubted what we were told or saw, but also sought ways to independently verify this information. We believe that we have accomplished this challenge in a manner that should satisfy reasonable parties.

This task was not a review of individual complaints or an investigation of individual circumstances. There are other processes for such oversight. Our initial meetings focused on defining what the task at hand was. While none of us are attorneys we were aware that due process as a topic that can clearly be viewed in a narrow context or much more broadly. The facilities are accredited, which is a significant task in and of its self and the Assistant Attorney General, Diane Sleek, for the Department of Corrections advised us that in her opinion the Department more than meets all legal requirements for due process under state and federal law. The focus group members all agree that such basic requirements for due process are in place in policy and procedures. We choose to take a much broader view of due process however and choose to go beyond the required scope of the charge. We each felt it was our challenge to offer whatever insights and assistance we could to improve the workings of these units. We sought to work toward an “evidence based/informed approach” with a desire to see these units be used in a rehabilitative fashion to the greatest extent possible and even made observations that we hope will greatly reduce the need for special management units. We are pleased to say this broader view was supported by the administration at all levels.

The report is based upon certain premises. First, is the fact that we believe that research and science should guide us whenever possible in our work. Secondly, we believe that despite the history of corrections, special management units should not be used for punishment per se. as we believe that the evidence does not support such an approach as effective in changing behavior. Thirdly, we all agree there are extremely challenging and dangerous individuals for whom placement in a general population would place themselves or others at extreme risk of harm or death and the use of some type of special unit will be necessary for the foreseeable future. Fourthly, because of the special aspects of the Mental Health Treatment Unit at Maine State Prison (MSP) and persons with mental illness we have dealt with our observations and recommendations in a specific

section of the report. Next, we did not attempt to develop a "Cadillac" or a frivolous system, but one which is just, practical and has a specific purpose for existing. Some of our recommendations carry a cost, a possible need for legislation, and many will take time to develop, implement, and evolve or mature. We did not see it as our place to dictate specific solutions but to offer ideas to shape directions, culture, and planning. We recognize that some of the goals and directions we recommend may have many possible solutions and it was not our task to consider all the possible ramifications that future exploration may uncover. We see this as an ongoing and developing task and that our report is only a step along the way. Finally, we know that relatively speaking, prisons are closed environments and many, clearly some members of the advocacy groups, fear what may go on behind closed doors. In the interest of these concerns, we are recommending the collection of relevant data and a process to review this data both internally and where relevant and legally possible, externally. In this regard, we also heard concerns about the grievance process. Some advocacy members felt there was a lack of access to a meaningful grievance process and that inmates are punished for filing grievances. It was felt this was largely beyond the scope of both our charge and ability to respond to. We did however include some recommended data collection that may shed light on the process.

We feel that the observations and recommendations in our report should help address the broadest view of "due process" but contains information that should enhance positive behavioral change that hopefully for some inmates will carry over to release into the community. The Focus Group also recognizes the nationwide trends for litigation regarding the use of special management units and the treatment of inmates with mental illness and we feel the recommendations contained in this report should go a long way in not only doing what is right and wise, but if implemented should also help to shield the State of Maine from such legal action as well as making us a model for other states to follow.

Getting into a Special Management Unit (SMU)

It may sound strange, but one of our concerns that arouse very quickly was the question of how does one get into a Special Management Unit (SMU). Why are they there in the first place? The policies are clear and well articulated. They seem to be followed correctly to the extent we could determine although there is considerable room for individual discretion and no tracking that we could discern about "areas" of the facilities or particular Correctional Officers (CO's) that were responsible for sending inmates. This makes it impossible to monitor on an ongoing basis if problems exist with any particular staff or unit. Conversely, it does not allow for positive recognition of areas that have more effectively dealt with problem behavior resulting in fewer referrals to SMU's.

There was a concern voiced at both facilities that individuals previously housed in the juvenile facilities made up a larger percentage of the members in the SMU's. We were able to collect some interesting data that clearly disproves this hypothesis. The juvenile facilities have reportedly almost completely done away with their special management unit and the data we collected demonstrates that less that 1% of all admissions to a SMU

are from an individual who previously were in a juvenile facility. The data indicates that very few juveniles from the two state facilities end up in a state correctional facility. It did indicate however of those few who do, many present as problematic since half will likely end up in an SMU.

Another presumption that we heard was that the residents of the SMU's were largely younger inmates. Again, we found the data did not support this view. The average age has been in the 30's, but has actually been showing a consistent upward trend in age going from a low of 28 years in 1999 to 34.75 years in 2011. These two facts alone appear to be contrary to assumptions of many staff in the units and could be seen as possibly critical factors in understanding better management approaches. It also calls up the need to have data rather than assumptions guide policy and management.

The Focus Group also found differences in how the two facilities carry out the management of their units. This is not to say, one was better than the other but it made the members wonder why when the policy was the same between facilities, were there such differences. Maine is unique in many ways but reviewing other programs across the country may prove helpful in guiding future changes. A common problem for both facilities but especially for MSP is dealing with inmates who engage in "cutting and self mutilation". The staff has already begun reviewing other programs that report success in this area. The group feels that such exchanges of information within the state facilities as well as beyond should prove very helpful.

