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Long Creek Youth Development Center  
Conditions Assessment Narrative Report

September 2017

CENTER FOR  
Children's  
Law *and* Policy

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## INTRODUCTION

In August 2017, the Maine Juvenile Justice Advisory Group (JJAG) entered into a contract with the Center for Children’s Law and Policy (CCLP) in Washington, DC, to conduct an assessment of conditions at the Long Creek Youth Development Center (Long Creek) in South Portland, Maine. CCLP staff and a team of experts in education, medical care, and mental health care reviewed materials and conducted the inspection of Long Creek during August and September 2017. This narrative report, along with the corresponding assessment checklist, constitutes the team’s findings and recommendations.

## METHODOLOGY

The assessment team consisted of the following:

- **Mark Soler**, Executive Director, Center for Children’s Law and Policy
- **Jason Szanyi**, Deputy Director, Center for Children’s Law and Policy
- **Jennifer Lutz**, Staff Attorney, Center for Children’s Law and Policy
- **Andrea Weisman**, Ph.D., Consultant and Mental Health Expert
- **Ronald Shansky**, M.D., Consultant and Medical Expert
- **Peter Leone**, Ph.D., Professor, Department of Counseling, Higher Education, and Special Education at the University of Maryland, and Education Expert

The members of the team have significant experience conducting conditions of confinement assessments. Mark Soler has worked on juvenile justice reform, with a special focus on conditions of confinement, for nearly 40 years – 28 years at the Youth Law Center and the last 11 as founder and Executive Director of CCLP. Jason Szanyi has worked at CCLP since 2009, where he has focused on improving conditions in juvenile justice facilities. He has particular expertise in implementation of the Prison Rape Elimination Act (PREA) standards for juvenile facilities. Jennifer Lutz has been a staff member at CCLP since 2015, where she manages the Center’s campaign to end the solitary confinement of youth and trains individuals on conditions in juvenile facilities. Dr. Andrea Weisman has experience directing health and behavioral health services in juvenile and adult facilities in Washington, DC, and Maryland for two decades and has served as a mental health consultant to the U.S. Department of Justice and the U.S. District Court for the Southern District of Ohio. Dr. Ronald Shansky is a former Illinois Department of Corrections Medical Director who has served as a consultant on correctional health care for more than 25 years and was the federal court-appointed receiver for health care for the Washington, D.C. jail. Dr. Peter Leone is a Professor in the Department of Counseling, Higher Education, and Special Education at the University of Maryland. Dr. Leone has evaluated education services, monitored educational programs, and provided technical assistance in jails, detention centers, training schools, and prisons in a number of states. He is the former Director of the National Center on Education, Disability, and Juvenile Justice at the University of Maryland.

From September 6-8, 2017, team members conducted an on-site assessment of Long Creek. Following an introductory meeting and brief tour of the facility, the team engaged in interviews,

observations, and review of records at the facility. As part of the assessment, team members interviewed facility administrators, medical and mental health staff, direct care staff, supervisors, unit managers, maintenance and food service staff, educational professionals, youth, and other staff. Prior to the on-site visits, team members requested and received policies, incident reports, grievances, data reports, and a wide variety of other records about Long Creek's operations. The team also conducted an exit interview with facility administrators and staff, which was attended by Department of Corrections (DOC) Commissioner Dr. Joseph Fitzpatrick and DOC Associate Commissioner Colin O'Neill.

When conducting the assessment, the team used the most demanding set of standards for juvenile detention facilities in this country, the Annie E. Casey Foundation's Juvenile Detention Facility Assessment Standards. The standards were co-authored by CCLP and the Youth Law Center for the Foundation's Juvenile Detention Alternatives Initiative (JDAI). The standards are used to assess and improve conditions in over 300 JDAI sites in 39 states and the District of Columbia. The State of Maine participates in JDAI. In 2014, a team of local officials and individuals conducted an assessment of Long Creek using a previous version of the JDAI standards, which have since been revised.

The JDAI standards have been cited in investigations by the U.S. Department of Justice's Civil Rights Division. They have also served as the basis for federal and state legislation, as well as many agencies' policies. For example, CCLP staff worked with legislative task forces in Louisiana and Mississippi in recent years to help those states develop comprehensive mandatory statewide standards for their juvenile facilities following numerous lawsuits and concerns about conditions in those states.

The Detention Facility Assessment Standards were initially released in 2006 and revised in 2014. The standards were developed following an extensive review of applicable federal statutes; federal and state court decisions; settlement agreements in conditions of confinement lawsuits brought by the U.S. Department of Justice and public interest law offices; professional standards, including those of the American Correctional Association, the National Commission on Correctional Healthcare, and Performance-based Standards; best practices in jurisdictions throughout the country; and consultation with over three dozen recognized subject matter experts, including former facility administrators.

The standards are organized into eight categories that cover all major areas of a facility's operations and use the acronym CHAPTERS:

- Classification and intake;
- Health and mental health services;
- Access to family and counsel through mail, telephone, and visitation;
- Programming, including education, special education, recreation, and religious services;
- Training and supervision of staff;
- Environment, including issues related to sanitation and the physical plant;
- Restraints, room confinement, due process, and grievances; and
- Safety of youth and staff in the facility.

The team used these standards to prepare this narrative report and a checklist of conformance or non-conformance with each individual JDAI detention facility standard. The team added a number of standards around individual treatment planning to reflect the fact that Long Creek houses both committed and detained youth. These standards are highlighted in yellow in the accompanying checklist.

There are inherent limitations in this type of assessment. The team did not interview every staff member at the facility, nor did it visit the facility over an extended period of time. Nevertheless, the comprehensiveness of the assessment standards; the extensive interviews conducted with administrators, staff, and youth; the experience of the members of the assessment team; the review of available data and records; the observations made throughout the facility; and the receipt of consistent information from multiple sources provided a strong foundation of information for developing this report.

In addition, the assessment process inherently focuses attention on areas of concern, and may not fully explore all of the strengths in the facility. The assessment team appreciates the effort that DOC Associate Commissioner Colin O'Neill, facility administrators, their staff, and others put into making the assessment process a success. We extend special thanks to Chris Concannon, who spent significant time and energy preparing for and coordinating the team's assessment among his many other responsibilities at the facility.

## FINDINGS AND RECOMMENDATIONS

We first outline general findings and recommendations with respect to the facility, as they provide important context for the entire report. We begin with general areas of strength, and then outline general areas of concern. We also include a section on external factors beyond DOC's control that the team believes are contributing to dangerous and unhealthy conditions for both youth and staff at Long Creek.

The report then outlines findings and recommendations in each of the eight areas of the CHAPTERS framework. The report concludes with final recommendations for Long Creek and its partner agencies. As outlined below, the team recommends a comprehensive look at the trajectories of youth into the juvenile justice system and a new conversation with state agency officials about gaps in services for at-risk youth in Maine.

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### GENERAL STRENGTHS

Several aspects of operations of Long Creek are excellent. We discuss these in detail in the body of this report. First, we want to point out some overall strengths of facility operations.

**Long Creek has some energetic and highly motivated leaders who are interested in raising the level of practice at the facility.** The team was very impressed with many of the facility administrators during its assessment. Although the facility is facing a number of serious challenges, as outlined below, it is clear that there are dedicated professionals at Long Creek who are committed to tackling long-standing problems and improving conditions, policies, and practices at the facility. As mentioned below, these individuals are not responsible for many of the factors contributing to problematic conditions at Long Creek. To the contrary, they have been diligently working to try to remedy these problems in the face of significant shortcomings among Maine's other support systems for at-risk youth and families. The team also learned that DOC had recently hired a new Superintendent for Long Creek, Caroline Raymond, who is a licensed clinical social worker and a former chief executive of a substance abuse treatment provider for youth in Maine. The team believes that Ms. Raymond's experience as a treatment provider and her history of working with youth (including youth at Long Creek) will help the facility shift toward implementation of policies and practices that are consistent with adolescent development and the mental health and treatment needs of youth. We hope that Ms. Raymond takes advantage of existing networks of juvenile justice professionals, such as the JDAI community and the Council of Juvenile Correctional Administrators. We are committed to working with Ms. Raymond and other administrators to identify peers and learning opportunities that can help the team advance its mission and vision for the facility.

**Many line staff and supervisors demonstrate high levels of skill and professionalism.** Long Creek has staff members who have spent many years working at the facility, and it was obvious that many staff members took great pride in their work with young people. The experience and dedication of staff was apparent in our conversations with these senior staff members. As mentioned below, these staff members have worked to operate the institution in the face of significant staffing challenges and a need for additional mental health resources.



**Administrators and staff have done an outstanding job of bringing outside volunteers and programming to youth in the facility.** The team was thoroughly impressed with the effort that staff and administrators have made at Long Creek to bring in outside organizations and volunteers to provide programming and skill-building opportunities for youth. As described in more detail in the Programming section below, these partnerships include a relationship with Goodwill Industries to provide job readiness skills to youth and partnerships with Southern Maine Community College and the University of New England to provide enhanced educational opportunities for youth (including college-level courses). The facility has an active list of over 100 volunteers who come in to work with youth on a regular basis, and administrators regularly secure special one-time programs for young people as well, which the team had the opportunity to observe while on-site. Team members could not recall another facility that had invested as much effort into bringing in such a wide array of programming as Long Creek has done.

**Long Creek has recently invested in raising base pay for line staff and identifying candidates for staff positions who are well-equipped to work with the facility's population.** As mentioned below, staffing shortages, resulting from a range of interconnected issues within and outside of Long Creek, have put the facility in a dire situation. Nevertheless, the team was encouraged to hear about recent efforts to raise the base pay for Juvenile Program Workers. The team also heard from multiple administrators that recent changes to the hiring process had brought in more qualified candidates for open positions. The team encourages administrators to continue to invest in this effort given the grave concerns with the safety and security of youth and staff in the facility at this time.

Other strengths of Long Creek's operations are discussed below in the body of this report.

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## GENERAL AREAS OF CONCERN

During the assessment, the team identified a number of concerns that impact all aspects of facility operations.

**Staffing shortages at Long Creek are hindering the ability to supervise youth in a safe and humane manner, and they are jeopardizing the safety of staff as well.** The team was alarmed at the staffing shortages at Long Creek, which have led to a number of very concerning conditions and practices, outlined below. Overall vacancy rates for the facility have nearly doubled since the same time last year, and there are many vacancies among direct care staff and supervisors. The team understood the staffing shortage as being a product of many interrelated factors. These include (1) many resignations resulting from low staff morale and high levels of stress, (2) an influx of new staff who lack the same level of experience and skill in working with youth and who often do not last longer than two years at the facility, (3) the frequent and significant use of forced overtime, which contributes to low morale and staff member exhaustion, (4) a significant number of staff being out for extended periods on some form of medical or administrative leave, (5) a relative lack of mental health resources at the facility given the profound mental health problems of so many youth at the facility, and (6) high rates of youth engaging in self-harming behavior, which pull staff away from supervision of other youth. There are other contributors to the current staffing shortages at Long Creek, but there is no understating

the seriousness of the problem. Notwithstanding the new hiring efforts that are underway, the facility is at a serious risk of continuing to lose staff at a rate that will make it impossible to run the institution safely for youth and staff.

**Long Creek houses many youth with profound and complex mental health problems, youth whom the facility is neither designed for nor staffed to manage.** Staff and administrators at Long Creek were the first to admit that the facility is not the right place for many of the youth in its care. Long Creek was designed as a secure facility for the small number of justice-involved youth in Maine who require that level of restriction because of their likelihood of committing violent offenses. However (and as mentioned below), a relatively small percentage of youth at Long Creek have been adjudicated for a violent offense, let alone a felony. A January 2017 DOC report on the youth population at Long Creek found that just 23% of committed youth had one or more felony adjudications at the time of commitment.<sup>1</sup> That same report found that over 75% of youth at Long Creek had previously received mental health outpatient services, 80% of youth had received family and community-based mental health services, and 49% of youth had an inpatient hospitalization for mental health problems.<sup>2</sup> As described below, these youth are often committed to Long Creek after these community-based interventions have not succeeded in meeting their needs. An August 2017 report by Disability Rights Maine noted that high rates of law enforcement involvement by some residential service providers raised questions about how effective many treatment services were, particularly given the fact that many incidents referred to law enforcement appeared to stem from the very behaviors for which youth were in treatment.<sup>3</sup>

**Staffing shortages, coupled with the severe mental health problems of youth, have led to a number of dangerous and harmful conditions and practices.** Nobody could expect the staff at Long Creek to be as effective in their positions as they could be given the significant staffing problems and forced overtime. These staffing issues are made much worse by the fact that the facility is housing so many deeply troubled youth, many of whom engage in repeated violent behavior toward other youth and staff. Together, the staffing shortages and nature of the youth population have led to several very concerning conditions and practices. These include:

- Youth concern about their personal safety at the facility. While many youth reported feeling safe while at Long Creek during interviews at the facility, there are clearly many youth who do not feel safe at the institution. The team spoke with youth who expressed concerns about the ability of staff to prevent and intervene in confrontations between youth, and the team observed some youth who were not programming with other youth because of fear of being assaulted. The facility has been averaging approximately 18 resident-on-resident assaults per month in 2017, which are undoubtedly a product of the concerns outlined above.

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<sup>1</sup> Maine Department of Corrections, Profile of Youth Committed at Long Creek Youth Development Center as of July 1, 2016 (January 2017), available at [http://digitalmaine.com/cgi/viewcontent.cgi?article=1032&context=doc\\_docs](http://digitalmaine.com/cgi/viewcontent.cgi?article=1032&context=doc_docs).

<sup>2</sup> *Id.*

<sup>3</sup> Disability Rights Maine, Assessing the Use of Law Enforcement by Youth Residential Service Providers (August 2017), available at <http://drme.org/assets/uncategorized/Law-Enforcement-08.08.17.pdf>.

- Clustering of inexperienced staff together on undesirable shifts. The facility's policies around forced overtime lead to the grouping of the most inexperienced staff on undesirable shifts. Because forced overtime is tied to seniority, new staff are the ones most likely to be assigned to shifts that are not desirable (e.g., weekends). These are also the shifts that lack the same level of presence by managers and administrators. It is unsurprising that many incidents occur during these shifts. This trend also means that new staff who are supposed to receive on-the-job training from experienced staff are learning from the more inexperienced staff at the facility.
- Inconsistent staffing of living units by the same staff, which limits the ability of staff to work well together and which creates problems with youth. Because of the severe staffing shortages at Long Creek, staff reported not knowing who they could expect to be on shift with from day to day. This is a problem for staff, as it is impossible to function as a cohesive unit and engage in team-building when different Juvenile Program Workers are assigned to units because of immediate staffing needs. The team also heard about the problems that this creates for youth at the facility, who are very aware of the staffing shortages and inconsistencies. Youth and staff reported high level of youth's anxiety and frustration with the fact that they did not know who to expect to be supervising them each day. Given the wide variability in skills and approaches to managing youth behavior, particularly among new staff, this creates an atmosphere of unpredictability and randomness – exactly the opposite of what you would want to see in a rehabilitative setting. The dynamic also limits the ability of staff to engage in relationship-building with youth.
- An overuse of room confinement. The team observed many incidents where skilled staff members de-escalated situations involving violent and disruptive youth without resorting to use of force. Indeed, the team observed many videos of incidents where staff demonstrated a remarkable degree of patience with youth who were engaging in defiant, disruptive, or assaultive behavior. However, as described in more detail below, the team also observed many incidents where a relatively minor incident escalated into a youth being placed in room confinement. Youth with mental health problems can see those problems worsen while in room confinement, which raises the likelihood of youth engaging in self-harming behaviors. Additionally, youth in room confinement may not receive access to legally required services, such as educational services and recreation.
- Inappropriate uses of force leading to youth and staff injury. As mentioned above, the team observed many incidents where staff were very patient with youth who were acting out in some way. However, other incidents did not feature staff members taking an active role to de-escalate the situation through verbal skills and body language, something that may be a reflection of the inexperience of many staff members. As recommended below, the team believes that the facility would benefit from additional training on de-escalation and crisis management strategies. Additionally, there were a number of incidents where staff moved to use force and restraints when it was not clear that those interventions were necessary. The team observed incidents where youth and staff received serious injuries as a result of those

interventions. Again, this is likely to be a product of inexperienced staff, staff who are burnt out from forced overtime, and the fact that staff are not equipped to manage youth with severe mental health problems.

- High numbers of youth engaging in self-harming behavior. One data point that should raise alarms among state officials is the high rate of youth engaging in self-harming behavior at Long Creek. While some youth engage in such behavior as a ploy to obtain individualized attention from clinicians and staff, there are clearly many youth who are engaging in this behavior because of mental illness and trauma. While we applaud the facility for bringing in an outside suicide prevention expert to assess the facility's policies and practices following a recent completed suicide, any outside observer should see the number of suicide attempts and self-harming gestures as clear evidence of the inappropriateness of Long Creek as a placement for many youth. Moreover, the fact that some youth are engaging in displays of self-harming behavior to obtain individual attention or to be removed from general programming raises concerns about those youth's perceptions of their own safety.
- Criminally charging youth with mental health problems and disabilities who engage in assaultive behavior, driving their involvement deeper into the justice system. While charges are certainly appropriate in some situations where youth assault other youth or staff, and while the facility does not criminally charge youth involved in every altercation, there are youth being funneled deeper into the criminal justice system because of behavior that stems from an unmet mental health need or disability. This practice makes it more likely that youth will graduate to the adult corrections system in Maine, the exact opposite result of what Long Creek is intended to achieve.

**DOC training provided to staff assigned to Long Creek provides some helpful information, but it is not adequate to equip Juvenile Program Workers and supervisors with the skills needed to work with at-risk youth.** Maine is one of relatively few remaining states whose secure juvenile justice facilities sit within an adult corrections department. This means that many policies and trainings offered through DOC are geared toward working with an adult population. While DOC does provide some training on topics relevant for work with adolescents, the team heard that the current offerings are not equipping new staff with the skills needed to succeed in their roles at Long Creek. Moreover, as mentioned above, the clustering of inexperienced staff together on certain shifts and the unpredictability of staff assignments is limiting the ability of new staff to learn from their senior colleagues through a structured on-the-job training system. As described in the report below, the team recommends much more training on a range of topics, including adolescent development, mental illnesses and trauma manifestation in youth, and de-escalation and crisis management strategies for youth.

**Long Creek must do more to create a safe and supportive environment for lesbian, gay, bisexual, questioning, gender non-conforming, and transgender (LGBQ/GNCT) youth.** The team reviewed a number of grievances regarding alleged harassment and abuse of LGBQ/GNCT youth the facility. Allegations included both youth and staff engaging in inappropriate conduct, and the team spoke with youth and staff who corroborated incidents and noted a need for additional training on LGBQ/GNCT young people, as well as greater accountability for youth

and staff who engage in abuse and harassment of LGBTQ/GNCT residents. During our assessment, a team member overheard a Long Creek staff member made a disparaging comment that implied that staff would not want to be associated with anything that appeared “gay.” The team will not identify this staff member, but the fact that someone would make a comment such as this in a team member’s presence is clear evidence of a culture that needs to change. We were encouraged to hear about training being planned to address this population, but it is clear that the facility needs a strong policy on this population, as well as staff members who will consistently speak to the importance of supporting and respecting all youth, regardless of sexual orientation, gender identity, or gender expression.

