MAINE YOUTH CORRECTIONS REVIEW

REPORT TO
GOVERNOR JOHN E. BALDACCI

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INTRODUCTION

On November 6, 2003, Governor Baldacci confirmed his request for a review of current[1] restraint and isolation[2] policies, procedures and practices at the Long Creek Youth Development Center in South Portland ("Long Creek") and the Mountain View Youth Development Center ("Mountain View") in Charleston. (Attachment A). He specifically stated that allegations of past conduct at the Maine Youth Center ("MYC"), employment relationships and labor/management issues at the facilities were not within the scope of the requested review. However, he invited a report of any identified issues that might suggest additional inquiry. A deadline of January 31, 2004 was suggested for completion of the review.[3]

The laws, rules and regulations governing restraint and isolation, policies and procedures at the two Centers have evolved from the time of the original Houses of Correction, through the era of the MYC, to their current form and applicability to the existing juvenile Centers. Attachment C is a summary of some of the current pertinent provisions taken from Maine statutes and regulations, national and international standards and comparable policies in other

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[1] The request was to review "current" restraint and isolation policies, procedures and practices at the two Centers. This Report considers "current" as the period from the opening of the two new juvenile facilities in 2002: February for Mountain View and August for Long Creek.

[2] "Isolation" was properly descriptive of past practice and, in a real sense, is descriptive of any solitary segregation. However, the correct statutory term (34-A M.R.S.A. §§ 3809, 4108) and present regulations mandate use of "observation" rather than "isolation." Although "isolation" was the term used to describe part of the Governor's request, "observation" will be used throughout this Report.

[3] This review could not have been undertaken or this Report completed without the cooperation and total support of my partners at Pierce Atwood and my able assistants, Elizabeth Umland and Polly Plourde. I am particularly grateful to Jared des Rosiers and Mark Porada, also lawyers at Pierce Atwood, who, despite their heavy responsibilities for firm client representation, willingly answered my invitation to work on this *pro bono* matter. Their diligent devotion to the task has made it possible to complete a complex assignment in a relatively short timeframe and in a very thorough manner. Their *curricula vitae* are Attachment B.

jurisdictions, prepared as a template against which to measure whether Maine's policies, procedures and current practices comply with them.

Long Creek is the latest incarnation of an institution with a long history. That history, with all its baggage, dogs its image today despite sincere attempts to change and improve its philosophy and culture, including restraint and observation practices. That history has been detailed in many other reports, has led to lawsuits and the current wave of remedial actions and will not be repeated here. Mountain View, on the other hand, is a new structure with a new staff and without Long Creek's history.

Both facilities are constructed in a virtually identical manner. Each facility consists of several separate units that are designated for different classifications of residents, such as high risk males, moderate risk males, females, and detained males. Each unit has a common area where the residents of that unit may congregate. Within each unit there are several separate pods. The pods contain their own smaller common area, as well as the individual rooms assigned to the residents. Each resident has his own room. In some of the pods, the rooms have their own toilets; in other pods, the toilet facilities are shared and are located off of the pods. Each room has a wooden door.

The facilities have identical Special Management Units ("SMUs"), where residents are sent for observation. The SMUs contain several individual cells. Each cell has a bed with a removable mattress, as well as a sink and toilet. The SMU cells have metal doors with a window. One of the cells in each SMU has a built-in digital camera mounted on the ceiling.

These Centers *are* – regardless of their names – *corrections* institutions housed under the umbrella of the Maine Department of Corrections ("DOC"). Against this background, it is probably not surprising that the ancient history and, to some extent, the more recent history, of Long Creek (formerly MYC) was punishment oriented. It was created and staffed during a period when a punishment-driven culture was the national norm. That clearly has changed, both nationally and locally. Beginning with its last Superintendent and, more effectively through the strong management skills of its Acting Superintendent, Long Creek clearly has evolved into an institution structured to obtain behavior modification through rehabilitative measures consistent with the stated statutory purpose of these Centers. *See* 34-A M.R.S.A. §§ 3802(1)(C) and 4102(4) (Attachment C, p. 1). Mountain View, while founded on the same statutory and cultural base, has developed into a more structured, disciplinary-oriented regime.

Authorities in the DOC have seen fit to allow each institution to evolve separately and without hands-on, top-down direction. Given the histories – long and short – of the two Centers, these different approaches provide interesting contrasts and will be addressed in greater detail below.

The residents at these facilities have traveled a troubled road. Familial and societal neglect and abuse have shaped them. It is estimated that at least 60-70% of the residents in Maine's juvenile corrections facilities have been the victim of abuse, 80% are on psychotropic medications and 75% have substance abuse problems. *See* Attachment D, an informative study prepared by Mountain View's clinical team in 2003, underscoring these estimates. This is reality. These conditions need to be addressed and appropriately treated. At the same time,

reality also dictates recognition of the fact that some of the residents are dangerous and pose a threat to themselves, other residents and staff. For instance, how does administration deal with gang members, confined at the same time, whose bad behavior is reinforced and worsened when together? How does administration deal with a resident who is repeatedly assaultive? How does administration deal with a resident who will use every opportunity for self-mutilation? How does administration protect a resident who is in constant danger of being victimized by other residents? It may be that statutory/regulatory provisions need to be reformed to recognize that rigid observation and record-keeping policies must be flexible enough to address these and similar situations.

The questions to be answered by this review are:

1. What are the current restraint and observation policies, procedures and practices at Long Creek and Mountain View?

2. What, if any, changes should be made?

3. What, if any, other matters suggest the need for further independent inquiry?

The short answer to the first question is that restraint and observation practices at both facilities are greatly improved; that there is no hard evidence of deliberate abuse; but that there are certain remedial steps to be taken and certain process changes required. The second and third questions require multiple responses that will be addressed later in this Report.

In evaluating the substance of this Report, several things must be kept in mind.

First, there has been complete cooperation with this review at every level. Every single individual contacted was responsive, candid and helpful. Every request for documentation was

met with a prompt response even when it was recognized that there were some problems posed by materials being supplied.

Second, clearly there have been positive changes in the culture and programs at both facilities. Phrases such as "as different as day from night," "light years away from where we were," and "positive progress" were common.

Third, those interviewed were consistent in their appraisals of performance and of staff and resident needs. From those interviews, it is clear that, for the most part, those involved, in Augusta and at both facilities, are well-intentioned and want to do the right thing.

Fourth, some of the recommendations in this Report require changes that can be effected by the DOC itself. However, there are many other recommendations that can only be accomplished with additional funding. Realistic recognition of current statewide budgetary constraints inevitably dictates that there will be delay and frustration in their accomplishment. One concrete example of this is that construction of one pod of one unit at Mountain View has just now been completed, nearly two years after the opening of the facility. The request for this Report did not suggest establishment of priorities or triage recommendations and the Report does not contain them. Those are decisions best addressed within the DOC and, ultimately, by the legislative and executive authorities who have the difficult, if not impossible, responsibility for allocating scarce funds among worthy causes.

Fifth, this review itself has jump-started some needed initiatives and changes as administrators recognized need.

PROCESS

This Report is based upon review of thousands of pages of pertinent documents (a partial bibliography of those most germane is Attachment E); tours of both facilities; interviews of over one hundred people, including the present Commissioner of the DOC, Associate Commissioners, prior Commissioners, the Director[4] and Deputy Director at Mountain View, prior Superintendents and the present Acting Superintendent and Deputy Superintendents at Long Creek, the Chief Advocate and his assistant, legislators, consultants, contract workers and judges and, at both institutions, other members of the administration, Juvenile Facility Operations Supervisors (JFOS), Juvenile Program Managers (JPM), Juvenile Program Staff (JPS and JPW),[5] mental health clinicians, educational staff, social workers, members of the Boards of Visitors, chaplains, volunteers and residents. The review also included viewing and examining restraint devices, observation units and resident facilities (including those used for observation) and documents relating to physical restraint usage, in order to compare that data with available national data.

[4] For some unexplained reason, the administrative heads of the two facilities bear different titles: Superintendent at Long Creek; Director at Mountain View. *See* 34-A M.R.S.A. §§ 3803, 4103(1). This Report refers to the administrators of both facilities by their statutory titles. For functional purposes, the Director and Deputy Director at Mountain View refer to themselves as the Superintendent and Deputy Superintendent, consistent with their colleagues at Long Creek. While it is a small matter, the statute should be amended, so that both sets of administrators bear the same title, to underscore the similar identity and common purpose of both facilities.

[5] The JFOSs are supervisors are responsible for facility security. They have authority over the use of restraints and the placement of residents in the SMU, and are involved in the disciplinary process at both facilities. JPMs are managers of individual units at each facility where the residents are housed, and are responsible for overseeing the programming of residents placed in their units. Juvenile Program Supervisors (JPS) and Juvenile Program Workers (JPW) are the line staff assigned to the units who provide the direct care and supervision of the residents.

The following Report is the result of that comprehensive review.

SUMMARY OF CONCLUSIONS

The DOC's policies and procedures for restraint and observation comply with Maine law and, in general, are consistent with recognized national standards and best practices. As shown by Attachment C, a review of comparable juvenile restraint and observation policies in effect in Florida, Georgia, Maryland, North Carolina, Oregon, Texas and Virginia indicates that, although each state has its own idiosyncrasies and unique terms of art, by and large Maine's regulations are in line with those in other jurisdictions. The differences appear to reflect policy decisions rather than any divergence from a uniform national practice.

Similarly, Maine's policies and procedures regarding restraints and observation are largely consistent with standards promulgated by national organizations such as the American Correctional Association ("ACA") and the Council of Juvenile Correctional Administrators ("CJCA"). There are, however, as noted below, some differences.

In addition, the practices at both facilities generally comply with DOC policies and procedures, with certain exceptions noted below.

Practices at the MYC, before it became Long Creek, included the regular and repeated use of mechanical restraints on residents for extended periods of time and the regular segregation (isolation) of juveniles for extended periods of time in what is now called the SMU. Those practices at the MYC do not continue at Long Creek or, for the most part, exist at Mountain View. The use of mechanical restraints, the duration of their usage and the duration of residents' stays in the SMU have declined substantially, and continue to decline, at both facilities.

The reduction in the use of restraints and isolation (observation) at both facilities is a clear indication of sincere efforts to redefine (Long Creek) and define (Mountain View) culture and programming as therapeutic and rehabilitative rather than as correctional or punitive. Maine is one of only two states chosen by the National Institute of Corrections, an agency within the U.S. Department of Justice, Federal Bureau of Prisons, to model the rehabilitative approach. It has begun with programs but is intended to include operations, both at the adult and juvenile levels. These efforts are on-going and not without challenges. The long-standing correctional culture of MYC casts a shadow over the intended cultural and programmatic development of Long Creek that must be removed. In contrast, Mountain View, an entirely new facility without any similar history and, with, for the most part, new staff, is challenged to define itself and its culture – a process that is ongoing and evolving.

As a result of their different development histories and personnel, and the generally hands-off management approach of the DOC Central Office, the facilities currently do not have any effective means for regular communication, sharing of information or coordination. This has led to variations in the practices of the facilities with respect to restraints and observation, among other things. For example, the facilities use different mechanical restraint devices. Most notably, Long Creek does not use or even possess a restraint chair, while Mountain View has used the chair sixteen times since the opening of the facility. Variations in other practices of the facilities are also notable with respect to the treatment of the most violent and disruptive juveniles and the documentation each facility uses to track restraint and observation usage.

Each of these points will be discussed in more detail below.

FINDINGS

I. RESTRAINTS

There are no Maine statutory provisions governing the use of restraints in juvenile facilities.

Under DOC regulations, the use of mechanical restraints on residents may only occur in situations where it is apparent that the resident "presents a real and immediate threat to the safety of the resident or others or the security of the facility and only when no other reasonable alternative exists." DOC Regs. Ch. 9, pol. 9-15(III) (Attachment C, p. 2). Restraints may not be used for punishment. *Id.* Currently, both facilities regularly and consistently comply with this regulation. Mechanical restraints are used when appropriate and maintained in use only as long as necessary. Required medical checks are performed. Neither facility currently uses restraints for punishment.

Both facilities, however, do not consistently comply with certain of the recordkeeping requirements of the mechanical restraint regulations, as discussed in more detail below. In addition, significant variations exist between the facilities in the types of mechanical restraints used, the documentation and record keeping of restraint usage, and certain restraint practices. These variations create a perception that the facilities apply different standards with respect to restraint usage and make it very difficult to compare in any meaningful way the restraint usage data maintained by the facilities.

A. RESTRAINT PRACTICES.

Under current practices at Long Creek, when a resident "acts up" (a very broad term that can include everything from verbal abuse through self-mutilation to assault), the staff is now directed to try to "talk" the resident "down." If that is unsuccessful, the resident is invited to walk to the SMU in the company of one or more of the staff. If the resident refuses, and the conduct is such that the resident is perceived to be a threat to himself[6] or others, he is restrained by the staff (which may involve the use of a "takedown") and either escorted or carried to the SMU.

At the SMU, every attempt is made to "talk down" the resident and remove the restraints as soon as possible in order to be able to return the resident to his unit. If the JFOS determines that the resident remains a threat to self or others, the restraints stay on. In most cases, nylon and leather restraint devices are substituted for the metal handcuffs and shackles used during transport. The restraint devices remain on until the resident has calmed down and makes a sincere commitment to refrain from further improper behavior.

At Mountain View, the practices are generally the same, with a few noteworthy differences highlighted below, namely the form of restraints and the use of restraints during transports.

Historically, mechanical restraints, including the restraint chair, were used regularly at the MYC. Restraint usage peaked in 1999 when the various restraint devices, including the

[6] Because the same policies and practices apply to boys and girls, for simplicity's sake, the masculine is used throughout this Report to include both sexes.

restraint chair, were used 480 times. Beginning in 2000, the use of restraints started to decline. This downward trend has continued to date, such that restraints were only used at Long Creek 39 times during 2003. Attachment F is a graph prepared by Long Creek staff depicting restraint usage by year.

This data requires a caveat. Depending on the circumstances, residents are from time to time transported to the SMU in handcuffs and occasionally in leg shackles at Long Creek. Long Creek interprets DOC Regulation 9.15, which includes an express exception for "transport situations," to mean that the mere transport of a resident in such restraints does not constitute the use of mechanical restraint under the regulation for recordkeeping and statistical purposes. A resident is counted as having been restrained for recordkeeping and statistical purposes only when an appropriate supervisor determines that the resident remains a threat to self or others and therefore needs to stay in some form of mechanical restraint device at the conclusion of the transport to the SMU. Thus, the restraints summarized in Attachment F reflect only instances in which a resident was deemed to be a continuing threat to self or others, requiring continued placement in restraints *after* transport in restraints.

In contrast, Mountain View tracks as being a restraint *each* instance in which handcuffs are used, whether for transport or for continued restraint within the SMU. Thus, Mountain View's 2003 records reflect restraint devices used in 188 instances during the year. According to Mountain View officials, restraints were used in the vast majority of these instances only for transport and they estimate that only one out of every ten transports resulted in a resident being restrained in the SMU during 2003.

The pertinent regulation provides that mechanical restraints "shall be used, as a matter of routine, during transport of a resident" to the SMU. DOC Regs. Ch. 9.15(VI)(A)(3) (Attachment C, p. 2-3). At Mountain View, the general practice is that all residents being taken to SMU are transported in restraints in accordance with this regulation. Mountain View does so to protect the safety of staff during the transport. At Long Creek, restraints are not automatically used for every transport to the SMU, but rather the staff makes a case by case determination as to whether restraints are necessary. Long Creek officials believe that in certain instances the required use of restraints may cause increased resistance and, therefore, create a more dangerous situation. In order to enable more meaningful comparison of restraint data for both facilities, the DOC should (1) review the justification of each facility for its practices; (2) determine national best practices; and (3) establish a uniform practice for the facilities in use of restraints during the transport of a resident and a common protocol for tracking restraint usage both for transportation and for continued restraint within the SMU.

B. RESTRAINT DEVICES.

DOC regulations approve several types of restraints that may be used at the facilities, including handcuffs, leg shackles, nylon belts, leather wrist and ankle restraints and belts, flex cuffs, nylon mitts and the restraint chair. DOC Regs. Ch. 9, pol. 9.15(VI)(C)(2) (Attachment C, p. 4). The facilities have very different practices with respect to the restraint devices they use.

Most notably, Mountain View periodically uses the restraint chair, while Long Creek does not. Long Creek has not used that device since 2000 and removed it in 2001.

In the view of Long Creek's administration, the restraint chair does not represent best practices in the field. As reflected on Attachment F, during the period 1997-2000, the MYC made significant use of the restraint chair. Based on this experience, Long Creek officials believe that use of the restraint chair, and even its mere presence at the facility, creates an inappropriate atmosphere among the residents and that some residents act up in order to be placed into the chair.

In contrast, Mountain View continues to possess and use the restraint chair. Mountain View used the chair eleven times in 2002 and five times in 2003. The durations of this use ranged from a few minutes to approximately three hours. Mountain View officials stated that the restraint chair is only used in those instances where a resident is, and remains, so out of control that it would be necessary to have several staff members hold the resident down in order to prevent the resident from hurting himself, or staff. In their view, the restraint chair is a more humane tool to control such an out-of-control resident.

The DOC should (1) research and document the best practices in juvenile facilities across the country; (2) consult with leading experts in the field; and, (3) implement a uniform protocol with respect to the use or non-use of the chair. If, based upon that research and advice, the DOC should conclude that use of the restraint chair is appropriate, it should promulgate very clear guidelines for the situations in which use of the chair is appropriate. The risk that the chair will be misused as a punishment is significant. If use of the restraint chair is authorized, the facilities must be ever vigilant to prevent such misuse.

The DOC also should develop uniform regulations as to what other restraint devices should be used. Long Creek has essentially eliminated its use of plastic flex cuffs. Instead, Long Creek now uses, individually or in combination, handcuffs, leg shackles, soft leather restraints, nylon belts and nylon mitts. The latter devices are generally used where the restraint continues longer than a brief period because they tend to be safer. In contrast, in addition to the restraint chair, Mountain View only uses handcuffs, leg shackles and plastic flex cuffs, when necessary. The DOC should determine which restraint devices are best used under different circumstances and ensure that all staff in both facilities are trained on, and make use of, the appropriate devices.

C. RESTRAINT DOCUMENTATION

1. RESTRAINT DOCUMENTATION FORM

DOC regulations require that in all non-transport situations staff must complete a "Restraint Documentation Form" for all restraints. The form itself is attached to the regulations. DOC Regs. Ch. 9, pol. 9.15(VI)(F)(1). Long Creek uses this form to track its restraint usage. With the exception of one restraint in December 2003, it appears that Mountain View has not used the Restraint Documentation Form but rather tracks its restraints on its "Use of Force" report form, required any time a staff member lays a hand on a resident. The six-page Restraint Documentation Form is set up to record the events leading up to the restraint, all staff involved, the supervisor approving the restraint, the required medical review, the condition of the resident during the restraint and the termination of the restraint (Attachment G). Mountain View's form (Attachment H) does not capture this same quantum of important information. Mountain View should use the Restraint Documentation Form consistently for all restraints in accordance with

DOC regulations. The current version of the form is somewhat lengthy and cumbersome and is not set up for electronic data entry. The DOC, with advice and input from the facilities, should consider revising the form so that it is both user friendly and captures all of the important information mandated by the regulations.