We want to pause for a moment and remind the reader that the "High Risk" inmates are included in the SMU population. These include individuals who make up the most dangerous population in the State of Maine and who have a history of repeated violent and antisocial behavior. Careful consideration needs to be used when applying the recommendations with this population. Because the "High Risk" classification is partially based upon behavior prior to coming into the institution some of the recommendations will have a limited impact on the numbers of individuals being placed there.

One other special situation was brought to our attention that bears comment. Individuals who are suspected as possible participants in criminal activity while serving time may be housed in an SMU. We were told of extended time frames for investigations to be completed. While this is a challenging area and safety and order are critical, considerations should be given to monitoring how long someone is classified in such status and if investigations are truly active. It is reasonable to use such a placement, but we were told of cases that seem to be taking an extraordinary amount of time. The possibility of such a situation where this is ongoing and not brought to a reasonable conclusion can be viewed an abuse of due process.

Recommendation 1 Overview: The Focus Group recommends consideration of exploration and development of alternatives developed for the *general population* of inmates so *general population staff* will have more alternatives for behavioral intervention than what is afforded by the use of Disciplinary Segregation, Administrative Segregation and the Protective Custody inmates. This should result in hopefully

preventing many of them from being placed in an SMU. When an inmate is placed they frequently loose their bed and receive the most intensive/costly interventions available in the facility. The individual also has the experiences of the greatest degree of restriction and loss of liberty and rights. This could arguably be justifiable if the program worked at permanently changing behavior but current research and experience suggest that we achieve questionable positive effects on the inmate or their future behavior. One can even argue that repeated use of SMU's without the type of behavioral/prescriptive programming we are suggesting may well have a deleterious effect on future pro-social behavior. Better management of behavioral responses and contingent reinforcers, could well reduce not only the use of these units but result in an increase in appropriate behavior in the general population and hopefully a better transition to appropriate behavior in the community.

It appears that inmates in the general population currently receive a number of privileges that are not necessarily contingent on particular appropriate behaviors. It is likely that many of the inmates have come to see privileges, beyond required entitlements, as "rights". This creates a challenge in shifting the general population to a "contingent behavioral system" and could be problematic if not done slowly and carefully. It may in the short term even result in an increase in problematic behaviors as inmates deal with the shift. If done appropriately and with consistency any possible disruption should be short termed. This recommendation should not be viewed as a simple material reward program, but as one of total staff participation in a positive behavioral response program.

Such a program would of course have to take into account special challenges posed by inmates with medical, cognitive, brain compromises, or serious mental illness.

Recommendation 2 Overview: This is actually a recommendation that is carried over from the Mental Health recommendations that suggests hiring an experienced individual with skills in behavior modification. Such a person could well assist in making these changes for the general population as well as special management units.

Recommendation 3 Overview: It is recommended that the staff from both facilities meet periodically to discuss individual operations and ideas. The policy is the same for both adult facilities and there may be good reasons why operations differ, but much could be potentially be learned from each other and good ideas shared. In this meeting, if it does take place relevant data (outlined elsewhere) should be shared.

R**ecommendation 4 Overview:** In order to track and appropriately manage the SMU's a statistical overview must be collected on an ongoing basis. This would allow for target points to be set, oversight of operational referrals, and measurement of the efficacy of various proactive and rehabilitative efforts and finally achieve some public oversight of the use of the SMU's. More on the suggested data areas to be considered are included elsewhere.

Recommendation 5 Overview: Staff is encouraged to continue the process that has already begun to review other programs that have achieved an element of success in

addressing the challenges faced by our facilities. Data vs. assumptions should help clarify the challenges we face.

Recommendation 6 Overview: Careful consideration should be given to the High Risk population in implementing these recommendations. While the principals remain the same and should be considered, the impact may well be limited and conducted much slower.

Recommendation 7 Overview: An ongoing review of inmates placed in an SMU who are there awaiting completion of investigations should be undertaken and where necessary making investments in completing the investigative process in a timely fashion. The names and amount of time in an SMU should be sent to Central Office on a periodic basis.

The Units

A complete description of the units is incorporated in the addendum. A separate section is devoted to the Mental Health Unit at Maine State Prison.

The Maine State Prison includes the High Risk Management Unit (50 beds), which houses the most dangerous inmates and the Disciplinary and Administrative Segregation Unit (50 beds), and the Mental Health Unit (Two pods 32 beds). Each unit has attached an outdoor exercise area. These units were all very busy and there was clearly a significant amount of contact with staff and ability for inmates to observe, albeit from a small window, to goings on in the commons area. One problem that was immediately noted was a delay in the ability of inmates to leave the SMU‘s when they were behaviorally ready or had completed “their sentence”. A shortage of bed space to move them out prevented a timely departure. This is of course, further complicated by possible adverse associations that may have been related to the reasons for the inmate being in the SMU and of course security levels that dictated housing unit assignment. This was viewed as an area of serious concern by the Focus Group.

Maine Correctional Center (MCC) located in Windham, serves medium and minimum security inmates and houses the female inmates. It also serves as the primary “receiving and classification unit” for the entire system. The Maine Correctional Center has 17 male segregation beds and 5 female segregation beds. The female cells were stacked with 2 on the lower level and 3 above. The area out side these room was another enclosed area with no ability to observe the “action” outside as was the case with the men. Each room did have a window to the outside, but a wooden barrier was placed a few feet from this window that prevents both observation of the women flashing to an adjoining building but also prevents being able to see much or the outside. The walls are painted a bland color. The upshot of this discussion is the fact that the degree of stimulation deprivation of any sensory type is greatly increased.