**Detained youth at Long Creek are not receiving legally mandated general and special education services.** Educational services are often an area of weakness in juvenile detention facilities because of the fluid and wide-ranging nature of the detained population and difficulties coordinating with local school districts. However, the quality of education and special education services for Long Creek’s detained population in particular is lacking in many different areas (with some exception for educators who are clearly doing their best to provide meaningful instruction in a challenging environment). As outlined below, we have concerns and recommendations about the education program for committed youth, but the problems with the lack of educational services for detained youth are an invitation for litigation by child advocates and parents of youth at the facility.

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## CLASSIFICATION AND INTAKE

*Detention can be highly stressful and potentially traumatic event for a young person. From the moment the youth arrives at the facility, staff need to gather information quickly, make critically important decisions, and address the young person's emotional, health, mental health, and physical needs. The Classification and Intake section addresses these "front end" considerations, including intake, criteria governing who comes into detention, housing and programmatic assignments to keep youth safe, and mechanisms to reduce crowding and unnecessary detention. This section also covers the orientation process necessary for youth to understand what to expect in the facility, what rights they have, and how to ask for services or help.*

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### INTAKE PROCESS

When youth are brought to Long Creek, intake staff ask about and observe whether youth are intoxicated or injured or if there is any other emergent condition. In such cases the youth is denied admission and sent to a hospital for clearance. Admitted youth are given a shower and facility clothing. Soon after youth arrive at the facility, a nurse conducts the initial health screen in a private area. If a youth does not speak English or has limited English proficiency, the Intake Officer can obtain translation services.

Either before or after the nurse conducts the health screen, youth meet with an Intake Officer. The Intake Officer provides the youth with an initial phone call. The officer gives the youth a "Spiritual Assessment Form" which asks about the youth's religious preference and whether the youth has any special religious needs (e.g., diet, prayer rug) or concerns, and whether the youth would like a visit from the Chaplain. The officer provides the youth with a copy of the Resident Handbook, which the youth may keep, and reviews with the youth certain parts of the Handbook pertaining to rules of conduct, penalties for violations, disciplinary procedures, and incentives for good behavior.

The officer also provides the youth with several types of notification of the youth's rights under the Prison Rape Elimination Act (PREA). A one-page document titled "Being Sexually Safe at Long Creek" defines "sexual harassment" and "sexual abuse" and states that such conduct is not allowed and is a crime. It also notes several ways to report such conduct, including by a PREA hotline. The document also offers some basic things to keep in mind such as "Trust your gut, if something feels wrong it most likely is." The document is also available in Spanish. The Intake Officer also provides youth with a three-page memorandum from the former Commissioner of the Department of Corrections that explains in more detail their rights under PREA, how to report sexual misconduct, and what happens after a person files a report. The officer also has the youth view a Department of Corrections video on the rights of facility residents under PREA. The officer also completes a two-page PREA Screening Instrument on sexual violence and sexual vulnerability. Finally, the officer has the youth read and sign a document entitled "Prisoner/Resident Acknowledgement of Prohibition on Sexual Misconduct," which states that the youth has viewed the educational video and received the Resident Handbook which outlines the Department's "zero tolerance" policy on sexual misconduct.

The Intake Officer also provides the youth with a receipt for the youth's property and has the youth fill out a "Gang Intake Questionnaire." The officer also has the youth sign an acknowledgement that the youth has completed this portion of orientation.

The Intake Officer completes a Risk Assessment screen and assigns the youth to a housing unit based on the youth's legal status, age, sex, nature of offense, and past delinquency history. Subsequently, committed youth meet with the Classification Committee multiple times, and then at least quarterly, to develop the youth's case plan and monitor the youth's progress.

When the youth moves to a living unit, a Juvenile Program Supervisor or Juvenile Program Worker provides a housing unit orientation on the specific rules of the unit, and a general facility orientation that goes over the Resident Handbook in some detail and provides additional information about facility programs and procedures.

Within 24 hours of admission, a social worker contacts the youth's parent or guardian. A Resident Handbook is mailed out to the parent or guardian within five days (after the youth's court appearance for detained youth).

Staff handle intake in a professional manner. Intake staff calm youth down if they are upset, tell youth what is going to happen, advise them on the rules of the facility, and introduce them to the protections of the Prison Rape Elimination Act. The initial medical screen is conducted by a nurse immediately after youth are admitted to the facility, which is excellent practice. Youth receive information about PREA by viewing a video, which makes it possible for all youth to receive consistent messages about their rights in the facility and the importance of reporting any sexual harassment or abuse. A combination of in-person, telephone, and internet translation services makes it possible to provide admission and initial orientation to any youth who have limited English proficiency (LEP). The Resident Handbook begins, admirably, with a "Superintendent's Welcome" and introductory paragraph. The Handbook is written in the second person ("You can expect the staff to work very closely with you..."), which is likely to be easier for youth to understand than text in the third person (e.g., "Residents can expect staff to work closely with them...").

Nevertheless, there are several things that could be improved in the intake process. For example, intake interviews occur in an open area, which makes it difficult to preserve confidentiality. The facility could make some minor modifications in the counter area used for intake interviews in order to keep conversations private.

**Recommendation:** Modify the counter area used for intake interviews to protect the confidentiality of the intake process. The assessment team would be happy to connect facility administrators with the administrators of the Louisville Metro juvenile detention facility in Kentucky, which has made such modifications.

Second, there is a single item about lesbian, gay, bisexual, transgender, and questioning youth in the PREA Screening Instrument. It is not in the form of a question, contrary to every other item on the instrument: it simply says "Lesbian, bisexual or transgender or gender non-conforming or perceived to be." When interviewed, intake staff were not sure how to turn that into a question.

Additionally, the question does not reference a youth's status as intersex, which facilities are required to consider. Intake staff agreed that the items should be revised to provide a specific question or questions to ask.

**Recommendation:** Revise the item about LGBTQ youth in the PREA Screening Instrument. Ask all youth a standard set of questions according to the guidance available through the recently released JDAI practice guide on LGBTQI youth: <http://www.aecf.org/resources/lesbian-gay-bisexual-and-transgender-youth-in-the-juvenile-justice-system/>.

As noted, intake staff provide youth with written materials about their protections under PREA. Youth read the materials while they are sitting in intake and can take the materials with them when they go to their unit. The three-page PREA memorandum contains dense text and wording that may be difficult for youth to follow and understand. In addition, youth who have just arrived at the facility have other things to worry about and are not likely to focus on and absorb much information from text material, particularly if they are sitting at the counter with staff for their initial intake. Interviews with youth at the facility confirmed that the youth did not pay much attention to the printed PREA materials during intake. We had several other concerns about the written PREA youth education materials and posters, which are outlined in the Safety section.

**Recommendation:** Revise the text-dense PREA materials to break up the paragraphs, use language that is more accessible to youth, and incorporate design elements – such as color, graphics, pictures, and variable fonts – to make the material more interesting to young people. For example, in contrast to the three-page memorandum, the one-page “Being Sexually Safe” document contains short paragraphs and declarative sentences. The Safety section includes examples of youth-friendly education materials from other jurisdictions.

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## RESIDENT HANDBOOK

The Resident Handbook contains long lists – 19 visitation rules, 20 programmatic rights, 13 programmatic responsibilities, and 21 behaviors that constitute Major Misconduct – with no graphics or pictures. It may be difficult for many youth, including those with limited reading abilities, to absorb the information as presented. As mentioned during our exit interview, the facility could enlist the help of youth at the facility to add artwork and redesign the Resident Handbook to be more developmentally appropriate. The facility could also partner with a graphic arts program at a local college or university to enlist students in the creation of a more visually engaging Resident Handbook.

**Recommendation:** Make the Resident Handbook more accessible for youth by incorporating design elements such as color, graphics, pictures, and variable fonts. Consider enlisting the help of youth at Long Creek and partnering with a college or university graphic arts program.



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## HEALTH AND MENTAL HEALTH CARE

*Youth often come into detention with medical and mental health conditions needing prompt attention. Many youth have not received adequate health care in the community and have unrecognized health needs. Other youth have chronic medical or mental health care needs. Still others have care needs arising from the incident leading to detention. The Health and Mental Health section highlights key elements in meeting the medical and mental health needs of youth, including initial screening for medical and mental health problems, full health assessments, ongoing health services, emergency services, and mental health services.*

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### INTAKE

At Long Creek, nursing staff is made aware of an arriving youth, and either a registered nurse or a licensed practical nurse performs an assessment to determine whether or not the youth has some urgent problem that may require a hospital assessment. Most youth are not referred to a local hospital, although it does happen occasionally. The nurse may contact a physician or nurse practitioner to make them aware of findings. This process, which is required by the JDAI standards, does conform to the standards.

Once youth are accepted into the facility, they receive an intake nursing screen, usually conducted by a registered nurse or, as an alternative, by an LPN. The nursing form is electronic and it is completed by the nurse with the data collected in the computer. The intake process requires sexually transmitted infection screening, which is accomplished by a urine gonorrhea test and chlamydia test, as well as a mental health screen and a TB skin test.

There was general compliance with the JDAI standards regarding the nurse screen with the following exceptions:

1. There was no question of the youth with regard to medical problems he or she would like to talk about to a doctor.
2. There was no specific question regarding sensory or neural limitations.
3. There were no questions regarding, during previous confinement, if there were medical, mental health, or suicide risks.
4. There were no questions regarding a family member or close friend who has ever attempted or completed suicide.
5. The current policy does not require a mental health assessment within 72 hours for either patients who have experienced prior sexual victimization or who have perpetrated sexual abuse.

**Recommendation:** The five areas that do not comply with the standards should be modified in the computer form so that critical information will be obtained.

**Recommendation:** The policy should be modified to require a more timely assessment for youth who have experienced either sexual victimization or perpetration.

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## FULL HEALTH ASSESSMENTS

The full health assessments are conducted by a physician or a nurse practitioner. The full health assessments were in compliance with the JDAI standards, with the exception of the following requirements:

1. Review with a parent or guardian of the health and mental health needs of the youth. Ordinarily, this is done by lower level staff. Clearly, more complex cases require a clinician, be it the doctor or nurse practitioner, to explain the details of the condition as well as the plan.
2. There is no specific history regarding preventable risk to life and health, including smoking, illegal use of drugs, and unsafe sex practices. Inquiry about unsafe sex practices requires much more specific questions in the computerized form.
3. A history of services for intellectual, developmental, or learning disabilities. This area may be covered by mental health or education assessments, but the JDAI standards also require it to be addressed by the clinician performing the full health assessment.
4. A history of psychiatric hospitalization and outpatient treatment, including all past mental health diagnoses.
5. History of current and previous use of psychotropic medications.
6. History of traumatic brain injury. Although the nurse screen does require history regarding seizures, it does not include the history of traumatic brain injury.
7. Inquiry about symptoms of post-traumatic stress.
8. Inquiry about recent injuries or exposure to physical trauma.
9. Inquiry into current self-harming behavior and suicidal ideation.
10. Identification of medical needs related to a youth's identification as transgender or intersex.

**Recommendation:** The items listed above that are not addressed should be addressed by modifying the electronic version of the full health assessment to include those items.

**Recommendation:** For youth who return to the facility after a short period, a mini health exam should be performed, including an interval history (what has transpired clinically since release) and a targeted physical exam based on present problems.

**Recommendation:** For more complex cases, a clinician must discuss the findings and plan with parents or guardians.

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## MEDICAL AND MENTAL HEALTH SERVICES STAFFING

There are medical and mental health positions provided through contract with CCS. The staffing consists of 1.0 FTE Health Services Administrator, 1.0 FTE psychologist, 4.2 FTE RNs, 3.0 FTE LPNs, 2.0 FTE clerk, 5.6 FTE mental health clinicians, 0.3 FTE physician, 0.2 FTE dentist, 0.1 FTE oral surgeon, 0.3 FTE dental assistant, 0.2 FTE psychiatrist, 0.4 FTE nurse practitioner, and 0.2 FTE nursing director. The staffing affords one registered nurse on site 24/7.

The program does not have a facility infirmary, although it does provide special medical housing for those youth who need to be separated for medical purposes. Patients who are screened are determined to be in a risk status for HIV/AIDS or not, and those determined not to be a risk status do not receive any HIV education. Youth who are assigned a risk status are provided HIV education. There is no segregation of patients with HIV, and the care of HIV-infected youth is overseen by a physician and an HIV specialist who is a consultant to the state contract.

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#### SICK CALL

Youth fill out a slip which is picked up daily and triaged within 24 hours, and then they are seen by a nurse. All youth are generally seen within 24 hours of handing in a slip. The computer contains nursing pathways that, based on the complaint, require the nurse to select the correct pathway based on organ system. The team did not have time to do a detailed review of the quality of the sick call services.

**Recommendations:** As part of the quality improvement program, a nursing consultant to the program should review both the appropriateness of the pathways selected as well as the completeness of the documentation and the plan in order to determine opportunities for improvement.

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#### MENTAL HEALTH SERVICES

Long Creek has talented and committed mental health leadership. This leadership is provided by Correct Care Solutions staff and by the Department of Health and Human Services (DHHS). Nevertheless, as was noted in the introduction to this report, Long Creek houses many youth with profound and complex mental health problems, youth whom the facility is neither designed for nor staffed to manage. Almost 30% of youth come directly from psychiatric residential treatment facilities (PRTF) as a consequence of the PRTF's inability to manage youth's behavior – behavior that is attributable to youth's underlying mental health conditions. Over 75% of youth at Long Creek have received mental health outpatient services and 80% have received family or community-based mental health services.

The level of acuity in the mental health problems of youth at Long Creek is extraordinarily high. This has led to staff feeling overwhelmed at all levels of the facility. As mentioned in the introduction, the prevalence of serious mental health problems among youth is also one of the reasons for high turnover rates among direct care staff. As stated in the introduction, there is an urgent need for a more comprehensive assessment of Maine's juvenile justice system and the drivers of youth with mental health problems into Long Creek.

While Long Creek meets some of the JDAI standards related to mental health services, the team also identified areas of concern. First, direct care staff at Long Creek administer the MAYSI-2 to all youth upon admission. Juvenile Program Workers administer the instrument, then report any flags to medical staff, who notify mental health staff. This is a sound and appropriate process.

However, the facility has a policy of administering the MAYSI following the return of a youth from a community-based event or intervention (e.g., court or off-site medical appointments). The

frequent and repeated administration of this instrument limits its validity and utility, as youth tend to simply check boxes when given the same form over and over again. Staff with experience administering the MAYSI shared this concern.

**Recommendation:** Discontinue administration of the MAYSI following off-site trips. Work with mental health staff to develop a set of questions regarding a youth’s mental health state following court and other significant events.

Second, the facility would benefit from additional programming designed to help youth with trauma histories focus on adaptive behaviors in the face of triggering events. Interviews with young people at Long Creek included many reports of extensive physical, sexual, and emotional abuse. This is consistent with research in the field, which indicates that as many as 90% of incarcerated youth have a history of trauma.

Long Creek has begun to employ Dialectical Behavior Therapy (DBT) as an intervention, which is a good program that should generate positive results. The team learned that the facility had also been implementing another program in the past, known as TARGET (Trauma Affect Regulation: Guide for Education and Training). TARGET is an exceptionally effective program for incarcerated youth. However, the team was told that TARGET was discontinued because of its cost. Resuming the TARGET program would help youth with trauma histories develop skills to manage triggering events, which would help reduce the number of incidents of aggression toward other youth and staff.

**Recommendation:** Resume the TARGET program at Long Creek.

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#### INDIVIDUALIZED TREATMENT PLANS

Long Creek uses two types of treatment plans: Case Plans and Individual Treatment Plans (ITPs). The Case Plan is completed by DOC staff within five days of a youth’s admission and is primarily focused on criminogenic issues. For example, one youth’s case plan goal read “Decrease antisocial or pro-criminal attitude,” and another read “Improve juvenile’s realistic self-image.” ITPs are completed by CCS’s mental health professionals and focus more on youth’s mental health problems.

Long Creek’s ITPs are divided into four sections: Treatment Modality, Focus of Treatment, Goals, and Interventions. The “Treatment Modality” section documents the youth’s diagnoses. This is confusing as diagnoses are not treatment modalities. The label “Focus of Treatment” is also confusing, as this section reads as information solely for clinicians to consider while working with the youth. For example, one youth’s ITP Focus of Treatment read “anxiety management, SBT Phase 2 – individual.” Another read “affect dysregulation, inappropriate expression of anger and other intense emotions.”

The Goals section outlines what the youth should focus on during treatment. Examples from the ITPs that were reviewed include “explore Risk Reduction curriculum and explore risk factors explore negative thinking patterns; learn and practice skills for expressing anger; increase use of

pro-social coping skills.” The final section, Interventions, lists the various groups the youth is expected to attend.

The team had several concerns with the structure of the ITPs. First, the plans do not articulate the youth’s strengths anywhere on the form. Effective plans must identify the youth’s strengths, including the youth’s interests (e.g., sports, music, extended family); abilities (e.g., art, listening skills, making new friends); activities (e.g., hunting, church, family reunions); and capacities (e.g., empathy, pride). This is important because ITPs should be used as opportunities to connect with youth’s interests to structure interventions.

Second, ITPs should articulate goals and objectives that are objective, measurable, and observable. For example, a goal might be to “increase the use of pro-social behaviors over the next 30 days.” Sample objectives would be “when the youth feels threatened, he will ask for assistance from a staff member” or “youth will learn and practice self-calming strategies such as deep breathing or meditation.” For objectives to be effective, they must be strength-based, achievable within a short period of time, and easily understood by the youth.

Third, the Interventions section should focus on descriptive statements about the treatment that the youth will receive in specific and observable terms. The Interventions section should focus on the who, what, where, when, and how often of the youth’s treatment.

While ITPs that the team reviewed did contain some elements of effective plans, most descriptions of services and goals were stated in amorphous terms that were neither objective nor measureable. ITPs did not clearly connect objectives to corresponding goals. Objectives must specify the incremental steps toward achieving goals, including the new skills that youth will acquire to accomplish the goal. Moreover, many plans listed a group that the youth was expected to engage in, but did not specify the frequency of the group or the facilitator.

The team also had several general concerns with how the Case Plans and Individual Treatment plans are developed and used at Long Creek. First, both plans are electronic, with drop down menus that allow for limited selections. As such, both plans appear to be rote and not at all individualized. Second, the team questioned why these plans had not been combined into one integrated Individualized Treatment Plan. Youth’s criminogenic risk factors and mental health problems are interrelated and inform each other, yet the current plans attempt to address them separately. Third, as discussed above, neither plan is written using objective, measurable, and incremental steps toward the achievement of treatment goals, even though facility policy (18.3) requires this. For example, as in the examples cited above, how would youth or facility staff determine evaluate whether a youth had a more “realistic self-image?”

**Recommendation:** Integrate Case Plans and Individual Treatment Plans into one Individualized Treatment Plan.

**Recommendation:** Ensure that Individualized Treatment Plans include objective, measurable indicators that allow youth and facility staff to assess a youth’s progress toward achieving treatment goals.

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## BEHAVIOR MANAGEMENT PLANS

Long Creek does not have adequate behavior management plans. The facility relies on a form called the Intensive Behavior Management Status (IBMS), which is used to detail the restrictions placed upon youth. The team was able to review IBMSs for two youth. Both youth had been placed on the Special Management Unit (SMU), with limitations on off-unit activities and other restrictions (e.g., all meals on the unit, no contact visits).