2. VIDEOTAPING

The DOC's regulations also require that each restraint be videotaped, "unless emergency circumstances prevent it." DOC Regs. Ch. 9, pol. 9.15(VI)(G)(1) (Attachment C, p. 5-6). The videotaping is supposed to last "for the duration of the time the resident is in restraints and when the restraints are removed." *Id.* The videotape is then supposed to be labeled properly and secured for further reference. *Id.*

Both facilities do make efforts to videotape restraints in accordance with this regulation. However, neither facility complies completely with the regulations in every case.

At Long Creek, the video camera is not always kept running for the full duration of the restraint. Rather, the placement of the resident in restraints and the removal of the restraints is generally videotaped. Long Creek does maintain in a secure location a library of videotapes labeled in accordance with the regulations.

At Mountain View, until very recently, restraints were videotaped by the built-in digital camera within the SMU rather than by a portable video camera. Using this digital recording system, the video image supposedly was maintained on Mountain View's computer system. As a result of this review, Mountain View discovered that its system does not automatically generate a copy of the videotape for preservation. Rather, the digital image is stored on the computer only

for a fixed period of time (30 days) and then is written over. In order to preserve a copy, the image must be burnt to a CD-Rom for permanent retention. Until December 2003, Mountain View staff did not create such CD-Roms and so there is no video record of the facility's restraints prior to December 2003. The digital system also does not record sound. So there is no record of the statements/sounds made by the resident and staff during the restraint. This is a significant issue as the determination that a restraint is necessary, and its duration, are often based on threats made by the resident.

Each restraint should be videotaped, except in emergencies, from inception to end, with full sound and those videotapes should be properly labeled and preserved indefinitely for future use and reference. Complete and consistent videotaping is an important safeguard for the residents and staff alike. Both facilities should review their videotaping practices to ensure that they are in compliance with the DOC's regulations in this regard and the DOC should put procedures in place to ensure compliance.

D. RESTRAINT TRAINING

As stated above, both facilities use restraints appropriately and in accordance with the DOC's regulations. Based on review of the available videotapes and the statements made by most of the persons interviewed, including residents, it also appears that staff, for the most part, apply the restraint devices properly and with an appropriate amount of force.[7] Persons at both facilities, however, indicated that some staff do not know the proper techniques for applying

[7] Forty-four abuse reports from Long Creek and eleven abuse reports from Mountain View from the date of the opening of each facility were reviewed thoroughly. Out of those fifty-five reports, only two complaints were found

restraints. In large part, this appears to be the result of the significant influx of new staff at both facilities, the reduction in the use of restraints and infrequent training.

The reduction of restraint usage at both facilities is to be applauded, but both facilities should regularly and consistently train staff, whether new or existing, on the proper application of all approved restraint devices. This basic training is important, particularly as restraints are used less frequently, because residents and staff could be injured seriously during the application of restraints if not done correctly. Regular and consistent training of all staff on the proper ways to de-escalate residents without the use of restraints is also equally important and should be an established priority for both facilities.

E. OTHER RESTRAINT ISSUES

Two other issues merit consideration by the DOC as it works to make the restraint practices in both facilities uniform and consistent. They are the storage of restraint equipment and the use of searches before the application of restraints in the SMU.

It is the practice at Long Creek to store all of the restraint devices, with the exception of handcuffs stored in the units or worn by certain of the line and security staff, in a locked, centralized storage room under the control of the JFOS on duty. Only the JFOSs (or their superiors) are authorized to determine when restraints are to be applied. When a JFOS determines that a restraint device is appropriate, the JFOS then can have the device retrieved from the storage room. The handcuffs stored in the unit or worn by some staff are only for

to be "substantiated" by the appropriate government agencies. One was verbal abuse by an art teacher on complaint of another teacher and, the other was unnecessary physical roughness during the course of restraint.

immediate restraint when necessary in transport to the SMU. The rationale for this practice, which appears common in other jurisdictions, is to maintain institutional control over the use of restraints. In contrast, at Mountain View there is no central storage room. All line staff wear handcuffs on their belts and leg shackles are stored within each unit. Those devices are then used immediately to restrain a resident and for transport to SMU. Those same restraint devices are then left on the resident in the SMU when necessary. The rationale seems to be that restraints should be immediately at hand and not remotely stored.

The DOC should review these practices to determine what is consistent with the best practices in juvenile facilities across the country and the mission of both facilities to be rehabilitative and therapeutic institutions. In doing so, the DOC should weigh the safety of the staff and residents, the impact on the programming of both facilities and other relevant considerations in order to determine and direct a uniform and consistent practice in both facilities. The ACA standards require that a written log be kept noting how and when restraints are distributed to staff. Maine may wish to adopt a standardized policy on the distribution and tracking of restraints, comparable to the tracking contemplated by the ACA standards.

The DOC also should review the practices of both facilities with respect to conducting searches of residents upon their arrival in the SMU. Long Creek generally requires all residents placed in observation in the SMU to be strip-searched before the handcuffs (and shackles, if applied) are removed in order to determine whether the resident has any contraband or items that could be used to injure the resident or staff. This practice is permitted by the regulations. *See* DOC Regs. ch. 10, pol. 10.1(C)(2). In the event the resident resists the strip-search, the restraints

are left in place and the resident is continuously observed in an open SMU cell. Mountain View, in contrast, does not require strip-searches because of a belief that they can be traumatic and increase the resident's agitation, but generally will, at most, conduct a pat search of the resident. Whether to conduct strip-searches raises important issues with regard to the safety of the staff on the one hand and the physical, emotional and mental well-being of the resident on the other. The DOC should determine and document what are best practices in juvenile facilities across the country. The DOC should carefully weigh this balance with input from both facilities in order to establish a uniform practice for resident searches.

II. OBSERVATION

The Maine statute governing "observation" provides that a juvenile may be "placed under observation" if he:

> Presents a high likelihood of imminent harm to that juvenile or to others, presents a substantial and imminent threat of destruction of property or demonstrates a proclivity to be absent from the facility without leave as evidenced by a stated intention to escape from the facility or by a recent attempted or actual escape from any detention or correctional facility.

34-A M.R.S.A. §§ 3809(1), 4108(1).

There is no statutory definition of "observation." Thus, it is unclear when the statutory observation limitations apply. The DOC has promulgated detailed regulations that permit disciplinary confinement of a resident in his own room with the door locked, *see* DOC Regs. ch. 15, pol. 15.3, as well as short duration "time-outs," during which a resident may be sent to his room or another room in the facility with the door either open or shut but unlocked. *See* DOC Regs. ch. 15, pol. 15.5 (Attachment C, p. 18-24). Because the statute does not define "observation," it is unclear how, if at all, these procedures comply with the observation statute. For instance, does an administrative time-out in a resident's room constitute observation status, such that the confinement may only last as long as the resident remains a threat to self or others?

The issue seems to turn on whether one views observation as a placement only within the SMU, or includes *any* action isolating and confining a resident away from the general population. The DOC does not consider disciplinary room confinement or time-outs to be within observation status, largely because those confinements typically do not occur in the SMU and, in the case of a disciplinary confinement, occur only after a resident has been afforded certain due

process rights prior to the imposition of the confinement. Thus, the DOC seems to view statutory observation strictly as a placement within the SMU. The CJCA through its Performance-based Standards ("PbS") initiative, however, considers any confinement of a juvenile resident an isolation for data tracking and comparison purposes. In light of the ambiguity, the observation statute should be amended to clarify whether these other forms of segregation qualify as observation status or are expressly excluded from that statute.

Maine has adopted a series of regulations that apply to residents placed on observation status. Maine's policies regarding observation status generally are compatible with the ACA's standards. However, the DOC's regulations do not impose any outside maximum duration for confinement in the SMU, contrary to the ACA standards. In that respect, Maine's policies are inconsistent with the ACA guidelines on special management status. The DOC should consider defining an outside maximum limit on SMU placements.

The CJCA standards recommend that "facility and agency administration make frequent spot checks of isolation rooms and units ... conducted in facility during off-hours inclusive of evenings, holidays and weekends." The DOC's regulations do not provide for regular spot checks by either facility or by DOC administrators to ensure that the staff are in compliance with observation policies.

The current administration at Long Creek frequently is involved in the placement and assessment of residents placed in the SMU. Administrators at Mountain View are less involved in that process. High level DOC administrators are virtually never involved in visiting and reviewing placements in the SMU on a spot check basis or otherwise. Numerous suggestions

were made by representatives of different disciplines that such meetings and reviews should occur. They suggested a process whereby those involved and other responsible officials would meet after each incident to attempt to determine causation and remediation. Regular administrator involvement and critiques should be formalized and should include at least quarterly reviews, in person, on site, by a high administrative DOC official of all restraints and observations during the prior quarter.

A. SMU PRACTICES

Under the regulations, placement in the SMU must be approved by the superintendent "or designee." DOC Regs. ch. 10, pol. 10.1(VI)(A)(3) (Attachment C, p. 8). The practice at Long Creek is for residents placed in the SMU for observation to be reviewed on an ongoing basis to determine the point in time at which they no longer pose a high likelihood of imminent threat to self or others, and thus may be released back to the general population. The JFOS on duty is responsible for making that assessment. Typically, the current administration at Long Creek has shown an active involvement in SMU placements. It is not uncommon for the Acting Superintendent personally to go to the SMU to assess the need for continued isolation and to push staff to work on ending the observation status as quickly as possible. Some staff have expressed concern that this policy sends the wrong message, *i.e.*, that there is no adverse consequence for disruptive behavior and that early return to the unit creates a false impression and is dangerous. There is obviously a balance to be weighed here. Statutory and regulatory requirements dictate that the touchstone be "imminent danger to self or others." That criterion, and the emphasis on non-punitive methodology, inevitably lead to reduced observation time and

justify the current practice. It appears that most staff who work closely with the residents are comfortable with this policy and that only those who do not have reservations. Statistics show that the policy is working but risks cannot be denied.

The practice at Mountain View is for residents placed in the SMU to be assessed by the JFOS or other supervisory staff after the initial two hours of placement. If the resident is deemed no longer a threat to self or others, the resident may be removed from the SMU and returned to his unit at that time. If the resident is considered a continuing threat to self or others, review by the JFOS or other supervisor occurs every two hours thereafter. Each of those reviews is supposed to be recorded on an Initial Special Management Placement ("ISMP") form, discussed in more detail below. Although staff may review a resident's placement more frequently, by and large the assessment follows those two-hour increments. Although such a practice is administratively convenient, it poses the potential of leaving residents in the SMU long after they have ceased posing a threat to self or others. By statute, a resident may only be placed in observation status for as long as he poses an imminent threat of (i) danger to self or others, (ii) destroying property, or (iii) escape. *See* 34-A M.R.S.A. § 4108(2)(C) (Attachment C, p. 6). A review every two hours to determine whether a resident continues to pose such a threat, creates the possibility that some residents may be kept under observation status beyond the time period permitted by statute.

At Mountain View, the general practice is for the JFOS who initially approves the placement of a resident in the SMU to contact the Deputy Director to inform him of the placement if the resident is to be kept in the SMU for more than two hours. That practice is

confirmed on the ISMP form. Although the supervisor who oversees the JFOSs (classified as the JPM Operations) often is involved in SMU placements, there appears to be little involvement by upper level administration in either the review of SMU placements or the development of plans to return a resident to his unit. It also does not appear that the Deputy Director is consistently informed of SMU placements at or near the time the placement occurs, rather than two hours later.

B. SMU PLACEMENTS

Data from Long Creek indicates that staff placed residents in the SMU for observation a total of 283 times in 2003, or an average of 23.6 times per month. Many of those instances involved the same residents making multiple trips to the SMU. For committed juveniles, the average duration of observation at Long Creek ranged from 0.615 hours in April 2003 to 3.01 hours in October 2003, compared to a national average of 10.899 hours in April and 24.31 hours in October. The percentage of segregations in observation status at Long Creek that concluded in four hours or less typically ranged from 80% to 100% each month.

For detained (but not yet committed) juveniles, the average duration of observation ranged from 0.991 hours in April 2003 to 3.44 hours in October 2003, compared to a national average of 20.324 hours in April and 45.219 hours in October. In 2003, over 90% of all placements of detained residents in observation status ended within four hours.

Thus, the duration of SMU placements for both detained and committed juveniles at Long Creek is well below national averages.

Data from Mountain View reveals that staff at that facility used the SMU at least 251 times between January and November 2003.[8] Thus, there was an average of 28.8 placements in the SMU each month. Some of those 251 SMU placements represent multiple trips to the SMU by the same residents. For instance, in April 2003, there were 30 recorded SMU placements. Of those 30, five involve one resident, six involve a second resident, and three involve a third resident. Thus, three residents accounted for close to half of the total number of SMU placements that month.

The average duration of SMU placements at Mountain View has decreased since the facility opened its doors. During 2003, most residents placed in the SMU remained there for a few hours or less. There are, however, several notable instances, discussed below, where residents remained in the SMU for substantially longer periods of time.

C. SMU DOCUMENTATION

Long Creek tracks placements in the SMU in part through a pink colored Observation Report that requires tracking of regular checks, room inspections, shower time, medication and other items of interest (Attachment I). Long Creek staff typically have completed these forms as required and they are maintained for review. The records generally are maintained in good order and are complete.

Mountain View tracks placements in the SMU in part through an SMU Placement Report that records residents' names, date and time placed in the SMU, the reason for the placement,

[8] Due to deficiencies in the recording of SMU placements at Mountain View, discussed in more detail below, the exact number of SMU placements is not clear.

who authorized the placement, and the date and time the resident was released from the SMU (Attachment J). Mountain View also has developed the ISMP form (Attachment K), circulated to all supervisors in June 2003, that is supposed to be filled out for each placement in the SMU and then reviewed by the Deputy Director. The ISMP form provides more detailed information about each SMU placement, and also provides spaces for staff to record each of the mandated checks and reviews of residents that are supposed to occur for each SMU placement. Unfortunately, reviewing the facility's SMU placements has been difficult due to sporadic and incomplete recordkeeping. The administration was able to locate ISMP forms for only about 50% of all instances in which residents were placed in the SMU after June 2003. In certain months, even though the SMU Placement Report indicated that a dozen or more residents were sent to the SMU, very few ISMP forms could be found. The ISMP forms that were located often were incomplete. Accurate and complete recordkeeping is important to allow facility administrators to review and analyze SMU placements, and is essential for the DOC, Board of Visitors or outside reviewers to assess the facility's compliance with statutory and regulatory requirements.

There is also reason to question the accuracy of the SMU Placement Report itself. That report is supposed to list every SMU placement each month. However, after reviewing the file for one resident, it is clear that the SMU Placement Report does not always include each of the instances where a resident is sent to the SMU. As requested, Mountain View staff created a narrative description of disciplinary problems related to this particular resident in 2003. That narrative has been compared to the SMU Placement Report to see if both documents tracked one

another. The narrative states that the resident was sent to the SMU on observation status on at least five occasions between June and September 2003. However, the SMU Placement Report contains no reference at all to three of those observations (which typically lasted several days), incorrectly states the date on which the resident left the SMU on a fourth occasion (by 16 days), and contains no information regarding when the resident left the SMU on the fifth occasion.

Thus, the SMU Placement Report is replete with omissions and errors regarding this one particular resident. Time did not permit similar examination of other placements and it is not known whether this is an isolated aberration. However, if not, it is imperative that SMU recordkeeping improve, as the facility is mandated to maintain accurate records for all observations. For the safety of the residents and, in order that records have any meaning for or use by reviewers, there must be some assurance that the facility's SMU records are complete and correct.

D. DURATION OF SMU PLACEMENTS

As stated above, the average duration for any placement in the SMU at Long Creek is well below national averages. Typically, most SMU placements are resolved, and the residents are returned to their units, within a matter of hours, at the most.

At Mountain View, many SMU placements also are concluded in a matter of a couple of hours. However, SMU Placement Reports for 2003 reflect many residents placed in the SMU for anywhere from one day to several days at a time. This appears to have occurred in every month of 2003. Several residents were kept in the SMU for even more extended durations during 2003. For instance, a few residents were placed in the SMU in June and kept there for

several weeks. Those placements apparently occurred as a result of fighting that the administration believes was related to gang activity. The records are unclear as to whether the residents were regularly assessed to determine if they continued to pose an immediate threat to self or others for that entire duration.

These instances are reflective of the tensions between the goal of creating a truly and totally therapeutic and rehabilitative environment on the one hand and the need to provide a safe and secure environment for residents and staff on the other.

1. OVERNIGHT STAYS IN THE SMU

In the past, residents brought to the Long Creek SMU late in the evening often were left to sleep in the SMU until the following morning, and then returned to their regular units. The current administration has worked hard to end this practice. So, for the most part, it occurs with less frequency. Residents typically are released from observation status in the SMU as soon as they no longer are judged to pose a high likelihood of imminent threat to self or others. Some staff express frustration at having to wake a sleeping resident in the SMU just to return him to his regular unit, potentially disturbing the entire unit in the process.

Mountain View has adopted a practice whereby residents who are brought to the SMU for observation at or after the resident's normal bedtime may be left to sleep in the SMU cell overnight. The JFOS on duty has the discretion either to return the resident to his regular unit once he is no longer a threat to self or others, or leave the resident in the SMU until the following morning. In practice, it appears that the JFOSs often have left residents in the SMU overnight. This practice has an intuitive logic to it, in that it may make little sense to wake up a sleeping

resident simply to return him to his room in his regular unit to sleep the rest of the night and possibly disturb others in the unit during the return process. Under a strict reading of the statute, however, it appears that such residents are being kept under observation status in the SMU beyond the point at which they no longer pose any danger to themselves or others. As noted above, a different practice now prevails at Long Creek.

There certainly are logical reasons to leave a resident who has fallen asleep in the SMU until the next morning. However, there is a countervailing danger that staff may use such a practice as a means of impermissibly placing and retaining residents in observation status past the point when they are no longer a threat to self or others instead of abiding by the statute. Accordingly, the appropriateness of this practice needs to be determined. The DOC should inform itself of national best practices and establish uniformity.

2. WEEKEND PLACEMENTS IN THE SMU

Another explanation for Mountain View resident retention in the SMU for several days at a time involves placements occurring on the weekend. The practice at Mountain View is that, once a resident has been sent to the SMU for observation, the resident typically remains in the SMU until his unit treatment team ("UTT") has had the opportunity to evaluate him and make any necessary adjustments to his treatment plan. Most members of the UTTs only work during normal working hours, Monday through Friday. If a resident is sent to the SMU on a Friday night or over the weekend, it is not possible for a resident's UTT to meet until the following Monday morning. In the past, the practice at Mountain View was to leave residents in the SMU for the weekend until the UTT was able to complete its assessment on the following Monday. It

is probable that, under that practice, many residents were kept under observation status in the SMU after they ceased posing any imminent risk of danger to themselves or others. Long Creek has not adopted any comparable practice.