No high risk inmates are housed at MCC other than an occasional high risk female. In such situations, where there is expected to be a need for long term placement such a

woman would be considered for an out of state placement. The MCC is an older facility and does not have the ventilation or climate control available at MSP.

Recommendation 1U: It is our understanding that the Department has opened another pod at MSP to help alleviate the backup of inmates in the SMU who are ready to leave. We were not able to observe, if this will completely address the problem or not. One additional solution could be to consider keeping the inmates "old cell open" for their return except in those cases where it is clear that due to security level changes or permanent reassignment they would not be returning.

Recommendation 2U: The Focus Group recommends that additional sanctions and behavioral incentives be developed for infractions in the general population that could alleviate as much need as possible for the use of administrative and disciplinary segregation. Such a program should include addressing, to the extent possible, criminogenic needs. This then "keeps the problem local" and makes staff share in the problem solving with the inmate, likely reinforces more pro-social behavior that should be of benefit on the outside and of course does not result in the loss of the bed.

Another concern was voiced about the possibility under the current policies that an inmate could be housed in an SMU cell for an extended period of time if "charges" were served sequentially vs. concurrently. We were not able to confirm, if this is in fact a problem but it was voiced as a possible concern and it appears possible under the policies we read.

Recommendation 3U: Inmates total time in any SMU status across the course of a year should be tracked and reported. Inmates who serve an excessive amount of time (TBD) in a unit should be reviewed by unit management, the warden, and central office. Such inmates should have a behavioral development plan put in place. Consideration of tracking sequential "sentences" should also be considered.

Policy calls for the availability of "Counsel Substitutes" to assist inmates in understanding the process and to serve as both advocates and advisors to inmates involved in Disciplinary and Administrative hearings. The inmate is given a list of possible Counsel Substitutes to choose from and this list may include both staff as well as inmates. It was clear that the SMU at MCC use the "Counsel Substitute" but this was not the case at MSP. At MSP reportly no inmates are currently trained and the two trained staff is in the process of being transferred. In our observation of the hearings taking place at MCC the Counselor Substitutes were in use and none were used or discussed with inmates at MSP. Members of the Focus Group observed several hearings of various types with such an individual at MCC. The particular ones we observed appeared competent and invested. The policies call for these individuals to be trained and to have ongoing training. It was our understanding that no additional training has been conducted although in a subsequent conversation there are plans to resurrect this process at MCC. At MSP, this appeared to be a largely foreign concept. The lack of training or availability is

complicated by the fact that due to budget constraints there is no longer an "Inmate Advocate" position at Central Office.

A secondary concern was some assurance that persons with serious mental illness or significant cognitive disabilities from whatever source receive additional support. This may come in the various forms including additional training on these disabilities for the Counsel Substitutes but in cases of serious disabilities this will likely be inadequate.

A related concern came from the lengthy document given as an orientation to the facilities and subsequent documents given to inmates in SMU's. There is little reason to believe that inmates with significant mental health problems or cognitive difficulties could understand the information provided.

Recommendation 4U: The policy calls for the availability of trained Counsel Substitutes and ongoing training. Unless policy is changed, Counsel Ssubstitutes should be made available at MSP as they are at MCC. This will require immediate selection and training of both inmates and staff who have the interest and capacity to do so. The training of additional counselor substitutes at both facilities should be ongoing. Insurance that the current Counsel Substitutes receives supervision and updated training should be considered. It should be mentioned that the Focus Group felt this is a challenging task for inmates to assume. We were not aware of any historical evaluation of the effectiveness or the degree to which their use does in fact safeguard inmate's rights in the process. Some form of evaluation could be considered and the future of the program be based upon the outcome.

Recommendation 5U: The loss of the "Advocate" position closed one avenue of recourse for inmates when differences arise between staff and inmates. The Focus Group understands the financial constraints of having such a position but recommends exploring possible alternative options to having such a position.

Recommendation 6U: Additional training should be offered to Counsel Substitutes to ensure they have an understanding of severe mental illness and cognitive difficulties that may interfere with an inmate's ability to properly participate in the proceedings. While they will not be able to have sufficient training to completely overcome such challenges they should be able to recognize when additional intervention is necessary to protect the rights of an individual.

Recommendation 7U: Consideration of reviewing any written material for inmates with major mental illness and or cognitive deficits should be considered to ensure they fully understand their rights and obligations.

The day we visited the MCC it was very hot and humid. The rooms in the woman's segregation unit were extremely hot with no discernable air flow. On the one hand, it is fortunate that there is not a need for more beds, but the lack of social stimulation and sensory deprivation in the women's area is a major concern. Several of the Focus Group

members voiced a concern over the sense of claustrophobia they experienced in these rooms even with our brief visit inside. We have no idea what the temperature is like during the winter but it is stifling in the summers.

Recommendation 8U: Consideration should be given to enhancing the air flow and climate control in the SMU's at MCC. This is especially critical in the woman's segregation area. Several CO's complained of the heat and the negative impact it has on them as well as inmates.

Recommendation 9U: Some consideration should be given to enhancing the sensory stimulation available in the woman's area. A painting on the wooden barricade, paintings on the walls in or out of the cell could go a long way to enhance this. The inability to observe human interaction out side the cell complicates this situation further. The need to change this environment to allow for more sensory input was considered a very high priority for the FG.

