

Elevating the System:

Exploring Alternatives to Restrictive Housing



Restrictive Housing Systems Study,
Program Validation and
Best Practice Recommendations

Submitted March 2021

Independent Report Commissioned by the Massachusetts Department of Corrections (MADOC)

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Cover Letter

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February 1, 2021
Carol A. Mici Commissioner
Massachusetts Department of Correction
State of Massachusetts
50 Maple Street
Milford, MA 01757



Re: MADOC Restrictive Housing Systems Study

Dear Commissioner Mici,

I write on behalf of the Falcon team of experts engaged to study the Commonwealth of Massachusetts Department of Correction (MADOC) Restrictive Housing Systems. With your leadership over the past two years, MADOC is emerging as a national leader in state corrections: your inmate population has consistently declined every year for more than ten years; you have improved and expanded treatment services for the Seriously Mentally Ill (SMI); you have provided thoughtful suicide prevention training for your correctional staff, and, with this aspirational study, you have positioned MADOC to implement systemic changes to restrictive housing - improving the overall health, safety and security of inmates and also your staff, for many years to come.

Falcon's Report, *Elevating the System: Exploring Alternatives to Restrictive Housing*, is enclosed, and includes our Key Observations and Recommendations and Options for your consideration.

Senior Expert and Falcon Vice President, Dr. Robin Timme, Psy.D., ABPP, CCH-MH has taken the lead for Falcon, and assembled and drawn upon a team of national experts to conduct this study and develop key observations and recommendations: Falcon Senior Corrections Experts, Rick Raemisch, Scott Semple, Mark Richman, PhD, and David Stephens, Psy.D. and all have participated in this systems study.

Falcon's six-member inter-disciplinary team has worked collaboratively with your senior staff members to 1) conduct a focused review of data and population trends, 2) review and assess MADOC's existing systems and restrictive housing practices, 3) facilitate a series of workshops for internal and external stakeholders, 4) tour five of your 16 institutions, 5) interview individuals and small groups of current and former inmates and staff, 6) identify and analyze key observations, and, 7) develop the enclosed set of recommendations and options.

Thank you for the opportunity to assist you and the Department of Correction. Falcon would like to continue to work with you, and we would be very pleased to participate in discussions as you develop next steps. Please feel free to contact me or Dr. Timme if you would like more information about the enclosed report

Sincerely,

Elizabeth Falcon

Elizabeth Falcon
Psy.D., CCHP-MH, MBA
Encl.

Executive Summary

The Massachusetts Department of Correction (MADOC) has long been a leader in correctional policy and practice across the United States. Consistent with their stated mission “to promote public safety by incarcerating offenders while providing opportunities for participation in effective programming to reduce recidivism,” MADOC commissioned a study aimed at assessing its use of restrictive housing and associated programs. MADOC leadership sought to validate those aspects of its disciplinary system that were working well, and to suggest specific evolutions in policy and practice that can bring MADOC’s use of restrictive housing in line with best correctional and clinical practices today and in the future.

Falcon Correctional and Community Services, Inc. (“Falcon”) was tasked with studying three domains of inquiry:

1. Perform a comprehensive review of MADOC’s existing Restrictive Housing practices, including policies, procedures, processes, and operations.
2. Conduct a thorough analysis of the Restrictive Housing System for the purposes of program development and validation.
3. If it is found that areas of improvement are possible, provide a range of actionable short- and long-term solutions.

This independent assessment was undertaken by an interdisciplinary team of Falcon consultants, including those with expertise in the administration of prison systems and facilities, correctional medical and behavioral health, management of criminogenic risk, and large-scale system assessment, leadership and organizational change. The six-member team worked to validate current and historical efforts made by MADOC leadership to enhance treatment of those in the disciplinary process, identifying opportunities for further evolution,

and identified additional recommendations based on information discovered in the process of answering these specific questions.

The purpose of this independent assessment report is to function as a collaborative road map, arriving at recommendations for system improvement and pivoting toward guidance for implementation. This report aims to maximize the use of alternatives to restrictive housing practices, while enhancing system-wide safety and security. Ultimately, the team did arrive at key observations and recommendations for system elevation. It should be noted that all observations, conclusions, and recommendations offered in this report are done so to a reasonable degree of professional certainty, based on the information available at the time of writing.