The Mountain View administration has taken some steps to correct this condition. Residents may be returned from the SMU to their regular unit, where they are placed on unit or room restriction pending the meeting of the UTT on the next regular work day. In practice, however, many staff still express the belief that it is acceptable and expected that residents remain in the SMU for an entire weekend as a matter of course. This practice violates the statutory requirement that residents may only be kept under observation while they continue to pose an imminent threat, and not for days thereafter waiting for off duty staff members to return to work, and should be addressed.

3. OBSERVATIONS LASTING 72 HOURS OR MORE

Prior to keeping any resident under observation status for more than 72 hours, and every 72 hours thereafter, the facility is required to seek the written approval of the Commissioner or Associate Commissioner. *See* 34-A M.R.S.A. § 4108(F); DOC Regs. ch. 10, pol. 10.1(VI)(A)(4) (Attachment C, pp. 8-9). The purpose of seeking approval presumably is to ensure that facilities are properly applying the observation statute and regulations, and to provide an additional independent assessment of the propriety of any observation placement.

It does not appear that Long Creek has had any observation placements in 2003 that exceeded 72 hours, so there has been no need to obtain written approval from the Commissioner or Associate Commissioner for any extended stays in the SMU.

As discussed above, Mountain View placed several residents in the SMU for extended durations of more than 72 hours during 2003. Mountain View did not always comply with the statutory approval requirement for those placements. In at least 14 instances between January and November 2003, Mountain View failed to obtain any approval from the Commissioner or Associate Commissioner for placements in the SMU that extended beyond 72 hours. Those SMU placements lasted anywhere from 74 hours to 27 days. Most recently, a resident was placed in the SMU on December 11th, and remained there until December 24th – 13 days. Thus, written approval was required on December 14th, and every 3 days thereafter. However, during those 13 days, Mountain View staff obtained written approval from the Associate Commissioner on only two occasions, neither of which was within 72 hours of the initial placement. Thus, even in the midst of this review, the facility has had difficulty complying with the statutory and regulatory reporting and approval obligations. Obviously Mountain View needs to comply with its statutory obligations, which serve an important purpose in ensuring proper oversight by DOC Central Office administrators.

4. TENSIONS AMONG STAFF REGARDING SMU PLACEMENTS

As discussed above, the practice at Long Creek is for residents placed in the SMU for observation to be reviewed on an ongoing basis by the JFOS on duty to determine the point in time at which they no longer pose a high likelihood of imminent threat to self or others, and thus may be released back to the general population. Typically, the current administration at Long Creek has been actively involved in reviewing SMU placements and the need to resolve them promptly.

At Mountain View, under facility policy, the responsibility has been given to the JPM Operations and the JFOSs to review the SMU status on a daily basis and to ensure that residents are returned to their units as promptly as possible. In practice, there appears to be ambiguity regarding whether the JFOSs or JPMs are empowered to make the final decision to return a resident to his unit. It has been reported that the practice appears to be that a resident's JPM may direct a JFOS or other SMU staff to leave a resident in the SMU until the JPM determines that the resident can return to the regular unit. On occasion this has resulted in JPMs determining at the time that a resident is sent to the SMU, or shortly thereafter, that the resident will remain in the SMU for a day or more. Once that decision has been made, the JFOS on duty will no longer continue to assess the resident's condition to determine whether he continues to pose an imminent threat to self or others, and the resident will remain in the SMU for the specified period of time. Such a practice, to the extent it occurs, violates the observation statute and regulations. It is clear that a juvenile may not be placed under observation status as punishment. *See* 34-A M.R.S.A. § 4108(2)(C) (Attachment C, p. 7). To the extent that residents are placed and kept under observation in the SMU as a consequence for their actions, rather than because they pose any imminent threat, that placement is punitive at worst and negligent at best and inconsistent with the statutory and regulatory framework. This practice should be discontinued.

E. OTHER FORMS OF SEGREGATION OR ISOLATION

1. TIME-OUTS

Residents may be sent to their rooms, or to another room in the facility, as a time-out to cool down. Time-outs typically occur in a resident's own room, or sometimes in an otherwise

unoccupied room in the facility. The door of the room generally is left open, or shut but unlocked. Both facilities appear to apply the time-out regulations comparably. However, the facilities track and record time-outs differently, which makes any comparison of the frequency of such practices difficult.

How such time-outs square with the observation statute and regulations is unclear. The observation statute and regulations should be amended to clarify exactly what constitutes an observation, as opposed to any other form of segregation, so that it is clear whether these practices fall within or without the scope of the observation limitations.

2. ROOM CONFINEMENTS

The DOC has adopted detailed regulations that explain the disciplinary process at both facilities. Briefly stated, a resident may agree to an "informal consequence," which essentially is a form of discipline proposed by staff to which the resident has consented. Alternatively, a resident may elect not to agree to the "informal consequence," and the matter is then investigated and reviewed by staff, who ultimately impose some form of discipline if the charge is sustained. Through either channel, a resident may be sent to his room for room confinement for a specified duration of time. Presumably, such discipline is appropriate. As already discussed, however, room confinement in some respects appears to be a form of observation, in that a resident is segregated from the general population, yet presumably there is no imminent threat of harm that forms the statutory predicate to placing a resident on observation status. The statutory and regulatory regime needs to be clarified to address this issue.

Residents occasionally are confined to their rooms in other instances, as well. At Mountain View, residents released from the SMU and returned to their units typically are placed on unit restriction pending the outcome of any disciplinary investigation into the events that caused them to be sent to the SMU in the first place. Sometimes, however, residents are released from the SMU and sent directly to their rooms, where they are confined pending the completion of any disciplinary investigation. This may occur if the staff is concerned that placing the resident on unit restriction, where he could interact with other residents on his unit, might result in follow-up assaults or other unacceptable behavior. Typically when a resident is placed on room restriction, his chair, pencil and perhaps other potentially dangerous objects are taken away. The effect of this practice is that a resident is confined to his room, with the door shut, for an indeterminate period of time, and presumably not because the resident poses any *imminent* threat of harm to self or others. Thus, the observation requirements are not met. Whether such confinement qualifies as observation, even though it does not take place within the SMU, is unclear due to the vagueness in the observation statute. According to the DOC's regulations, room confinement qualifies as a form of punishment that may only be imposed with the resident's consent or after affording due process. *See* Maine DOC Regs. ch. 15, pol 15.3(VI)(B)(2). This practice needs to be addressed and clarified by the DOC, to the extent it is deemed to be permissible at all.

The practice at Mountain View in the past has been to place any resident who is the subject of a pending disciplinary investigation – even those residents who have not been sent to the SMU – in room confinement pending the outcome of that disciplinary process. In other

words, if a resident would not consent to the "informal consequence," and disputed the charge through the disciplinary process, the resident would be confined in his room until that disciplinary investigation and hearing process was completed. Although the administration has taken steps to curtail this practice, it is unclear if, and to what extent, it might still be occurring. To the extent that solitary confinement in one's room qualifies as observation status, that form of confinement seems to exceed the boundaries of the observation statute. It also appears to constitute punishment, as defined in the regulations, without the benefit of due process. *See* Maine DOC Regs. ch. 15, pol. 15.3(VI)(b)(2). This practice needs to be addressed and clarified by the DOC, to the extent it is deemed to be permissible at all.

Finally, the facilities have different methods of tracking instances where residents are confined to their rooms. Long Creek, for instance, reported a total of 1,332 instances of room confinements in 2003. However, this number is artificially inflated for several reasons. First, many instances of room confinement were voluntary in nature, and thus do not represent compelled isolation. Second, many of the instances involved the same handful of residents. For instance, there were 368 reported periods of room confinement in April 2003. The vast majority of those instances of confinement were related to one female resident, and were of short duration. Third, and most importantly, Long Creek tracks instances of room confinements or time-outs by separate instance. The practice at Long Creek is that room confinement generally will not interfere with a resident's participation in programming and other activities, nor can it be fulfilled during normal bedtime hours. Thus, a resident might only be able to fulfill his room time commitment in short increments, such as ten minutes at a time. Long Creek tracks each

period of confinement as a separate incident. Thus, by way of example, if a resident were assigned to four hours of room confinement, but only able to fulfill that commitment in ten minute increments, the resident would undergo 24 separate ten minute room confinements. Long Creek would then record that as 24 separate time-outs in a particular month, even though each incident was simply part of one larger room confinement commitment arising out of a single event. For statistical and comparative purposes, consideration should be given to changing the recordkeeping to reflect the fact that many segments actually constitute a single incident, and to ensure that both facilities track room confinements similarly to permit comparison.

3. THE RESIDENT INTENSIVE SUPERVISION PROGRAM

Mountain View has adopted a program called the Resident Intensive Supervision Program ("RISP"). Long Creek has no similar program. Residents who pose special security risks or who otherwise lack motivation to engage in programming may be referred into Mountain View's RISP. The RISP residents are housed in one of the pods in the high-risk unit. Residents in the RISP are categorized in three stages, known as Stages 1-3. Residents start at Stage 1, where they are confined within the pod on their unit for most of the day. Through proper behavior, residents progress into Stage 2 and then Stage 3, where there is more integration with the general population. Within each stage, individual residents are assigned a specific level, from Level D-A. Residents start at Level D and must earn their way to Level A. While on Level D, C or B in Stage 1, or on Level D or C in Stage 2, residents are confined to their rooms for essentially all free time, including meals. Programming provided to such residents is minimal. In essence, the residents are segregated in their own rooms for most of each day. Like other

forms of room confinement, it is unclear whether such confinement amounts to a de facto observation status, even though it does not occur in the SMU. It also appears to qualify as a form of punishment that is inconsistent with the due process requirements of the regulations. *See* Maine DOC Regs. ch. 15, pol. 15.3(VI)(b)(2). The observation statute/regulations need to be clarified by the DOC to address the propriety of this program.

4. SHOCK SENTENCES

Maine's District Courts occasionally sentence juveniles to "shock sentences" of typically fairly short durations, in an effort to discourage juveniles who have committed minor offenses from continuing with a life of crime. Sometimes such juveniles are given a shock sentence of 72 hours or less.

At Long Creek, juveniles on a short shock sentence are housed in the detention unit and treated similarly to other detained juveniles (although they typically do not receive educational programming for the short duration they are at the facility). Mountain View's practice, on the other hand, is that juveniles who are sentenced to the facility for 72 hours or less will be confined to a room for virtually the entire duration. Those residents are let out of their rooms for approximately one hour per day to shower, and let out during meal times. They are confined to a room for the remainder of their sentence. Because juveniles given a short shock sentence rarely bring many personal belongings with them, they inevitably will have little with them in the room to occupy their time. Although these residents are not sent to the SMU for 72 hours, and typically are housed in a regular unit such as the detention unit, nevertheless they are isolated and segregated from the general population, much like residents who are sent to the SMU. It

does not appear that applicable statutes/regulations were drawn with shock sentences in mind. This practice needs to be examined closely to assess whether such confinement amounts to an observation, regardless of whether the confinement takes place in the SMU or elsewhere. If this form of room confinement does qualify as observation, then it is contrary to the observation statute and either should be made to conform or statutory changes should be made to accommodate it.

5. GOING TO THE SMU INSTEAD OF SCHOOL

Mountain View has a practice of placing residents who refuse to go to school in the SMU until the classes are over. Typically such residents are placed in an SMU cell, just as they would be sent into their own rooms in their regular units if they were not sent to the SMU. By sending these residents to the SMU instead of leaving them in their own rooms, the residents are consolidated into one location, and less staff are occupied overseeing them. Placement of these residents in the SMU imposes less of an administrative burden on the facility. Nevertheless, it is unclear how this practice impacts the observation statute and regulations. Obviously these residents are not sent to the SMU because they pose any imminent threat of danger to themselves or others. Thus, they do not qualify for observation status under the statute. However, since the Mountain View administration generally views the observation statute as being triggered by the placement of a resident in the SMU, on the surface it appears that residents who refuse to attend classes are being placed under observation status.

There is an inherent conflict between the concept of viewing the SMU as the trigger for any observation status and the practice of placing non-threatening residents in the SMU merely

for administrative convenience. Ideally, the education program should be made so attractive that few, if any, residents refuse to attend school. However, since most of the residents have had bad experiences in school settings and many have special education needs, it is probable that there will always be less than 100% enthusiasm for educational opportunities. Thus, this practice needs to be examined by the DOC and, if necessary, the statute/regulations should be modified to address how, if at all, the practice of sending residents to the SMU in lieu of school impacts the observation statute and regulations.

III. ISSUES THAT MIGHT SUGGEST ADDITIONAL INQUIRY

This list is not intended to suggest that any one of the listed items is more important than another. Nor, given the short timeframe for the review and the nature of the charge, should the list be considered complete.

1. Boredom and inactivity will inevitably lead some mischievous and manipulative residents to bad behavior. Data maintained by the facilities indicates that both have made progress in reducing the number of idle hours for residents each day, but the need for further improvement remains. Programs and plans should be designed to provide as much activity as possible with the goal of leaving the residents with little or no time to foment trouble. Education, exercise, involvement of volunteers, participation by the community in the facility, participation by deserving residents in activities outside the facilities, and work-related activities should be programmed and followed closely.

2. Existing mentoring programs should be developed, encouraged and supported by the facilities so that the residents will have role models, a sense of support and, perhaps, assistance after release.

3. There should be greater direction and supervision from the DOC's Central Office, recognizing that there is a fine line between the autonomy needed by the heads of these facilities and the administrative responsibilities at the DOC. It is clear that both facilities suffer from the absence of oversight and direction. In large part, this is due to funding and staffing problems at the DOC Central Office and not to benign neglect. More staffing support to the top administrators and better guidance and direction will strengthen both facilities and provide better

results. The DOC needs to provide strong leadership and guidance to the facilities. To date, the DOC has allowed both facilities to operate independently of one another and to chart their own courses. While this tendency may be understandable, to foster independent thinking and innovative ideas from the ground up, there needs to be a counter-balance from the top reviewing what both facilities are doing and assessing which, if either, track is preferable. With no communication occurring between the two facilities, and not enough oversight by the DOC to review what each facility is doing and determine which methods are working or not working, neither facility is able to gain from the experiences of the other. While there are benefits to letting each facility take its own path, the DOC needs to take a more active role in assessing those choices, determining which of those choices is more effective, and setting Department-wide policies.

The DOC also should take a more active role in standardizing the forms and procedures in place at both facilities. It is exceedingly difficult to compare the two facilities to one another. The DOC should be commended for the facilities' participation in the CJCA's PbS initiative for tracking performance data for comparison purposes with national data. However, both facilities record their PbS data differently, making that meaningful comparison between facilities difficult. Likewise, both facilities have created and use their own forms for reporting restraints and observation. Indeed, Mountain View has created no less than four different forms, roughly one form for each unit, to record residents' in-room time. Without consistency, the data becomes almost impossible to review and track. The Department needs to adopt standardized forms and

procedures, so that both facilities operate comparably and record data in the same measurable ways.

4. The correction facilities are simply a part – albeit an important part – of a larger system. Problems begin in the home or in the absence of a home environment and ultimately are addressed in court. Too often there is no alternative choice between letting an offender go free and sending that offender to one of the Centers. At the other end of the spectrum, the residents are released back into the environment from which they came, often without any support or resources other than supervision by a juvenile community corrections officer ("JCCO"). There should be uniform planning from start to finish and that planning should involve the JCCOs, including their participation during incarceration. "Half-in" and "half-out" houses, better diagnostic and treatment facilities at all stages, and community education and support are required. This is not a short-term project.

5. The facilities have made significant progress in the areas of restraint and observation as compared to the MYC. To improve further, there should be more focus on treatment and education and less on restraint, observation and punishment as the two facilities move into a truly treatment and rehabilitative culture. While the process will never be perfect, if the transition is handled properly, increases in psychiatric, psychological and medical services, changes in behavioral management education and additional training should result in a continued decrease in the need to use restraints and observations and/or punishment methodologies. Both facilities now have dedicated and for the most part competent mental health professionals who provide invaluable treatment to the residents, many of whom suffer from mental illness and/or

addictions. *See* Attachment L. The DOC is to be commended for its efforts in establishing the cooperative arrangement that exists with the Maine Department of Behavior and Developmental Services and for contracting for outside psychiatric and mental health (Sweetser), and substance abuse (Day One) services. These programs should be maintained and enhanced going forward such that consistent and ever improving mental health and substance abuse services are provided to all residents as needed.

6. There appears to be a chronic need to fill the medical director position at Long Creek. At present, there is not even an acting medical director. Due to this void, there is no one to provide guidance and structure for the mental health program or any of the medical programming and there is inconsistency in the available psychiatric services, now provided by part-time contracted physicians. Although some individuals have tried valiantly to fill at least a part of this void, the clinical staff and programming would benefit greatly from active and effective full-time leadership.

7. For the most part, clinical staff and contract workers appear to work regular, first shift hours at the facilities. The exception appears to be one of the psychologists on staff at Long Creek, who has adjusted her schedule so that she works into the early evening hours on certain days. It is clear from a review of restraint and SMU logs that much of the activity that results in both restraints and SMU placements occurs in the afternoon or early evening hours, after school has ended and when residents are confined together in their units or pods. It would be beneficial to have more clinical staff working during these non-traditional hours, not only to provide

services during the time of day when they may be most needed, but also to perform an important role of observing and monitoring the facility after most of the administration has left for the day.

8. On a related note, at least at Long Creek, there appear to be no mental health providers on-call or available during evening hours at all, even to provide critical services like suicide prevention or to respond to other crises. Apparently the two staff psychologists previously were forced to be on-call 24-hours a day, seven days a week, but no longer do so as a result of a grievance process. It is unreasonable both to expect staff psychologists to be on-call all day every day, and to fail to provide for any alternative mental health providers in their absence.

9. At present, there is virtually no communication between Long Creek and Mountain View. The relationship between two facilities has been strained and less than cooperative for much of their histories. This has impeded the constructive sharing of ideas and the coordinated development of effective programs and other practices for the treatment of the juveniles.

The two facilities are in different locations with different populations and there will be some variations in programs and operations. However, the facilities have the same purpose and numerous talented and highly motivated persons dedicated to the treatment of juveniles. These resources should be shared between facilities for the betterment of all involved. To accomplish this goal, the competitive tendencies of the facilities should be put aside and renewed efforts at coordination and collaboration should be pursued.

Specifically, there should be regular periodic high-level meetings between the administrations of both facilities. Long Creek staff have had years to experiment with different techniques. Even if some attempts at change have been failures, those failures can provide important guidance, as well. Similarly, Mountain View, which is a new institution which essentially started operations from scratch, may have new and innovative ideas to share with its sister facility. The administrations of both facilities will, in fact, be meeting in February. Such meetings should be continued on a regular basis, and the institutions should be encouraged to be forthright and candid in sharing their successes and failures to encourage progress in both facilities. In addition, there should be a regular schedule of meetings at all other levels, administrative, staff, and clinical in order that practices and procedures at each facility can be shared with the goal of better coordination and the adoption of best practices by both.

If these efforts are to succeed, the DOC Central Office must provide improved and vigilant supervision and facilitation.

10. By statute, each facility has a Board of Visitors consisting of five individuals appointed by the Governor. The Boards are to report to the Governor and the Legislature concerning their assessment of the facilities. They have not done so regularly. The present structure and reporting requirements of the Board of Visitors should be reviewed and the Boards at each facility should be made accountable for their statutory and regulatory responsibilities.