As written, IBMSs at Long Creek are not effective behavior management plans. Effective behavior management plans outline a structure that encourages youth to develop and use new pro-social replacement behaviors in lieu of problematic behaviors. Skill building is at the core of effective plans, which accomplish this by rewarding the youth when he or she engages in the replacement behaviors. Plans must be written with objective and measurable terms so that staff and youth can assess progress toward achieving the stated goals.

Long Creek's IBMSs focus overwhelmingly on punishing undesirable behavior, not encouraging youth to learn new behaviors. For over 70 years, behavioral psychological research has demonstrated that rewarding desired behavior is much more effective than simply punishing undesirable behavior. Youth must learn what to do, not just what not to do. Rewarded behaviors have a much greater likelihood of being repeated as opposed to behaviors that are not reinforced, which have a tendency to extinguish.

While IBMSs are essential for a well-functioning mental health program and effective behavior management, the seriousness of staffing shortages and other systemic challenges facing Long Creek will limit the effectiveness of such plans until they are addressed.

**Recommendation:** Develop IBMSs that focus on rewarding skill building and the development of positive pro-social behaviors, with objective and measurable goals and incremental rewards for youth who make progress toward those goals.

**Recommendation:** Develop and implement a plan to address the staffing shortages and other systemic challenges confronting the facility.

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## CHRONIC CARE SERVICES

When youth enter the facility and medical staff determine that they have a chronic disease, youth are enrolled in the chronic care program. Youth are generally seen within a week or two. However, if youth are stable, the follow up is only once every six months. This strategy may be appropriate for a knowledgeable, well-educated patient who understands his or her disease process. It is, however, inappropriate for the youth population at Long Creek. Every opportunity a clinician has to interact with youth is an opportunity to not only educate the youth, but also find out where confusion arises and how to mitigate the confusion. A policy of following up once every three months at a minimum would be appropriate. Some facilities follow up monthly, and this would be an even better practice.

**Recommendations:** Require follow up with stable patients with chronic diseases at least every 90 days if not every 30 days, and use the follow-up as an opportunity for patient education.

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#### SCHEDULED OFF-SITE SERVICES

Some patients require investigations or consultations beyond the capability of the contracted staff on site. These services, both procedures and consultations, are generally scheduled at the Maine Medical Center. Access, from the team's review, is timely, and off-site service documents were available as scanned reports in the electronic record. It is important for continuity of care that both emergency room reports as well as discharge summaries for patients who are admitted to the hospital are also available in a timely manner and scanned into the electronic record.

**Recommendation:** Review the off-site services as part of a quality improvement program to determine whether timely and appropriate follow up has occurred, and if not, why not.

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#### ADMINISTRATION OF PRESCRIPTION MEDICATIONS

CCS has a contract with a large correctional health vendor for pharmacy services, and services are both reliable and timely. A prescription is required for all prescription medications, and staff generally provide them in a timely manner. The team did identify the presence of an outdated antifungal cream in the medication room. This area requires a pharmacy consultant who can review for outdated medicines, and on a weekly or monthly basis, an RN who can review for outdated medications. This expired medicine should have been removed.

**Recommendation:** Ensure RNs review the medication room monthly to ensure no outdated medications are present, with at least quarterly review by a pharmacist.

There is a policy to provide up to 14 days of medications upon a youth's release, or longer if needed. This flexibility should ensure that there is no discontinuity when follow-up care occurs in the community. On the other hand, there is a problem with psychiatrists not seeing youth on psychotropic medications for 90 days. This should be changed to at least every 30 days.

**Recommendation:** Ensure that the psychiatrist reviews youth on psychotropic medication at least every 30 days.

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#### UNSCHEDULED ON-SITE AND OFF-SITE SERVICES

Maine Medical Center is the designated resource for care that needs to be provided beyond what CCS can offer at Long Creek. Youth have presented with urgent and emergent problems, and the facility seems to have managed these youth well. Many programs have problems accessing the emergency room report from the local hospital. However, in the few records the team reviewed, the emergency room report was present. There was no urgent care log, which is commonly used in correctional settings to select cases for review as part of a quality improvement program.

**Recommendation:** Create an urgent care log that contains urgent care services, which can be used by the quality improvement program to identify areas for improvement.

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#### INFORMED CONSENT AND CONFIDENTIALITY

In general, Long Creek was in compliance with this area of the standards. The one exception was that the standards require a policy that that youth notify the youth and his or her attorney upon receipt of a subpoena or court order for the youth's medical or mental health records. The team did not observe any such policy.

**Recommendation:** Develop policies, procedures, and actual practices that notify the youth and his or her attorney about subpoenas for the youth's medical and mental health records before disclosure.

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#### RECORDS AND INFORMATION SHARING

Medical and mental health staff at Long Creek rely upon multiple databases to manage information about medical care, mental health services, behavior management, and substance abuse treatment. CCS staff rely on a proprietary electronic medical records system known as ERMA (Electronic Medical Record Application). DOC relies on a separate system, CORIS (Corrections Information System), to maintain documents such as case plans, Classification Committee notes, and community reintegration plans. The team was informed that Day One, the facility's designated substance abuse service provider, maintains their documentation in yet another database. The existence of multiple databases makes the integration of services at Long Creek difficult, as service providers do not have ready access to important information about youth and their treatment needs.

**Recommendation:** Identify how to share key information across data systems so that service providers and staff have ready access to information they need to know to work most effectively with youth.

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#### CONTINUOUS QUALITY IMPROVEMENT

There is a corporate quality improvement (QI) program that has been in place for several years. Virtually all studies that have been performed result in 97-100% compliance. Many studies are at the 100% level. Even the finest hospitals in the country develop skills in finding opportunities to improve. They tend to look at high-risk, high-volume, or problem prone services. The QI program, as designed by CCS corporate headquarters, contains almost nothing specific to the facility's own shortcomings.

A quality improvement program that results in 100% of the studies achieving 100% compliance is not looking in the right places. There are opportunities to improve in every juvenile facility in the country. Long Creek's challenge is to identify which areas need improvement.

This process should also be used to assess the efficacy of mental health services and behavioral interventions. CCS has initiated many group strategies to address the needs youth at Long Creek,



including Aggression Replacement Therapy, Risk Reduction, and Interpersonal Violence. It is important to determine which of these strategies is having its intended effect. For example, some facilities have administered the Beck Depression and Anxiety Inventories both before and after youth's participation in these programs. Results indicated that youth's reported anxiety levels were significantly reduced consequent to their involvement in the yoga program. Long Creek would benefit from the same type of assessment.

**Recommendation:** Develop brainstorming sessions where possibilities are suggested for areas of improvement based on experience. Develop and implement QI studies based on those suggestions, and take appropriate corrective action.

**Recommendation:** Ensure that quality improvement activities include strategies to assess the efficacy of mental health procedures and programs.

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## ACCESS

*Success in the community is often linked to supportive relationships that youth have with family and others. This section addresses the rights of detained youth to have access to the outside community through visitation, correspondence, and access to the telephone. It also addresses the need for youth to be able to visit with and communicate with their attorneys and other advocates about their cases, problems in the facility, or other issues requiring legal assistance. Standards also ensure that administrators and staff value the input and participation of families.*

In general, youth at Long Creek reported being satisfied with their level of contact with family members and other important individuals outside of the facility. We were pleased to see that visitation opportunities occurred multiple times per week, were more than an hour in length, and were open to a broad range of approved visitors, including siblings and other supportive adults. We also commend the facility for allowing youth to receive books, magazines, and periodicals through approved vendors. This policy broadens youth's access to reading materials of interest.

The team was concerned with limits on certain types of contact in policy and practice, the use of a collect calling system, the routine recording of telephone calls, the use of routine strip searches following family visitation, a lack of confidentiality with attorney mail and telephone calls, problems with some detained youth receiving timely appointment of counsel, and the accessibility of orientation materials for families with limited literacy.

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## MAIL

In general, youth reported being happy with mail service at the facility and understood the rules around delivery and receipt of mail. There were two main areas of departure from the JDAI standards, however. First, the facility provides postage for only two letters per week (excluding legal correspondence), although youth can earn additional stamps for good behavior or have their parents bring extra postage. The team recommends that the facility provide youth with additional postage if they choose to write more than two letters per week. It is worth encouraging youth to express their feelings in writing if they choose to do so. Moreover, given the limitations on phone and visitation contact, letters may be the best avenue to stay connected to certain individuals while youth are detained.

**Recommendation:** Do not limit youth to two stamps per week for non-legal mail.

Second, staff and youth reported that staff routinely “scan” incoming and outgoing mail, and that this has included legal mail in some situations (although we saw recent efforts to prevent legal mail from being opened upon receipt). Additionally, non-legal mail is opened in the mailroom and inspected for contraband prior to delivery to youth.

Staff should only read non-legal mail upon reasonable suspicion that the content of the mail contains a specific threat to the safety or security of the institution. In situations where mail is opened to inspect for contraband, it should be opened in front of the youth. Staff should never read mail marked as legal mail under any circumstances, as such correspondence is protected by the attorney-client privilege.

**Recommendation:** Clarify in written policy, procedure, and actual practice that staff should not read incoming or outgoing non-legal mail unless there is reasonable suspicion that the letter contains a specific threat to the safety or security of the institution. Ensure that any mail that is opened to inspect for contraband is opened in front of the youth.

**Recommendation:** Clarify in written policy, procedure, and actual practice that staff are never to open or read incoming or outgoing legal mail.

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## TELEPHONE

We were pleased to see that Juvenile Program Managers allowed youth to use their telephone privileges to contact a broad range of individuals outside of the facility who are meaningful to youth. As with mail service, we had concerns about three main areas of departure from the JDAI standards.

First, the facility's phone system relies on collect calls. Staff did report that youth could make accommodations through the Juvenile Program Managers if a youth's family could not afford to establish or maintain an account for phone calls. However, the current system pegs phone privileges to the financial resources of a youth's family. It is rare that our team members visit a juvenile facility that employs a collect calling system, which we understand may be a product of Long Creek's falling within the state's Department of Corrections. We strongly urge the facility to allow youth to make free phone calls.

**Recommendation:** Replace the collect calling system with a system that allows youth to make free phone calls. Google allows for free long-distance calling through its Google Voice service if that is necessary.

Second, some staff and youth reported that youth in the Special Management Unit and youth in room confinement are not allowed to make or receive phone calls, and telephone access is not listed as a right regardless of disciplinary status in the Resident Handbook. While the team agrees that access to additional phone time can serve as an incentive for good behavior, all youth should receive a minimum amount of phone time regardless of disciplinary status. A phone call with a family member can be particularly valuable for youth who may be struggling at the facility.

**Recommendation:** Allow all youth, including youth on the Special Management Unit and youth in room confinement, to have a minimum amount of phone time.

Third, although staff reported that they do not routinely listen in on youth's conversations, calls from Juvenile Program Managers' offices – including legal calls – are made with staff present in the room. Calls that are made through the collect calling system are recorded, although staff reported not routinely monitoring conversations in real time. As mentioned above with mail service, staff should only listen to non-legal phone calls with reasonable suspicion that the call constitutes a threat to the safety or security of the facility. Staff should never listen to calls with attorneys, which are protected by attorney-client privilege. Many facilities have found ways to make accommodations that allow staff to maintain supervision of youth without listening in on

phone calls. We were encouraged to hear that recent conversations had begun at Long Creek to determine how to make those accommodations.

**Recommendation:** Clarify in written policy, procedure, and actual practice that staff should not routinely listen in to non-legal calls unless there is reasonable suspicion that the call contains a specific threat to the safety or security of the institution. Discontinue routine recording of telephone calls.

**Recommendation:** Clarify in written policy, procedure, and actual practice that staff are never to listen in on legal calls, and identify accommodations to allow youth to make calls confidentially.

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## VISITATION

The team had an opportunity to observe a visitation period for detained youth during the on-site visit. We were impressed with how well the Juvenile Program Worker managed the process, as well as how professional and respectful staff's interactions were with parents and family members. Additionally, youth generally expressed being happy with the visitation process with four exceptions, which are also deviations from the JDAI standards.

First, children are routinely strip searched following family visitation. Some youth stated that this was a deterrent to wanting to visit with family members, and it is an unnecessarily traumatic and intrusive practice, particularly among a population with high rates of prior physical and sexual abuse. Strip searches are not necessary in a well-supervised and well-managed visitation process. The team would be happy to refer Long Creek administrators to other administrators of juvenile facilities that do not rely upon strip searches following family visitation.

**Recommendation:** Discontinue routine strip searches of children following family visitation.

Second, while we were pleased to see that visits were over one hour in length, we learned that hugging was prohibited as a general rule, and that youth on the Special Management Unit and youth who are deemed to be high risk could be assigned to non-contact visits. Contact visits should be allowed and encouraged. Again, restrictions on appropriate physical contact are unnecessary in a well-supervised and well-managed visitation process.

**Recommendation:** End restrictions on appropriate physical contact (e.g., hugs) during family visitation, and ensure that all youth (including those on the SMU and those deemed to be high risk) have contact visits.

Third, the JDAI standards provide that facilities make alternative arrangements through the use of technology for family members who live far from the facility. This is particularly important given that Long Creek is the sole juvenile facility in Maine. We heard from administrators that while Skype had been used in the past, it was no longer used because the facility would pay for lodging for family members who traveled to visit with their child. We were pleased to hear about the accommodations that DOC would make, which are to be commended, but we spoke with

some youth from northern Maine who stated that their family members could not make a trip such as this on a regular basis because of travel time, other associated expenses, and obligations with work and responsibilities to care for other children and family members.

**Recommendation:** Resume using Skype as an alternative to in-person visitation for youth whose families live far from the facility.

Fourth, youth expressed some confusion about the process for requesting special visits, and the Resident Handbook does not clearly outline how youth should do so.

**Recommendation:** Include in the Resident Handbook a clarified and streamlined process for requesting special visits.

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## ACCESS TO COUNSEL

The team spoke with juvenile defense attorneys, reviewed records of attorney visits, and spoke with youth about their experience with their lawyers. It is clear that Maine has some exceptionally dedicated and skilled juvenile defense attorneys. Nevertheless, the team had two primary concerns with access to counsel.

First, the team heard that it was difficult to visit with clients outside of standard business hours. The team did review logbooks that showed some attorney visits outside of business hours, but the vast majority occurred during standard hours on weekdays. Attorneys are often in court during standard business hours on weekdays, so ensuring that attorneys have access to clients outside of those hours is important.

**Recommendation:** Clarify through policy, procedure, and actual practice that attorneys are allowed to meet with clients at any reasonable time, not just standard business hours.

Second, the team spoke with some youth and staff who stated that detained youth may sometimes go weeks without knowing whether counsel has been assigned and who that individual is. The team heard that this occurs because of parents' difficulties proving financial need or completing paperwork needed to finalize an appointment. It is unacceptable for detained youth to not have access to a lawyer, and it can also lead to confusion and fear by young people about what they should expect with their case. Other youth stated that their attorneys were nearly impossible to reach and that they would only see them just before court appearances. This was a source of frustration of many youth, and in some situations, led to acting out behavior at Long Creek. While these issues are not problems of the facility, they are problems that impact youth and staff at the facility. They warrant immediate attention by juvenile justice stakeholders.

**Recommendation:** Identify the reasons why some detained youth are not immediately appointed counsel and implement policies, procedures, and actual practices to remedy those problems.

**Recommendation:** Establish clear standards for client contact with juvenile defense attorneys and a mechanism to monitor complaints from youth and family members about the quality of appointed counsel.

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## FAMILY ENGAGEMENT

The team reviewed the family member survey that is routinely sent to parents and legal guardians, which is designed to obtain information that may help staff work more effectively with youth at the facility. The team understood that the Resident Handbook was the primary written document designed to educate family members at the facility. As mentioned above in the Classification section, the Resident Handbook is very dense and written at a level that would be difficult to understand for someone with limited literacy.

**Recommendation:** Revise the text to lower the reading level of the Resident Handbook and find ways to make presentation of the information more visually appealing.

Additionally, the team did not observe much information posted for family members within the facility about their rights, the ways of reporting problems, and other essential information beyond the list of rules outside of the facility front door. The facility lobby is a good place to provide information such as this, as well as information about other programs and services that may be of interest to family members. This is particularly true given that parents may be waiting 15 minutes or more before visitation begins.

**Recommendation:** Post more information for family members about rights within the facility, avenues for reporting problems, and other information that may be of interest and use.

Finally, the team heard that Google translate had been used in the past to make information available for family members with limited English proficiency. Although these efforts are well-intended, Google translate is not a substitute for ensuring that materials are translated appropriately and reviewed by a qualified and certified translator.

**Recommendation:** Ensure that all materials created for family members with limited English proficiency are created or reviewed by a qualified and certified translator.

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## PROGRAMMING

*Youth in detention are, first and foremost, adolescents. They need to be involved, to the extent possible, in the same kinds of age appropriate, healthy, educational activities youth would experience in the community. This section outlines the requirement that detained youth receive a full academic education, with special services for youth with disabilities or limited English proficient youth. Youth are also entitled to go outdoors regularly, engage in physical exercise, participate in a range of recreational activities, and have the opportunity to practice their religion. This section also covers the ways youth are encouraged and motivated through positive reinforcement and incentives for good behavior.*

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## EDUCATION

Education services and the education staff at the Long Creek are part of the Maine Department of Corrections. Long Creek has two education programs: one serving youth in detention and one serving youth committed to DOC. The quality of service is remarkably different for detained versus committed youth. Staff vacancies and state regulations that charge local school districts with the responsibility for providing education for detained youth contribute to the uneven quality of education at Long Creek. For example, while local school districts cede the responsibility for educating youth in detention to DOC, parents are required to enroll or re-enroll their children in local school districts before files can be released to the education staff at Long Creek. Thus, obtaining prior school records and coordinating services for students with special education eligibility is a problem for Long Creek staff. Moreover, a large number of teaching staff vacancies at Long Creek have created conditions under which it is impossible to meet the academic needs of all students. The DOC has taken steps to address some of the serious shortcomings in the education program during the past few months.

Long Creek's educational program does have a number of strengths. For example, DOC's partnership with Southern Maine Community College (SMCC), the availability of Career and Technical Education (CTE) courses, the variety of extramural athletic activities, and impressive library services are positive features of the education program. Additionally, education policies and procedures at the facility are well developed, and instructional resources appear to be adequate for the school.

The narrative below addresses two broad areas: Educational Access and Special Education Services.

### **Educational Access**

The team visited Long Creek during the first week of school of the Fall 2017 semester. Students attend school from 8:05 a.m. to 3:00 p.m. each week except for Wednesday afternoons, when staff development and other meetings are held. Students eat lunch during a 75-minute break during the middle of the day. Students are assigned to classes based on their academic needs, with the exception of students in detention. Boys and girls do not attend class together, except for youth enrolled in post-secondary education courses.

Long Creek conforms to some of the JDAI standards for education. Policies are in place and classrooms have adequate supplies and instructional materials. The facility is well equipped with educational technology, smart boards, and supplemental teaching materials. The teachers on staff appear to be well-qualified, and the recently appointed Education Director appears to be providing much-needed leadership and support for the school. A quality assurance system for education was being developed at the time of our visit.

Students are able to earn credits through both traditional and on-line instruction. Students are also able to prepare to take the HiSET, a high school equivalency examination. Through a partnership with Southern Maine Community College (SMCC), students at Long Creek who have graduated from high school or those who have earned high school equivalency certificates are eligible to enroll in post-secondary courses. Discussions with students about the SMCC courses as well as the CTE courses suggested that these programs are well received and enjoyed by youth. During the fall 2017 semester, three community college courses, two in-person and one on-line, were being taught to students at Long Creek.