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Key Observations

1. Senior leaders recognize the evolving nature of correctional practices, lean into the issue of Restrictive Housing reforms, and are flexible and adaptable.
2. There exists a deep mistrust of MADOC from public advocacy groups and the legislative Criminal Justice Reform Caucus (CJRC).
3. MADOC is forced to be reactive to outside pressures in enacting system improvements, policy changes, and reforms.
4. MADOC experiences outside groups as unsympathetic to the challenges faced by those providing care and custody in prisons.
5. Leadership views this study as an opportunity to confirm what is done well, but also for proactive system change and implementation of best practice correctional and rehabilitative models.
6. Conceptually, it is helpful to separate 'Pre-DDU' [i.e., Restrictive Housing Units (RHU)] from the Department Disciplinary Unit (DDU) itself, which is a physical place rather than a condition of confinement.
7. Conditions of confinement in the DDU result in prolonged stays in Restrictive Housing.
8. Procedural due process afforded to those referred to the DDU can create unpredictable lengths of stay in Restrictive Housing.
9. Programming for criminogenic needs in the DDU should be assessed and enhanced, to improve the quality of time-out-of-cell for meaningful interaction, not only the quantity.

Recommendations and Options

1. Develop a team, plan, and schedule for implementation of system enhancements decided upon based on review of recommendations and options in this report.
2. Develop a transparent communication strategy.
3. Dissolve the DDU.
4. Consider eliminating all use of Restrictive Housing as currently defined.
5. Study Mental Health Watch and assess the allegations made in the Department of Justice (DOJ) Report, using the opportunity to enhance safety and quality of healthcare delivery.
6. Use the disciplinary process to assess clinical and criminogenic needs that contributed to requirement for increased restrictions.
7. The Secure Adjustment Unit (SAU) has excellent potential – consider expansion, segmentation by risk level, and clinical or criminogenic tracks within the program.
8. Evaluate the effectiveness of treatment and programming in the revised specialized housing, including the experiences of those who live and work in those programs, and expand bed capacity when implementing enhancements.
9. Create a Substance Use Disorder treatment program for those with positive Urine Drug Screens (UDS) or who are otherwise entering the disciplinary system secondary to use of drugs or alcohol.
10. Expand availability of tablets and tablet-based treatment and programming system-wide.
11. Enhance training initiatives, including matching staff to specialty programs.

Assessment and Methodology

Falcon consultants utilized a multi-method approach to information-gathering and data analysis, utilizing a combination of quantitative and qualitative sources. In addition to an initial data and document request, Falcon consultants submitted two additional data requests supplementing those documents that were provided and those that were publicly available. Documents included legal, policy, and operational guidance, along with various site procedures and clinical practices. Data sets were generally obtained through public access databases available through legislative and statutory oversight bodies like the Restrictive Housing Oversight Committee (RHOC).

Falcon consultants facilitated two series of workshops spanning the months of May through October of 2020, interviewing various internal and external stakeholder groups, and inviting participation from a broad array of stakeholder groups. Workshops included those with lived experience as formerly incarcerated persons, some of whom had been placed in Restrictive Housing during their periods of incarceration. Additionally, local advocacy groups participated in several workshops, along with a wide array of administrative, operational, and healthcare representatives from MADOC and its contracted providers of medical, mental health, substance use disorder treatment, and criminogenic risk programming.

In addition to workshops and small focus groups, two of Falcon's consultants conducted site tours, which included individual and group interviews with staff and inmates within five MADOC facilities. Falcon consultants presented preliminary impressions to the Core Working Group of MADOC in July of 2020, and provided an overview and update to the RHOC in September of 2020 at the request of its Chair, Undersecretary of Criminal Justice, Andrew Peck. Lastly, the Consulting Team held a final workshop with the Core Working Group on December 4, 2020 to provide a feedback session regarding key observations, recommendations, and to suggest strategies for implementation.