Policy calls for special training for staff on the SMU's and the ability of management to select and appropriately rotate individuals to avoid burnout and development of antagonistic attitudes. We heard this was not the practice in place. Union contracts control the placement of individuals and there has not been special training of staff. There was a Criss Intervention Training provided for selected staff on the mental health unit at MSP shortly after our visit however.

Recommendation 10U: Consistent with written policy, management needs the ability to select staff for the various management units and be able to rotate them. Leadership needs to provide ongoing training and support. This becomes even more important if a behavior management approach is in place. Such a program will only be successful if it includes consistent responses from all staff.

From what we could discern, the required checks by mental health and medical were completed on a timely basis. There was however clearly no consistent definition or data kept on what was assessed. There was also little evidence in any of the units that there was sufficient time for the mental health staff to do any true consistent therapy. Subjectively, it appeared and was reported to us that many of the individuals in the SMU's (outside of the Mental Health Unit) had a history of mental illness. The SMU's are also used to house a variety of inmates beyond the narrow definition of the original purpose. Suicidal inmates frequently find their way to these units and are held there as a measure of safety. While this may prevent a suicide because of the close watch status; it is far from therapeutic to have the degree of restriction placed upon them that mirrors the other units. Being cut off from family visitation is but one example. The MSP has been exploring ways to have differential privileges based upon behavior and the Focus Group encourages this continued exploration. The Focus Group also heard complaints from security staff of protracted suicide watches that to the security staff had little purpose.

There was a clear disconnect between the security staff and clinical staff. Little cross discussion was evident.

Recommendation 11U: Consideration of developing a varied protocol of supervision and care should be developed. This should include special provisions for suicidal inmates or other populations housed in the unit than what it was originally designed for. Such a program should incorporate therapeutic approaches relevant to the population served. Allowance for greater out of cell time including more social contact with others especially family where security concerns allow for it. The standard "no contact" visitation rooms are not ideal in addressing the depression and hopelessness that accompanies suicidal thoughts. Of course, each case must be handled individually. The Focus Group understands the challenge this creates for security personnel to have potentially more than one set of rules to adhere to in a pod. Nevertheless it was felt this should be pursed. Of course, other options for a different placement location other than an SMU could be considered as well. Placement in an SMU should not be universally equated with being placed in "solitary confinement". "Special management" should increasingly be defined as individually defined management.

Recommendation 12U: To properly address the mental health needs in this population it appears clear that more mental health staff will have to be hired. Ratios of staff to inmates should be considered that allow for minimal treatment to take place and not just the required checks.

Recommendation 13U: The development of a consistent behavioral check list and an assessment protocol should be developed, that all mental health staff will use for the required periodic checks. This should be charted and reviewed by senior mental health staff on a regular basis. Appropriate interventions should take place when deleterious effects are noted on an inmate. The actuarial outcome of this assessment should be tracked over time both individually and collectively. This recommendation is repeated for the MHU.

Recommendation 14U: Specialized training should be developed and offered on an annual basis for all staff on the SMU'S. This includes items on mental illness, de-escalation techniques, and the effects of a lack of stimulation. Additional topics should include brain injuries and other cognitive deficits. Cross training at Riverview the State psychiatric hospital could also prove helpful.

Recommendation 15 U: Security staff should be a part of any intervention plan. This includes joint meetings between treatment staff and security with a mutual respect for the challenges that each face. Security when appropriate will always trump treatment but efforts should be made to become a true team with joint decision making whenever possible.

Recommendation 16 U: For all inmates where significant security or safety concerns are not issues, increased out of cell time should be encouraged. "Normal activities", when and to the greatest extent possible, should be allowed especially for inmates housed in

this area that are not security risks. We understand that this could effect staffing. By policy and practice it currently takes a minimum two staff members to be present whenever an inmate is out of his cell. This maybe able to be reviewed if the inmates are carefully classified and have a history of compliance with an intervention plan. Clearly we are talking about inmates where it is reasonable to believe that less supervision and structure can safely be accomplished. This calls for careful risk and individual assessment.

Recommendation 17 U: From what we could ascertain, there is a perceived mission by the various staff members, but not a unifying 'Mission Statement" for each unit. The Focus Group recommends that each unit, by type, have a mission statement that directs the work on the unit. Similar units at both facilities should have the same mission statements unless there is a difference due to population differences. This mission statement should be posted as a daily reminder to all staff and direct the work on the unit. Staff and management may even be evaluated based upon the degree of evidence that their behavior is consistent with the mission. Data that supports the stated mission should be made public so the unit can be publicly evaluated as to its outcomes.

Recommendation 18 U: Individuals housed in a unit pending the outcome of an administrative or criminal investigation should have their cases reviewed monthly by the Warden and Central Office. Investigations should be concluded in a timely fashion and the outcomes dictate the subsequent placements.

Data Recommendations

The Focus Group was sensitive to the observations that the advocacy groups feel a need to have data available for internal and external review to measure and honestly reflect what is going on in the units. This was a concern shared by the Focus Group not because we believe that there is abuse, but to assure the public and to guard against abuse. Data should also provide markers indicating performance objectives and progress or lack there of toward identified goals. In this regard, the policies allow for many data monitoring points. A comprehensive data system should allow for not only problem identification but for positive recognition of areas or units as well. The following chart includes some areas that administration may consider collecting and the recommended output for review. Any public data will not have individual identifiers. The Board of Visitors should also be a source of review.