Through Project IMPACT, Long Creek has a well-developed process for requesting students' prior school records, as well as coordinating transition of youth back to the community. Non-profits, including Goodwill Industries, provide job coaching and support to youth prior to their release from Long Creek as part of transition activities. However, as described above, current state regulations that require parents to sign youth into school districts before records can be transferred are an impediment to providing services to youth.

At the time of our visit, there were a number of teaching vacancies at Long Creek. Teacher shortages included two instructors on the detained unit, two English teachers, two history teachers, a carpentry teacher, and a math teacher. There were also special education teacher vacancies. In addition to a recently-appointed education director, the leadership and support staff include a principal, special education director, and school counselor. The detention center currently operates with only one teacher who serves all students on the unit. Because of teaching and other staff shortages, detained boys only receive about half of the required instructional minutes per day. At the time of our visit, girls were not consistently receiving a full-day of instruction because of teacher shortages. Some teachers who had instructional and other responsibilities were unavailable in the classroom. Several committed youth did not have a first period class, and others had periods during the school day when they did not have an assigned class. One related problem is that the education program has no substitutes who can fill in when teachers are out. While there is nominally one substitute teacher on staff, the person currently in this position has been working full-time as an hourly employee for more than a year and a half, according to teachers at the facility.

The quality of communication between housing unit staff and educators could be improved. While regular meetings are scheduled to discuss students' status, the movement of youth through the phase and level system needs further attention. This issue is discussed in greater detail in the behavior management section of this report.



Finally, the school does not appear to meet the intent of state law as outlined in Chapter 125, Basic Approval Standards: Public Schools and Administrative Units. Although the Maine Department of Education (MDE) considers the school at Long Creek a local education agency, Long Creek's school does not have the autonomy or resources to provide legally mandated services to youth. The assessment team did not meet with any MDE representatives during our visit. However, many of the issues outlined below call for greater MDE involvement in resolving specific problems.

**Recommendation:** Hire additional certified teachers. Ensure that instructors are available for all content areas required for graduation.

**Recommendation:** Hire additional special education teachers.

**Recommendation:** Work with MDE to review and resolve impediments to the transfer of students' records. Consider transferring responsibility for education services from LEAs to Long Creek.

**Recommendation:** Consider developing an intake classroom where students would spend their first week at the facility. Conduct initial screening and assessments, review students' records, and provide instruction in numeracy, literacy, and current events. Use the intake classroom to help socialize students who may have been out of school for an extended period of time, as well as to provide basic instruction for students who may be in detention for just a few days.

**Recommendation:** Ensure that all teachers provide instruction in areas in which they are certified.

**Recommendation:** Develop career and technical education (CTE) programs for youth in detention. Short-term courses and certifications in areas such digital literacy and OSHA 10 safety fit well into short-term placements and should be added to the curriculum.

**Recommendation:** Develop a system of Positive Behavior Interventions and Supports (PBIS). PBIS, widely used in the public schools, is also used in a number of juvenile facilities. Discontinue punitive, unproductive discipline systems.

### **Special Education**

According to the special education director at Long Creek, more than 85% of the youth at the facility have a history of special education services. The school does a good job of managing paperwork associated with developing IEPs and notifying parents. Case plan reviews – part of the DOC treatment process and IEP meetings – are held at the same day. The school staff reported that more than 80% of parents participate in IEP meetings in person or via teleconference.

At the time of our visit there were two special education vacancies at the facility: one special education teacher and one evaluator. Because of these vacancies, students do not receive services

as specified on their IEPs. The current special education staffing at Long Creek is inadequate to meet the needs of residents.

The school at Long Creek is not involved in discussions about discipline involving students with disabilities. The majority of students eligible for special education services had a history of emotional or behavioral problems associated with their disability. There was no indication that the facility conducts manifestation determinations and Functional Behavior Assessments (FBAs) or implements Behavior Intervention Plans (BIPs).

Special education services for students in detention are delayed when schools fail to transfer records to Long Creek. As mentioned above, under current state regulation parents are required to sign documents in order for LEAs to release records. However, in some instances, youth may have been in residential placement and may not have been enrolled in the LEAs where their parents reside for a year or more.

In addition to the failure to transfer records for youth in detention for long periods of time, current state regulations appear to allow local school districts to suspend related services, such as counseling or speech therapy, while youth are in detention. Districts that opt to suspend these services agree to provide compensatory services after youth are released. In reality, this regulation allows LEAs to abrogate their responsibility to youth in detention and, in many cases, avoid the cost of related services when youth who are released from custody fail to return to school for compensatory services.

**Recommendation:** Conduct a comprehensive review of special education services and ensure staffing is adequate to provide services as indicated on students' IEPs.

**Recommendation:** Hire or contract with specialists for youth in detention to provide related services such as counseling and group therapy as specified on students' IEPs.

**Recommendation:** Hire two additional special teachers and an instructional assistant to ensure that students receive services as specified on their IEPs.

**Recommendation:** Develop a behavior management system based on the principles of positive youth development. A collaborative effort between school staff and Long Creek juvenile program workers and managers has the potential to minimize youth disruption, promote positive behaviors, and most importantly, teach youth new skills.

As mentioned above, the education program at Long Creek has a number of positive features. However, DOC and MDE must review regulations and funding mechanisms for the school at Long Creek. The failure to fully staff the education programs and ensure that students receive special education services as specified on their IEPs leaves DOC and MDE vulnerable to legal challenges for failure to provide an adequate education program for students in general, and for the more than 80% of the students eligible for special education services.

## GENERAL PROGRAMMING

The team was pleased to see that Long Creek had arranged for a wide range of programming options and activities for youth. Two particular strengths are the Volunteer Services and Recreation programs. Long Creek has approximately 150 volunteers from the community who regularly provide services to youth. Each housing unit has a unit sponsor, i.e., an organization or group that organizes at least one activity per month with youth. Volunteer Services staff also match individual youth with volunteers through a mentorship program. Volunteer Services raises funds for activities, organizes special events, and applies for grant funding to support programs. Activities include yoga (available weekly through multiple volunteers) and pet therapy (1-2 times per month). Another local group visits the facility at least weekly to provide support for LGBTQ youth.

The two Volunteer Services Coordinators spend as much time as possible inside the facility interacting with youth and staff. Whenever possible, they schedule additional recreational activities and programs to meet the changing needs of the youth population. For instance, during the summer, Volunteer Coordinators organized cookouts and ice cream socials on Tuesday nights for residents on Phases 3 and 4. Many youth mentioned these events as something they looked forward to and enjoyed, especially during periods where they needed something to look forward to. Unfortunately, it is difficult for staff to continue these events year-round because of limited resources and staffing challenges.

As mentioned above, DOC contracts with Goodwill Services to provide job readiness services and arrange for employment both inside the facility and at work sites outside the facility. Religious programming is available to youth through a full-time chaplain. The facility has a dedicated chapel where group services are offered. The facility has a library with a large number of reading materials across a variety of topics, and the library is staffed by a full-time librarian. Youth have regular access to additional books through an inter-library loan program, and they may receive additional books and periodicals through approved vendors.

When committed youth arrive at Long Creek, classification staff create a case plan with program requirements that each youth must achieve to move through the facility. Staff provide treatment programs as determined by residents' case plans. These programs include: Aggression Replacement Training, Risk Reduction, Dialectical Behavior Therapy, Sexual Behavior Treatment, and Interpersonal Violence. Most programs take several months to complete. Most programs are structured around a standardized curriculum. Long Creek offers programming for youth with substance abuse needs. Four clinicians in the Day One program provide both group and individual substance abuse therapy to residents identified in the assessment and orientation process.

The facility exceeds expectations in the range of programming and has exceptionally dedicated staff in this area. We have recommendations in three areas of general programming.

The team's first and overarching concern in programming is a lack of meaningful interaction between many direct care staff and youth. We observed a noticeable sense of tension and mistrust between youth and staff, especially on housing units during time without off-unit or

volunteer programming. Youth repeatedly described feeling bored and frustrated during time on the unit where there were no constructive or stimulating activities planned. During unit time, we observed most JPWs complete security functions and return to their security desk or “station” within the unit.

There are several reasons why staff may not prioritize engagement with youth. As discussed, staff are emotionally taxed by forced overtime and demanding work. They do not have training to deal with the unique needs of the young people at Long Creek. Youth at Long Creek who have experienced violence or trauma may not understand how to react appropriately to attempts by staff to control behavior if they do not feel safe. If staff feel unsafe, they may psychologically distance themselves from youth (i.e., viewing the environment as “us vs. them”) and attempt to impose control on youth behavior rather than engaging a youth who they see as part of their community. It can also lead to friction and volatility between youth and staff. Data revealed that 95 out of 136 physical restraints occurred on non-SMU housing units during 2017. Likewise, 13 of 29 resident assaults on staff and 88 of 123 fights and assaults between youth occurred on housing units.

This disconnect also represents a missed opportunity for Long Creek staff to build positive relationships, mentor youth, and create a sense of community that many residents have never experienced. Youth are susceptible to influences by peers. By creating a sense of community between youth and staff, the facility could develop a powerful avenue for promoting positive behavior.

**Recommendation:** Prioritize positive relationships with youth in the institutional culture. Change policy, training, and supervision to require direct care staff to develop unit programming for youth. Encourage Juvenile Program Workers to view their role as both maintaining security and developing the skills of residents. Certify direct care staff in delivery of ART and other programming.

**Recommendation:** Involve Recreation and Volunteer Services staff in helping direct care staff to learn skills and maximize resources to create more unit-wide programs and activities for youth. These do not necessarily need to occur on the living unit.

The team’s second concern was that programming is not accessible to all youth on a regular basis. While the list of volunteers, art, and vocational services is long, the weekly schedule for any one youth contains gaps in meaningful activities. Due to safety concerns about grouping certain youth together, some volunteer activities are only accessible to a relatively small number of youth. For instance, on the team’s final day at Long Creek, a talented musician performed for approximately 15 youth, while the facility held over 65 youth. Likewise, detained youth are housed on Maple Unit, where they have limited access to programming. While certain treatment programs are inappropriate for pre-adjudicated youth, youth on Maple need programming and support from staff. Many youth on Maple are frightened and unfamiliar with the detention process, and some may not have communicated with their attorneys. As discussed below, there are programs designed for detained youth that would be of value at Long Creek.

**Recommendation:** Make activities available to all residents. Address potential safety concerns by creating a staffing plan and including sufficient staff supervision. Invest additional resources in maintaining programming and adapting programming for detained youth.

The team's final concern was that there is no formal process for youth to provide input on facility programming. While the Volunteer Coordinators interact regularly with youth, there is no routine method of collecting input from youth on facility programming. The team was told that the Recreation Coordinators may have used youth surveys in the past. If so, renewed commitment and resources should be dedicated to regularizing this process.

**Recommendation:** Create a process to encourage youth, families, and staff to think about and express recommendations for programming. Build upon the Long Creek resident committee to create a channel for feedback and input from all youth and staff. This could be done through regular surveys, focus groups, or suggestion boxes.

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## RECREATION

Long Creek is staffed for two recreation JPWs and a Recreation Director. One recreation JPW position is currently vacant. The facility provides some of the strongest recreation programming that we have ever encountered. Based on multiple reports from youth and staff, the recreation staff interact with individual youth on a daily basis and are exceptionally dedicated to helping them succeed. Recreation staff understand the challenges facing youth at Long Creek, as well as the transformative power of athletics and recreation for at-risk youth. Engaging and developmentally-appropriate recreation programming can help solve some of Long Creek's systemic problems, and it can help rehabilitate young people and reduce future recidivism.

Long Creek's recreation staff works with volunteers, local colleges, companies, and staff to create many programs to suit residents' interests. Youth can participate in a wide range of sports, including basketball, softball, volleyball, kickball, flag football, Ultimate Frisbee, lacrosse, running, and weight lifting. Long Creek also offers sports tournaments, summer sports camps, a running program, music, yoga, Zumba for girls, and an obstacle course program. Many residents also play interscholastic sports, with a total of 110 spots across all sports teams. The basketball and soccer teams traveled to other high schools to compete during the regular season. Both teams played off-campus in post season playoffs.

Long Creek has an impressive and well-maintained indoor gymnasium and separate activity room. Youth can play pool, table tennis, foosball, shuffleboard, and watch movies in the activity room. Each housing unit has a regular recreation schedule including time in the gymnasium and activity room. In dayrooms and units, youth have access to televisions and, in some cases, video games.

While noting the strengths outlined above, the team has three concerns about the current state of recreational programming at Long Creek.

First, youth do not have sufficient access to non-athletic recreation supplies. The Recreation Director keeps a supply of games, puzzles, writing supplies, and activities in the gym area, but does not have a system to inventory or replenish these items. Youth reported that many games are missing pieces or parts. The team did not observe many games, cards, paper, or writing materials on living units. Many youth expressed boredom and frustration with the lack of recreational options on their units other than TV or books. This lack of structure contributes to a culture of distance and disengagement between youth and unit staff, as described elsewhere in this report.

**Recommendation:** Invest in additional recreational activities such as games, puzzles, and art supplies for youth. This includes updating recreation supplies and purchasing new ones. Keep these supplies on living units so that they are more likely to be used and task JPWs with keeping track of supplies. Survey youth on each unit to learn more about which recreation activities would be of the greatest interest.

**Recommendation:** Use additional recreation staff to train and support unit staff in planning relationship- and skill-building activities for residents.

Second, although Long Creek has ample outdoor space, youth do not always enjoy use of the space on days when weather allows for it. The team learned that three staff are required in order to take youth outside, and that staffing shortages have limited opportunities to go outside. This was a source of frustration from youth and staff.

**Recommendation:** Fill the vacant recreation JPW position.

**Recommendation:** Obtain additional direct care staff to be able to take youth outside, weather permitting. Address concerns about security of the outdoor area through any necessary structural modifications.

Third, the team has concerns about the accessibility of off-campus programming opportunities. After an incident where three youth escaped during an off-grounds trip in early 2017, many programs were terminated or suspended. The team was disappointed to learn that off-campus employment through the Goodwill program, one of the most beneficial programs at Long Creek, was also halted after the incident. The Recreation Coordinator previously took youth off-campus for programming including bass fishing, boxing events, and leadership events.

We cannot overstate the value of cultivating and protecting off-campus programming. These opportunities not only inspire youth and encourage them to set positive goals after they leave the facility, but they act as powerful incentives to motivate youth to follow rules inside the facility. Likewise, off-campus job programs are critical to the successful reintegration of youth at Long Creek into Maine's communities. Many at-risk youth have not had the opportunity to learn life skills they need to prepare them for successful reentry into the community. The team spoke to several youth and staff who suggested programs that allow youth to practice these skills in the community under the supervision of staff. Examples include grocery shopping, setting up a bank account, or shopping for clothes for a job interview.

**Recommendation:** Reinstate off-grounds programming. While this may present a challenging issue between the agency and the community, administrators must be prepared to make a stand for the futures of youth at Long Creek. Seek support from research and outside advocates to explain the immense value of off-campus programming compared to a relatively low risk to the community.

**Recommendation:** Implement additional programming that allows youth to focus on practical reentry skills from the moment they enter the facility. Create opportunities for all youth to practice necessary skills in the community while supervised by Long Creek staff.

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## BEHAVIOR MANGEMENT

Long Creek’s behavior management system consists a level system to track behavior and a phase system to monitor progress through the facility’s treatment programs. A resident’s level is determined weekly at a unit meeting, based in part by reviewing the resident’s daily behavior cards and a recommendation from a staff member designated as the resident’s “coach.” Incentives associated with higher levels may include pizza or Chinese food on Fridays, opportunities to assist with environmental services (e.g., doing unit laundry or cleaning), snacks, and later bedtimes.

Staff may also impose a range of sanctions for behavior that constitutes major or minor violations. These sanctions include verbal re-direction, a writing assignment, an “unacceptable” rating on a daily behavior card, activity restriction, unit restriction, and pod restriction. A youth on pod restriction must remain in his or her pod except during off-unit activities and meals. The facility does have an isolation unit, or Special Management Unit (SMU) for youth on “observation” status. One of the facility’s strengths is that isolation is not used as punishment, although we do have concerns about the use of pod time as a behavioral sanction. Per Policy 15.3, the maximum amount of pod and unit time that a youth may receive is 30 hours.

Long Creek also has four program phases. Youth receive privileges and increasing levels of responsibility and freedom based on their phase. Privileges generally begin at phase 3, including the opportunity to earn off-grounds work privileges and to listen to iPods with supervision. In general, a male youth’s phase also determines his living unit. This is not true for girls, as there is only one female living unit. There are certain requirements that youth must complete to be eligible for phase advancement, and a classification review is held at least every 90 days. Requirements for advancement include completing treatment programs established in a youth’s case plan. Unit Treatment Team (UTT) meetings are held monthly for each youth. The UTT may also recommend that the youth advance to the next phase.

The effectiveness of Long Creek’s behavior management program is limited by three factors. First, Long Creek’s behavior management system should focus more on rewarding positive behavior. For example, the Resident Handbook includes more than three pages of rules and sanctions, but it does not mention incentives. The team commends Long Creek for creative and resourceful recreation activities and privileges for youth on higher phases. However, the current system does not foster a culture of staff recognition of positive youth behavior at all times. Staff

who the team interviewed did not intentionally identify or promote positive behavior. Moreover, staff did not understand the importance of recognizing positive behavior. Current research shows that adolescents respond more favorably to incentives for positive behavior than to punishment for negative behavior. Revisiting the facility's commitment to identifying positive behavior will also improve the dynamic between JPWs and youth.

**Recommendation:** Incorporate recognition, verbal or otherwise, as a regular part of the behavior management system. Include a list of possible incentives in the Resident Handbook. Establish clear examples of positive behavior. Consider requiring staff to document the use of positive reinforcement in order to create a culture that recognizes staff who “catch youth doing something right.”

**Recommendation:** Create a process to identify new and effective incentives, such as through the resident committee, focus groups, or a standing item on the agenda at monthly meetings.

Second, youth require greater access to counseling services. Social work services are provided either through unit social workers or clinical social workers. Unit social workers are charged with providing case management services. While each housing unit usually has a dedicated social worker (Pine Unit's social worker position is currently vacant), social workers are only required to see youth weekly. Clinical social workers identify residents who may need mental health services and provide services. Some youth reported that they did not see one of the facility's six clinical social workers routinely.

As discussed above, the facility's mental health services are inadequate, especially given the prevalence of mental illness in the youth population. Mental health services are provided only to certain youth, generally for one hour per week. When youth wish to speak to a clinician, they must put their name on a waiting list. Several Long Creek staff members strongly objected to this practice, noting that youth should not have to “wait weeks to receive the help for behavior that got them here.” In some cases, it appears that youth may actually engage in negative or suicidal behavior in order to obtain attention from a clinician.

**Recommendation:** Use existing mental health and social service staff to maximize both structured clinical time and regular interaction with youth. As discussed elsewhere in this assessment, address the mental health needs of Long Creek's youth through other channels.

Staff also expressed a need for clinical staff to work more closely with them on a regular basis in order to understand challenges presented by particular youth rather than based on limited observation in a clinical setting. While weekly unit meetings are held for each unit and monthly UTTs are held for each youth, clinical staff are not always able to be present. Moreover, monthly meetings do not substitute for the consistent exchange of information and regular interaction between direct care and clinical staff on living units. Integrating mental health staff into the daily functioning of housing units would allow JPWs to observe and model best practices and encourage them to view issues or situations as opportunities for clinical support. When clinical staff spend more time with youth on the unit, they may have suggestions for developing tools to



help security staff work more effectively with youth. By taking clinical work outside of the clinical realm, mental health staff can help youth think about how to apply skills in their daily lives.