These sources of information were reviewed and incorporated into this written report.

MADOC leadership was notably engaged and cooperative throughout the study, and it was clear to the team that MADOC leadership its authentically invested in evolving their system of care and custody. It should be noted that this study was conducted during a global pandemic that has put on full display the unique vulnerabilities of prisons, systems of public health and public safety, and the people who live and work within them.

Workshops and Focus Groups

In addition to the Core Working Group of MADOC leadership, on June 1st and June 2nd, the team held virtual two- to three-hour workshops with the following subject matter groups internal to MADOC: 1) Legal, Policy and Classification; 2) Treatment and Programming; 3) Release, Systems Issues, and Follow-Up.

Subject Matter Groups

1. Legal, Policy and Classification
2. Treatment and Programming
3. Release, Systems Issues and Follow-Up

Following completion of this first series of workshops to orient to the system, the team held an additional series of focus groups, each lasting approximately 90 minutes, with participation from internal and external stakeholders, including supervisory and line staff from MADOC, Wellpath, LLC (contracted provider of healthcare services), Spectrum Behavioral Health (contracted provider of Substance Use Disorder treatment and programming for criminogenic thinking), Prisoners' Legal Services (PLS), and former clinical and program staff. Topics for focus groups included the following: Programming, Staffing and Training, Security Operations, Advocacy, Mental Health System Overview, Data and Documents, Healthcare Operations, Legislative, People with Lived Experience, Former Clinical and Program Employees.

Focus Groups Topics

- Programming
- Staffing and Training
- Security Operations
- Advocacy (Prisoners' Legal Services)
- Mental Health System Overview
- Data and Documents
- Healthcare Operations (Wellpath)
- Legislative
- People with Lived Experience
- Former Clinical and Program
- Employees

On July 16th, the Consulting Team held a four-hour workshop with the Core Working Group to summarize the work to date, and to confirm a thorough understanding of the MADOC prison system and its substantive and procedural disciplinary processes and placements.

On September 24th, three members of the Consulting Team presented the study, methods, and preliminary observations to the RHOC, requesting and receiving feedback, concerns,

questions, and additional guidance as the team began formulating this report. Following that meeting, additional focus groups were held with a group of legislators on October 1st, and a group of formerly incarcerated persons on October 6th. Both of the latter groups were arranged with the assistance of PLS, an engaging and passionate group of legal and mental health professionals who were very helpful to the Consulting Team in the data collection process.



Restrictive Housing: Operational Discussion

Restrictive Housing¹ is defined in the Code of Massachusetts Regulations (CMR)² as any placement in a correctional facility that requires confinement to a cell for more than 22 hours per day on average, with the exceptions of conditions imposed on the order of a healthcare provider. This CMR definition is based on that promulgated in the Criminal Justice Reform Act (CJRA) of 2018, which codified for the definition under Massachusetts law as, “[A] housing placement when a prisoner is confined to a cell for more than 22 hours per day; provided, however, that observation for the mental health evaluation shall not be considered restrictive housing.”³

While these definitions approximate those contemplated by accreditation and professional bodies, namely the American Correctional Association (ACA)⁴ and the National Commission on Correctional Health Care

(NCCHC),⁵ placement in the DDU is an important departure, and one that allows for up to ten years of confinement in conditions that would otherwise be labeled as Restrictive Housing by most definitions (i.e., average of 22 or more hours per day confined to cell, longer than 15 days, without the order of a healthcare provider). Similarly, conditions imposed on the order of a healthcare provider as the least restrictive means of ensuring safety from imminent harm to self or others, while a critical exercise in medical autonomy, do present the risk of inappropriate use, prolonged isolation, and other conditions that - but for the order of the healthcare provider - would be considered Restrictive Housing. Both exceptions warrant attention in this report.

¹ We use the term Restrictive Housing, but consider it to be analogous with terms such as segregation, solitary confinement, isolation, and any other condition that requires confinement to one’s cell for an average of 22 hours per day, without the written order of a healthcare provider.

² 103 CMR 425.05.