Recommendation 1D:

Data Collection Item	Output to
1). Numbers in the various units and basic demographics (No Names)	Central Office, Facility Administration, Facility Mental Health Authority and Public

2). Length of Stay in the various units (This includes individual and collective time)	Central Office, Facility Administration, Facility Mental Health Authority, and Public
3). Length of Stay past completion dates	Central Office, Facility Administration, Facility Mental Health Authority, and Public
4). Location referred from and by whom	Facility Administration and Board of Visitors
5). Grievances filed and outcome (By staff, inmate and area)	Facility Administration and Board of Visitors
6). Charted mental health "cell evaluations" (Common evaluation form)	Facility Administration and Facility Mental Health Authority
7). Individual inmate data (Cell extractions, Length of Stay in restraint chair Total time spent in SMU) Critical markers should be identified that would trigger a review by Central Administration.	Central Office, Facility Administration, Mental Health Staff and Board of Visitors
8). Individual Length of Stay shall be reported for persons housed in an SMU awaiting completion of administrative or criminal investigations	Administration and Board of Visitors
9). Individual treatment plans containing the persons age, crimes, educational history, mental health diagnosis and history of treatment, trauma history and the nature of misconduct in addition to the SMU history	Central Office, Facility Administration, Facility Mental Health Authority and Board of Visitors

This would be reviewed whenever a question or concern was raised regarding an individual inmate.

10). Number on suicide watches	Central Office, Facility Administration Mental Health Staff, and Board of Visitors

Length of Stay on a suicide watch by name markers should be set to determine when a review is triggered to go to Central Office

Recommendation 2 D: A plan should be developed indicating what data reflects the mission statement. Such data should be openly shared on the unit and with administration as well as the Board of Visitors. This data should be trended over time to reflect the progress and to assist in properly managing the unit. Where possible this data should be made public.

Recommendation 3 D: The Focus Group recommends the combined staff and administration develop achievable goals, derived from the Mission Statement, based upon data, be set and communicated to all on the unit. Some goals for example could be a reduction restraint chair time and frequency of use, a reduction in the number of extractions needed, and a reduction in staff and inmate injuries. These are examples of what maybe considered. Many will say that such goals are not within the control of the staff but solely dependent upon the inmates behavior. While this is partially true, research and experience tells us that, when something is identified as a goal, measured and valued there can be positive change in areas as challenging as these identified.

General Conclusion:

This review is only the beginning of a process that should be ongoing. The members of the Focus Group, the advocates and the participants from Department of Corrections and the Department of Health and Human Services administration all felt that significant progress is possible beyond, where we are at and that it will require open collaboration and communication of all of the stakeholders. While there is a cost to some of the recommendations most are based upon the "way we do business" and have no direct cost. Those that do have a cost must be weighed against competing demands, long range outcomes, expected effects on recidivism and public safety and the simple humanity of what we do.

Mental Health Unit Recommendations

Introduction:

The Mental Health Unit at the Maine State Prison (MSP) presents unique challenges; thus, the Mental Health Focus Group (MHFG) is devoting a separate section of its report to this unit. The MHFG observations and recommendations are offered in an effort to improve the quality of focused treatment that these inmates receive, and to support both correctional and mental health staff in their challenging role with a complex group of individuals. Generally, the MHFG was impressed with the level of commitment on the part of both the correctional officers and mental health staff, and their desire to treat inmates in a humane and therapeutic manner

The report that follows describes the nature of the Mental Health Unit (MHU), its inmate population and the inherent treatment/management issues. It includes a series of recommendations divided into four major areas:

- "Milieu Therapy".
- Access to medications
- Access to valid therapy
- Interventions focused on "Axis II" personality disorders & criminogenic risk factors

Each of these areas will be described in more detail later in this report, with specific recommendations immediately following the description.

MHU - Physical location

By way of physical orientation, the Mental Health Unit is contiguous with the segregation units. All of the "special management units" share staff, administration and a generally similar physical environment.

The Mental Health Population

Most inmates placed in the MHU have a history of chronic psychiatric conditions that have been poorly managed for a variety of reasons including:

- individual compliance with prior treatment recommendations;
- difficulty accessing the complex care they require;
- presence of two or more "co-occurring" and other factors that make for difficulty in developing a comprehensive evaluation and management plan

These individuals frequently experience substance abuse disorders, traumatic brain injuries, chronic medical conditions, serious mental health problems (often with behavioral component), and criminogenic risk factors. Most have extensive experience in

both the mental health and criminal justice systems. Separating out what behaviors are due to mental health conditions, personality disorders (which are often not particularly amenable to treatment) and criminogenic risk factors is a major challenge in itself. Housing and treating persons with major mental illness and co-occurring disorders in correctional settings is a challenging task under the best of circumstances Successful treatment of troubling behaviors requires expert assessment and management.

Mental Health Unit – Interventions & Recommendations

The Mental Health Unit is largely a "**housing unit**" as opposed to a treatment unit. Successful treatment and ultimate behavioral change in incarcerated persons with major mental illness falls into the four major areas of intervention noted above. The **first** is **"milieu therapy"**, or milieu management.

Milieu therapy involves structuring the physical environment, staff mix, and the mix of "patient populations" to achieve therapeutic aims with the population being served/treated (in this case mentally ill inmates). The "milieu" at the MSP unit leaves much to be desired. Access to therapeutic resources is severely limited. Inmates have few activities, minimal access to outside resources and a very restricted. physical environment. The MHU performs multiple functions in addition to serving inmates with serious mental illness. It is variously used as a protective custody unit, an, acute crisis unit, and at times as a substitute infirmary. Compared to a hospital setting there are few therapeutic activities. This detracts from the primary focus of the unit.