**Recommendation:** Create opportunities to integrate clinical and unit staff, such as cross-training and joint programming. Schedule clinical staff to spend regular time on living units. Consider satellite offices for clinical staff in living units to increase collateral exposure. Some facilities have created group DBT sessions with youth on housing units co-facilitated by clinical staff and direct care staff.

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## TRAINING AND SUPERVISION OF EMPLOYEES

*The quality of any facility rests heavily upon the people who work in it. This section requires that the facility hire properly qualified staff and provide the necessary pre-service and continuing training they need to work with troubled youth. Staff should also perform their work in an operational setting that enables them to do their work well – through appropriate staffing ratios and proper administrative supervision. The section further requires that facility staff engage in ongoing quality assurance and self-improvement through documentation of serious incidents, citizen complaints, and child abuse reports.*

The team met many Long Creek staff members who are deeply committed to serving young people. Residents mentioned several staff members by name who they felt helped them and cared about them. Unfortunately, staff shortages and vacancies create a constellation of issues around staff and staffing that undermine facility operations and jeopardize the safety of residents and staff.

The facility does have an organized system designed to ensure that all staff receive new employee training and annual refresher trainings. Long Creek's hiring and training process is conducted with oversight by DOC. DOC provides five weeks of training at the Maine Criminal Justice Academy (MCJA). New staff receive two weeks of on-the-job training upon returning to the facility. The facility maintains detailed training records.

As mentioned below, despite these strengths, the training program omits several key topics required by the JDAI standards, topics that are of particular importance to working with an at-risk youth population. Additionally, Long Creek should enhance the level of supervision and oversight in the use of discipline and incentives in its behavior management system.

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## QUALIFICATIONS AND STAFFING

Long Creek is facing three significant staffing challenges. First, the facility is understaffed. There are seven vacant Juvenile Program Worker positions. The facility requires a staff to youth ratio of 1:8 during waking hours and 1:16 during sleeping hours. Unfortunately, the facility can only maintain this ratio by using regular forced overtime.

Almost all staff expressed anxiety about and frustration with the impact of short staffing and the amount of forced overtime. Long Creek staff have completed 5,454 hours over overtime so far this year. Staff are regularly required to work double shifts. The selection process for forced overtime operates on reverse seniority, which increases the proportion of new and inexperienced staff on each shift. No one can expect staff, no matter how experienced, to be effective in the very demanding jobs at Long Creek for sixteen hours at a time.

**Recommendation:** Hire enough JPWs to maintain a staff to youth ratio of 1:8 or less in each housing unit during waking hours, as required by the PREA standards and the JDAI standards without forced overtime.

Second, the facility struggles to recruit and retain qualified staff. Administrators described difficulties hiring and keeping skilled staff who can meet the needs of the facility. The education and experience requirements for Juvenile Program Workers are basic and do not require the type of experience that would be most helpful for working with at-risk youth, such as a background in psychology.

Neither DOC nor Long Creek require that Juvenile Program Workers have at least 2 years of college or a high school diploma or the equivalent and 2 years' experience working with youth. The official recruiting criteria seem to be geared toward an adult corrections environment as opposed to the therapeutic and rehabilitative environment Long Creek was created to be. As a result, there are staff at Long Creek who have little or no experience working with teenagers. High turnover means that almost 20% of staff at the facility have less than one year of experience. Juvenile Program Worker positions are opportunities for recent graduates to assist Maine's most vulnerable children. With adequate staffing resources, Long Creek could do more to attract applicants with more interest and experience in working with troubled youth.

**Recommendation:** Require staff who have direct contact with youth to have at least 2 years of college or a high school diploma or the equivalent and 2 years' experience working with youth.

**Recommendation:** Create a recruitment plan involving internship and recruiting programs through schools of social work, psychology programs, and local colleges. Involve testimonials from youth who benefitted from the help and guidance that Long Creek staff provided to them.

**Recommendation:** Re-name positions to reflect an emphasis on working closely with youth on behavior change and skill development, such as Youth Development Specialist or Youth Behavior Specialist. Consider creating additional positions that allow staff opportunities for professional advancement, such as staff positions with special focus on specialized programming or trauma.

**Recommendation:** Explore options to increase the salaries of staff to improve hiring and retention. Although base wages increased during the past three years, current salaries still hinder the ability of the facility to attract and retain quality staff.

Third, the current staffing patterns impede staff's ability to work effectively with youth. As mentioned above, new Juvenile Program Workers are generally assigned to the least desirable shifts, which usually involves working during weekends with Tuesdays and Wednesdays off. While the facility has many experienced staff who can mentor new Juvenile Program Workers on supervising high-needs youth, these two staffing groups do not overlap as much as they should on shifts. Multiple staff told the team that serious incidents at the facility often occur on Friday and Saturday nights, when youth are bored and when senior management is least likely to be in the building. These scheduling patterns, along with insufficient mental health resources and training, result in unsafe conditions for youth and staff.

Some staff at Long Creek are consistently assigned to a certain unit. These staff, who were described to the team as “bid staff” are able to develop relationships with both other staff on the same shift and youth in the housing units. Staff stated that getting to know the triggers, needs, and strengths of particular youth on the unit increased their sense of safety and job satisfaction. One experienced staff shared a story with team members about a situation when the staff member was able to anticipate a youth’s mounting anxiety during an incident between two other residents on the unit. Because the staff was familiar with the youth’s background of abuse, the staff member understood that the incident might trigger a potentially violent post-traumatic stress response. To prevent an incident, the staff member engaged the youth in conversation about a topic that he knew the youth enjoyed. This helped the young person self-regulate his emotions before the situation escalated. Another youth told the team that when staff members who care about youth and treat them fairly are on duty, youth try to “show respect” by following rules and notifying the staff member about any concerns on the unit.

These examples illustrate the laudable skills of some Long Creek staff, as well as the benefits of respect and trust between youth and staff. These skills can only be taught through a combination of training, on-going mentorship, and an institutional culture that prioritizes these goals. As mentioned in the introduction, staffing shortages have resulted in random placement of inexperienced staff throughout the facility, which create an atmosphere of unpredictability and randomness that undercut the trust of youth with staff.

**Recommendation:** Develop a rotating shift schedule that allows overlap between senior and junior staff. Compensate senior staff who serve as mentors or “specialists” on less desirable weekend and evening shifts. The integration of senior and junior staff is essential to developing consistency for youth. It would also allow Long Creek to maximize existing and limited resources – dedicated and experienced staff – to share their knowledge with newer staff.

**Recommendation:** Maintain consistency with assignments of staff to housing units.

**Recommendation:** Consider increasing the staff to youth ratio beyond 1:8 during waking hours, especially during a period of intentional culture change. Assign one additional JPW to housing units during early and late shifts as well as weekend shifts. Another option for Long Creek is to make additional investments in hiring, training, and supervision to ensure that staff are able to fulfill security functions while also engaging in active community-building with youth.

Third, Long Creek can provide more recognition and incentives to staff. The individuals who serve as Long Creek’s direct care and clinical staff are the facility’s most valuable resource. While an employment appreciation committee gives employee of the month and employee of the year awards and organizes other staff luncheons, DOC and Long Creek would benefit from investing more resources into staff recognition. Staff appreciation efforts cost a fraction of other facility expenses and can produce immediate improvements in staff morale. Recognition for staff may include donated tickets to local sporting events, donated food items, movies, small gift cards, and regular verbal recognition from supervisors and coworkers. One facility the team recently toured provided free massages on site for staff to address work-related stress.

Another untapped resource for positive feedback for staff is young people. Some facilities have created a process where youth can give staff positive feedback through a comment box, or “shout out board.” If a town hall was organized to announce a new focus on “catching youth doing something right,” the facility can empower youth with the responsibility to “catch staff doing something right.”

**Recommendation:** Provide on-going positive feedback and recognition to staff on all shifts. Use the employee recognition committee to help cultivate and sustain incentives described above.

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## TRAINING

Long Creek and DOC have committed considerable resources to developing an expansive and organized training program. All new staff receive five weeks of training from the Maine Criminal Justice Academy (MCJA) prior to returning to Long Creek to begin facility-based training and on-the-job training. Despite this demonstrable commitment, the team has three concerns about the training program at Long Creek.

First, the MCJA training is designed for staff who will supervise adult inmates. In July 2015, the MCJA created a five week, 200-hour training curriculum for all new corrections officers. Trainings on techniques and philosophy for work with adults is not, however, aligned with knowledge of how to effectively supervise and work with youth. United States Supreme Court jurisprudence and overwhelming scientific consensus has made it clear that adolescents are fundamentally different from adults. A training grounded in adult corrections does not prepare staff to work with vulnerable youth at Long Creek, many of whom suffer from histories of mental illness, trauma, and abuse.

To be sure, some training at the MCJA is essential for all agency employees, yet the large amount of time spent on training modules geared toward working with adult inmates is concerning. Initial pre-service training is a critical building block in the foundation of positive institutional culture and facility safety. Not only do many parts of the required MCJA curriculum fail to equip staff with the necessary skills for work in a youth facility, they undermine Long Creek’s training by imparting inappropriate information for work with youth.

**Recommendation:** Identify sections of the MCJA curriculum that new Long Creek staff must attend. Use the remaining time to enhance training for staff at Long Creek in the areas outlined below.

Second, Long Creek’s Training Coordinator requires additional support. Following training at MCJA, new hires return to Long Creek for an additional 2 to 3 weeks of training on topics specific to work with youth. This curriculum is designed with oversight from the training department at DOC with input from Long Creek. Long Creek has an excellent Training Coordinator who organizes all pre-service and in-service training. The Training Coordinator is responsible for conducting and organizing all training, which limits her ability to spend time inside the facility to assess training needs. Additionally, the Training Director does not have experience working with youth as a direct care staff member. Because there is no defined role for

direct care staff as trainers, the Training Coordinator must often ask staff with “hands-on” experience to help her deliver a training as a favor. While the team supports the integration of existing staff into training roles, this participation should be structured and matched with appropriate compensation.

**Recommendation:** Hire a staff trainer with direct care experience to assist the Training Coordinator. This staff can also act as a “specialist” or field training officer when not involved directly involved in training. As mentioned in the introduction, this will be particularly valuable with topics that may engender staff resistance, such as training on effective and professional work with LGBTQ/GNCT youth.

Third, Long Creek staff are not sufficiently prepared by the on-the-job training program to safely supervise youth. After completing the Academy and Long Creek training, new Juvenile Program Workers are required to receive 40 hours of on-the-job training before working with youth unsupervised. During on-the-job training, new staff are supervised by a current Juvenile Program Worker. Supervising Juvenile Program Workers sign off on required skills that a new hire is required to complete.

Because of staffing shortages, the supervising Juvenile Program Worker can be anyone who happens to be on the same shift with the new staff. This selection method does not allow Long Creek to handpick and train the staff who will be responsible for providing on-the-job training. Because inexperienced staff are clustered on certain shifts, this also means that new staff will receive on-the-job training from the newest staff at the facility.

**Recommendation:** Create a field training officer (FTO) program. Select senior staff to serve as FTOs for all new Juvenile Program Workers. Provide FTOs with additional training on adult learning and supervision skills. Ensure that FTOs shadow new staff during all on-the-job training, regardless of shift. As an alternative to creating full-time FTO positions, compensate select staff to fulfill FTO duties on less desirable shifts.

**Recommendation:** Include positive youth development skills in the required certification skills for on-the-job training (e.g., developing activities for youth, using positive feedback on a regular basis, and spending time interacting with youth).

MCJA and Long Creek are in compliance with several of the JDAI standards related to training. In other areas, staff receive training in required topics, but the training is inadequate based on content or duration. The team has identified three particular areas of concern in the content of the training curriculum.

First, Long Creek does not provide adequate training on trauma responsiveness. While MCJA offers training on trauma as it appears generally in adults, this content is inadequate to prepare staff to understand the abuse and trauma histories of justice-involved youth. Based on the team’s interviews and observations, some staff view youth who have experienced trauma as defensive and non-compliant. Staff must receive practical skills training on how to respond to this behavior and help traumatized youth develop new behaviors. This training should be a substantial part of pre-service and regular in-service training for all staff who have direct contact with youth.

**Recommendation:** Enhance training to better prepare staff to deal with the causes, nature, and symptoms of trauma that they will encounter in justice-involved adolescents. Require facility pre-service training and in-service refreshers at least annually.

**Recommendation:** Train staff to understand youth behavior in the context of adolescent development, culture, and trauma. Enhance training to better prepare staff to deal with the causes, nature, and symptoms of trauma that they will encounter in justice-involved adolescents. Implement the TARGET program, as recommended above.

Second, Long Creek's training curriculum does not offer enough training on crisis intervention and verbal de-escalation techniques. The facility's current curriculum includes content on these topics, but staff would benefit from additional and more specific training on the particular challenges that adolescents may present for staff in a secure facility. Given the significant trauma and mental health histories of youth at Long Creek, staff need more skills training on verbal de-escalation and crisis intervention, including practice and role playing using actual scenarios. .

**Recommendation:** Provide additional pre-service and in-service training on the use of conflict management and verbal de-escalation strategies with youth. Adopt additional training with a focus on non-physical interventions for adolescents, such as Safe Crisis Management: <http://www.jkmtraining.com/>.

Third, DOC and Long Creek provide training on cultural diversity, but this training does not cover specific and concrete ways that staff can work with youth of various racial and ethnic backgrounds in a culturally responsive manner. Staff could benefit from training on communicating with youth with different racial, ethnic, and cultural backgrounds.

**Recommendation:** Provide training on the racial and ethnic backgrounds of youth in custody and how to work with youth in a culturally responsive manner.

Fourth, Long Creek's training program omits several important topics in the JDAI standards. Staff need additional training, especially training on how to identify and respond to youth with mental illness. These topics include:

1. Signs of physical, intellectual, and developmental disabilities, the needs of youth with such disabilities, and the ways to work and communicate effectively with youth with those disabilities;
2. Signs of mental illness and the needs of and ways of working with youth with mental illness, including working effectively with mental health staff;
3. Signs and symptoms of mental illness and emotional disturbance;
4. Access to mental health and crisis intervention services for youth, including information on best practices for assisting youth connect with these services;
5. Procedures for appropriate referrals of health and mental health needs, including transportation to medical or mental health facilities;
6. Adolescent development for girls and boys, including sexual health and sexual development.

7. Gender-specific needs of youth in custody, including special considerations for boys and girls who have experienced trauma, pregnant girls, and health protocols for both boys and girls;
8. Signs and symptoms of medical emergencies, including acute manifestations of chronic illnesses (e.g., asthma, seizures) and adverse reactions to medication;
9. Signs and symptoms of chemical dependency, including withdrawal from drugs and alcohol;
10. Confidentiality of records and limitations on disclosure of confidential information.

**Recommendation:** Develop and implement training curricula on the topics outlined above.

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## SUPERVISION

New Long Creek staff receive performance reviews at three months, six months, and one year. Regular employees receive annual performance reviews unless they receive a new position or a new supervisor.

Despite an established process for supervision, the facility culture does not encourage JPWs to develop a positive environment for youth. Staff do not document the use of verbal de-escalation, crisis intervention, or incentives.

As discussed above, the facility could benefit from new staffing patterns and staff positions to provide greater consistency in supervision and support of JPWs. The goal of this support and supervision is to help staff build skills, to promote unity, and to ensure program consistency.

**Recommendation:** Review the recommendations outlined above to create tracks for promotion for staff who demonstrate exceptional skill working with youth or who develop specialized skills in working with troubled youth.

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## QUALITY ASSURANCE

Administrators have created processes to assess and review facility progress. The Chief of Security reviews all incident reports. The Superintendent reviews all incidents of discipline that are not addressed informally. Administrators review critical incidents such as assaults and observation time weekly through an “incident mapping” chart and in monthly Commissioner reports.

Meetings with administrative staff and Juvenile Program Managers are held on Mondays and Fridays. Executive staff meetings are held weekly to support an exchange of information. With respect to the use of discipline, the team was impressed that much of this information is stored electronically. Senior staff were able to provide data to answer almost any question about the rate or number of incidents inside the facility.

Much information is stored in one centralized online database, but much information in the database must be entered by hand from physical forms created by staff. As a result, it is not possible for facility staff to track information on a practice or identifying factor that they have



not already identified as important. For instance, the team was unable to obtain information on the use of “pod time” broken down by underlying behavior. Additionally, the team heard complaints from youth that level drops and advancement through the program were used “differently for everyone.” While this may be based on the individual needs and challenges of youth, the facility is not able to address the issue because it does not track this information.

If Long Creek tracked and reviewed information on non-critical incidents like “pod time” or phase and level advancements, administrators could ensure that staff are applying the behavior management system consistently and effectively. For example, the goal of the level system is to reward good behavior, while making higher levels accessible and sustainable for all youth. If data showed that that girls or youth of color continually cycle through levels without maintaining a high level, the facility could take a closer look at policies and practices.

**Recommendation:** Develop a system to collect and review information about the use of discipline and incentives, including pod time and the duration of time on levels and phases.

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## ENVIRONMENT

*Juvenile detention facilities should not look like or be operated as jails. This section encourages facilities to provide a non-penal environment appropriate for youth who need to be held in a secure setting. It requires that the facility is clean, meets fire and safety codes, has properly functioning temperature controls, light, and ventilation, and offers youth appropriate living conditions. This section also encompasses quality of life issues – assuring that youth will have clean, properly-fitting clothing; pleasant, healthy eating experiences; permission to retain appropriate personal items; and some measure of privacy.*

There were several strengths in this area of the standards. First, the facility itself was generally clean and well-maintained, with some exceptions outlined below. Youth are involved in a significant amount of sanitation activities at the facility, but they perform them under close staff supervision. Laundry services are also a strength of the facility, with a dedicated staff member in charge who is committed to using the opportunity to help with laundry services as an incentive for good behavior. Finally, while we have some recommendations about the facility's emergency planning outlined below, we were impressed with the level of detail and thought that has gone into Long Creek's emergency preparedness plans.

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### POSITIVE INSTITUTIONAL ATMOSPHERE

As outlined in the JDAI standards, a positive institutional atmosphere depends on two factors: (1) the atmosphere conveyed by the physical plant and decor of the living units and other spaces where youth and staff spend time, and (2) the atmosphere created by the nature of staff interaction with youth.

With respect to the first factor, the facility has not been altered much to avoid feeling like a correctional facility. There are notable exceptions, including the library, the gym, and some areas of the facility with colorful murals. However, many living units were very stark and had limited or no imagery or information posted to convey high expectations for youth. We recommend introducing more murals, artwork, and positive imagery into the living units and other parts of the facility. The two photographs below from the Worcester Reception Center in Massachusetts and the Multnomah County (Portland) Juvenile Detention Center illustrate two examples of how color and imagery can create a more positive and relaxed environment in living units.

**Recommendation:** Introduce more murals, artwork, and positive imagery into the living units and other parts of the facility. Involve youth and staff members who have an interest and skill in art.



With respect to the second factor contributing to a positive institutional atmosphere – staff’s interactions with youth – the team encountered significant variability among Juvenile Program Workers. As mentioned in other sections of this report, we observed some new staff and senior staff engaging in very positive and supportive conversations with youth. However, we observed other staff, including many new staff, who clearly did not see this kind of interaction as a priority.