In addition, the Boards of Visitors of both facilities should consider arranging periodic meetings with one another. The Boards potentially can serve an important oversight and monitoring role for the facilities. While the Boards do not have any supervisory authority over

the facilities, they do have the ability to perform critical monitoring and an independent review of what the facilities are doing to ensure compliance with statutory and regulatory requirements. Regular discussions between the Boards could further that end.

11. Training is vital and indispensable and should be encouraged and supported both by the DOC and the administrations at both facilities. There is an increased recognition that current training is inadequate in some respects. Faced with limited resources for training, special attention should be paid to the basics of the proper ways to treat juveniles including, especially, non-confrontational de-escalation techniques. In that regard, Mountain View has recently sponsored a one-day workshop, for its staff by Dr. Ross Greene, author of *The Explosive Child*, with representatives of other agencies invited. The topic is collaborative problem-solving. Dr. Greene is a Harvard-based psychiatrist and he will also do staff training over six months in order to approve de-escalation skills for staff. Hopefully, there will be coordination and cooperation between the two facilities so that Long Creek can similarly take advantage of this opportunity.

12. In response, in part, to complaints by Amnesty International, the DOC retained Edward J. Loughran, President of Loughran and Associates, the Executive Director of the CJCA, to evaluate the conditions of confinement at the MYC. Dr. Loughran's reports in 1999, 2000, and 2001 contained detailed recommendations. Those recommendations and their current status are reflected in the spreadsheet that is Attachment L, prepared by the DOC as requested for this Report. That updated spreadsheet is obviously a self-summarization and there has not been time to verify the current status reports. It is included for completeness. Dr. Loughran's visits ended in September of 2001 because of lack of funding. The renewal of periodic reviews of both

facilities by a recognized juvenile corrections expert like Dr. Loughran would likely foster the continual assessment and improvement of both facilities and assist them to achieve and maintain best practices for juvenile corrections.

13. The Superintendent for Long Creek should be named as promptly as possible since there is uncertainty as to whether procedures and changes made by the Acting Superintendent will continue.

SUMMARY OF RESTRAINT AND OBSERVATION RECOMMENDATIONS

- Establish a uniform practice for the facilities' use of restraints during the transport of a resident.
- Establish a common protocol for tracking restraint usage both for transportation and for continued restraint within the SMU.
- Implement a uniform protocol with respect to the use or non-use of the restraint chair based on best practices.
- If the restraint chair is to be used, promulgate clear guidelines for its use.
- Determine which restraint devices are best used under different circumstances based on best practices.
- Ensure that all staff are trained on and make use of appropriate restraint devices.
- Revise the Restraint Documentation Form so that it is both user-friendly and captures all of the important information mandated by regulations and is consistently used by both facilities.
- Ensure compliance at both facilities with videotaping regulations so that each restraint is videotaped from inception to end with full sound and the videotapes are properly preserved.
- Determine and direct a uniform and consistent practice for storage of restraint devices.
- Establish a uniform practice for searches of residents transferred to the SMU.
- Amend the observation statute to define specifically what forms of segregation qualify as observation status.
- Enforce regulations requiring uniform observation practices.
- Establish regulations governing overnight retention in the SMU of sleeping residents who no longer pose a high likelihood of imminent threat to self or others.
- Establish common protocols and consistent forms for recording and reporting observations in both the SMU and residents' rooms at both facilities.

- Establish regulations governing residents who are given "shock sentences."
- Establish common protocols requiring the facilities to investigate, review and make recommendations after incidents of disorder.
- Establish protocols that require facility administration and DOC officials to make spot checks of isolation rooms and units, especially during off hours.
- Establish at least quarterly reviews, on site, by a high administrative DOC official of restraints and observations during the prior quarter

SUMMARY OF OTHER IDENTIFIED ISSUES

- Lack of involvement and leadership by the DOC Central Office to facilitate coordination and cooperation between the facilities and resolve practice differences, including standardizing the forms and procedures.
- Insufficient programs and plans to minimize idle time for residents.
- Need for the development and improvement of mentor programs.
- Revisions to the structure of the Board of Visitors to make it accountable for its statutory and regulatory responsibilities.
- Recent lack of coordination between the two facilities through regular meetings of administrative and clinical staff.
- Increased focus on treatment and education.
- Demand for a full-time psychiatrist and a Medical Director at Long Creek.
- Need for periodic reviews of both facilities by a recognized juvenile corrections expert like Dr. Edward J. Loughran to foster the continual assessment and improvement of both facilities and assist them achieve and maintain best practices for juvenile corrections.
- Appointment of the permanent Superintendent of the Long Creek facility as soon as possible.

Respectfully submitted,

January 28, 2004

Ralph J. Lancaster, Jr.

ATTACHMENT A

STATE OF MAINE
OFFICE OF THE GOVERNOR
1 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0001

JOHN ELIAS BALDACCI
GOVERNOR

November 6, 2003

Ralph Lancaster, Jr.
Pierce Atwood
One Monument Square
Portland, ME 04101

Dear Ralph:

Per our recent conversations, Governor Baldacci seeks your independent review of matters relating to the current and future safety of youth in Maine's corrections systems. As a starting point to resolve any questions about youth safety, his request to you is that:

1. You inspect the Long Creek Youth Development Center in South Portland and the Mountain View Youth Development Center in Charleston and report as soon as possible, preferably on or before January 31, 2004, with regard to the restraint and isolation policies and procedures currently in place at these facilities and current practices implementing those policies and procedures.

2. In the course of this inspection, you should review pertinent documents and data, interview knowledgeable persons, including MDOC officials, the facilities' administrators and managers, a cross section of the staff of the facilities, residents, volunteers, and members of the facilities' board of visitors, review videotapes and logs of physical restraint usage and compare that data with available national data.

3. In view of pending litigation, you should not review allegations of past conduct at the Maine Youth Center, conduct an employment review, or review any labor/management issues at the facilities.

During your review, we look forward to any interim updates on issues you have identified which might suggest additional inquiry.

Sincerely,

Alan B. Steams
Senior Policy Advisor

PHONE: (207) 287-3531 (Voice) (207) 287-6548 (TTY) FAX: (207) 287-1034
www.maine.gov

ATTACHMENT B

JARED S. des ROSIERS

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Employment History

Associate, Pierce Atwood, Portland Maine (1992-1998)

After completing a summer internship program in 1991 at the firm, Jared joined Pierce Atwood, northern New England's largest law firm, full time in September 1992 as an associate in the litigation department. Jared represented plaintiffs and defendants in civil litigation in Maine's state and federal courts. He developed significant expertise in handling complex commercial litigation in Federal Court. Most notably, he served as second chair on a several hundred million-dollar Federal tax appeal for Unum Corporation, and a multi-million dollar partnership dispute involving an oriented strand-board mill in New Brunswick, Canada. Jared also developed significant expertise in insurance matters, regularly counseling insurance companies on coverage matters and appearing before the Maine Bureau of Insurance.

Associate Independent Counsel, Office of Independent Counsel, Ralph I. Lancaster, Jr., Washington, D.C. (1998-2001)

In August 1998, Jared took a leave of absence from Pierce Atwood to serve as Associate Independent Counsel under Ralph I. Lancaster, Jr., who was appointed in May 1998 to serve as Independent Counsel to investigate allegations that Alexis M. Herman, then Secretary of Labor in the Clinton Administration, had engaged in influence-peddling and the solicitation of illegal campaign contributions. Jared served in this position full time throughout the Independent Counsel's investigation, which concluded in 2000. In this position, Jared regularly appeared before the special grand jury empanelled for the Independent Counsel, worked on a daily basis with the FBI and IRS agents

assigned to the investigation and was the one of the lead attorneys conducting the international money tracing aspects of the investigation. Jared was also responsible for establishing and overseeing the computerized data management system used by the Office to organize and ultimately archive the significant volume of evidence and other data the Office gathered.

Partner, Pierce Atwood, Portland, Maine (2000 -)

In April 2000, Jared returned to Pierce Atwood after the completion of the Independent Counsel investigation. Upon his return he was elevated to equity partner within the firm. Since his return, Jared's practice has had three principal components: white collar crime, insurance and complex commercial litigation.

White Collar Crime: Jared has represented several individuals in State and Federal criminal investigations. Most notably, Jared participated on the team that successfully represented Senator Robert G. Torricelli with respect to a grand jury investigation conducted first by the U.S. Department of Justice's Campaign Finance Task Force and then by the U.S. Attorney's Office of the Southern District of New York. In addition, Jared has represented and continues to represent several individuals under investigation by the Maine Attorney General's office and Maine Revenue Service for tax evasion.

Complex Commercial Litigation: Jared spends much of his time on complex commercial litigation matters in State and Federal Court and before regulatory agencies. Jared conducts and oversees all aspects of this litigation including discovery, motion practice and trial work. Through this work, Jared has developed particular expertise in managing and effectively using large quantities of data in both paper and electronic form and in trying complex, document intensive disputes to judgment.

The following matters are typical of Jared's practice in this area:

In 2000, Jared represented the Warren Sanitary District in a major Clean Water Act citizen suit brought in Federal Court by two environmental groups. After extensive discovery and expert work, the Pierce Atwood team, lead by Jared, was able to settle this matter in a very positive manner. Under the settlement, the citizen suit was dismissed, the client received new State and Federal water permits allowing it to expand its operation and the client incurred no civil penalties despite the strict liability and mandatory penalties called for by the Act.

In 2001-02, Jared served as trial counsel for Maine Yankee in two related cases pending in Federal Court in Maine and Bankruptcy Court in Delaware arising out of the termination of Stone & Webster as the lead contractor responsible for the decommissioning of Maine Yankee's nuclear plant in Wiscasset. In the bankruptcy court proceeding, the Pierce Atwood team tried Maine Yankee's claims against Stone & Webster during a two-week trial in November and

December 2002. This trial resulted in a $20.8 million damages determination for Maine Yankee. After this trial, the Pierce Atwood team then succeeded in settling on the eve of trial the Federal Court case against Stone & Webster's bonding company for an additional $44 million.

In 2002 and continuing to the present, Jared has served as litigation manager and trial counsel for the California Electricity Oversight Board in litigation before the Federal Energy Regulatory Commission concerning several long-term energy contracts the California Department of Water Resources entered during the California energy crisis. In this matter, which was tried over two weeks in December 2002, Pierce Atwood's client seeks the abrogation or reformation of these long-term contracts, which are worth several billion dollars. This matter remains pending.

Insurance: In the insurance area, Jared regularly advises insurers and insureds on insurance coverage matters and insurance litigation. Jared has particular expertise in the area of bad faith and unfair claims handling. He also regularly appears before the Maine Bureau of Insurance on behalf of insurance company clients.

Public Service

In September 2000, upon his return to Maine after completing his service as Associate Independent Counsel, Jared was nominated by then Governor King and confirmed by the Legislature to the position of Alternate Public Member of the Maine Labor Relations Board. He continues to serve in this capacity, acting as the hearing officer and panel chair for labor disputes involving state and local employees.

Education

Jared received his B.S. (1989) and his J.D. *summa cum laude* (1992) from the University of Notre Dame, where he was Lead Articles Editor (1991-92) for the *Notre Dame Law Review* and received the "Dean Joseph O'Meara" award for outstanding academic achievement.

Admitted to Practice

Jared is admitted to practice in Maine (1992) and the United States District Court for the District of Maine (1992).

Professional Affiliations

Jared is a member of the Cumberland County and Maine State Bar Associations and the Maine Trial Lawyers Association.

MARK E. PORADA

Associate

Litigation

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Admitted to Practice
Maine, New Jersey, Pennsylvania, District of Columbia

Mark Porada practices in the Litigation Department at Pierce Atwood, where he has a broad litigation practice that draws upon his experience in all phases of state and federal litigation. Mark's practice has a focus on complex litigation, commercial disputes, insurance coverage disputes, and ERISA litigation.

Before joining Pierce Atwood in 2001, Mark was an associate with Covington & Burling in Washington, D.C. His litigation practice there involved representation of corporate clients in multi-million dollar insurance coverage actions, regulatory litigation before various federal agencies, general commercial litigation, and pro bono work in a variety of federal trial and appellate courts, including the U.S. Supreme Court. While at Covington & Burling, Mark also served as staff attorney to the Neighborhood Legal Services Program, advising and representing clients in D.C. Superior Court in a variety of housing, consumer, and domestic cases.

Previously, Mark was a law clerk to Judge Norma Shapiro for the U.S. District Court, Eastern District of Pennsylvania.

Mark is admitted to practice in Maine, the District of Columbia, Pennsylvania, and New Jersey.

Mark received his B.A. in History from Trinity College (*Phi Beta Kappa,* 1994). He earned his J.D., *summa cum laude,* from the University of Pennsylvania Law School (Order of the Coif, 1997), where he was senior editor of the University of Pennsylvania Law Review and served as a member of the Moot Court Board.

Mark currently serves as a member of the Scarborough Planning Board.

PIERCE ATWOOD

ATTACHMENT C

ATTACHMENT C

SUMMARY OF MAINE STATUTORY AND REGULATORY PROVISIONS AND NATIONAL AND INTERNATIONAL STANDARDS REGARDING USE OF RESTRAINTS AND OBSERVATION

As a starting point, the facilities were created, in part, to "rehabilitate juveniles," not just to confine them. 34-A M.R.S.A. §§ 3802(1)(C), 4102(4).

The facilities are statutorily empowered to impose a variety of forms of punishment. In general, "[p]unishment at juvenile correctional facilities and any detention facility may consist of warnings, restitution, labor at any lawful work and loss of privileges." 34-A M.R.S.A. § 3032(5)(B). In addition, "[s]ecurity measures, whether in the form of physically restrictive construction or intensive staff supervision, when appropriate, may be taken to accomplish these purposes." 34-A M.R.S.A. §§ 3802(2), 4102(6).

I. Restraints.

A. Statutory Provisions.

There are no statutory provisions governing the use of restraints in juvenile facilities.

B. DOC Regulations.

The Department's regulations, effective May 1, 2002, define "mechanical restraints" as "any device or material that limits movement by binding, tying, strapping, etc." DOC Regs. ch. 9, pol. 9.15(III).

1. Policy on Use of Restraints.

The Department has adopted the following policy regarding the use of restraints:

> Except for transport situations, the use of mechanical restraints on residents in the Department's juvenile facilities shall be limited to those

> situations in which it is apparent that the resident presents a real and immediate threat to the safety of the resident or others or the security of the facility and only when no other reasonable alternative exists. When it is necessary to use restraints, they shall be applied with the least amount of force necessary and in the least restrictive manner possible. Residents shall not be restrained in unnatural positions. Restraints are not to be used as punishment. Except for routine transport situations, the use of restraints must be reviewed and approved by supervisory staff."

Id.

The regulations thus require that, aside from transport situations, mechanical restraints may only be applied in response to a legitimate threat of danger.

> Except for transport situations, mechanical restraints may be applied only when it is apparent that a resident poses a real and immediate threat to his/her safety or to the safety of others or to the security of the facility, as shown by stated intention, recent conduct, or other factors. Restraints may only be used if another reasonable alternative would not be effective to alleviate the threat.

DOC Regs. ch. 9, pol. 9.15(VI)(A)(1).

Residents are deemed to pose an immediate threat to themselves or others if the situation indeed poses an immediate danger of injury. In addition, the regulations provide that

> a resident shall be deemed to pose as such a real and immediate threat if the resident has a history of serious self-inflicted injury and threatens to engage or engages in an attempt to inflict injury on himself or herself, including, but not limited to, searching for contraband that might be used to inflict injury on himself or herself.

DOC Regs. ch. 9, pol. 9.15(VI)(A)(2).

The regulations provide that restraints are routinely required to be used when residents are transported, including when they are transported within the facility from a unit or classroom to the SMU for observation.

> Mechanical restraints, consisting of handcuffs, Posey belt, and ankle restraints, shall be used, as a matter of routine, during transport of a

> resident if the resident is a detainee, is still undergoing assessment and orientation, is in or requires placement in the Special Management Unit, or has been classified high risk. Restraints may be used during the transport of another resident if approved by the [JFOS], provided that restraints shall not be used during the transport of a resident who is pass/leave eligible except in an emergency.

DOC Regs. ch. 9, pol. 9.15(VI)(A)(3); *see* DOC Regs. ch. 9, pol. 9.15(VI)(D)(1).

2. Authorization for Use of Restraints.

Except during transportation, a JFOS or higher level supervisor must approve the use of all restraints. *See* DOC Regs. ch. 9, pol. 9.15(VI)(B)(1). Staff are required to "immediately notify the [JFOS] and provide reasons why restraints are necessary." DOC Regs. ch. 9, pol. 9.15(VI)(B)(2). The JFOS may either immediately authorize use of restraints, or travel to the area to observe the resident to determine whether restraints are necessary. *See* DOC Regs. ch. 9, pol. 9.15(VI)(B)(3). If the JFOS authorizes the use of restraints sight unseen, he is required to immediately travel to the area to determine if the use of restraints should be continued. *See* DOC Regs. ch. 9, pol. 9.15(VI)(B)(4). A staff member may apply restraints prior to contacting the JFOS only when the JFOS cannot be reached immediately, due to exigent circumstances. *See* DOC Regs. ch. 9, pol. 9.15(VI)(B)(5).

If a JFOS approves the use of restraints in any non-transport situation, the JFOS is required to notify the Superintendent, or, when not available, another designated supervisor, for approval. The JFOS is also required to ensure that any determination to use restraints is recorded in the appropriate log books and that a Restraint Documentation Form is completed. *See* DOC Regs. ch. 9, pol. 9.15(VI)(B)(6), (7).

3. Application & Types of Restraints Permitted.

The regulations state that only approved restraints may be used. *See* DOC Regs. ch. 9, pol. 9.15(VI)(C)(2). Approved restraints include:

> Non-locking leather wrist restraints;
> Non-locking leather ankle restraints;
> Locking leather belts;
> Non-locking leather transport belt with "D" ring;
> Non-locking leather transport belt with handcuffs;
> Tube-restraints;
> Nylon transport belt with handcuffs;
> Shackles;
> Flex cuffs;
> Restraint chair.

DOC Regs. ch. 9, pol. 9.15(VI)(C)(2), Attachment B. Staff must use the least restrictive means of restraint, and apply them with the least amount of force reasonably believed to be necessary. DOC Regs. ch. 9, pol. 9.15(VI)(C)(3), (5).

Mechanical restraints may be applied only "to a resident's limbs and trunk." DOC Regs. ch. 9, pol. 9.15(VI)(C)(6). Hands and feet may not be shackled together at one point; a resident may not be restrained in an unnatural position; a resident may not be shackled to a fixed object, other than the restraint chair, without written approval from the Commissioner or Associate Commissioner for Juvenile Services; and a resident may not be restrained with his hands behind his back, except when being transported to the SMU, when in a restraint chair, when the resident has destroyed prior restraints, when the resident "needs to be taken to the floor in order for restraints to be applied," or when necessary during transport. DOC Regs. ch. 9, pol. 9.15(VI)(C)(6), (7).