"Milieu" Focused Mental Health Unit Recommendations

Recommendation MHU 1: The unit should, except in extreme emergencies, be used to house only persons who are experiencing major mental illness or are in need of crisis stabilization.
Recommendation MHU 2: Ideally, the MHU should be separated from the other SMU's, physically, administratively, and through dedicated staffing. If capital construction is not feasible, strong consideration should be given to administrative/staffing separation.
Recommendation MHU 3: Despite the previous recommendation, the Department of Corrections/Maine State Prison should introduce more of the educational, training, and support services that are accessible to the general population.
Recommendation MHU 4: Further exploration into use of enhanced milieu treatment should be undertaken. For example, the use of "sensory rooms" similar to what used in the state hospitals may prove effective in reducing behavioral escalation, and confrontations.

The **second** major and necessary component of treating major mental illness is **access to psychiatric medications**. Use of such medications in the MHU targeted directly toward psychiatric symptoms of the various mental illnesses among this population, as opposed

to use of drugs for behavioral control (chemical restraint"). A major obstacle to successful medication management with this challenging population is the lack of legal authority to administer involuntary medications with incarcerated populations. In the absence of enabling legislative authority, inmates must voluntary agree to take these medications, with the exception of a legal guardianship specifying that medications may be administered involuntarily. The Mental Health Focus Group was informed that it can take up to two years to process a successful application for a medical guardian.

While the primary concerns in medication management for this population is targeting psychiatric symptoms, many of the psychiatric conditions these Mental Health Unit inmates experience do, in fact, have significant behavioral components. These features can make it difficult for these inmates to conform to expected behaviors, and without treatment it is often unrealistic to expect these individuals to moderate aberrant or out-of-control behaviors. When a mentally ill inmate acts out in a way that presents safety or health concerns, without reasonable access to psychiatric medications the only option left is to "lay hands" upon them and use restraint or room isolation. The availability of medications to treat these conditions will improve both quality of life for the individuals, reduce the likelihood of physical confrontations, and reduce episodes of restraint. Restraining an inmate typically presents a high level of risk for both the inmate and correctional staff.

Inmates suffering from serious mentally illness, and possibly psychosis, often do not possess consistent "capacity" to make informed, rational decisions regarding the potential benefits of medications or other treatment interventions. It is noteworthy that many of these individuals have significant histories of non-compliance with medication and overall treatment regimens. This non-compliance for some has been a significant contributing/precipitating factor leading to their incarceration in the first place.

The Mental Health Focus Group acknowledges the valid concern that medications can be used inappropriately for behavioral control. The Mental Health Focus Group believes that with proper monitoring such concerns can be largely mitigated. The Rights of Recipients of Mental Health Services (RRMHS) which have been in effect since 1985 provide a model for safeguards in administering involuntary medications when medically necessary. These rights pertain to hospitalized inpatients, and with some additional controls and monitoring should be sufficient to achieve therapeutic goals while protecting individual rights.

Medication Management Recommendations

Recommendation MHU 5: Introduction of legislation providing for involuntary medication use through a combination of judicial and psychiatric supervision should be seriously considered. This legislation would provide additional safeguards over and above those in place for civilly admitted psychiatric inpatients. The use of such a provision should require the administrator of the facility, the medical provider and an outside medical provider to agree on the proposed treatment plan. A similar mechanism for the county correctional facilities could be useful as well.

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Recommendation MHU 6: Even with enabling legislation in place, it will be important to explore ways to accelerate the process for obtaining medical guardianship in select cases. This is an issue that goes well beyond the MHU. The DOC may want to consider ways to develop a separate application and assignment system for appointment of guardians.

The **third area** of required treatment of mental illness for this population is **access to valid therapies**. The Mental Health Focus Group is concerned about the thinly staffed mental health services. We reviewed records, individual charts, and time sheets, as well as speaking with inmates and staff. A preponderance staff time is spent completing inmate checks required by policy. One inmate noted a problem with staff turnover. This inmate stated that that he sees a therapist for 30 minutes a week, and even that time is often cut short because of therapists being called away. No consistent access to therapy is possible given the staffing ratios and the demands on therapists. Access to appropriate therapy is further complicated by the high proportion of inmates who also have co-occurring substance abuse disorders. This is another problem area needing attention.

Recommendations focused on access to valid therapy

Recommendation MHU 7: Serious consideration should be given to providing additional mental health staff to ensure a program of ongoing therapy. These therapists should be "co-occurring qualified" to address both mental health and substance abuse issues. Additionally, we recommend that serious consideration be given to hiring a "Behavioral Therapist" to consult in individual cases and to assist the entire facility in developing more effective behavioral management approaches. This is a foundational recommendation upon which several other recommendations in this report are built.