During lunch time, for example, we saw units where staff sat at their own tables separate from youth. We observed other programming periods where staff were either behind the unit’s desk or

limiting their communication with youth to directives. These types of interactions do not build rapport between staff and youth, and they fuel a feeling of “us vs. them” between youth and staff that can lead to tension, defiance, and altercations. As mentioned above, the team recognizes that many new staff do not have adequate training on working effectively with young people, and forced overtime has strained Juvenile Program Workers’ patience with youth. However, it is everyone’s interest to have a positive institutional atmosphere, which promotes safety and security of youth and staff.

**Recommendation:** Enhance training to equip new staff members with additional skills for communicating and working with youth.

**Recommendation:** Ensure that policy, procedure, and actual practice require staff to interact with youth in a positive and developmentally appropriate way. For example, the facility could have a policy of providing free lunch to staff members, so long as staff members eat and communicate with residents while they do so.

As mentioned in the discussion of general areas of concern at the beginning of this report, Long Creek must do more to create a safe and supportive environment for lesbian, gay, bisexual, questioning, gender non-conforming, and transgender (LGBQ/GNCT) youth. Long Creek’s non-discrimination policies and codes of conduct do not clearly prohibit discrimination on the basis of gender identity and gender expression, and the facility does not have a specific policy for working with LGBQ/GNCT youth (although we learned that one is currently in development).

The team reviewed a number of grievances regarding alleged harassment and abuse of LGBQ/GNCT youth the facility. Allegations included both youth and staff engaging in inappropriate conduct and comments. Grievances about mistreatment involving LGBQ/GNCT youth were often delegated to Juvenile Program Managers for follow-up, and documentation did not always reveal what actions, if any, were taken to prevent future harassment or bullying.

Finally, as mentioned in the introduction, a team member overheard a Long Creek staff member make a disparaging comment that implied that staff would not want to be associated with anything that appeared “gay.” As mentioned earlier, the need for additional training is clear, as is a need for staff members who will consistently speak to the importance of supporting and respecting all youth, regardless of sexual orientation, gender identity, or gender expression. The team heard from staff members who would be willing to partner in delivering this training.

**Recommendation:** Adopt a policy on working with LGBQ/GNCT youth that is modeled after those of the New York City Administration for Children’s Services, the Massachusetts Division of Youth Services, or other agencies with strong policies. Model policies are available at [www.equityprojects.org](http://www.equityprojects.org).

**Recommendation:** Include clear prohibitions on discrimination on the basis of gender identity and gender expression in policy.

**Recommendation:** Provide additional training on the needs of and effective interactions with LGBQ/GNCT youth, and involve line staff who are knowledgeable about and

supportive of LGBQ/GNCT youth in delivering those trainings. Model training materials are available at the website listed above.

**Recommendation:** Improve oversight of incidents of alleged abuse and harassment of LGBQ/GNCT youth. Develop a policy and practice of documenting interventions to address alleged mistreatment, and monitor and document youth and staff behavior following the intervention.

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## FOOD SERVICE AND NUTRITION

Consistent, high-quality food service can help maintain a positive institutional atmosphere and reduce the number of incidents involving physical aggression and violence. The team reviewed many grievances related to the quality and quantity of food provided to youth prior to arriving on site. Interviews with staff and youth, coupled with the team's experience with meal service while on site, provided additional information about shortcomings within the food service and delivery at Long Creek.

The team recognized that the kitchen had recently implemented a new menu with the goal of remedying areas of concern, and we learned about changes in providers of food to address previous concerns about quality. As any juvenile facility administrator knows, problems with these areas of food service and delivery lead to unhappy youth who are more likely to engage in disruptive behavior.

First, the meals that the team observed delivered to youth (and that some team members consumed) were not visually appealing or particularly appetizing. Some food items were cooked in a way that made them difficult to consume. For example, French fries prepared for lunch the second day of our visit were hard to the point of being inedible. The team also questioned whether portion sizes matched what was prescribed via the menu. On our first day at the facility, the prepared meal did not match what was posted on the menu for lunch that day. Deviations such as this mean that the facility may be falling short of what a dietician had approved.

Second, when the team asked youth about the one thing they would change at Long Creek, almost every single youth stated the quality and quantity of the food. Many youth reported that the meals left them hungry later in the day. One reason is that many youth were not eating much of the prepared meals. Indeed, the team observed female residents taking an apple and packets of peanut butter in lieu of a lunch tray without any questions by staff as to why they did not take a tray. Another reason is that more than 14 hours can elapse between dinner and breakfast per schedule and per policy, which is a longer period than the most recent guidance of a maximum of 12 hours from the American Academy of Pediatrics. Finally, many youth stated that the evening snack was often the same from day to day.

The team recognizes that the facility's adherence to the federal school lunch guidelines can present challenges in preparing food that youth enjoy eating, but we have seen many facilities that provide a much stronger food service program within those guidelines. For example, the facility could create a salad bar station to encourage youth to eat an array of healthy vegetables,

which is an offering that is consistent with the federal guidelines. Additionally, the facility could survey youth about their preferred meals and make those available on a more regular basis.

**Recommendation:** Ensure that meals are both visually appealing and appetizing to youth.

**Recommendation:** Solicit youth input on preferred meals and offer such meals more regularly than those that many youth decline to eat.

**Recommendation:** Reconsider whether participation in the federal school lunch guidelines is consistent with the needs of the growing adolescent population at the facility.

**Recommendation:** Ensure that prepared meals follow what a licensed dietician has approved as the designated meal that day.

**Recommendation:** Introduce a salad bar as a means for exposing youth to healthy vegetables.

**Recommendation:** Create a rotating schedule that ensures variety in evening snacks.

**Recommendation:** Develop a meal schedule that does not allow for more than 12 hours to elapse between dinner and breakfast.

**Recommendation:** Consider whether a partnership with the facility's Culinary Arts program could help enhance the quality of food service.

Finally, policy provides that youth with special dietary needs, youth with medical conditions, and youth with religious beliefs can receive alternative meals. The team had two concerns about how those accommodations were being made in practice. First, the team encountered a youth who was regularly vomiting and clearly had some sort of gastrointestinal problem. The facility's medical staff were in the process of settling on a diagnosis for his condition, but no accommodations had been made by the medical or food service staff for alternative meals in the meantime. Second, the alternative menus if youth refuse to eat or cannot eat a main course are very limited – the substitute is peanut butter or cheese on most days. If there is a youth at the facility for an extended period with a special dietary need (e.g., a vegan youth or a youth who is observing Ramadan), they are not likely to see much, if any, diversity in food service.

**Recommendation:** Ensure that there is a process for communicating regularly with medical staff about youth who have needs for special diets, even prior to a formal diagnosis.

**Recommendation:** Introduce a broader range of alternative menu items for youth with special dietary needs.

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## EMERGENCY PREPAREDNESS AND FIRE SAFETY

As mentioned above, the facility has an impressive and comprehensive set of emergency preparedness plans that account for many different types of emergencies and natural disasters. We applaud the facility for thinking through how it would manage those situations. We have several recommendations that we believe would strengthen the plans. The plans do not explicitly address the process for transporting essential medications off-site, notifying family members (including designating staff who would be responsible for making the notifications), and addressing how to meet the needs of youth with disabilities and limited English proficiency. The team encourages administrators to think through how they would manage those aspects of the facility's response to emergencies and integrate them into the existing plans. Additionally, the binder that the team reviewed did contain a facility schematic, but it did not include a diagram of emergency exit routes. Diagrams were, however, posted throughout the facility.

**Recommendation:** Include additions to existing emergency preparedness plans that address the process for transporting essential medications off-site, outline the process for notification of family members (including designating staff who would be responsible for making the notifications), and address how to meet the needs of youth with disabilities and limited English proficiency. Ensure that all emergency planning binders include a facility diagram with emergency exit routes clearly identified.

The facility conducts regular fire drills on all shifts and has documentation of the outcomes of drills. We also learned that the facility had not drilled on its emergency preparedness plans in recent months, in part because of staff having to respond to actual emergencies within the facility. Drills serve a vital function of showing where there are weaknesses in emergency response policies and procedures. Those lessons should not be learned from actual emergencies.

**Recommendation:** Resume regularly scheduled emergency and “man down” drills.

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## PHYSICAL PLANT AND SANITATION

As outlined in the checklist, the physical plant at Long Creek suffers from significant shortcomings. Administrators and staff at Long Creek are all too familiar with the challenges presented by the facility, including chronic maintenance problems, inconsistent air and water temperatures, lighting problems, and other problematic conditions. There is, unfortunately, no easy remedy to these problems, but Long Creek could certainly benefit from additional resources directed at preventive and corrective maintenance.

**Recommendation:** Secure additional resources for preventive and corrective maintenance and develop a prioritized list of chronic maintenance issues to be addressed in order of their relation to the life, health, and safety of youth and staff at the facility.

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## CLOTHING

As mentioned above, laundry services at the facility were generally excellent. The team did observe that the facility gave pink shirts to the girls, which some girls complained about. Others

noted that if a transgender boy was housed on the girls' unit (as has occurred in the past), he would be forced to wear pink clothing, something that could signal rejection of his gender identity. There is no need for pink clothing when other neutral colored shirts are available.

**Recommendation:** Retire or donate the pink shirts for girls and replace them with a more neutral color.

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## SEARCHES AND SUPERVISION

First, as mentioned above in the Access section, the facility conducts routine strip searches after family visitation. Many juvenile facilities conduct less intrusive searches following family visitation, in large part to avoid the trauma and humiliation of a strip search.

**Recommendation:** Discontinue routine strip searches of children following family visitation.

Second, the facility also provides for routine strip searches of committed youth at intake, and policy allows for strip searches based on the nature of a youth's previous offenses as opposed to the likelihood that he or she is in possession of contraband that could not be found with a less intrusive search. Strip searches of children, at intake or otherwise, should be limited to situations where a youth is suspected of being in possession of contraband that could not be located through a less intrusive search.

**Recommendation:** Discontinue routine strip searches of committed youth at intake. Ensure that strip searches are only conducted when a youth is suspected of being in possession of contraband that could not be located through a less intrusive search.

Third, the renovation of the Special Management Unit includes a room with a camera that is allows for view of the entire cell, including the toilet area. This arrangement would allow for cross-gender viewing of youth in a state of undress when a female juvenile program worker is in Control and a male youth is housed in the SMU. Other juvenile facilities employ a mechanism for digitally or otherwise obscuring the toilet area of rooms such as this.

**Recommendation:** Digitally or otherwise obscure the toilet area in the video feed of the cell with video monitoring on the SMU.

Fourth, we did not observe staff consistently announcing themselves when entering housing units where youth of the opposite gender were present. We recommend reinforcing the need to make such an announcement by posting a reminder on housing unit doors or through some other means.

**Recommendation:** Develop signage or some other mechanism to ensure that staff of the opposite gender of youth on a housing unit announce their presence.

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## ACCOMMODATIONS FOR YOUTH WITH PHYSICAL DISABILITIES



Although the facility had designated rooms and bathrooms that were intended to accommodate youth with physical disabilities, the rooms and bathrooms included grab bars that created opportunities for tie-off points for suicidal youth. There are specially designed grab bars available from correctional supply outlets that place a piece of welded steel midway down the bar to prevent this problem.

**Recommendation:** Install suicide-resistant grab bars with welded steel between the wall and the bar, which are available from correctional supply outlets.

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## RESTRAINTS, ROOM CONFINEMENT, DUE PROCESS, AND GRIEVANCES

*Security and good order in a facility are best achieved when expectations are clear; the facility encourages compliance with rules through positive behavior interventions; staff are well-trained to help prevent and de-escalate crises; and there are positive relationships between youth and staff. This section addresses what happens when those protective factors are insufficient. This section includes the facility's rules for restraint, use of physical force, room confinement, discipline, provisions for due process, and disciplinary sanctions. This section also addresses the facility response to concerns and complaints by youth through an effective grievance process.*

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### GENERAL RULES REGARDING YOUTH MISCONDUCT

The Resident Handbook contains a summary of facility policy. Long Creek has a graduated array of consequences for misconduct, including, in order of restrictiveness, Verbal Redirection or Modification, “Unacceptable” rating on a youth’s daily Behavior Card, Writing Assignment, Extra Work Duties, Monetary or Service Restitution, Specific Activity Restriction, Unit Restriction, Pod Restriction, or Room Restriction. Verbal Redirection or Modification, “Unacceptable” rating, Writing Assignment, and Monetary or Service Restitution may be imposed for minor or major misconduct. Minor misconduct is inappropriate but does not create a substantial safety threat to the youth or others or the security of the facility. Major misconduct is behavior that does create a substantial threat to the safety of the youth or others or the security of the facility. For minor misconduct, a youth may receive one hour per day of extra work for up to two days, one activity and/or one loss of privilege for up to a week (two weeks with authorization of a Juvenile Program Manager), up to twelve hours of unit and/or pod restriction, and up to two hours of room restriction. For major misconduct, a youth may receive one hour of extra work per day for up to four days, two activities and/or loss of privileges up to four weeks, and up to 30 hours of unit, pod, and/or room restriction. Unit restriction means the youth is confined in the day room area; pod restriction means confinement in the area of the pods, which are located off the day rooms; and room restriction is confinement in the youth’s room.

If a youth allegedly commits minor misconduct or some types of major misconduct, staff determines the consequences. If the youth accepts the consequences, the matter is resolved informally. If the youth disagrees, the matter is referred to the formal disciplinary process. If a youth allegedly commits major misconduct, there is an investigation, the youth is given the opportunity to make a statement, and the matter may go to a Violation Hearing. In such situations, youth receive due process protections including notice of the alleged violation, availability of assistance by staff, the opportunity to make a statement and present evidence, a decision by a Hearing Officer, and the right to appeal up to the Superintendent. The Handbook lists nine examples of minor misconduct and 21 examples of major misconduct.

The Resident Handbook notes that any youth may file a grievance about any policy, action, decision, or condition the youth feels is unfair, in violation of the youth’s rights, or in violation of departmental policies and procedures, with three exceptions. Youth may not grieve classification decisions, disciplinary decisions, or leave decisions. The Resident Handbook lists the names, addresses, and phone numbers for four legal advocacy organizations that youth may contact by letter or collect phone call for advice on matters other than their own delinquency

charges: the American Civil Liberties Union of Maine, Disability Rights Maine, Maine Equal Justice Partners, and Pine Tree Legal Assistance.

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## USE OF FORCE AND PHYSICAL RESTRAINTS

There are many youth at the facility who have serious mental disorders. They are, at times, challenging, provocative, hostile, and aggressive. Some spit on staff, which is both a safety and a health issue. Youth have set off water sprinklers, which is very disruptive to facility operations. Until recently, the Special Management Unit (SMU) had low ceilings, making it relatively easy for youth to set off the sprinklers.

Violent behavior and assaults are serious concerns at the facility. Each staff member in the facility, and each visitor who spends time in the living units, wears an electronic device that immediately can call for help. The facility has two security teams working on each shift, the “A Team” and the “B Team.” Each team consists of three staff. The A Team is called immediately when a confrontation situation occurs. Members of the teams wear body cameras to record the events. The cameras provide much better quality video and a closer view of the participants than the ceiling cameras in the facility.

The assessment team interviewed youth and staff and reviewed records of many incidents, including videos of incidents. Many staff are very patient with youth who are disruptive: trying to engage the youth in conversation, working to de-escalate the situation, and allowing youth to vent without enlisting other staff to directly confront the youth and seize control with physical restraints. In situations in which youth pose an immediate physical threat to staff or other youth, or to themselves, staff are proficient in quickly applying physical restraints to gain control.

However, the interviews, records, and videos also demonstrate that there are significant inconsistencies among staff in how they handle disruption and confrontation situations. Even within one incident, staff may be very patient with youth at one point and use excessive force at another point. In one video, staff appropriately waited 30 minutes for a youth to calm down when he was cursing at staff and throwing things around in the day room area while other youth were confined to their rooms. Later in the same incident, however, in gaining physical control over the youth, one staff lost control and punched the youth in the back and in the thigh. In another incident, a child in his room was cursing at staff and threatening to throw his shoe at the sprinkler on the ceiling. When the youth spit at staff, two large staff rushed in to restrain the youth, and the restraint the staff members used seriously injured the youth.

Like many youth at the facility, both of the boys in the two incidents have serious mental disorders. There is no question that the boys’ disruptive behavior was closely related to their mental health problems. The team reviewed other comparable incidents involving youth with serious mental health problems and questionable use of force by staff.

Facility administrators are clearly concerned about such behavior by staff. Following the first incident described above, the staff member was fired. There is an ongoing investigation into the second incident. However, these and other incidents raise serious concerns about the safety of youth at the facility.

A number of factors appear to contribute to these situations. Some of the factors are specific to training for, or handling of, confrontation situations:

1. There is a lack of clarity in the restraint training. Crisis Consultant Group (CCG) provides de-escalation and restraint training for staff. After the closeout meeting at the end of the on-site visit, the training director for CCG told the assessment team that staff are not trained to restrain youth face down on their stomachs, because pressure on the back can cause asphyxiation, and that any restraint of a youth in that position would be contrary to training. Yet multiple videos showed staff restraining youth in that position.
2. There is inadequate staff training on handling youth with mental health problems and disabilities. For many youth at the facility, their disruptive behavior is a manifestation of their mental health problems and disabilities.
3. By policy, staff do not contact mental health clinicians at the facility to intervene directly in confrontation situations, even though the clinicians are trained to work with youth in crisis. The clinicians generally only get involved during reviews of the incidents. The rationale for this is that engaging the clinicians directly would positively reinforce youth who are acting out to obtain one-on-one meetings with the clinicians. It is true that many youth told the assessment team that they wanted more one-on-one time with clinicians, and that they have manipulatively told staff that they want to harm themselves in order to get to see clinicians. But the rationale seems to mix up priorities in the facility. The purpose of having clinicians at the facility is to provide mental health services to youth who need them. In many situations the assessment team reviewed, clinicians could have intervened effectively as third parties in standoffs between youth and staff.
4. There are problems with follow-up to the incidents. Ideally, follow-up includes debriefing with staff directly involved, independent review by a supervisor, and review by administrators and clinicians. In practice, however, it is not clear that a debriefing occurs soon after each incident. Incident report packets did not always reflect that a debriefing had occurred. Also, some reports were less than accurate. In the report on the young boy who had his front teeth knocked out, the summary report of the incident stated that the two staff “made directional contact with [the boy] bringing him down on the bed.” The supervisor who reviewed the report stated that the staff behavior was inconsistent with facility policy because staff did not pursue the least restrictive course, in this case backing away from the youth until he calmed down. That is technically true, but omits the fact that staff clearly used excessive force. In addition, reports on incidents do not contain information about the review by administrators and clinicians: that information is in a separate database. Finally, there is no indication in the report packets if there has been any change in policy or practice as a result of the incidents.
5. De-escalation training should include more material about adolescent development and how that relates to de-escalation efforts. It should include more role-playing with scenarios involving youth who may be attention-seeking, needy, hostile, and aggressive.

The training should also have additional competency testing specifically focusing on de-escalating confrontations.

Other factors are more systemic and have been discussed earlier in this report. Some of these issues require action by the Department of Corrections and the legislature, as well as facility administrators.