Staff must use the "two finger" test immediately after applying restraints and after any resident complains that the restraints are too tight. DOC Regs. ch. 9, pol. 9.15(VI)(C)(8). Medical staff shall examine the restraints within 10 minutes of

application, not including use of restraints during transport, to ensure that the restraints are applied in a safe manner. *See* DOC Regs. ch. 9, pol. 9.15(VI)(C)(9).

A JFOS determines if and when restraints may be removed. *See* DOC Regs. ch. 9, pol. 9.15(VI)(D)(2). A JFOS or higher supervisor shall review the continued use of restraints beyond 30 minutes, and every 30 minutes thereafter. *See* DOC Regs. ch. 9, pol. 9.15(VI)(D)(3). After one hour, the resident shall have one limb at a time removed for exercise, unless the resident threatens to do bodily harm to himself or others or to break free if a limb is removed. *See* DOC Regs. ch. 9, pol. 9.15(VI)(D)(4), (5), (6).

4. Observation and Recording of Restraints.

Whenever restraints are used, staff "shall personally observe the resident on a constant basis for the duration of the period that the resident is restrained," unless there are too many residents currently in restraint to permit constant observation, in which case staff shall patrol the area on a continuous basis, ensuring that each resident is observed at least once per minute. DOC Regs. ch. 9, pol. 9.15(VI)(E)(1), (2).

Except in transport situations, staff are required to complete a Restraint Documentation Form for all restraints. Those forms are given to the JFOS, who forwards them to the Superintendent, or his designee, for further review. *See* DOC Regs. ch. 9, pol. 9.15(VI)(F)(1).

All non-transport uses of restraints are required to be videotaped during the duration of the restraint. Except in transport situations, the JFOS "shall ensure that the placement of a resident in restraints is videotaped, unless emergency circumstances prevent it. The JFOS shall ensure that the resident is videotaped for the duration of the time the resident is in restraints and when the restraints are removed." The JFOS is then

required to properly label the videotape and forward it to the Superintendent, or his designee, for review. *See* DOC Regs. ch. 9, pol. 9.15(VI)(G)(1). Each restraint videotape "shall be secured" for further use or reference. *Id.* If there is an emergency that precludes videotaping, the JFOS shall complete a report documenting the emergency and the reasons why recording was not possible. *See* DOC Regs. ch. 9, pol. 9.15(VI)(G)(2).

II. Observation.

A. Statutory Provisions.

By statute, residents may be placed "under observation" only in a limited number of scenarios, namely due to an imminent risk of (i) injury to self or others, (ii) destruction of property, or (iii) escape.

> When the behavior of a juvenile residing at [either the Long Creek Youth Development Center or the Mountain View Youth Development Center] presents a high likelihood of imminent harm to that juvenile or to others, presents a substantial and imminent threat of destruction of property or demonstrates a proclivity to be absent from the facility without leave as evidenced by a stated intention to escape from the facility or by a recent attempted or actual escape from any detention or correctional facility, the juvenile may be placed under observation if the juvenile demonstrates that anything less restrictive would be ineffectual for the control of the juvenile's behavior.

34-A M.R.S.A. §§ 3809(1), 4108(1).

The statutes do not define "observation" or dictate where it is to be carried out. The practice at both facilities is to use the SMU for all "observations." Both facilities also appear to consider the statutory requirements to apply only when residents are placed in the SMU and not during other instances when residents are isolated or segregated from the general population.

The statutory treatment of juveniles differs in that regard from the adult correctional population. On the adult side, prisoners may be sent to "segregation" for misbehaving. *See* 34-A M.R.S.A. § 3032(3). "Segregation" for adults is specifically defined to mean "the separation of a prisoner from the general population of a correctional facility for administrative or punitive reasons." 34-A M.R.S.A. § 1001(16). Thus, the statutory framework provides clearer guidance regarding when adult inmates are deemed to be in "segregation" than is available for understanding precisely when the "observation" requirements apply when juvenile residents are isolated or segregated from the general population.

Placement under observation "must be approved by the superintendent" at Long Creek or "by the director," *i.e.*, the superintendent, at Mountain View. 34-A M.R.S.A. §§ 3809(2)(A), 4108(2)(A). The statute itself does not provide for delegation of that authority to other staff. While under observation, a resident "must be under sight and sound supervision by facility staff, which must be constant if necessary to prevent imminent harm to the juvenile." 34-A M.R.S.A. §§ 3809(H), 4108(H).

A resident may be placed under observation only until the resident no longer poses an imminent risk of (i) a high likelihood of imminent harm to self or others, (ii) imminent threat of destruction of property or (iii) demonstrates a proclivity to escape. "Placement under observation may not exceed the period of time necessary to alleviate and prevent the reoccurrence of the behavior described in subsection 1 and it may not be used as punishment." 34-A M.R.S.A. §§ 3809(2)(C), 4108(2)(C).

The statute provides that medical staff shall examine residents in observation only after 12 hours have elapsed. "When placement under observation exceeds 12 hours, the

superintendent shall direct the facility physician or a member of the facility medical staff to visit the juvenile immediately and at least once in each succeeding 24-hour period the juvenile remains under observation to examine the juvenile's state of health." 34-A M.R.S.A. §§ 3809(2)(D), 4108(2)(D).

Following 24 hours of observation status, the superintendent "shall direct appropriate facility staff to develop a plan for the further care of the juvenile. The plan must be revised as needed to meet the changing needs of the juvenile." 34-A M.R.S.A. §§ 3809(2)(E), 4108(2)(E).

Residents may not be kept under observation for more than 72 hours without written approval from the Commissioner or Associate Commissioner. "Placement under observation may not exceed 72 hours without the commissioner's approval, which must: [initial caps??] (1) Be in writing; (2) State the reasons for that approval; and (3) Be kept on file." 34-A M.R.S.A. §§ 3809(F), 4108(F).

B. <u>DOC Regulations.</u>

The Department recently adopted a new policy on observation status, effective December 3, 2003. The new regulation provides that observation

> is a temporary status to observe and control the behavior of a resident who presents a high likelihood of imminent harm to self or others, presents a substantial and imminent threat of destruction of property, or demonstrates a risk of escape. Such a status may be used only if another reasonable less restrictive alternative would not be effective to control the resident's behavior. Placement on observation status is not to be used as punishment.

DOC Regs. ch. 10, pol. 10.1(III); *see* DOC Regs. ch. 10, pol. 10.1(VI)(A)(1), (2). A resident may be placed on observation status "only with the approval of the Superintendent, or designee." DOC Regs. ch. 10, pol. 10.1(VI)(A)(3). Thus, the

regulations permit the superintendent to delegate authority to place a resident on observation, although the statute does not expressly provide for such delegation.

The regulations state that all residents on observation status "shall be searched and re-issued appropriate clothing as necessary to eliminate contraband, provide for the safety of the resident and others, protect the security of the facility, and prevent property damage." DOC Regs. ch. 10, pol. 10.1(VI)(C)(2).

The regulations properly provide that the Commissioner or Associate Commissioner "shall review proposed continued placement of a resident on Observation status beyond seventy-two (72) hours and shall review proposed continued placement every seventy-two (72) hours thereafter," and shall provide authorization in writing. DOC Regs. ch. 10, pol. 10.1(VI)(A)(4).

The regulations follow the statutory requirement that residents on observation status must be returned to regular status "when the behavior that resulted in placement is no longer occurring and the threat of reoccurrence of any behavior justifying Observation status has been alleviated or when a reasonable less restrictive alternative would be effective to control the resident's behavior." DOC Regs. ch. 10, pol. 10.1(VI)(A)(6).

While a resident is on observation status, residents are entitled to access to "all services and programs the resident would otherwise be eligible for, except to the extent restrictions are necessary to maintain the safety of the resident or others or the security or orderly management of the facility, as determined by the [JFOS]." DOC Regs. ch. 10, pol. 10.1(VI)(B)(1). In particular, residents are entitled to the following, subject to any necessary safety restrictions: at least one hour of daily indoor or outdoor exercise, the normal amount of personal hygiene, the right to receive and send mail, have regular

bedding and clothing (unless the resident is likely to destroy the same), regular visits with family members, religious materials, meals as provided to other residents (modified as necessary to prevent the resident from "misusing food, dishes, or utensils"), and access to the courts, attorneys, legal advocacy organizations and legal materials. DOC Regs. ch. 10, pol. 10.1(VI)(B)(2). Residents are not entitled to possess any personal property, "except necessary medical devices, e.g., eyeglasses, dentures, etc., mail, legal items and religious materials." DOC Regs. ch. 10, pol. 10.1(VI)(C)(1).

The regulations further provide that a member of the facility medical staff "shall visit the resident at least once per shift." DOC Regs. ch. 10, pol. 10.1(VI)(B)(3). Likewise, a "member of the facility administrative, clinical, social services, religious, or mental health staff shall visit the resident at least once per day." DOC Regs. ch. 10, pol. 10.1(VI)(B)(4).

If a resident remains on observation status beyond 24 hours, the superintendent or designee and the resident's unit treatment team "shall develop a written plan for the further care of the resident while on Observation status and for the resident's removal from Observation status." DOC Regs. ch. 10, pol. 10.1(VI)(B)(5).

Under the Department's regulations, staff "shall directly observe each resident on Observation status a minimum of every fifteen (15) minutes." DOC Regs. ch. 10, pol. 10.1(VI)(D)(1). Staff are required to constantly observe a resident "if necessary to prevent imminent harm to self or if the resident is placed in restraints." DOC Regs. ch. 10, pol. 10.1(VI)(D)(2). All checks on, and visits to, residents on observation status must be recorded in the appropriate logbook. *See* DOC Regs. ch. 10, pol. 10.1(VI)(E).

* * *

The Department's regulations generally amplify the statutory framework regarding observations. The regulations appear to be consistent with the statutory requirements, with the possible exception of the approval process for admitting a resident into observation status. The statute provides that the superintendent must approve any placement into observation status. *See* 34-A M.R.S.A. §§ 3809(2)(A), 4108(2)(A). The regulations include a delegation of authority from the superintendent to an unspecified delegee. *See* DOC Regs. ch. 10, pol. 10.1(VI)(A)(3). If it is appropriate for a delegated supervisor to approve the placement of a resident in the SMU, rather than the superintendent himself, it might be appropriate to amend the statute accordingly.

III. Comparison of Maine's Restraint and Observation Procedures with International and National Standards and Comparable Policies in Other Jurisdictions.

A. International Standards.

The United Nations General Assembly has adopted several sets of general resolutions related to the treatment of inmates, both adults and juveniles. *See, e.g.*, Standard Minimum Rules for the Administration of Juvenile Justice, United Nations, Resolution 40/33, Nov. 29, 1985 (the "Beijing Rules").

The United Nations has provided standards that apply specifically to the adjudication and incarceration of juveniles. Some of those standards affect the general environment of juvenile correctional facilities, as well as the types of educational and athletic programming made available to juveniles. In general terms, the "objective of training and treatment of juveniles placed in institutions is to provide care, protection, education and vocational skills, with a view to assisting them to assume socially constructive and productive roles in society." Beijing Rules ¶ 26.1. "Juveniles in

institutions shall receive care, protection and all necessary assistance – social, educational, vocational, psychological, medical and physical – that they may require because of their age, sex, and personality and in the interest of their wholesome development." *Id.* ¶ 26.2. Facilities should pay special attention to female residents "as to their personal needs and problems. They shall by no means receive less care, protection, assistance, treatment and training than young male offenders. Their fair treatment shall be ensured." *Id.* ¶ 26.4

The design of juvenile facilities and their physical environments "should be in keeping with the rehabilitative aim of residential treatment, with due regard to the need of the juvenile for privacy, sensory stimuli, opportunities for association with peers and participation in sports, physical exercise and leisure-time activities." Rules for the Protection of Juveniles Deprived of their Liberty, United Nations, Resolution 45/113, Dec. 14, 1990, ¶ 32. Regarding education, "[e]very juvenile of compulsory school age has the right to education suited to his or her needs and abilities and designed to prepare him or her for return to society." *Id.* ¶ 38.

The United Nations has adopted at least two sets of standards on the use of restraints. One of those resolutions addresses the use of restraints on all inmates, both adults and juveniles, and provides the following:

> Instruments of restraint, such as handcuffs, chains, irons and straight-jacket, shall never be applied as a punishment. Furthermore, chains or irons shall not be used as restraints. Other instruments of restraint shall not be used except in the following circumstances:
>
> (a) As a precaution against escape during transfer, provided that they shall be removed when the prisoner appears before a judicial or administrative authority;
>
> (b) On medical grounds by direction of the medical officer;

> (c) By order of the director, if other methods of control fail, in order to prevent a prisoner from injuring himself or others or from damaging property; in such instances the director shall at once consult the medical officer and report to the higher administrative authority.

Standard Minimum Rules for the Treatment of Prisoners, United Nations, Resolution 663C (XXIV), July 31, 1957, and Resolution 2076 (LXII), May 13, 1977, ¶33. Furthermore, the resolution states that "[s]uch instruments must not be applied for any longer time than is strictly necessary." *Id.* ¶ 34.

The United Nations has adopted an additional set of standards on the use of restraints on juveniles in particular.

> Instruments of restraint and force can only be used in exceptional cases, where all other control methods have been exhausted and failed, and only as explicitly authorized and specified by law and regulation. They should not cause humiliation or degradation, and should be used restrictively and only for the shortest possible period of time. By order of the director of the administration, such instruments might be resorted to in order to prevent the juvenile from inflicting self-injury, injuries to others or serious destruction of property. In such instances, the director should at once consult medical and other relevant personnel and report to the higher administrative authority.

Rules for the Protection of Juveniles Deprived of their Liberty, United Nations, Resolution 45/113, Dec. 14, 1990, ¶ 64.

Maine's statutes and regulations on the use of restraints appear to be consistent with the resolutions on use of restraint adopted by the United Nations.

B. National Standards.

1. American Correctional Association.

Founded in 1870 as the National Prison Association, the American Correctional Association ("ACA") is the oldest and largest correctional association in the world. Among other things, the ACA has developed standards and guidelines for the operation

of correctional facilities, as well as a method for accreditation of facilities that comply with the organization's standards.

The ACA has issued a variety of general standards regarding use of restraint and isolation or "special management" of juveniles. According to the ACA standards, juveniles may be placed in a special management status when they "cannot control their assaultive behavior, present a danger to themselves, or ... are in constant danger of being victimized by other juveniles." 3-JTD-3E-01 cmt. (ACA 3d ed.). A "facility administrator or shift supervisor can order immediate placement in a special unit when it is necessary to protect the juvenile from him/herself or others. The action is reviewed within 72 hours by the appropriate authority." 3-JTS-3E-02 (ACA 3d ed.). The ACA standards do impose "a maximum of five days of confinement in a security room for any offense, unless otherwise provided by law." 3-JTS-3E-03 (ACA 3d ed.). Unless "case law and statutes" of a particular jurisdiction permit otherwise, "a maximum of 5 days of disciplinary detention should be considered sufficient for most cases." 3-JTS-3E-03 cmt. (ACA 3d ed.).

Juveniles placed in confinement must be "checked visually by staff at least every 15 minutes and are visited at least once each day by personnel from administrative, clinical, social work, religious, or medical units." 3-JTS-3E-04. An appropriate log must be maintained "recording who authorized the confinement, persons visiting the juvenile, the person authorizing release from confinement, and the time of release." *Id.* Special management housing must be "equipped with plumbing and security furniture." 3-JTS-2C-10 (ACA 3d ed.).

Maine's policies regarding observation status generally are compatible with the ACA's standards. However, the Maine Department's regulations do not impose any outside maximum duration for confinement in the SMU, contrary to the ACA standards. In that respect, Maine's policies are inconsistent with the ACA guidelines on special management status.

The ACA also has issued standards for the use of restraints on juveniles. For instance, "instruments of restraint, such as handcuffs, leg irons, and straightjackets, are never applied as punishment and are applied only with the approval of the facility administrator or designee." 3-JTS-3A-16 (ACA 3d ed.). Furthermore, facilities should maintain "a written record of routine and emergency distribution of restraint equipment." 3-JTS-3A-17 (ACA 3d ed.). All uses of restraints must be "reported in writing, dated and signed by the staff person reporting the incident; the report is placed in the juvenile's case record and reviewed by the facility administrator and/or the parent agency." 3-JTS-3A-18 (ACA 3d ed.).

2. Council of Juvenile Correctional Administrators.

The Council of Juvenile Correctional Administrators ("CJCA") is a national non-profit organization dedicated to the improvement of youth correctional services and practices. CJCA initiates and facilitates the exchange of ideas and philosophies among administrators from a variety of jurisdictions. The CJCA has issued a series of performance-based standards that are tracked at different facilities and compared nationally.

The CJCA has issued standards related to the use of restraints. Under those standards, facilities are expected to train staff on "the use of alternative and de-escalating

methods and techniques prior to the use of restraints." Safety Standard 2, Expected Practices (CJCA Oct. 2003). "Youths are not cuffed to walls, beds, fixtures or fences." Order Standard 2, Expected Practices (CJCA Oct. 2003). Furthermore, "[c]hemical restraints and restraint chair/bed are used only as a last resort following appropriate protocol." *Id.* The CJCA also recommends that facilities have a system "to investigate, review and make recommendations after incidents of disorder." Order Standard 2, Processes (CJCA Oct. 2003).

The CJCA also has set forth standards regarding the use of isolation. "The facility staff must record when youths are held in isolation whether in an individual room or cell or whether it is an isolation/segregation unit or dorm." Order Standard 2, Expected Practices (CJCA Oct. 2003). "All events and incidents resulting in isolation should be examined to determine if isolation could have been avoided or its use shortened." *Id.* The CJCA also recommends that "[f]acility and agency administration make frequent spot checks of isolation rooms and units. These checks are conducted in facility during off-hours inclusive of evenings, holidays and weekends." *Id.* "Isolation is used to neutralize out-of-control behavior and redirect it into positive behavior and should not be used as punishment." Order Standard 2, Processes (CJCA Oct. 2003).

C. **Standards in Other Jurisdictions.**

Regarding the use of restraints on juveniles, most states agree that restraints may only be used if the resident poses an imminent risk of harm to himself or others, is likely to escape or poses a risk to the facility. *See, e.g.*, Ga. Dept. of Juv. Justice Regs., ch. 8, Pol. 8.13(III)(D)(1), (6); N.C. Dept. of Juv. Justice Pol. 10.1(II)(G)(1); Ore. Rev. Stat. Ann. § 169.750.

8.13(III)(F)(7); Tex. Juv. Prob. Comm'n Regs. § 343.60(2)(E), § 343.66. Certain states have imposed a cap on the number of hours that a resident may be placed in the restraint chair within any 24-hour period. *See, e.g.*, Tex. Juv. Prob. Comm'n Regs. § 343.66(1)(E)(iv) (5 hours). Maine does not impose any maximum duration for the use of the restraint chair.

At least one state requires that a juvenile's parents and attorney be notified after the use of any form of restraint. *See* Ore. Rev. Stat. Ann. § 169.740. Some states also limit the number of hours that a resident may be placed in restraints. *See, e.g.*, Ore. Rev. Stat. Ann. § 169.750. Maine's regulations do not impose similar limitations.