Interventions Focused on Personality Disorders and Criminogenic Risk Factors

The **fourth area** of focus relates to **treatment of those inmates who suffer from mental illness complicated by "Axis II" personality disorder diagnoses and/or criminogenic risk factors.** Mental Health Unit treatment plans should address these challenges. Opportunities must be provided to develop and practice pro-social behaviors while incarcerated. Risk factors for hospitalization, substance abuse relapse, and criminal recidivism should be addressed through ongoing programming and as release dates approach. Addressing risk factors in the inmate population with criminogenic thinking and/or personality disorders is extremely challenging; still, approaches do exist that can have a modifying effect e.g. Cognitive Behavioral Therapy (CBT), and Dialectical Behavioral Therapy, (DBT). Follow up into the community upon release is more essential

for this population that for most inmates. Targeted support services are essential to reduce the likelihood of relapse or recidivism.

Recommendation MHU 8: Every treatment plan should include a plan for addressing risk factors for relapse or recidivism. Structured opportunities to practice pro-social behavior while incarcerated, coupled with careful release planning that includes this information is essential.

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Recommendation MHU 9: Exploration of ways to enhance support services around these inmates upon release should be explored. This is clearly an area for systematic joint planning between the DHHS and the DOC.

The remaining section addresses the same major areas contained in the complete overview report for all Special Management Units. These include ***Policy, Physical Plant*****,** ***Staffing, Training*** **and** ***General Recommendations*****.**

Policy: Mental Health Unit policies appear to be comprehensive and cover all the expected and core areas. With a couple of exceptions, it appears that the letter of the policies is carried out. One concern is that there is no clear definition of what constitutes a "check." This concern crosses all of the Special Management Unit's.

Secondly, despite the adequacy of policies related to use of administrative segregation, the Mental Health Focus Group acknowledges the universal concern among advocacy groups related to the potential adverse effects of isolation on inmates. In a strict sense this is not a concern on the "A" pod of the Mental Health Unit; however, on the "B" pod inmates are "locked–down" in a manner similar to that in the high custody and administrative Special Management Units.

Recommendation MHU 10: A common behavioral rating checklist and assessment protocol should be used and documented for all individuals housed in an individually segregated cell. While still subjective to a degree this would call attention to critical areas requiring ongoing attention. The data produced should be monitored regularly to ensure that an inmate is not deteriorating or in need of additional treatment. Monitoring the mental/medical health status of the inmates and the effect of being in a Special Management Unit (SMU) is a joint responsibility of both security staff and the medical/mental health staff.

Recommendation MHU 11: A separate policy should be developed for the Mental Health Unit as distinct from the other SMU's. This reflects the Mental Health Focus Group strong belief that the Mental Health Unit should be treated as distinct from those SMU sections that serve a disciplinary or administrative function.

The Mental Health Focus Group reviewed the manual given to all SMU inmates. While comprehensive, it is clear that many inmates would not be able to make use of it. It contains very small print and is a densely written document. It would be minimally understandable for persons whose native language is not English, those who are illiterate or have other educational/intellectual deficits, and those who are severely mentally ill. Consequently, it is of little value in guiding behavioral expectations or assisting the inmate with understanding their rights and obligations. The Mental Health Focus Group is unaware of a resource to assist inmates whose ability to comprehend the manual is compromised. Finally, some of the policy information does not fit with the Mental Health Unit as outlined in this document since it is primarily focused on the administrative and disciplinary aspects of an SMU.

Recommendation MHU 12: This recommendation has three components:

A. The inmate manuals should be specific to the unit in which the inmate resides
B. Efforts should be made to make the document comprehensible and useable by all. This may require an abbreviated document that contains pictures, other languages or larger print and a reading level test.
C. For those inmates who have impairments that make understanding of this document challenging some type of assistance should be offered to make certain those inmates both understands expectations and can receive full benefit of the "Due Process Rights" and appropriate assistance in safeguarding all their rights.

The policy calls for "specially trained," "selected," and "rotated" staff in all of the SMU's. This does not appear to be happening. The Mental Health Focus Group does recognize that the DOC did recently have a National Alliance of the Mentally Ill (NAMI) Crisis Intervention Team (CIT) group training for several officers. This is a positive development. The collective bargaining contract restricts management's ability to specifically select correctional officers for work schedules/assignments, and the bid process makes it difficult to rotate officers. We heard from officers who indicated a desire to work on the SMU, but also heard they felt a need for an occasional break
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Recommendation MHU 13: This recommendation also has three components:
A. Staff should be carefully screened and specifically selected for work on this unit
B. MHU staff should receive initial and ongoing training. Exploration with DHHS for cross-training as mental health workers should be explored. Additional training should take place on an ongoing basis.
C. Staff should be allowed to rotate off of any of the SMU's on a periodic basis.

Physical Plant: The Mental Health Focus Group was concerned that the Mental Health Unit is contiguous to the other SMU units. Staff, administration, policy and culture are shared. These are clearly separate and distinct units that have very different missions. It is belief that facilitating all of the necessary changes will require these units being separated. The physical environment is not conducive to therapeutic change. The Mental

Health Focus Group fully recognizes that the MHU serves a "correctional" function, but it should also be designed to serve as a therapeutic environment.

Recommendation MHU 14: A plan should be developed with short and longer-term milestones to create a distinct MHU in terms of physical separation, environmental re-design, and separate management. Several MHU Correctional Officers recently toured the Riverview Psychiatric Center and were quite amazed at the differences in the physical environment even though at various times they house many of the same individuals. Well-trained staff are critical to positive outcomes, but the physical environment can enhance or constrain program effectiveness. Design and management issues should be a shared responsibility between Department of Health and Human Services and the Department of Corrections.