1. Staff cutbacks and vacancies have hurt staff morale and left fewer staff available at the facility to work with youth and intervene before small issues become big confrontations.
2. Mandatory double shifts leave staff exhausted and lacking in patience when youth act out.
3. Staff turnover has meant that some staff responsible for youth in the units have limited experience dealing with difficult adolescents. It was noted during the opening meeting of the visit that it takes about a year for staff to become seasoned youth workers.
4. Youth want and need more programming in the units after school and in the evenings. Keeping youth busy with structured activities is an effective way to reduce disruptions. A number of youth we interviewed admitted that they got disruptive because they were bored.

**Recommendation:** For facility administrators and CCG training director, clarify the restraint training to explicitly prohibit restraint of youth in prone position with staff putting pressure on the youth's back, and monitor videos of restraint incidents to ensure that staff do not use such physical restraints.

**Recommendation:** For administrators and training coordinator, provide staff with training on handling youth with mental health problems and disabilities, including how disruptive behavior may be a manifestation of mental disorders.

**Recommendation:** Ensure mental health clinicians are involved in standoffs between youth and staff and confrontation situations while the incidents are going on, when intervention by the clinicians may help defuse the situation and the safety of the clinicians would not be threatened.

**Recommendation:** Have mental health clinicians spend more time in units like Cedar, which house youth with the most serious mental health disorders and youth who are most likely to cause disruptions.

**Recommendation:** For facility administrators, review videos of confrontation situations and compare them with the reports of both (1) staff involved in the incidents and (2) supervisors who review the incident reports, to ensure that reports do not minimize the impact of staff use of physical and other restraints.

**Recommendation:** For the training director, provide more training on adolescent behavior and how it relates to de-escalation of young people, more role-playing with scenarios that are directly related to situations at Long Creek, and additional competency testing specifically focused on de-escalation skills.

**Recommendation:** For facility administrators and the Department of Corrections, fill staff vacancies at Long Creek.

**Recommendation:** For facility administrators, discontinue involuntary double shifts by staff.

**Recommendation:** For facility administrators and supervisors, ensure that staff with limited experience do not have responsibility for youth who are regularly disruptive or who have significant mental disorders.

**Recommendation:** For facility administrators and unit staff and supervisors, provide additional programming and structured activities for youth in the units after school and in the evenings.

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#### CHEMICAL AND MECHANICAL RESTRAINTS

There is a supply of pepper spray canisters at the facility. According to staff, pepper spray is “never used” but is available “if necessary.”

Pepper spray (oleoresin capsicum) is a chemical substance derived from compounds found in plants in the Capsicum genus such as chili peppers. Pepper spray can cause intense pain, swelling, and blistering of the skin; wheezing, an inability to breathe or speak, and respiratory arrest; and potential asphyxiation when used in conjunction with physical or mechanical restraints, or when used on individuals with respiratory conditions such as asthma.

The effects of pepper spray on children and adolescents have never been studied, so there is no information available to determine long-term consequences for young people’s health of single or repeated exposures. Research on pepper spray use on adults has found that the effects of pepper spray are exacerbated in confined spaces and areas with poor ventilation such as correctional facilities.

Being sprayed with pepper spray is a traumatic experience for young people. The psychological and physiological dangers of pepper spray are magnified for youth who have serious mental disorders such as many of the youth in Long Creek. Chemical agents such as pepper spray may also interact dangerously with psychotropic medications, as both substances can affect blood flow, heart rate, and breathing.

Use of pepper spray opens up Long Creek to legal liability. Federal courts have concluded that the use of chemical agents in secure facilities can violate the U.S. Constitution. The Civil Rights Division of the U.S. Department of Justice has investigated several juvenile facilities over use of

pepper spray and has consistently found that such use violates the Constitution, particularly in view of less restrictive measures that can be utilized.

The fact that pepper spray has never been used in Long Creek is strong evidence that it is not necessary in the facility. Staff suggested another reason for not using pepper spray: it may provoke youth to act out in order to show that they “can take it.” They may perceive being able “to take it” as an enhancement of their status. Members of the assessment team have seen other facilities (during litigation) that have used pepper spray, in which use of the spray did provoke youth to act out to show they could take it. All pepper spray should be removed from the facility, in order to protect confined youth and staff from the harmful effects, protect Long Creek from legal liability, and prevent authorization of its use by future administrators who are insufficiently aware of, or who disregard, the risks posed.

The facility has several types of mechanical restraints. Handcuffs and leg shackles are kept in the living units. In the Control Center, there are soft leather cuffs, zip ties, and heavy black protective gear including helmets for staff to use in “cell extractions.” According to staff, the leather cuffs, zip ties, and protective gear are very rarely used. There are also waist belts, which we were told are used routinely depending upon the Phase and Level of the youth.

Items like leather cuffs, zip ties, and heavy protective gear, which are used rarely if ever, should be removed from the facility. As with pepper spray, the fact that they are so rarely used demonstrates that they are not necessary in the facility to ensure safety and security. In addition, leather cuffs are more difficult than handcuffs to apply, and zip ties can cut off circulation and cause injury to youth’s hands and wrists. Heavy protective gear is inappropriate in a juvenile facility. It makes staff look like a riot squad. It is a carryover from Department of Corrections policies regarding adult prisons. It should not be used in “cell extractions” at Long Creek. When youth refuse to leave their rooms, staff should talk with youth, for as long as it takes, to determine the underlying problem. Mental health clinicians may be very helpful to intervene in such situations. The availability of such protective gear makes it easier for staff to give in to frustration during verbal de-escalation and instead rely on physical force. In addition, staff noted that, as with pepper spray, the protective gear may provoke youth to act out in order to show that they “can take it.”

As a general matter, most use of mechanical restraints in a juvenile facility should be use of handcuffs to gain control over a youth so that the youth can quickly be taken to his or her room. Once the youth is in the room, the handcuffs should be removed immediately. Thus, most use of mechanical restraints should be brief.

The assessment team was provided with data on the use of mechanical restraints in the facility from January 1, 2017, to July 7, 2017. During that period, there were 98 reported incidents of use of mechanical restraints. Some incidents involved very long periods of restraint: 100, 103, 105, 112, and 229 minutes. The average length of mechanical restraint was just under 38 minutes. It does not take very long to move a youth from one point in the facility to another if the youth walks. If the youth struggle and resists all the way, it could certainly take longer. However, the assessment team viewed videos of youth in restraints in their rooms, where the youth were not violent and were simply sitting on the floor. All of this information raises the question whether

staff keep youth in restraints after they place youth in their rooms, which is unnecessary, punitive, and dangerous.

**Recommendation:** Remove pepper spray from the facility.

**Recommendation:** Remove leather cuffs, zip ties, and heavy protective gear from the facility.

**Recommendation:** Closely review incidents involving mechanical restraints to determine whether staff remove restraints promptly after they transport youth to their rooms.

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## ROOM CONFINEMENT

The usual stated purpose of room confinement is as a temporary response to youth behavior that threatens immediate harm to the youth or others. When the youth ceases to threaten immediate harm to self or others, staff should release the youth from room confinement. This principle is embodied in the JDAI Juvenile Detention Facility Assessment Standards and has been approved by the American Correctional Association, National Partnership for Juvenile Services (composed of administrators and staff of juvenile detention facilities), Council of Juvenile Correctional Administrators (composed of administrators of the state juvenile correctional agencies), National Commission on Correctional Health Care, American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, American Probation and Parole Association, American Psychological Association, and the National Council of Juvenile and Family Court Judges. Room confinement can have long-lasting and devastating effects on youth, including trauma, psychosis, depression, anxiety, and increased risk of suicide and self-harm. The American Correctional Association is in the process of adopting a new standard that explicitly requires these limitations on the use of room confinement in juvenile facilities.

This principle is also embodied in policies at Long Creek. The policies governing the various forms of room confinement at Long Creek explicitly state that room confinement is not to be considered a sanction for inappropriate behavior (“not to be used as punishment” – Observation Policy 10.1, Intensive Behavior Management Status Policy 10.3), but only as a tool “to aid the resident in controlling or calming their own behavior” (Time Out Policy 15.5). Youth are to be released from room confinement and returned to general programming as soon as the youth regains control.

Room confinement is used in several ways at Long Creek. Youth who misbehave may be given a “time out,” not to exceed one hour. There are three forms of time out. “Time out, staff controlled” usually involves stopping a youth from participating in an activity and locating the youth in close proximity to and under observation of staff for 5-10 minutes. “Time out, resident’s room” involves confining a youth in the youth’s room when other strategies are ineffective. “Time out, time out room or other area” occurs when a youth is confined in a specialized time out room or other area. Facility policy provides that staff shall not lock a youth into a room during time out unless the youth’s behavior escalates to a high likelihood of imminent harm to self or others or a substantial and imminent threat of destruction of property.



If a youth poses an imminent threat of harm of self or others, or destruction of property, or risk of escape, staff may place the youth on Observation Status. Youth on Observation Status are confined to a room except when permitted to leave for exercise, showers, and visits. Programs and services are brought to the youth, either inside the room or elsewhere on the housing unit. Youth are not allowed to participate in services and programs with other youth. If a youth is on Observation Status for more than 24 hours, the Superintendent or designee and the youth Unit Treatment Team (UTT) develop a written plan for the youth.

Youth may be placed on “intensive behavior management status” if they engage in behavior that presents a likelihood of harm to the youth or others, a significant threat of destruction of property, a risk to security, interference with the treatment progress of other residents, or other disruption of the orderly management of the facility, and there is a likelihood that the behavior will continue, but the youth does not require observation status. These youth are placed on the Special Management Unit (SMU) and staff prepare a Behavior Stabilization Plan. The youth may program in the dayroom area of the SMU unless their behavior presents an imminent threat to self or others or destruction of property.

Youth may also be confined to their rooms for unit lockdowns or facility lockdowns. Unit lockdowns occur when one youth acts out, staff need to take action to control the youth, and staff want to move other youth in the unit out of the way. Unit lockdowns routinely occur as a result of individual confrontation situations. Staff report that unit lockdowns are very short, only for a few minutes until staff gain control of the youth, although some incidents last considerably longer, and youth report longer unit lockdowns.

Facility lockdowns occur when a situation prompts staff to lock all youth in the facility in their rooms. Central Control logbooks list 13 facility lockdowns from the beginning of 2017 to the date of the onsite assessment in September. The reasons for the lockdowns included fire alarm going off, fight among residents, and resident self-harm. The reported lengths of the facility lockdowns ran from 27 minutes to over three hours.

Interviews with staff and youth and review of the records and videos demonstrate that many staff use room confinement according to these policies. As noted earlier, many staff demonstrate great patience and skill in working with youth who are disturbed and destructive.

The interviews and review of the records and videos also demonstrate that these policies are not followed consistently. One problem is that a part of facility policy on Observation Status undermines the principle of room confinement for safety only and only as long as the youth is out of control. The facility policy on Observation Status requires approval of the Commissioner or Associate Commissioner of Corrections if the youth is on observation beyond 72 hours.

Facility records from January through July of 2017 show that youth get placed on Observation Status largely for two major categories of behavior: (1) fights and assaults and (2) suicidal behavior and self-harm. Some incidents fit into both categories – e.g., self-harm behavior followed by assault on staff. The table below shows the breakdown of incidents by month. Observation time is recorded in minutes. The table reports the number of incidents in the month,

the number of incidents that involved placing a youth on Observation Status, the total minutes of observation for all youth that month, the total number of incidents in which a youth was on Observation Status for more than 60 minutes (1 hour), and the total number of incidents in which a youth was on Observation Status for more than 240 minutes (4 hours). Under the JDAI standards, if a youth is in room confinement more than four hours, staff should return the youth to the general population, develop specialized individualized programming for the youth, or consult with a qualified mental health professional about whether a youth's behavior requires that he or she be transported to a mental health facility.

	Number of Incidents	Number of Incidents with Observation Status	Total Observation Status Minutes	Number of Incidents Greater than 1 Hour	Number of Incidents Greater than 4 Hours
<b>January</b>	44	0	0	0	0
<b>February</b>	71	7	11,044	6	4
<b>March</b>	53	6	3,516	3	2
<b>April</b>	38	12	2,970	12	4
<b>May</b>	62	12	4,518	11	7
<b>June</b>	64	4	7,634	4	4
<b>July</b>	69	11	39,150	11	10
<b>Total</b>	401	52	69,192	47	31

Three things should be noted at the outset to place these data in context. First, the minutes reported on Observation Status for each incident may include time that the youth was asleep. Staff include time that youth are sleeping in total Observation hours. Thus, Observation time does not equal room confinement time. Second, staff develop a plan for each youth placed on Observation and Intensive Behavior Management Status. These plans are discussed earlier in this report. Third, July was an outlier month in which four youth received more than 6,000 minutes of Observation (100 hours) for one incident, and one of those youth received more than 8,000 minutes of Observation (130 hours) for an incident 13 days later.

Overall, the data in the table show that Observation occurred in 13% of the incidents, in most of those incidents (90%) Observation lasted more than an hour, and in almost 60% of the Observation incidents the Observation time was longer than four hours. It should also be noted that the records show that some of the Observation incidents were very long: one was more than 3,400 minutes, four were longer than 6,000 minutes, one was more than 7,000 minutes, and one was longer than 8,000 minutes (133 hours, or more than five days).

These data indicate a number of important things about Long Creek and the use of room confinement. First, incidents involving fights, assaults, suicidal behaviors or self-harm occur on average about twice a day at the facility (average of 57 per month). Second, the great majority of incidents (87%) are handled without the use of room confinement. As noted above, many staff are very skillful at de-escalating youth and resolving conflicts peacefully. Third, when Observation is used, it is usually used for more than an hour, and in more than half of the incidents it was used longer than four hours. Fourth, many of the long and very long incidents in which Observation was used involved suicidal or self-harm behaviors.

These data and the available incident reports make it difficult to believe that every youth put into room confinement posed a high likelihood of imminent harm to self or others or a substantial and imminent threat of destruction of property during the entire time the youth was in room confinement. The facility's policy toward room confinement as non-punitive and only to help the youth calm down is appropriate. The policy is fully consistent with the JDAI standards. However, it is not being consistently implemented. Some youth are clearly being locked in rooms long past the time it takes for them to regain control. For youth who do regain control, such extended room confinement is punitive. The small number of youth who continue to act out over a long period of time should be transferred to a psychiatric facility or other mental health program that is equipped to handle them.

**Recommendation:** Ensure that unit lockdowns and facility lockdowns last no longer than actually necessary for staff to gain control of the situation.

**Recommendation:** Limit the use of room confinement to four hours. At the end of four hours, release the youth to a living unit, transfer the youth to a psychiatric hospital or other mental health program that is equipped to handle the youth, or provide continuous 1-on-1 supervision by staff with hourly visits by mental health clinicians.

**Recommendation:** Develop more effective individualized behavior modification plans based on positive reinforcement of desired behaviors and measurable positive steps youth can take to get released from room confinement.

**Recommendation:** Involve mental health clinicians much earlier in confrontation situations, as discussed earlier in this report.

**Recommendation:** Provide more 1-on-1 time for mental health clinicians with youth, especially youth who have histories of serious mental disorders and disruptive behavior.

**Recommendation:** Identify staff who are most effective at de-escalation and have them closely mentor new staff at the facility.

**Recommendation:** Reduce the use of the Special Management Unit and close it completely within six months. At the time of the onsite visit the SMU had been off-line for several weeks while it was undergoing renovations. We were told that, with the SMU unavailable, staff were doing a better job of handling disruptive youth in their own units. This is an opportune time to reduce the use of the SMU by providing additional training and making other reforms discussed in this report.

**Recommendation:** Track the issues involved in incident reports over time to look for patterns or repeated problems. Review the data monthly to determine if there are issues such as additional needed resources or staff re-training that require further investigation and policy or practice change.

As discussed above, the discipline process at Long Creek is not a vehicle for assigning room confinement as a sanction, as it is in many other juvenile facilities across the country. The facility policy “Resident Discipline System” sets forth those behaviors that constitute “minor misconduct” and those that constitute “major misconduct.” The policy also sets forth the potential consequences for major and minor misconduct, including the potential duration of each consequence. There are eight graduated levels of consequence, from the least restrictive (verbal redirection or modification) to the most restrictive (pod restriction). Notably, room confinement is not a potential consequence of misconduct.

The policy also provides for informal resolution of misconduct, with a guarantee that the youth will have an opportunity to explain his or her behavior prior to the staff’s determining the consequence. Staff also ask youth what they think would be an appropriate consequence. There is also a formal disciplinary process which includes an investigation by staff not involved in the incident and extensive and full due process protections for youth.

Two aspects of the formal disciplinary process are noteworthy. First, policy provides that youth shall not be placed on observation status during the investigation unless they meet the criteria for Observation Status. This is a welcome departure from policy in many juvenile facilities in which youth are held in room confinement pending formal due process. Second, if the resident is found not guilty in the formal disciplinary process, all disciplinary documentation relating to the incident “shall be destroyed.” This is an excellent policy to prevent a youth from being prejudiced in any later proceedings involving a different incident.

Overall, youth report that staff use consequences in ways that are fair and appropriate. The multiple levels of consequences allow staff appropriate flexibility in responding to misconduct. The intentional absence of room confinement as a consequence, and the presumption that youth will not be held in their rooms pending an investigation, are exemplary.

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## GRIEVANCES

A grievance system is a valuable component of operations in a juvenile facility. It functions as a pressure release valve for young people who are in a compressed and often anxiety-filled environment. It also provides a valuable means of getting feedback to management about what is troubling youth in the facility. Grievances are not annoying complaints from youth: they are important windows of communication about problems and potential problems in the facility. Of course, not every grievance will be well-founded. However, it is important to monitor patterns of grievances as indicators of policies or practices that should be reviewed.

The grievance system at Long Creek accomplishes its primary goal: the Grievance Coordinator investigates grievances to determine which are justified. However, the system has multiple reasons for “dismissal” of grievances and complex procedures that undermine its purpose.

Facility policy is that youth may not file grievances regarding certain subjects because there are separate appeal procedures for those matters: classification procedures and decisions, including decisions to place a resident on individual behavior management status or a decision about risk level, participation in an institutional or community-based program, or transfer; disciplinary

procedures and decisions; and furlough-pass/furlough-leave procedures and decisions. Youth may not file grievances regarding medical or mental health care, community corrections, or sexual misconduct, because there are separate grievance procedures for those subjects. Grievances may be dismissed if they pertain to more than one subject. Grievances may also be dismissed if youth do not file the grievance within 15 days of the event that is grieved.

Many grievances are dismissed for these reasons. In fact, there is a printed form, entitled “Notification of Dismissal/Return,” which has 11 check-boxes and reasons why the grievance is dismissed, and an additional check-box for returning the grievance because the youth did not provide sufficient information to show when the 15-day time limit began. The form also states, in capital letters in bold, **“YOU MAY NOT APPEAL DISMISSAL.”**

In addition, the grievance process is very complex. Once the Grievance Review Officer receives the grievance, he determines if one of the reasons for dismissal applies and if there is sufficient information to show that it was filed within 15 days of the event. If the grievance passes these hurdles, the Officer forwards the grievance to the supervisor “having jurisdiction over the subject.” That person has to meet with the youth in an attempt to resolve the grievance informally, “if possible.” If the grievance is not resolved, the supervisor and the youth sign a form acknowledging that the grievance was not resolved and the supervisor returns the grievance and the form to the Grievance Review Officer within seven days of being sent the grievance. The Grievance Review Officer then investigates the grievance, including interviewing relevant people and reviewing documents, and responds to the grievance in writing within 30 days. If the grievance requires action by the Superintendent or the Commissioner, the Officer forwards the grievance to those individuals. If the Officer cannot respond to the youth within 30 days, he advises the youth that the Officer will respond within 10 additional days. If the youth is unsatisfied with the Officer’s response, the youth may appeal to the Superintendent within 15 days of the grievance response. The Superintendent must respond to the appeal within 25 days. If the youth is still unsatisfied, the youth may appeal to the Commissioner within 15 days, and the Commissioner must respond within 20 days of the filing of the appeal.