At least one state imposes a cap on the number of hours that a juvenile may be placed in a special management unit. *See* Ore. Juv. Detention Facility Guidelines § 3-JDF-2C-09 (6 hours). Maine does not have any such restriction.

IV. Disciplinary Confinement to Unit, Pod or Room.

A. Statutory Provisions.

None.

B. DOC Policies.

For either minor misconduct or major misconduct, a resident may, among other non-restrictive punishments, be given "unit restriction," "pod restriction," or "room restriction."

Unit restriction "means that when the resident is not participating in normal educational and treatment programs and excluding regular bedtime hours, the resident shall report to the resident's housing unit for a specified period of time, during which time the resident has lost the privilege of participating in activities outside the unit, other

than regularly scheduled visits and meals. Time spent on Time Out or in the Special Management Unit shall not count toward restriction time. The resident shall maintain all the privileges associated with activities taking place in the unit." DOC Regs. ch. 15, pol. 15.3(VI)(B)(g).

Pod restriction "means that when the resident is not participating in normal educational and treatment programs and excluding regular bedtime hours, the resident shall report to the resident's housing unit pod for a specified period of time, during which time the resident has lost the privilege of participating in activities outside the pod, other than regularly scheduled visits and meals. Time spent on Time Out or in the Special Management Unit shall not count toward restriction time. The resident shall maintain all the privileges associated with activities taking place in the pod." DOC Regs. ch. 15, pol. 15.3(VI)(B)(h).

Room restriction "means that when the resident is not participating in normal educational and treatment programs and excluding regular bedtime hours, the resident shall report to the resident's room for a specified period of time, during which time the resident has lost the privilege of participating in activities outside the room, other than regularly scheduled visits and meals. Time spent on Time Out or in the Special Management Unit shall not count toward restriction time. While the resident is on Room Restriction, the door shall be closed and the resident must ask permission of a staff person to exit the room for any reason. If the resident exits the room without staff permission, the door may be locked. Staff shall check the resident a minimum of every 15 minutes while the resident is on Room Restriction." DOC Regs. ch. 15, pol. 15.3(VI)(B)(i).

For minor misconduct, the "imposition of Unit Restriction, Pod Restriction, or Room Restriction requires the approval of the resident's unit [JPM] or, in the [JPM's] absence, the [JPS]. If neither is available, the on-duty [FOS] may authorize the restriction." DOC Regs. ch. 15, pol. 15.3(VI)(C)(2)(c). A "description of the incident and consequence shall be made on the Informal Consequence Form," and, if the consequence is not completed immediately, "an entry identifying the resident and the consequence to be completed shall be made on the Consequence Sheet." DOC Regs. ch. 15, pol. 15.3(VI)(C)(2)(e)(4). In addition, unless the resident agrees with the confinement punishment, "the staff person shall complete a Misconduct Report." DOC Regs. ch. 15, pol. 15.3(VI)(E)(1). The misconduct report shall be forwarded to the FOS, who then sends it to the Deputy Superintendent or designee. The FOS provides a written notice of the alleged violation to the resident within 24 hours of the alleged violation. DOC Regs. ch. 15, pol. 15.3(VI)(E)(1)(b). The resident may either agree with the proposed confinement, through informal resolution, or the matter will be referred to the formal disciplinary process. DOC Regs. ch. 15, pol. 15.3(VI)(C)(2)(d).

For major misconduct, the staff person "shall complete a Misconduct Report." DOC Regs. ch. 15, pol. 15.3(VI)(E)(1). The misconduct report shall be forwarded to the FOS, who then sends it to the Deputy Superintendent or designee. The FOS provides a written notice of the alleged violation to the resident within 24 hours of the alleged violation. DOC Regs. ch. 15, pol. 15.3(VI)(E)(1)(b).

"A resident shall not be placed in the Special Management Unit pending investigation, hearing, or review or appeal of an alleged violation," unless the resident independently qualifies for observation status.

The misconduct report shall be forwarded to the FOS, who then sends it to the Deputy Superintendent or designee. The FOS provides a written notice of the alleged violation to the resident within 24 hours of the alleged violation. DOC Regs. ch. 15, pol. 15.3(VI)(E)(1)(e). An investigation is commenced within 1 day by a staff person not involved in the incident. DOC Regs. ch. 15, pol. 15.3(VI)(E)(1)(f). A complete investigation report is forwarded to the Deputy Superintendent of Operations or designee, at which point the matter is scheduled for a violation hearing, unless the resident agrees to an informal resolution. DOC Regs. ch. 15, pol. 15.3(VI)(E)(1)(g), (h). If a hearing goes forward, a hearing is held within 3 business days following receipt of the investigative report. DOC Regs. ch. 15, pol. 15.3(VI)(E)(1)(i). The resident must be given at least 24 hours notice of the hearing. DOC Regs. ch. 15, pol. 15.3(VI)(E)(1)(j). A decision is to be rendered within 24 hours of the completion of the hearing. DOC Regs. ch. 15, pol. 15.3(VI)(E)(1)(q). The resident may waive the right to an appeal, at which point the Superintendent or his designee reviews the disposition and approves of it. DOC Regs. ch. 15, pol. 15.3(VI)(E)(1)(r). If the resident does not waive the right to an appeal, the resident may appeal within 15 days. DOC Regs. ch. 15, pol. 15.3(VI)(E)(1)(s). The Superintendent or designee must decide the appeal within 30 days. DOC Regs. ch. 15, pol. 15.3(VI)(E)(1)(t).

IV. Time Outs.

A. Statutory Provisions.

None.

B. **DOC Policies.**

"The temporary separation of a resident from any program or activity to aid the resident regaining behavioral control or composure is considered a time out. A time out shall take place in the least restrictive setting and only for the period of time necessary for the resident to regain behavioral control and return to normal programs and/or activities." DOC Regs. ch. 15, pol. 15.5(III).

"Any staff member may temporarily place a resident on time out, when in the staff's opinion it is necessary to separate the resident from any program/activity because the resident is agitated and is in danger of escalation of behavior that may cause harm to self or other or may disrupt the program or activity in which the resident is engaged. A time out is not a punishment for inappropriate behavior but is only a tool to aid the resident in controlling or calming their own behavior." DOC Regs. ch. 15, pol. 15.5(VI)(A)(1).

"The staff making the decision to employ time out shall decide the degree of time out separation ... based on the nature of the problem, the resident's acceptance of the plan, and other factors leading up to the decision to impose the time out." DOC Regs. ch. 15, pol. 15.5(VI)(A)(3).

"The staff making the decision to employ time out shall decide the length of time out based on the resident's ability to regain control of behavior, but time out shall not exceed one hour without authorization of the supervisor responsible for the program/activity where the incident occurred. Time outs over one hour in a housing unit must be approved by either the unit [JPM] or a [FOS]." DOC Regs. ch. 15, pol. 15.5(VI)(A)(4).

"Any time a time out is imposed, it shall be documented on the resident's Daily Behavior Card by the staff that placed the resident on time out. Staff shall ensure the time out is also documented on the resident's Daily Progress Notes." DOC Regs. ch. 15, pol. 15.5(VI)(A)(7).

"Staff shall not lock a resident into a room during a time out or otherwise use physical means to keep the resident in the room during a time out, unless the resident's behavior escalates to the point that there is a high likelihood of imminent harm to self or others, or a substantial and imminent threat of destruction of property. In that case, the resident shall be considered for placement in the Special Management Unit. While authorization for placement is being sought and arrangements for escort to the Special Management Unit are being made, physical means, including locking the door, may be used to keep the resident in a room." DOC Regs. ch. 15, pol. 15.5(VI)(A)(8).

The "time out with the lowest degree of separation involves directing the resident to cease the program/activity and locating the resident in close proximity to and under the observation of staff (e.g., seated in the same general area but apart from other residents). Generally, these are short periods of 5-10 minute duration, do not involve the removal of the resident from the program/activity area, and when behavior control is achieved the resident usually is allowed to resume the program/activity." DOC Regs. ch. 15, pol. 15.5(VI)(B)(1).

"A resident's room may be used as a time out area when in the opinion of staff other less restrictive means have been or would be ineffective." DOC Regs. ch. 15, pol. 15.5(VI)(C)(1). Staff "may need to temporarily remove items to ensure the resident's

safety or the safety of others or to prevent the destruction of property." DOC Regs. ch. 15, pol. 15.5(VI)(C)(2).

"A specialized time out room or other area may be used when in the opinion of staff other less restrictive means have been or would be ineffective." DOC Regs. ch. 15, pol. 15.5(VI)(D)(1). "While in a specialized time out room, the resident shall be under constant monitoring by staff." DOC Regs. ch. 15, pol. 15.5(VI)(D)(2).

ATTACHMENT D

Mental Health Issues in Juvenile Corrections

Psychiatric Grand Rounds

May 2, 2003

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Mountain View Youth Development Center

- Juvenile Detention facility opened five years ago
- New construction done and first committed youths received in February, 2002
- Mental Health Staff include one psychiatrist, three psychologists, and seven social workers who have some mental health functions

Readily visible mental health problems include:

- Self-harm – suicidal and self-injurious behavior
- Anger control – irritability, explosiveness
- Psychotic and post-traumatic stress symptoms

Conceptualization of mental health problems in incarcerated youths

- As mental illness or psychiatric disorder
- As developmental disorder, with failure to develop self-regulation of attention, emotion and action
- These are not mutually exclusive, and each guides different and complementary approaches

Prevalence of Psychiatric Diagnoses in General Adolescent Population and Juvenile Justice Populations (from Juvenile Offenders with Mental Health Disorders, by Lisa Boesky, ACA, 2002)

Diagnosis	% in General Population	% in Juvenile Justice Samples
Mood disorders	5-9	10-88
ADHD	3-7	2-76
Learning disorders	4-9	36-53
Mental Retardation	1	13
PTSD and anxiety	6	5-49
Conduct disorder	1-10	32-100
Psychotic disorders	.5-5	1-16
Substance abuse/dependence	5.5-9	46-88

Data Describing MVYDC Residents

- N = 72 (retrospective chart review)
- 65 males, 7 females (in facility, about 10% of residents are female)
- 70 admitted since MVYDC opened, 2 transferred from LCYDC
- Average age 16.5
- If data missing for > 25% of cases, presented as a range – (e.g., 36-66%) - low number assumes variable applies for no missing cases, high number assumes variable applies in same proportion

Mental Health Treatment Prior to Commitment (N=72)

- History of mental health evaluations, 91%
- Diagnoses given in community:
- Conduct disorder, 45%
- ODD, 29%
- ADHD 22%
- Mood disorders, 40%
- Anxiety disorders, 22%
- Substance Abuse disorders, 37%
- Learning disabilities, 17%

Community Mental Health Treatment, cont'd.

- Suicidal ideation only 15%
- Suicidal ideation with plan, 6%
- Suicide attempts, 22%
- History of destruction of property, 51-76%
- History of fighting and aggression vs. persons, 89%

Community Mental Health Treatment, cont'd.

- Individual counseling, 72%
- Family counseling, 13%
- Psychiatric hospitalization, 30%
- Psychiatric day treatment, 2%
- Psychotropic medications, 82%
- Substance abuse treatment, 51%

Psychiatric symptoms in initial MVYDC evaluation

- Irritability/ anger control, 94%
- Mood swings, lability, 87%
- Attention & concentration problems, 85%
- Oppositional features, 82%
- Sadness, grief, 67%
- Anxiety, 60%
- Sleep disturbance, 69%
- Somatic complaints, 36%

Psychiatric symptoms in initial MVYDC evaluation, cont'd.

- Suicidal ideation (since commitment), 18%
- Suicidal ideation with plan, 18%
- Thoughts of self-injury, 30%
- History of hypomanic episodes, 22%
- History of fire setting, 22%
- History of hallucinations, 13%
- Current PTSD symptoms, 14%

Substance Abuse History

- Total substance-related diagnoses, 75%
- Substance abuse diagnoses, 16%
- Substance dependence diagnoses, 58%
- Average age at first alcohol use, 12.4
- Average age at first marijuana use, 11.8
- Daily marijuana use in past, 59-88%
- Daily alcohol use in past, 31-54%
- Blackouts or alcohol poisoning, 32-67%
- Substance use contributed to offenses, 53-87%

History of School Problems

- Special education for academics, 36%
- Special education for behavior, 52%
- History of suspensions or expulsions, 58-93%
- History of learning problems in English, reading or spelling, 50%

Referrals for Treatment at MVYDC

- Substance abuse treatment, 85%
- Individual psychotherapy, 73%
- Family therapy, 57%
- Psychotropic medication, 78%

Frequency of Problems in Early Development

- Developmental delays, 17%
- Speech delay, 14-19%
- Frequent tantrums, 14-33%
- "Hyper", high energy, 32-64%

- History of closed head injury with loss of consciousness, 33-51%

Parents' Behavioral Issues

- Substance abusing, 54-95%
- One or both with diagnosable mental illness, 36-93%
- One or both with history of felonies, 25-67%
- One or both with history of assaults, 18-59%

Parental Bond Issues

- Parents not married when born, 30%
- Parents not together at time of commitment, 81%
- Youth living with father at time of commitment, 16%
- Father left before birth, 16%
- Father left before age 4, 60%

Experience of Abuse

- Emotional abuse, 67%
- Physical abuse, 59%
- Sexual abuse, 29% (boys 23%, girls 83%)
- Witnessed abuse at home, 38-66%

DHS Involvement and Out of Home Placement

- History of DHS Investigations of home, 57%
- History of DHS custody of resident, 34%
- Current DHS custody, 15%

- History of foster care placement, 29%
- History of group home placement, 27%
- History of residential treatment, 18%

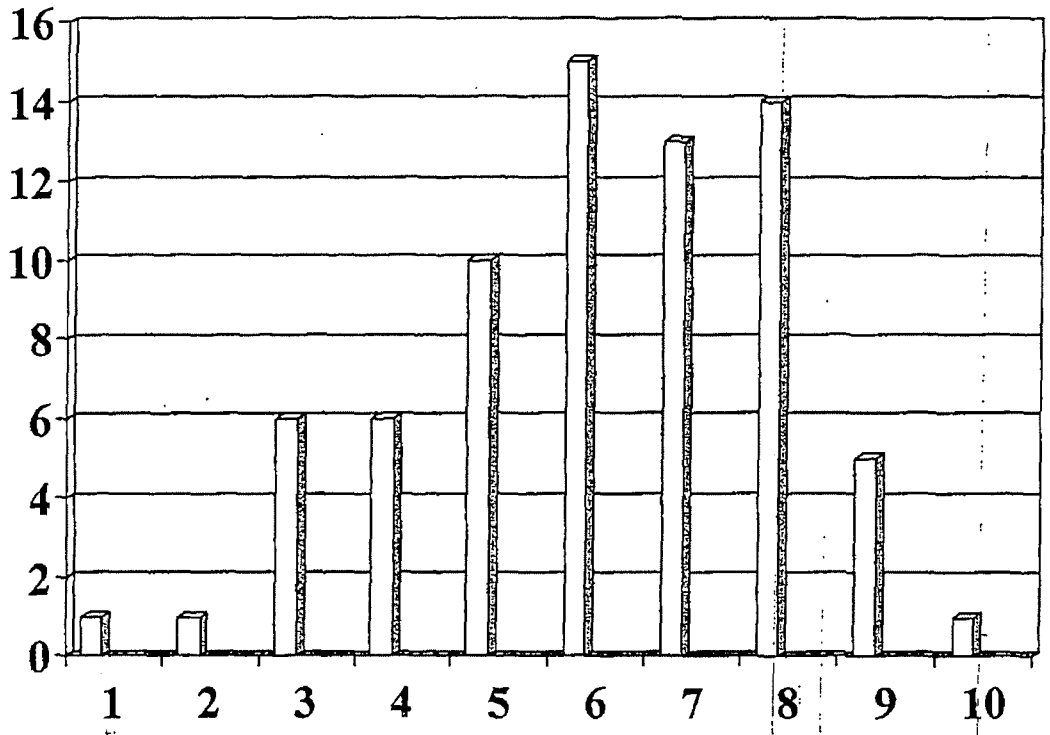
Risk Factors for Behavioral/psychiatric disturbance

- Perinatal problems
- Developmental delays
- Early temperament – frequent tantrums or "hyper"
- Neurological – seizures, head injury with LOC
- Language or academic problems
- Loss of parent – divorce, death
- Emotional, physical or sexual abuse

Risk Factors, cont'd.

- Substance abuse or dependence
- Parents' behavior problems – arrests, substance abuse, mental illness
- History of parental neglect
- History of placement outside home – foster home, group home, residential treatment

Frequency of Risk Factors in MVYDC Residents



Relation of these Statistics to Developmental Disorders

- Problems from "nature" – heredity, speech and learning problems, "hyperness", head injuries
- Problems from "nurture" – inconsistent and abusive parenting, major losses and failures, negative role models

Developmental Disorders, cont'd.

These factors result in:

- problems with trust and attachment
- learning that few or no limits apply
- self-centered and aggressive responses to stress

Developmental Disorders, cont'd.

- Poor self-regulation – not internalizing controls from caretakers, in selective inhibition of attention, emotion and action – little cognitive mediation between stimulus and response
- Manifest in psychiatric syndromes – attention deficit disorders, mood disorders, and conduct disorders, with high co-morbidity
- Substance abuse is both cause and result – self-medication and further disinhibiting action

Why are they in Correctional and not Mental Health System?

- More severe or chronic offenses
- Lack adequate connection to MH system – acting out obscures other issues, may not make or sustain connection to mental health providers
- Treatment not available in community – lack of appropriate community-based programs, skill-building treatments, step down (halfway house) facilities

Corrections is the Mental Health Provider of Last Resort

- Youths who assault in a mental health setting come to Corrections – "The juvenile justice system has become the default placement for many youth with mental health disorders who are not receiving appropriate psychological and psychiatric treatment in the community" Boesky, 2002

Comparison of Acadia Inpatients and MVYDC Residents

On MMPI-A, some scales similar, but some differences evident –

Acadia inpatients report more depression, anxiety, social withdrawal, and schizoid features

MVYDC residents show somewhat more defensiveness and conduct disorder features

Addressing MH Needs in Institutions, cont'd.

- Individual and family therapy work, by facility clinical staff and contracted agency (Sweetser)
- Psychiatric care – medications, and facilitating hospitalization when appropriate
- Substance abuse treatment by contracted agency (Day One)
- Educational programs centered around hands-on experience

Addressing Mental Health Needs in the Institutions

- Structured program, involving clear and consistent rules and limits, with reinforcement for pro-social behavior
- "Cognitive skills" groups, teaching understanding of emotions, anger management and conflict resolution, basic social skills, thinking and decision-making, and other basic life skills

What's Needed?