³ SECTION 87. Said section 1 said chapter 127, as so appearing, is hereby further amended by inserting after the definition of “Residential treatment unit” the following definition: “Restrictive Housing,” a housing placement where a prisoner is confined to a cell for more than 22 hours per day; provided, however, that observation for mental health evaluation shall not be considered restrictive housing. Available: malegislature.gov/Laws/SessionLaws/Acts/2018/Chapter69.

⁴ According to ACA’s Restrictive Housing Expected Practices (January, 2018), Restrictive Housing is “a placement that requires an inmate to be confined to a cell at least 22 hours per day for the safe and secure operation of the facility.”

⁵ According to NCCHC, solitary confinement is defined qualitatively as the housing of a person with minimal or rare meaningful contact with other individuals. The definition references “sensory deprivation” and “few or no educational, vocational, or rehabilitative programs.” They conclude, “Regardless of the term used, an individual who is deprived of meaningful contact with others is considered to be in solitary confinement.” See Position Statement on Solitary Confinement (Isolation) available: <https://www.ncchc.org/solitary-confinement>.



In their updated report titled *Time-in-Cell 2019: A Snapshot of Restrictive Housing*⁶ (September 2020), the collaboration between Correctional Leaders of America (CLA) and the Liman Center at Yale Law School defined Restrictive Housing as, “holding individuals in a cell for an average of twenty-two hours or more a day for fifteen days or more (pp. 1).” The focus on 15 days appears to derive international bodies that have focused on prolonged solitary confinement that eventually equates to torture, but we believe the moment an individual is placed into those conditions, the potential for prolonged solitary confinement exists on day one, and thus we afford little weight to the 15-day criterion.

Falcon consultants recognize that the qualitative components of isolation from others, (i.e., sensory deprivation, lack of meaningful contact, minimal access to care, decreased interpersonal engagement, etc.) are critical to appreciating the impact of Restrictive Housing on individuals. However, quantitative definitions are necessary to standardize these conditions of confinement across varied iterations of restrictive settings across jurisdictions. In this way, definitions of Restrictive Housing take on a letter and a spirit; the former represented in specific definitions like the one promulgated internationally in the United Nation’s Nelson Mandela Rules, nationally by the ACA and the Liman Report, and locally represented in the CJRA and 103 CMR 425.05. The latter spirit is represented more qualitatively in the NCCHC Position Statement or the writings of the World Health Organization (WHO).⁷ Both are critical to examine in this report.

For the purposes of this study, the Consulting Team defined Restrictive Housing as any condition requiring a person to potentially remain in a cell for an average of 22 or more

hours per day, and without the order of a licensed healthcare provider. Additionally, the team considered the quality of time-out-of-cell as a critical qualitative component to the definition, recognizing those components that may be less measurable, yet just as important as the quantitative elements.

Recognizing it as a condition of confinement rather than a physical location, the team observed people housed in units called RHUs, but who were not – in fact – living in Restrictive Housing conditions of confinement by this definition⁸; similarly, if a person were confined in a general population (GP) cell under the same conditions (i.e., 22 or more hours per day in-cell), he or she would still be considered to be in Restrictive Housing under this operational definition.



⁶ The updated Liman Center Report is available: law.yale.edu/liman/solitary2020.

⁷ Enggist, S., Moller, L., Galea, G. & Udesen, C. (Eds.). (2014). Prisons and health. World Health Organization. Available: https://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf.

⁸ Example: people identified as requiring additional clinical services were removed from their cells more frequently

U.S. DOJ Investigation into Mental Health Watch

On November 17, 2020 the United States DOJ issued a report titled Investigation of the Massachusetts Department of Correction (“DOJ Report”),⁹ along with a press release. According to the DOJ Report, MADOC was notified on October 22, 2018 that the DOJ had opened an investigation pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA).¹⁰ DOJ focused their investigation on two specific areas, including whether MADOC, “violates the constitutional rights of prisoners who have serious mental illness, or who are otherwise at risk of serious harm from restrictive housing, by placing them in restrictive housing for prolonged periods of time,” and whether MADOC, “violates the constitutional rights of geriatric and palliative care prisoners by failing to provide them with adequate medical care.” According to the DOJ Report, on November 21, 2019, MADOC was notified of two additional areas of investigation, specifically whether they, “provide prisoners in mental health crisis with constitutionally adequate mental health care,” along with investigating whether MADOC, “provides prisoners in mental health crisis with adequate supervision to provide reasonable protection from self-harm.” The DOJ Report stated,