The effect of all of this is to discourage youth from filing grievances and to allow staff to dismiss many grievances when they are filed. Many youth told us that they had no confidence in the grievance system. The requirement for separate grievances (with separate forms) for medical and mental health issues is clearly unnecessary. Both regular grievances and medical or mental health grievances go to the Grievance Coordinator, who performs the initial triage and then forwards them to the appropriate staff to start the process.

None of this detracts from the efforts of the Grievance Coordinator at Long Creek. He investigates and resolves many grievances informally. But he is working in an overly and unnecessarily complex system.

This policy is evidently a carryover from Department of Corrections policy for its prisons, where adult inmates are incarcerated for much longer periods of time, a highly structured grievance procedure may be more appropriate, and decisions on grievances are necessary prerequisites to filing legal actions. It is not appropriate in a juvenile facility, where the emphasis should be on simple procedures rather than complicated ones. A grievance process should allow youth to file a

grievance on any issue. There should be no time limit on filing grievances. Youth should receive a response in a short period of time such as one week.

**Recommendation:** Revise the grievance procedure to allow youth to file grievances on any issue without any time limitations. Provide youth with a response to a grievance within one week.

**Recommendation:** Track the subjects of grievances over time to look for patterns or repeated areas of concern. Review the data monthly to determine if there are issues such as program policies or staff training that require further investigation and policy or practice change.

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## SAFETY

*Although safety is the last section of this assessment tool, physical and emotional safety for youth and staff is the overarching principle underlying all of the other sections. This section identifies the facility's responsibilities to protect youth and staff, respond quickly and appropriately when incidents occur, provide support to alleged victims, and investigate allegations of misconduct.*

As we have described throughout this report, a combination of factors within and external to Long Creek have led to conditions and practices that raise serious safety concerns for youth and staff. This is not to imply that the administrators in charge of facility safety and security are ignoring safety issues or taking their responsibilities lightly. To the contrary, it was these individuals who recognized the severity the challenges confronting Long Creek at this time, as well as shortcomings that warranted immediate attention.

For example, the team learned that the facility was hopefully close to obtaining a \$300,000 upgrade to its video monitoring system, which is desperately needed given the number of blind spots with the current system and the significant limits on detail that can be obtained from video footage. The team was pleased to see administrators introduce body cameras while awaiting the upgrade, which provide much more information and context about significant incidents than the overhead cameras.

**Recommendation:** Secure needed upgrades to the video monitoring system at the facility, and ensure that the system eliminates blind spots throughout the facility.

The team had other concerns, many of which are also in other parts of this report, related to youth and staff safety, and the facility's efforts to prevent, detect, and respond to sexual misconduct.

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## YOUTH AND STAFF SAFETY

As mentioned in the introduction to this report and in other sections of the standards, the team had serious concerns about the safety of youth and staff at the facility, as well as LGBQ/GNCT youth in particular. We do not restate those details here, except to say that those findings and observations impact the facility's compliance with the JDAI standards in this area. As noted in the checklist, we recommend initiating regular surveys of staff members to obtain ideas of what else can be done from their perspective to improve the safety and security of the facility.

One additional area of concern, mentioned in the section above, is the timeliness of response to some grievances. The team reviewed many grievances with 10 days or more between the date filed and the official response, and there were many grievances where 5 or more days between date filed and receipt. Short staffing may contribute to these delays, as can staff being on leave who are responsible for responding to grievances. However, a timely response to all grievances is necessary to ensure that reports of abuse and neglect are identified and addressed right away.

**Recommendation:** Ensure that all grievances receive a timely response according to the timeframes outlined in the JDAI standards.

**Recommendations:** Ensure that policy, procedure, and actual practices require retrieval and review of grievances each day, regardless of whether the designated grievance officer is on duty.

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#### PREVENTION, DETECTION, AND RESPONSE TO SEXUAL MISCONDUCT

The team visited the facility when it was undergoing a PREA audit following a corrective action period. Although we had no role in the PREA audit, the team had a number of concerns about policies and practices related to the prevention, detection, and response to sexual misconduct.

First, the facility does have a policy on undue familiarity with residents. However, the policy only prohibits contact with current residents or residents released within the past year when such contact is unrelated to official duties. We recommend prohibiting contact unless required by official duties at any point following the youth's release, or at least prohibiting contact until the youth turns 21. Second, the policy does not address contact via social media, which has become a growing source of inappropriate boundary crossing behavior among juvenile justice agencies. We recommend outlining rules around contact on social media, including how and to whom staff should report such contact.

**Recommendation:** Extend the prohibition on contact with former residents that is unrelated to official duties to any time following a youth's release, or at least until the youth turns 21.

**Recommendation:** Develop an explicit policy on staff contact with current and former residents on social media, including how and to whom staff should report such contact.

Second, we had several concerns about the written materials used to educate youth about sexual misconduct, their right to be safe, the ways of reporting a problem, and their right to be free from retaliation for reporting. First, the PREA brochure given to us by the Intake staff contained a DOC hotline phone number that no longer worked. This brochure should be immediately taken out of the facility.

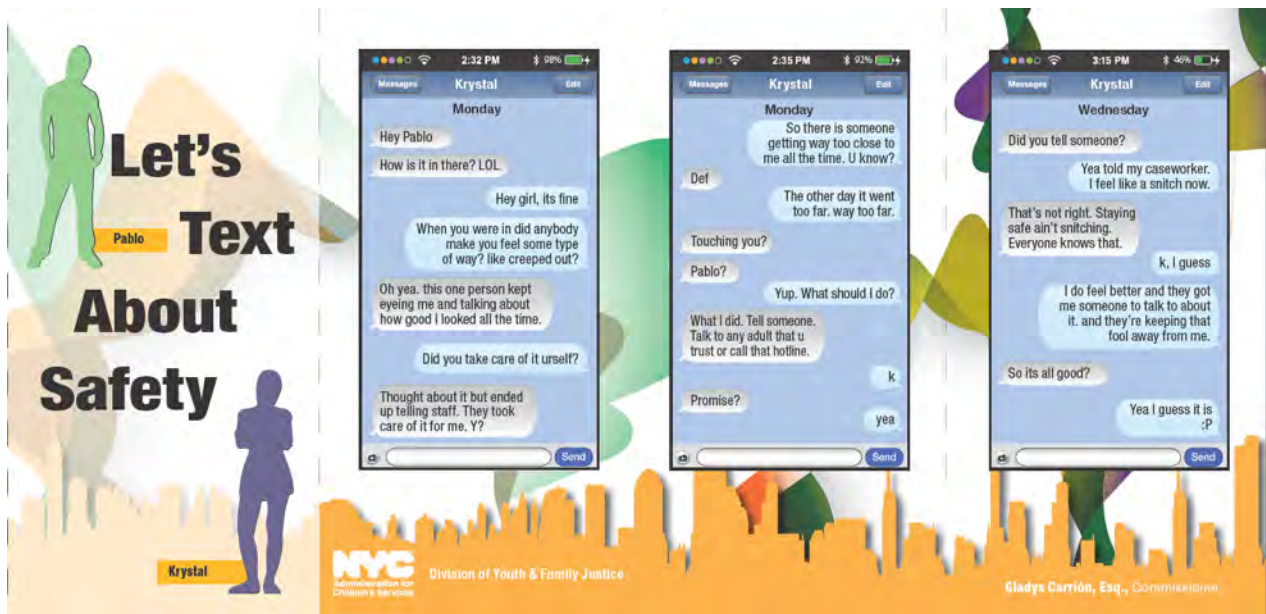
**Recommendation:** Remove all brochures with incorrect hotline numbers from Intake and other parts of the facility.

Second, the PREA acknowledgement form that youth must sign during their orientation is written for a combined adult and juvenile corrections setting. It is written at a very high level that many youth are unlikely to understand. It also describes the issue of sexual misconduct in a way that would be potentially frightening or traumatizing, particularly for younger youth and youth who have a history of sexual abuse. The form does not clearly inform youth of avenues to report problems to an entity that is not DOC, and it does not mention the right to be free from retaliation for reporting a problem. Finally, the form includes several typos (e.g., "tell a staff member if you have been sexually misconduct").



There are many examples of developmentally appropriate youth education materials that convey the key messages about the right to be safe, the ways to report a problem, and the right to be free from retaliation from reporting. For example, the palm card below from New York City's Administration for Children's Services and the handout from the Indiana Division of Youth Services are much more engaging, easy to understand, and developmentally appropriate. We recommend working with young people at the facility to develop more visually engaging and age-appropriate youth education materials.

**Recommendation:** Develop more engaging youth education materials that use simpler language and that focus on key messages and information. Involve youth in the creation of these materials.



# STAYING SAFE AT INDIANA DYS



Everyone has a right to be safe and supported during their stay with DYS. Here are some tips to help you do that.



## YOU HAVE RIGHTS

You have the right to be safe while here. That means being free from any kind of physical, sexual, or emotional abuse and harassment—either by youth or by staff. These kinds of things are **never allowed**, and we take it seriously if we hear about it.



## WHAT'S NOT ALLOWED

We expect all staff, other adults, and youth to follow the same rules. That means nobody should ever:

- Do or say things about your body that make you feel uncomfortable or unsafe
- Bother you because of who you date or like, how you look or act, or what your charges are
- Expose their private parts to you
- Ask you to expose your private parts outside of proper searches
- Touch any of your private parts
- Ask you to kiss or touch them in a sexual way
- Demand sex in exchange for offers of protection, favors, or special treatment
- Tell you that you will be punished or hurt if you report a problem



## WE TAKE ALL REPORTS SERIOUSLY

If we see or hear about any of the things above, we will take it seriously and conduct an investigation. If we find that youth or staff did any of these things, they will be punished. If someone has threatened or hurt you, we will separate you until we can investigate.

# TIPS ON STAYING SAFE AT DYS



Everyone has a right to be safe and supported during their stay with DYS. Here are some tips to help you do that.



## REPORT ANY PROBLEMS

If someone is doing or saying things that make you uncomfortable, report it right away by:

- Telling any staff member
- Telling another adult you trust, like family member or attorney
- Filing a grievance
- Calling #22 from any phone or dialing 1-877-385-5877
- Clicking "Sexual Abuse Report" on the JPay kiosk

You can keep your report confidential, and you do not have to tell anyone why you are making a report.



## NO RETALIATION ALLOWED

Nobody is ever allowed to bother you for making a report or helping with an investigation. We have staff watching to ensure nobody gives you a hard time for speaking up. Anyone who does will be punished immediately.



## RIGHT TO TREATMENT AND COUNSELING

If you are injured or require medical or mental health care, you have a right to receive it free of charge. We have people who have special training to work with victims of abuse, and any sessions will be confidential.



## QUESTIONS?

If you have any questions, talk to any staff member or supervisor here at any time.

Third, the facility's signage around prevention, detection, and response was limited. The team heard that the current PREA posters were hung in the week prior to our visit. Some of the posters also had hotline phone numbers obscured. As with the handout above, we recommend creating larger and more visually engaging PREA posters that contain the essential information for youth to know.

**Recommendation:** Develop more engaging youth education posters that use simpler language and that focus on key messages and information. Involve youth in the creation of these materials.

Fourth, a significant area of concern was youth's lack of consistent awareness of where they could report a problem outside of DOC. PREA requires access to at least one outside reporting mechanism be available to youth that will also (1) forward the youth's report to the facility so that the facility can take action, and (2) allow a youth to remain anonymous upon request. Some youth stated that they could call the Maine Coalition Against Sexual Assault (MECASA), but other youth stated that they had to report to a staff member or through the DOC hotline. This inconsistency is likely to be a product of the fact that the youth education materials being used, including the PREA notification form, the posters, and the handbook focus on requiring youth to report to staff. These materials do not clearly describe the outside reporting channel, nor do they emphasize youth's ability to report to a third party who can make a report on their behalf, such as a parent, attorney, or probation officer.

**Recommendation:** Clearly and prominently include a description of youth's ability to report sexual misconduct to an entity outside of DOC in all youth education materials, including brochures, posters, the PREA acknowledgement form, and the Resident Handbook. Also include information about third-party reporting options, including parents, attorneys, or probation officers. Eliminate language that suggests youth must report to a DOC staff member, regardless of whether they feel comfortable doing so. Ensure that youth and staff are aware of youth's ability to report to outside entities and third parties, and ensure that youth are allowed to do so in practice.

Fifth, the team was told that notifications to parents and legal guardians would be made following allegations of sexual abuse involving their child. However, DOC policy provides that such notifications are only made following consultation with the Attorney General's office "for advice on whether or not to notify the resident's parent(s) or legal guardian or attorney." We also understood from administrators that attorneys are not routinely notified when youth make a sexual abuse allegation. PREA requires notification of parents and legal guardians, attorneys, and child welfare caseworkers (if a youth has a caseworker).

**Recommendation:** Ensure that policy, procedure, and actual practice provide for notification of parents and legal guardians, attorneys, and child welfare caseworkers (if a youth has a caseworker) within 24 hours of receiving a sexual abuse allegation.

Sixth, some policies and the description of first responder duties use terms from the Survey of Sexual Victimization, such as "abusive sexual contact" and "sexual misconduct," that do not align with the definitions of sexual abuse and sexual harassment in the PREA standards. Many

auditors have become much more stringent around the use of appropriate terms and definitions from the PREA standards in policy, procedure, and training materials. We recommend revising these documents to use the terms “sexual abuse” and “sexual harassment” and the corresponding definitions from the PREA standards.

**Recommendation:** Revise policies, procedures, and training materials to use the terms “sexual abuse” and “sexual harassment” and the corresponding definitions from the PREA standards.

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## INVESTIGATIONS

The team was able to review some files of recently completed internal investigations, including investigations that were initiated following grievances and other reports of alleged misconduct, harassment, or abuse by other residents or staff. While the facility’s investigations generally complied with the JDAI standards, the team did have a concern about the facility’s responsibilities as a mandated reporter of child abuse. Although the team is not an expert in Maine law, states generally require staff of juvenile facilities to directly and immediately report any knowledge or suspicion of past, current, or future abuse, neglect, or maltreatment of children.

At Long Creek, there is no information posted on staff or youth’s ability to report child abuse or neglect. It does not appear that reports of alleged abuse (e.g., grievances alleging abusive treatment, incident reports) routinely trigger notification to DHHS as a mandated report, nor is there consistent documentation that such notifications are occurring in all situations that would trigger a mandated report. We understand that the facility has its own internal investigations process, but we recommend consulting with the agency’s lawyers and the Attorney General to ensure that staff at Long Creek are meeting their mandated reporting responsibilities.

**Recommendation:** Consult with the agency’s lawyers and the Attorney General to ensure that staff at Long Creek are meeting their mandated reporting responsibilities under Maine law.

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## FINAL RECOMMENDATIONS

Our team was aware of many of the challenges facing Long Creek prior to our visit. Our experience on-site puts the seriousness of these problems into a sharper context.

Several Long Creek staff members, including senior staff who had worked at the facility for many years, said that it was “hard to see the light at the end of the tunnel” in terms of remedying the concerns discussed in this report. Part of this feeling stemmed from the fact that many of problems at Long Creek have emerged from failings of other support systems and services outside of the facility.

There is an urgent need for a comprehensive assessment of those factors and a frank discussion among state officials about how to address them. These factors include the incarceration of many youth at Long Creek for low-risk offenses, the high rate of referrals of youth to Long Creek from mental health placements, the limited number of community-based mental health services for Maine’s adolescent population, questions about the quality and effectiveness of existing community-based mental health services, the high cost of keeping a youth at the facility (\$250,000 per year per youth), and the availability of federal funds (e.g., through Medicaid) to support community-based programs but not institutional care.

Reduction in the population of incarcerated youth is clearly achievable. Detention and commitment data for Long Creek show large numbers of young people incarcerated for relatively low-risk offenses which, in other jurisdictions, would not warrant confinement. For example, between January and July of 2017, many youth were detained for technical violations of probation (i.e., no new offense). The youth were typically detained for two or three days before going to court, then were ordered into detention for periods ranging from a week to seven weeks. Other jurisdictions have developed graduated response programs for violations that significantly reduce the use of detention through a combination of sanctions to hold youth accountable and positive reinforcements to promote compliance with probation terms. One of the members of the assessment team, Jason Szanyi, has developed a Graduated Responses Toolkit that has been used effectively by many jurisdictions across the country. The Toolkit is available at no cost on the Center for Children’s Law and Policy website at <http://www.cclp.org/graduated-responses-toolkit/>. Many youth are also held in detention at Long Creek following disposition of their case because there are no beds or slots available for their placement. This is a systemic failure to address a clearly-identified need.

Similarly, data on committed youth between January and July of 2017 show that, of 25 youth committed during the period, one was charged with Disorderly Conduct and Offensive Words and Gestures, one was charged with Theft, one was charged with Disorderly Conduct and Theft, one was charged with Criminal Mischief, one was charged with Criminal Mischief and Theft, two were charged with Criminal Mischief and Assault, and two were charged with Violation of Community Re-Integration. The assessment team did not receive any detailed information about the circumstances of any of these commitments or the delinquency histories of any of the youth, but the data strongly suggest that at least some youth who are committed could be safely supervised in the community with appropriate alternative-to-incarceration programs. Staff and

administrators at Long Creek told assessment team members that they thought that 25% to 50% of youth at the facility could be released to the community.

The team has two primary recommendations for this overdue and urgently needed assessment. First, state officials should conduct, or contract with an independent entity to conduct, a comprehensive review of the effectiveness of Maine's juvenile justice system to determine which policies and practices are hindering the goal of achieving an efficient and effective system in the state. This review should include looking at the practices of juvenile justice stakeholders, including law enforcement, judges, prosecutors, and defense attorneys, as well as the experiences of youth and family members.

This review should also examine the policies and practices of other agencies that have significant responsibility in meeting the needs of at-risk youth, such as the Department of Health and Human Services. The review should include an evaluation of the existing service array for youth, including identification of any gaps in services and an assessment of the quality and effectiveness of existing services. A review such as this is needed to understand the reasons why Long Creek is housing youth with so many unmet mental health needs, and, more importantly, what needs to be done to address the problems.

Second, the team recommends considering whether a different model of residential care for juvenile justice-involved youth would achieve better results for Maine's youth and their communities. A facility designed like Long Creek limits how well and how intensively staff can work with young people on skill-building and behavior change. When staff are charged with supervising a group of over 20 youth at any one time, it is difficult to devote the time and energy needed to dive deeply enough into an individual youth's needs to effect long-term change. States such as Missouri have moved away from large juvenile facilities toward smaller, home-like settings of 8-12 youth with intensive staffing. The "Missouri Model," as it is known, involves creating regionally-based facilities focused on providing intensive rehabilitation, treatment, and educational services for youth charged with the most serious felonies and youth deemed to be the highest risk to public safety. These programs have achieved significantly better results in the way of decreased recidivism and increased skill-building than traditional juvenile correctional facilities. The team encourages administrators and other state officials to visit with their counterparts in Missouri to learn more about these programs and whether they would be a better fit for Maine's juvenile justice-involved youth. More information about the Missouri Model can be found at [www.mysiconsulting.org](http://www.mysiconsulting.org).