- Develop a professional identity and culture in facilities that combines correctional and therapeutic goals and values
- Improve transition from institution to community, including case management to connect to community services, step down residential programs, further developing "Cog skills" curriculum and implementing it statewide before, during and after incarceration
- Improve assessment and screening, treatment, case management and alternative placements for detained youths

ATTACHMENT E

MAINE YOUTH CORRECTIONS REVIEW
DOCUMENTS REVIEWED

DESCRIPTION OF DOCUMENTS
ACA
ACA Report by Dupree (11/16/98)
ACA accreditation reports/data
ACA Standard: Juvenile Training School
ACA Standard Supplement
ACA Standard: Juvenile Movement
ACA Accreditation Reports / data
American Academy of Child & Adolescent Psychiatry Documents
Recommendations for Juvenile Justice Reform (October 2001)
Article: Restraint and seclusion: a review of the literature (1994)
Standards for Seclusion/Restraint for Behavioral Management: May 2000
Amnesty International Correspondence
7/22/98 letter from Amnesty International to Governor King
8/6/98 letter from Commissioner Magnussen to Amnesty International
8/14/98 letter from Amnesty International to Governor King
8/14/98 letter from Amnesty International to Commissioner Magnussen
1/15/03 letter from Amnesty International to Commissioner Magnussen
1/23/03 letter from Commissioner Magnussen to Amnesty International
3/5/03 letter from Commissioner Magnussen to Amnesty International
Board of Visitors
Long Creek and Mountain View Board of Visitors contact information
Dr. Judy Burke Documents
Mountain View: Individual Confinement/Isolation Event Record
Y-66 Therapeutic Restraints (essential)

MAINE YOUTH CORRECTIONS REVIEW
DOCUMENTS REVIEWED

DESCRIPTION OF DOCUMENTS
Mountain View: Administrative Restriction & UTT Review form
PbS Project Glossary
PbS Incident Report
CJCA
Standards/policies and procedures for isolation and restraint
Goals, Standards, Outcome Measures, Expected Practices and Processes (October 2003)
DOC Other Documents
DOC Division of Juvenile Services – Report for 2001-2002
DOC web page for Mountain View facility
Documents re: Correctional Best Practices: A summary of key what works concepts and principles. A Theoretical & Practice Approach Training Seminar Building capacity for applying the what works research. Division Plan for Effective Correctional Mgmt. Letter to Ralph Lancaster 1/8/04 Memo re performance management form 4/30/03 Memo to All RCAs Juvenile Division dated 1/29/01 Motivational Interviewing Moving from Correctional Program to Correctional Strategy: Using Proven Practices to Change Criminal Behavior TA #20C5045 Technical Assistance Report
Advocate Eve Richardson 3/31/98 memo and data
Mountain View Resident Handbook
Powerpoint Presentation: Juvenile Corrections (7/03)

MAINE YOUTH CORRECTIONS REVIEW
DOCUMENTS REVIEWED

DESCRIPTION OF DOCUMENTS
DOC Policies and Procedures
Extension of Residents Within the Intense Care Unit (4/3/97)
Long Creek Memo from Lars Olsen re: Behavior Stabilization Protocol (5/14/03)
Long Creek: Behavior Stabilization Protocol (5/14/03)
Mary Ann Saar memo (10/30/03)
Mary Ann Saar's files
Mountain View: Acute Care Program
Mountain View: Memo: SMU Placement (6/10/03)
Mountain View: Resident Intensive Supervision Program Review (11/13/03)
Mountain View: Resident Intensive Supervision Program Review (11/13/03)
Mountain View: Risk Assessment (10/14/03)
Mountain View: Sue Righthand Consultation Report (11/19/03)
Personnel Observing A Resident in the Restraint Chair (1/3/98)
Policy 9.13J: Use of Mechanical Restraints on Residents in the Intensive Care Unit (7/15/88)
Policy 9.15: Use of Mechanical Restraints (5/1/02)
Policy 9.17: Transport of Residents (2/1/02)
Policy 9.18: Use of Force, General Guidelines (2/1/02)
Policy 10.1: Risk Behavior Modification (draft)
Policy 10.1: Special Management Residents (5/13/97) Updated (12/3/03)
Policy 10.1, 10.2J: Supervision of Special Management Residents (7/15/88)
Policy 10.1J, 10.2J: Supervision of Special Management Residents (3/10/89)
Policy 10.4: Suicide Prevention Procedures (7/29/97)
Policy 10.5: Procedures on the Use of Mechanical Restraints (10/20/92)
Policy 10.5: Use of Mechanical Restraints on Special Management Residents (4/25/97)
Policy 15.1: Behavior Reinforcement, Redirection and Modification (02/01/02)
Policy 15.2: Behavior Motivation Program (02/01/02)
Policy 15.3: Resident Discipline System (07/30/02)

MAINE YOUTH CORRECTIONS REVIEW
DOCUMENTS REVIEWED

DESCRIPTION OF DOCUMENTS
Policy 15.4: Drug and Alcohol Testing of Juvenile Clients (07/09/02)
Policy 15.5: Time Out for Behavior Control (02/01/02)
Policy 23.1: Allegations of Abuse or Neglect (2/1/02)
Policy Group Files
Resident Housing Unit Oak: Behavior Stabilization Plan
Restraint Documentation (8/21/96)
Restraint Procedure (9/9/95)
Section 17: Mechanical Restraint Policy for Residents Assigned to Seclusion (3/86)
Special Management Residents, Procedure CF: Suicide procedures (undated)
Unit Mission statements (Mountain View and Long Creek)
Use of Mechanical Restraints on Special Management Clients (1/7/94)
Use of Mechanical Restraints (3/11/96)
Use of Mechanical Restraints (3/28/96)
DOC Policies and Procedures - Development
Development matrix
Juvenile Services Transition Organization
Overview of materials
Redline versions of various policies
Joint Standing Committee on Criminal Justice
Letter to JSCCJ (10/2/98)
Letter to JSCCJ (11/19/98)
Juvenile Information
Complaints of abuse/investigation files (Reviewed at DOC Central Office)

MAINE YOUTH CORRECTIONS REVIEW
DOCUMENTS REVIEWED

DESCRIPTION OF DOCUMENTS
Long Creek Forms
Restraint Documentation
Consequence Log
Misconduct Report
Notice of Violation Hearing
Notice of Alleged Rule Violations
Violation Hearing Report
Violation Hearing Appeal
Informal Consequence Form
Resident Time-Out
Observation Report
Long Creek Management Review Documents
LCYDC Management Review
Minutes: Management, Mental Health & Security 11/4/03 – Review of Sanctions and Privileges
Long Creek Other Documents
Long Creek: Memo to AFSCME Local 2968-01 Membership from McCormick (8/12/03)
Loughran, Edward Documents
Consulting Agreement
2/22/99 Report
4/7/00 Report
12/11/00 Report
9/21/01 Report

MAINE YOUTH CORRECTIONS REVIEW
DOCUMENTS REVIEWED

DESCRIPTION OF DOCUMENTS
Dr. Steve McKay Documents
Interdisciplinary Mental Health Meeting minutes 5/02 – 10/02; 12/2/03
Memos
Senior Mental Health Advisory Meeting minutes
Initial Special Management Placement form
Frequency Table – Number of SMU stays
Mental Health Issues in Juvenile Corrections – Psychiatric Grand rounds May 2, 2003
Mountain View Documents
Acute Care Program
Documents re: SMU Placements:
Memo (1/03): Use of Force
Memo (2/3/03): Restraint Chair Use 2002
Memo (6/10/03): SMU Placement
Resident In Room Log C-Unit
SMU Placement
Handwritten notes re 72 hour shock sentence
Interdisciplinary Mental Health Meeting minutes
List of Employees
Memo (10/16/02): Changes in disciplinary process
Memo (3/3/03): Room Confinement Time (Draft)
Memo (6/10/03): SMU Placement
Memo (10/8/03): Staff Safety
Memo (10/31/03): Use of Force numbers
Memo (11/6/03): Assault numbers
Resident Intensive Supervision Program Review 11/13/03

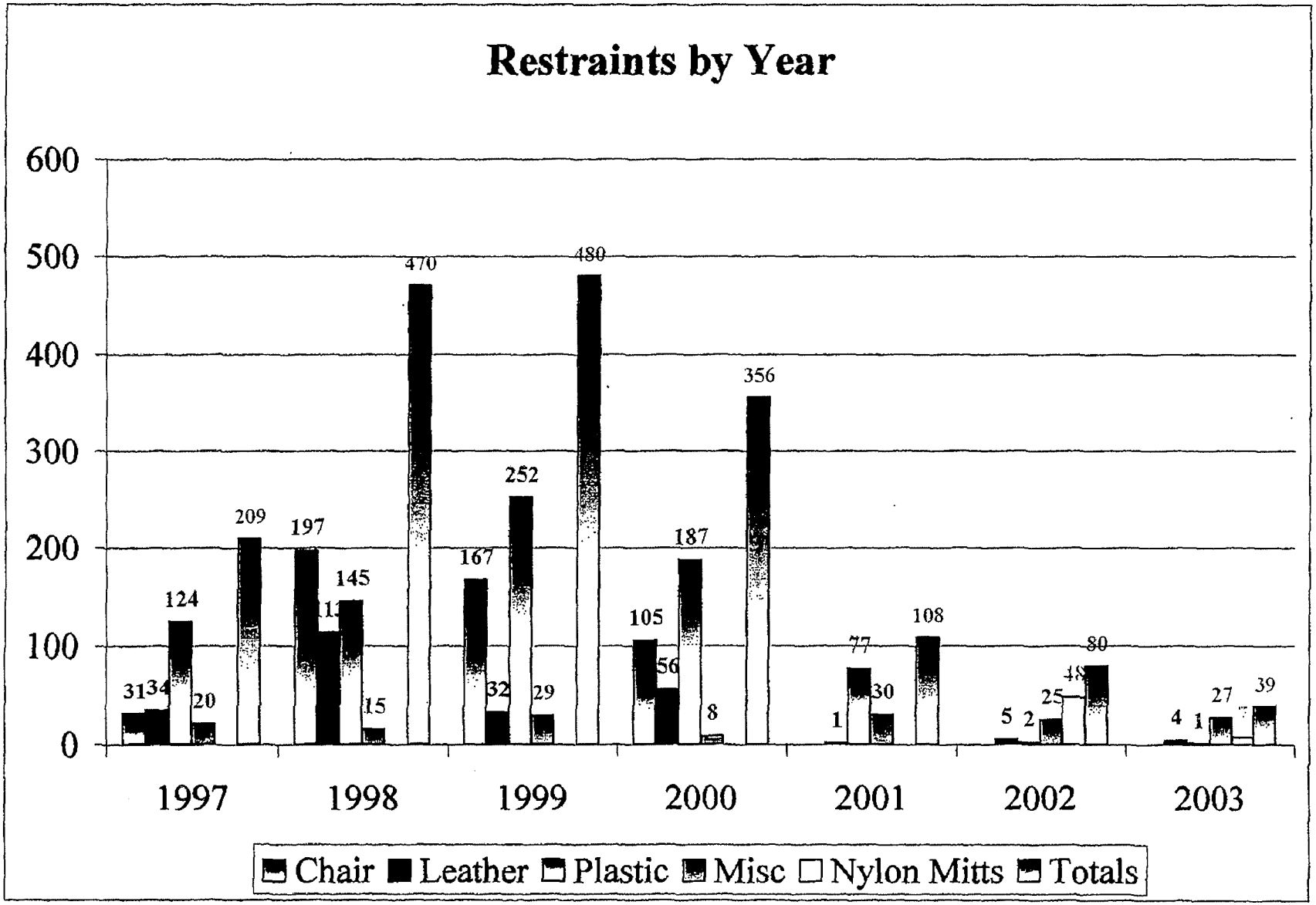
MAINE YOUTH CORRECTIONS REVIEW
DOCUMENTS REVIEWED

DESCRIPTION OF DOCUMENTS
Organizational Charts/Rosters
Long Creek Organizational Chart
Long Creek Employee Roster
Mountain View Organizational Chart
Mountain View Employee Roster
Dept. of Corrections Central Office
Other Documents
Mainely Girls Report
Sweetser: Long Creek – Juvenile Offender Treatment Program
Other Jurisdiction Standards
Other State standards:
Florida: Detention Screening (10/1/02)
Florida: Protective Action Response (PAR) Policy 6/1/01
Georgia: Use of Force (5/1/03)
Maryland: juvenile training development
North Carolina: Use of Force Directive (4/17/03)
Oregon: Juvenile Detention Facility Guidelines (10/01)
Texas: Standards for Secure Pre-Adjudication Detention and Post-Adjudication Correctional Facilities (9/1/03)
Virginia: Standards for Interdepartmental Regulation of Children's Residential Facilities (7/1/00)
UN Rules for the Protection of Juveniles Deprived of Their Liberty, Rules 53, 77 etc
UN Standard Minimum Rules for the Treatment of Prisoners
UN Standard Minimum Rules for the Administration of Juvenile Justice

MAINE YOUTH CORRECTIONS REVIEW
DOCUMENTS REVIEWED

DESCRIPTION OF DOCUMENTS
PBS Documents and Data
Performance standard reports and data (April and October annually since 2000)
PbS Introductory Guide April 2003
PbS Report – Long Creek Final Site Report April 2003: Committed Corrections Detention
PbS Report – Mountain View Final Full Site Report April 2003: A/O Unit Detention Girls Unit High Risk Unit
PbS Glossary October 2003
PbS Data Collection – October 2003 projections - Committed
PbS Report – Long Creek Final Site Report October 2003
PbS Report – Mountain View Final Site Report October 2003: Girl's Unit Assessment Detention Unit Moderate Custody High Custody
PbS Forms: Administrative Form Youth Record Incident Report Instructions Staff Climate Survey Informed Consent Information Sheet Youth Climate Survey Assent Information Sheet Youth Exit Survey Assent Form

ATTACHMENT F


Restraints by Year
600
500
400
300
200
100
0
1997
1998
1999
2000
2001
2002
2003
Chair
Leather
Plastic
Misc
Nylon Mitts
Totals

ATTACHMENT G

RESTRAINT DOCUMENTATION

Name of Resident: _____ Housing Unit: _____
Room #: _____
Date: _____

1. A list of the less restrictive alternatives that were used prior to restraining the resident and, if no less restrictive alternative was used, why not:

_____
_____
_____
_____

2. A description of the behavior posing a real and immediate threat to safety of self or others or to security (as shown by stated intention, recent conduct or other factors) which necessitated the use of restraints:

_____
_____
_____
_____
_____

3. The name and title of the person who authorized the use of restraints and the precise time at which restraints were applied:

Name and Title: _____ Time: _____

4. If authorization is by the Juvenile Facility Operations Supervisor, name and title of the person approving the authorization:

Name and Title: _____

5. The name(s), signature(s), and title(s) of any person(s) who applied the restraints:

_____
_____
_____

6. The name(s), signature(s) and title(s) of any other person(s) who were present when the resident was placed in restraints:

_____
_____
_____

7. The name, signature and title of the person operating the video equipment:

_____

_____

8. A description of the type(s) of restraints in which the resident was placed and parts of body restrained:

_____

_____

_____

_____

_____

_____

9. Description of any force used to apply restraints: _____

_____

_____

_____

_____

10. Two finger check of restraint equipment: _____

11. The name(s), signature(s) and title(s) of the person(s) responsible for monitoring the resident while in restraints:

_____

_____

_____

12. Facility medical staff notified – By: _____ Time: _____
Name & Title

13. Name, signature and title of facility medical staff examining the resident and restraints and the precise time at which the examination took place:

_____ _____ _____
Name and Title Signature Time

Comments: _____

_____

_____

_____

_____

_____

_____

_____

14. A detailed running description of the resident's behavior while in restraints (maximum of ten-minute time frames):

A. 0-10 minutes: _____

B. 10-20 minutes: _____

C. 20-30 minutes: _____

15. If necessary, request extension for use of restraints and provide detailed rationale for extension: _____

Name, signature and title of person requesting extension:

_____ _____

Name & Title Signature

Name and title of person authorizing continued use of restraints, the reasons for authorization and the precise time at which authorization was given: _____

_____ _____

Name & Title Time

16. Description of behavior during first extension:

A. 30-40 minutes: _____

B. 40-50 minutes: _____

C. 50-60 minutes: _____

17. If necessary, request additional extension for use of restraints and provide detailed rationale for extension: _____

Name, signature and title of person requesting additional extension

_____ _____

Name and title Signature

Name and title of person authorizing continued use of restraints, the reasons for authorization and the precise time at which authorization was given: _____

_____ _____

Name and title Time

18. Description of behavior during additional extension, to include removal of restraints, one limb at a time, for circulation (maximum of ten-minute time frames, using precise times):

Time: _____ _____

Time: _____ _____

Time: _____ _____

Use additional sheets as necessary.

19. If applicable, notification to the Juvenile Facility Operations Supervisor of resident's possible sincere commitment and description of visit by Juvenile Facility Operations Supervisor with the resident.

Name of JFOS: _____ Time of Visit: _____

20. Reasons for removal of restraints: _____

Name and title of person authorizing removal of restraints and the precise time authorization was given:

_____ _____
Name and Title Time

21. The date, time and signature of the staff who completed the report:

Date: _____
Time: _____ Signature: _____

ADDITIONAL SHEET

If necessary, request additional extension for use of restraints and provide detailed rationale for extension: _____

_____

_____

_____

_____

Name, signature and title of person requesting additional extension

_____ _____

Name and title Signature

Name and title of person authorizing continued use of restraints, the reasons for authorization and the precise time at which authorization was given: _____

_____

_____

_____

_____ _____

Name and title Time

Description of behavior during additional extension, to include removal of restraints, one limb at a time, for circulation (maximum of ten-minute time frames, using precise times):

Time: _____ _____

_____

_____

_____

Time: _____ _____

_____

_____

_____

Time: _____ _____

_____

_____

_____

ATTACHMENT H

Use of Force

Record No.

Resident Last _____ *Resident First* _____ *DOB* _____

Incident Date _____ *Incident Time* _____ *Unit* _____

Resident Injuries ☐ *Additional report in Med. Dept.* *Photo* ☐

Restraints Used *length of time each used on resident*

☐ *Handcuff*		☐ *Leg Restraints*		☐ *Video*	☐ *Camera*
☐ *Chair*		☐ *Mitts*		☐ *Other*	
☐ *Flex Cuffs*		☐ *Spit Mask*			

Surveillance Equipment

Description of Incident

Witnesses

Staff Involved

Notifications made: *check if yes*

Signature _____

		contact made @			*contact made @*
Superintendent	☐		*JPM*	☐	
Criminal Invst	☐		*Medical*	☐	
Other	☐		*Deputy Supr*	☐	

cc:

ATTACHMENT I

CCS: 18
(Rev. 8/03)

Department of Corrections, Division of Juvenile Services
Long Creek Youth Development Center

OBSERVATION REPORT DATE: _____

RESIDENT: _____ RESIDENT UNIT: _____

OBSERVATION UNIT: _____ RECEIVING OFFICER: _____

AUTHORIZING ADMINISTRATOR: _____ AUTHORIZING JFOS: _____

DATE & TIME ADMITTED: _____ DATE & TIME RELEASED: _____

	INITIAL		INITIAL		INITIAL		INITIAL		INITIAL
							SHOWER		
							TIME/INITIALS		
							ROOM INSPECTION		
							TIME/INITIALS		

MEDICATION (Prescribed) : _____

TIME OF: Breakfast _____ Lunch _____ Dinner _____ Snack _____

OUT OF ROOM FOR	OUT	IN	OUT	IN

D-1, 2, 3

CCS: 18
(Rev. 8/03)

Department of Corrections, Division of Juvenile Services
Long Creek Youth Development Center

STAFF VISITS AND RESIDENT ACTIVITIES

Juvenile Facility Operations Supervisor	TIME IN	TIME OUT	REMARKS

HOUSING UNIT STAFF:

CHAPLAIN:

PSYCHOLOGIST:

SOCIAL WORKER:

JUVENILE PROGRAM MANAGER:

NURSE:

OTHER:

PLACEMENT REVIEW

DATE	TIME	COMMENT	INITIALS

MAJOR MUSCLE EXERCISE TIME OUT: TIME IN:

ATTACHMENT J

SMU PLACEMENT

RESIDENT	DATE IN	TIME IN	REASON	AUTHORIZED	DATE OUT	TIME OUT

ATTACHMENT K

Initial Special Management Placement

Resident's Name _____ ID # _____ From Housing Unit _____

Initial Placement: Supervisor Authorizing:

Date _____ Time _____ Signature/Title _____

➢ Notification of Medical staff: within *15 minutes* of initial placement. Medical will contact the on call staff person for Mental Health. Documented @ Medical Dept.