Staffing: The Mental Health Focus Group was impressed with many of the security and mental health staff with whom we interacted. The MHU is a challenging work environment that requires Correctional Officers to serve both security and therapeutic roles. Some of the officers complained that they are not able to attend treatment team meetings, and further that their input on individual cases is not consistently valued. They also indicated that they are given tasks to accomplish with inmates, but with inadequate direction or support to accomplish those tasks. Several MHU staff expressed a degree of frustration that security staff is too restrictive with certain inmates and that mental health concerns take a back seat to security decisions.

In addition to the previous recommendations that concern staffing issues, (selection, training and rotation, additional mental health staff, and a consulting behavioral therapist) an additional recommendation for this area follows:

Recommendation MHU 15: Work flow should be re-designed in a way that allows both security and mental health staff to be mutually involved in each and every case. This may include opportunities for joint treatment team participation joint task responsibilities, shared goal setting, and shared intervention efforts.

General Recommendations: The Mental Health Unit receives patients/inmates from multiple sources, including:

- Riverview Psychiatric Center;
- County correctional facilities;
- Infirmary overflow:
- General population at Maine State Prison: and,
- All the other state correctional facilities.

A diverse mix of inmates is transferred to the MHU, often for purposes incompatible with the core MHU mission. The Mental Health Focus Group was concerned about the treatment mix of such a diverse group of individuals. Staff reported concerns about how

inmates were selected/accepted, how priority of entry is determined, and length of suicide watches, as well as the previously noted concern about their dual role as therapeutic agents and security guards. Staff further expressed their opinion that the MHU appears at times to become a "dumping ground" for inmates who present behavioral problems in other facilities or MSP units Other concerns expressed included difficulty securing services for community re-entry, problems with release placements, and the lack of a comparable unit for female inmates. One additional concern is that with the exception of A1 all of the inmates are largely treated with the same security measures (i.e. only one hour out-of-cell time daily) regardless of their reason for being transferred to the MHU.

Space and staffing are at a premium throughout the facility, and the Mental Health Focus Group understands the practical need to utilize all spaces in a functional manner; however, the Mental Health Focus Group is concerned that treatment is negatively impacted for those most in need when inappropriately diverse use is made of the MHU. Given the numbers of persons with major mental illness in our state and county system the MHFG was somewhat surprised there were not more truly mentally ill inmates admitted. Finally, as currently configured and staff, it is unclear how the MHU can function as a rapid stabilization and diagnostic/assessment unit

Recommendations MHU 16: Administration should clearly define the mission and optimal use of the MHU and develop clear, enforceable guidelines for admissions to the unit. Further, a review and analysis should be completed of ways to move the MHU toward becoming a functional diagnostic and crisis stabilization unit.

The issue of suicide watches and subsequent restrictions is highly complex, even in mental health settings. Essentially, it should be relatively easy for any staff with reason for concern to place an inmate on suicide watch. Only licensed staff should be permitted to remove such level of observation. Ideally, both placement on, and release from suicide watch should be a partnership between security staff and licensed mental health staff.

Recommendation MHU 17: In recognition of the complexity of the MHU population, the Mental Health Focus Group recommends the operation of the Mental Health Unit be made a joint responsibility of DOC and DHHS. The Mental Health Focus Group is unclear whether this is feasible or possible, but believes that the idea should be explored by the two departments and the legislature.

Recommendation MHU 18: The lack of a comparable unit for female prisoners was a concern for the Mental Health Focus Group. Female inmates are fewer in number but growing rapidly. There are fewer with psychotic disorders but as a group they tend to have more complex mental health challenges and trauma histories. The Mental Health Focus Group recommends that planning begin immediately to better serve this complex population.

Recommendation MHU 19: Although it presents a challenge to staff to have more than one set of rules in a unit, inmates who are housed in A2 who do not pose a security risk should have more out of room time whenever possible.

This is a complex population as outlined previously in this report. Not only are their needs more complex while incarcerated, but will likely be even more complex upon release from the structure of incarceration. Placement, treatment compliance, housing, access to services, and funding all present significant challenges. Relationships with law enforcement and public safety personnel generally also require significant attention.

Recommendation MHU 20: Detailed and careful release planning is a must for this group. Treatment, funding, housing, employment, individual and public safety as well as the complexity of funding resources is extremely challenging. These issues should be considered a shared responsibility between the Department of Health and Human Services and the Department of Corrections. Planning should start long before discharge and a means for funding basic required services for those not receiving any form of financial support should be defined.

Conclusion:

The Mental Health Focus Group recognizes that the recommendations contained in this report run the gamut from relatively straight-forward and achievable, to highly complex and difficult to envision in the near or longer-term. The Mental Health Focus Group also understands that we are essentially dealing with "downstream" problems in the case of many inmates who are placed in the MHU. We cannot over-emphasize the importance of "upstream" solutions such as pre-trial/jail diversion programs, mental health and drug courts, and other programs to reduce the number of individuals with mental illness who end up incarcerated in the first place.

Having said this, we must play the hand that we are dealt even while planning long-term system improvements. The Mental Health Focus Group is not suggesting that the MHU at the MSP become a state-of-the-art mental health treatment facility; however, it is critical that those individuals with significant mental health issues who become inmates in our correctional facilities receive access to the best possible set of interventions to address their psychiatric symptoms. In the long run, these interventions should have a positive impact on reducing recidivism, enhancing public safety, and contributing to an improved quality of life for these inmates when they return to the community.