Reason for placement: *after choosing check box – document brief explanation* – if available reference incident report number.

☐ Suicidal: ☐ Self-injurious: ☐ Detox: ☐ Escape Risk: ☐ Serious destruction of property:
☐ Threatening Others: ☐ Assaultive: ☐ Assaulted/Threatened by others:

➢ Placement review – must be reviewed at a minimum of *every *two hours* from time of initial placement.

Date/reviewed _____ Time/reviewed _____ Initials _____ Title _____

Continues to be – *provide brief documentation below*
☐ Threat to self
☐ Threat to others
☐ Suicidal/self-injurious
☐ Escape risk
☐ Other:

Supervisor reviewed – initial/date _____

***If the resident remains in SMU for longer than *two hours*, notify Deputy Superintendent**

Time of initial notification to Dep. Supt. _____ Contact made @ _____ Contacted by: initials/title _____

Date/reviewed _____ Time/reviewed _____ Initials _____ Title _____

Continues to be – *provide brief documentation below*
☐ Threat to self
☐ Threat to others
☐ Suicidal/self-injurious
☐ Escape risk
☐ Other:

Supervisor reviewed – initial/date _____

Date/reviewed _____ Time/reviewed _____ Initials _____ Title _____

Continues to be – *provide brief documentation below*
☐ Threat to self
☐ Threat to others
☐ Suicidal/self-injurious
☐ Escape risk
☐ Other:

Supervisor reviewed – initial/date _____

** Use back of this page for additional SMU review documentation*

Special Management Unit – checks

Date/reviewed Time/reviewed

Initials Title

Continues to be – *provide brief documentation below*
- ☐ Threat to self
- ☐ Threat to others
- ☐ Suicidal/self-injurious
- ☐ Escape risk
- ☐ Other:

Supervisor reviewed – initial/date

Date/reviewed Time/reviewed

Initials Title

Continues to be – *provide brief documentation below*
- ☐ Threat to self
- ☐ Threat to others
- ☐ Suicidal/self-injurious
- ☐ Escape risk
- ☐ Other:

Supervisor reviewed – initial/date

Date/reviewed Time/reviewed

Initials Title

Continues to be – *provide brief documentation below*
- ☐ Threat to self
- ☐ Threat to others
- ☐ Suicidal/self-injurious
- ☐ Escape risk
- ☐ Other:

Supervisor reviewed – initial/date

Date/reviewed Time/reviewed

Initials Title

Continues to be – *provide brief documentation below*
- ☐ Threat to self
- ☐ Threat to others
- ☐ Suicidal/self-injurious
- ☐ Escape risk
- ☐ Other:

Supervisor reviewed – initial/date

Date/reviewed Time/reviewed

Initials Title

Continues to be – *provide brief documentation below*
- ☐ Threat to self
- ☐ Threat to others
- ☐ Suicidal/self-injurious
- ☐ Escape risk
- ☐ Other:

Supervisor reviewed – initial/date

Release from SMU: Date Time of release

Administrative Restriction & UTT Review

Administration Restrictions – *as needed* – (in documentation reference logs, reports, UTT, if available)

Part A	**Restriction Assigned**
	☐ Unit restriction: ☐ Pod restriction: ☐ Room restriction: ☐ Other:
	Reasons for restriction:

Restriction assigned by: signature/title

1st Review date, no later than

Part B	**Restriction Review**
	Disposition: ☐ End restriction: ☐ Continue restriction (Provide rationale, who, what, where)

Review of restriction: _____ _____ _____

Date: Reviewed by: Signature/Title Next review date:

**Use back of this page for additional administrative restriction review documentation.*

UTT Review

UTT members present:

☐ Case Plan changed as follows:

☐ Case Plan Unchanged:

_____ _____ _____

Date Time of UTT review Signature UTT Member/Title

Administration Restrictions – *as needed* – (in documentation reference logs, reports, UTT, if available)

Restriction Assigned

Part A

☐ Unit restriction: ☐ Pod restriction: ☐ Room restriction: ☐ Other:

Reasons for restriction:

Restriction assigned by: signature/title

1st Review date, no later than

Restriction Review

Part B

Disposition: ☐ End restriction: ☐ Continue restriction (Provide rationale, who, what, where)

Review of restriction:

Date: Reviewed by: Signature/Title Next review date:

Restriction Assigned

Part A

☐ Unit restriction: ☐ Pod restriction: ☐ Room restriction: ☐ Other:

Reasons for restriction:

Restriction assigned by: signature/title

1st Review date, no later than

Restriction Review

Part B

Disposition: ☐ End restriction: ☐ Continue restriction (Provide rationale, who, what, where)

Review of restriction:

Date: Reviewed by: Signature/Title Next review date:

Cc: JPM of resident's housing unit
Deputy Superintendent
Mental Health Dept.
JFOS Office
Resident's Case Management file

ATTACHMENT L

	1999 Loughran Recommendation	MDOC Plans	Current Services Budget	Proposed Part II/Change Package	Cost of Loughran Recommendations Not Proposed in Part I or Part II	MDOC Action Plan	Current Status
	STAFFING						
1.	Staffing ratios of direct care staff to youths should be 1:8-10 in the open cottages and 1:4-5 staff to youths in NSB.	The Juvenile Service Master Plan includes enhanced staffing, but not to the level recommended in the report.	Part I budget. Days: 12-1 Evenings: 12-1 Nights: 19-1	Part II, including change package. Days: 12-1 Evenings: 9-1 Nights: 18-1	To bring existing staffing levels to recommended levels we would need to add 48 line staff at a cost of $1,876,500 in FY02. 76 positions would be laid off when the new SMJF is completed and a portion of the committed population is transferred to the new Northern Maine Facility.	No Dates	Since the move to the new building, we have consistently met or exceeded this recommendation.
2.	Increase the staffing salary of TSCs to the average starting salary of direct care staff in other New England states.	The Bureau of Human Resources will assess the impact that changing duties and associated qualification and training standards may have on current classification and salary grade assignments and to the extent to which career ladders are adequate to recognize and reward the increasing value of staff to the institution as new skills are developed and refined through experience and continued training and development. These assessments may				March and April 1999.	Completed.

	Loughran Recommendation	MDOC Plans	Current Services Budget	Proposed Part II/Change Package	Cost of Loughran Recommendations Not Proposed in Part I or Part II	MDOC Action Plan	Current Status
		result in changes to base salary ranges for TSCs in accordance with the State's standard salary setting practices. In addition, the DOC and BHR will determine eligibility for a recruitment and retention stipend to meet labor market demand.					
3.	Three additional program managers are required in order to provide adequate supervision to the case managers, TSCs and youths in each cottage as well as build a responsive treatment team.	The Department concurs. We are currently reclassifying one unit director to program manager and have requested two additional program managers in the Part II budget.	Part I budget includes funding for five program managers.	Part II budget includes two additional program managers.		July 1999	Complete
4.	Add one MSW level position to the sexual offender treatment program.	The Department concurs. The Juvenile Services Master Plan includes this position.	None	Part II budget includes funding for this position	None	June 2000	Complete
5.	Each cottage and the NSB should have a master's level clinician to provide ongoing therapy.	The Department recommends existing social workers with appropriate peer review.	None	None	6 Psychologist IIs $369,408	July 1999 – one	All Social Workers reclassified to Psychiatric Social Worker IIs, which is augmented by a contract with Sweetser Family Services.

	Loughran Recommendation	MDOC Plans	Current Services Budget	Proposed Part II/Change Package	Cost of Loughran Recommendations Not Proposed in Part I or Part II	MDOC Action Plan	Current Status
6.	There should be at a minimum one full time psychiatrist for MYC.	We have included funds for enhanced psychiatric services in our Part II budget, including the change package. 8 hrs to 24 hrs and 4 hrs from DMHMRSAS for 28 hrs total.	Part I budget	Part II budget including the change package. Reassign 4 hours from DMHMRSAS	Cost associated with increasing psychiatric services from 28 to 40 hours: FY00: $56,160 FY01: $58,126 FY02: $60,160	July 1999 – 28 hours (not full time)	24 hours of contract psychiatric services provided.
7.	A psychologist should be assigned to the NSB program who is responsible for developing intensive treatment plans and interventions for this difficult group of youths.	We are currently redesigning the NSB program as a high risk treatment program and will use, in part, resources currently supporting the sex offender unit.	Reassign portion of the time of the psychologist assigned to the sex offender unit.	Funding in Part II	See recommendation #5	Dates?	Complete
8.	An investigator who reports directly to the Associate Commissioner for Juvenile Services should be appointed to investigate alleged abuse of residents.	We have included this position in our Part II budget. Reporting structure to be developed.	None	Included in the Part II budget		Dates?	Investigator reports directly to the Deputy Supt for Administration. All completed reports on investigations into alleged abuse of residents are reviewed by the Associate Commissioner for Juvenile Services, Attorney General's office, Department of Human Services and State Police – CID.

	Loughran Recommendation	MDOC Plans	Current Services Budget	Proposed Part II/Change Package	Cost of Loughran Recommendations Not Proposed in Part I or Part II	MDOC Action Plan	Current Status
	TREATMENT PROGRAM						
1.	The Department should develop a specialized treatment program for mentally ill or seriously emotionally disturbed youths away from the Maine Youth Center. The proposal to open a forensic unit at the Jackson Brook Institute has merit. This move would not only relieve the pressure on the cottages and NSB where these youths are currently dispersed but place these youths n a setting with staff prepared to meet their needs.	We agree that we need additional resources outside the Maine Youth Center to meet the needs of the mentally ill and seriously emotionally disturbed. We are currently working with the Department of Mental Health, Mental Retardation and Substance Abuse Services on this issue.	None	None	Unknown	(staff training in 9/99)	The ongoing collaboration with the Bureau of Developmental Services (formerly DMHMRSAS) has been very successful at diverting developmentally disabled and mentally ill residents from LCYDC to more appropriate beds. In addition, there has been a significant increase (Sweetser contract) within staffing at LCYDC.
2.	The Department should develop a short-term revocation program (30-60 days) in a separate cottage for youths who would be identified through the risk/need classification process upon admission to	The Department concurs. A short-term revocation program is included in our Juvenile Services Master Plan.	None	To be included in next biennial budget.	Projected future costs in: FY02: $2,089,973 FY03: $2,152,672	No dates	Due to a reduction in overall recidivism, there is no need for a short-term revocation unit. We are currently addressing this need by designing programs through individualized treatment plans.

	Loughran Recommendation	MDOC Plans	Current Services Budget	Proposed Part II/Change Package	Cost of Loughran Recommendations Not Proposed in Part I or Part II	MDOC Action Plan	Current Status
	MYC.						
3.	The Department should consider converting the NSB to a treatment program for youths who would be identified through the risk/need classification process upon admission to MYC.	The Department concurs. The Juvenile Services Master Plan includes this program for both juvenile facilities.	Part I budget includes funding for NSB			Dates?	Complete
4.	Each youth should have a general service plan that is based on his/her individual needs.	The Department concurs. We will institute a reception/diagnostic assessment program at MYC this summer.	Part I includes some funding for the reception/diagnostic program	Part II includes the funding for fully bringing up this program		July 1999	Complete
5.	Psychiatric services need to be integrated into the overall treatment of youths.	The Department concurs. Additional psychiatric services, as proposed, will accomplish this objective	8 hours under medical contract and 4 hours from DMHMRSAS	Part II (change package) includes adding 16 hours to 28 hours total	40 hours weekly $79,880. This is the difference between 24 and 40	Dates?	Complete
6.	Youths who are being treated with psychotropic medications should have treatment plans that clearly spell out the target behaviors that are being addressed.	The Department concurs. Included in above recommendation	Included in 8 hours and the 4 hours from DMHMRSAS	Additional hours in package		July 1999? (not full time)	Complete
7.	Psychiatrists and psychologists should have a systemic and regular review of	The Department concurs. We are implementing this as psychiatric services are expanded as noted above.	3 psychologists, 12 hours of psychiatric time	1 additional psychologist in Part II and psychiatric hours in change package		July 1999? (not full time)	Complete

	Loughran Recommendation	MDOC Plans	Current Services Budget	Proposed Part II/Change Package	Cost of Loughran Recommendations Not Proposed in Part I or Part II	MDOC Action Plan	Current Status
	cases needing psychiatric services.						
8.	The Psychology Department should develop a standardized psychosocial instrument in order to identify juveniles psychosocial needs, problems and progress in the following areas: mental health, education problems, history of family abuse, neglect or violence and history of sexual abuse.	The Department concurs. Currently working with DMHMRSAS to identify instruments. The entire population will be assessed by the summer of 1999. Newly committed residents will be assessed in the planned reception/diagnostic assessment orientation program.	Psychology Department at MYC and MH Coordinator and staff at DMHMRSAS and contracted assessors.	None needed.		Summer 1999.	Complete
9.	The Psychology Department should prepare an annual written summary of data on residents psychosocial needs, problems and progress in order to make program improvements in needed areas.	The Department concurs. This will be assigned to the Psychologist IV.	Existing position.	None needed		Dates?	Not completed due to being short-staffed in the Psychology Department as a result of the transfer of one psychologist to another correctional facility.
10.	The MYC needs to conduct groups in the housing units that address pro-social skills, anger	The Department concurs. This is included in the treatment program to be implemented in March of 1999	CORE program developed with existing resources; staff serve as trainers	None needed; included in MYC's treatment program		March 1999 for CORE (not an established curricula)	Complete

	Loughran Recommendation	MDOC Plans	Current Services Budget	Proposed Part II/Change Package	Cost of Loughran Recommendations Not Proposed in Part I or Part II	MDOC Action Plan	Current Status
	management, substance abuse and moral reasoning.						
	TRAINING						
1.	The policy review process underway at MYC should be completed as soon as possible. An up-to-date policy book should be available to staff at the training center and at every workstation.	The Department concurs. Policy and procedures in draft form and under review by the Department's AAG.		None needed		June 1999	Complete
2.	The MYC pre-service training curriculum should be expanded to include modules on adolescent psychology, post traumatic stress disorder in children exposed to loss and violence, anger management, causes of delinquency, developing a therapeutic community and a normative culture in an institution.	The Department concurs. We are revising and enhancing the pre-services curriculum to include the recommended areas.	Existing staff	Staff Development Specialist in Part II; Training Coordinator to be funded with federal block grant		July 1999	Complete
3.	Incorporate non-abusive physical and	The Department concurs. We currently train all staff	Within existing resources		Working on training costs and will present	Dates?	Complete

	Loughran Recommendation	MDOC Plans	Current Services Budget	Proposed Part II/Change Package	Cost of Loughran Recommendations Not Proposed in Part I or Part II	MDOC Action Plan	Current Status
	psychological intervention training in the pre-service and in-service training program.	in CPI (Crisis Prevention Intervention), a nationally recognized de-escalation and intervention program.			future funding requests		
4.	Develop training modules for pre-service and in-service training that utilizes tapes of restraints and incident reports in order to teach staff how to diffuse volatile incidents.	The Department concurs. As we revise our pre-service curriculum, we will include this component.	Existing staff		Same issues as above	August 1999 to January 2000	Complete
5.	Staff who evidence excessive use of restraint and isolation should be required to participate in an in-service training program that teaches non-confrontational approaches.	The Department concurs. We have developed a database that tracks all restraints and placements in special management by staff, housing unit, date, time, resident, conduct, etc. and we regularly analyze the data to determine if inappropriate use or placement has occurred. Improving the supervisory to staff ratio will address this recommendation by providing greater monitoring and oversight.	Within existing resources	Adding one supervisory and 2 Juvenile Program Managers in Part II	Same issues as above	January 2000	Restraint and Isolation has significantly decreased. As a result, incidents are dealt with on an individualized basis.
6.	Staff who use profane or demeaning language towards	The Department concurs. Improving the supervisory to staff ratio will also	Not sufficient	Adding one supervisor and two Juvenile Program Managers in		Dates?	Completed – action taken as necessary

	Loughran Recommendation	MDOC Plans	Current Services Budget	Proposed Part II/Change Package	Cost of Loughran Recommendations Not Proposed in Part I or Part II	MDOC Action Plan	Current Status
	residents should be reprimanded, supervised specifically on this issue and offered interpersonal skills training.	address this recommendation by providing greater monitoring and oversight.		Part II. Goal is to have a program manager in every unit.			
	QUALITY OF CARE						
1.	Physical exercise: Each resident should have one hour of large muscle exercise daily on week days and two hours on weekends (e.g., basketball, soccer, running, workout, etc.)	The Department concurs. The Master Plan includes more physical exercise activities. The Department will accelerate hiring a Recreation Coordinator. This will greatly improve our ability to program physical activities for residents for residents and make better use of existing facilities.		Recreation Coordinator included in the Part II staffing package		April 1999	Complete
2.	A resident handbook that includes a general orientation to MYC, grievance policy, rules and regulations, behavior management plan, daily schedule and how to access medical and how to access medical and mental health and substance abuse services.	The Department concurs. We are currently developing a resident handbook.	Within existing resources	None needed		June 1999	Complete
3.	The institution's	The Department concurs.	Within existing	None needed		April 1999	Complete

	Loughran Recommendation	MDOC Plans	Current Services Budget	Proposed Part II/Change Package	Cost of Loughran Recommendations Not Proposed in Part I or Part II	MDOC Action Plan	Current Status
	grievance policy should be posted in every cottage and unit in the NSB	Grievance policy will be posted in March of 1999 in every housing unit	resources				
4.	A daily schedule should be posted in every cottage and unit of the NSB	The Department concurs. Daily schedules will be posted in every housing unit in March of 1999	Within existing resources	None needed		April 1999	Complete
5.	Institute an employee of the month award to recognize staff who consistently perform above and beyond their required duties, such as preparing special events and meals for residents, serve on various facility/school improvement committees and the like.	The Department concurs. We will review this recommendation with staff for suggestions on its implementation	Within existing	None needed		Dates? Labor/Management training Sept. 1999	Employee of the Year awards implemented in the following areas: Line Staff, Support Services, Education and Supervisory.
6.	Continue to place volunteers on committees formed to improve services at MYC.	The Department concurs. We include volunteers in many areas of the institution's operations and will continue in planning for the future.	Within existing resources	None needed		Dates?	Complete