“We are closing our restrictive housing - for housing other than mental health watch - and the geriatric and palliative care portions of our investigation without issuing a Notice of constitutional violation.” The DOJ Report concluded the following conditions in their notice to MADOC:

- [MADOC] fails to provide constitutionally adequate supervision to prisoners in mental health crisis.
- [MADOC] fails to provide adequate mental healthcare to prisoners in mental health crisis.
- [MADOC]’s use of prolonged mental health watch under restrictive housing conditions, including its failure to provide adequate

mental health care, violates constitutional rights of prisoners in mental health crisis.

While a comprehensive review of the Suicide Prevention and Mental Health Watch Systems were beyond the scope of this study, there are overlaps with Restrictive Housing as codified and defined in Massachusetts. Most importantly, mental health crises and self-directed violence are unfortunately common occurrences in Restrictive Housing settings across the country. Effectively minimizing or eliminating the use of Restrictive Housing will thus reduce the occurrence of these psychiatric emergencies and placement on Mental Health Watch.

The DOJ’s report suggests that the condition imposed on Mental Health Watch equate to Restrictive Housing conditions of confinement due the overly restrictive nature of Mental Health Watch, the lack of adequate mental health treatment that occurs while on Mental Health Watch, and the potential for prolonged isolation, regardless of the order of a healthcare provider. In other words, while the Commonwealth of Massachusetts and MADOC specifically exclude Mental Health Watch from the legal and regulatory definitions of Restrictive Housing, the conditions of confinement in practice equate to Restrictive Housing by another name; or as the DOJ Report asserts, “The legislature’s decision to exclude mental health units from the definition of ‘restrictive housing’ does not make it so (pp. 15-15).”

While it was beyond the scope of this study to comprehensively evaluate Mental Health Watch, the Consulting Team did not witness any of the egregious scenarios referenced in the DOJ Report during site visits. However, it is the strong recommendation of Falcon consultants that those allegations are investigated thoroughly and that MADOC use this as an opportunity to proactively examine healthcare effectiveness, safety, and quality for those accessing the medical observation and Mental Health Watch.

⁹ Full report available: <https://www.justice.gov/opa/press-release/file/1338071/download>.

¹⁰ 42 U.S.C. §1997b.

Review of Existing System

To conduct a study of this scope and substance, a thorough understanding of the existing system is crucial. Falcon consultants reviewed hundreds of documents provided by MADOC, conducted workshops and focus groups, and visited five facilities in August of 2020. Falcon consultants aimed to capture the Restrictive Housing System in the following areas: conditions of confinement, due process experienced by those who are alleged to have committed infractions, placement of individuals into disciplinary detention, referral to and placement in the DDU, the process of identification, referral, diversion, and placement into Secure Treatment Units (STU), the SAU, and the clinical determinations for individuals to be excluded from Restrictive Housing on the professional judgment of Qualified Health and Mental Health Professionals.

On August 18th and 19th, two members of the Consulting Team toured five MADOC facilities, including:

1. Souza Baranowski Correctional Center (SBCC)
2. MCI – Shirley
3. MCI – Concord
4. MCI – Cedar Junction
5. Old Colony Correctional Center (OCCC)

The purpose of these visits was to view the RHUs, as well as to observe the Residential Treatment Units (RTU), the DDU, the STUs, the SAU, and the two Bridgewater State Hospital inpatient “annex” units at OCCC. During these site visits, the Consulting Team conducted dozens of interviews with incarcerated persons in group and individual formats, as well as interviews of line staff from MADOC, Wellpath, and Spectrum.

Serious Mental Illness (SMI)

Recognizing that rates of behavioral health crises and disorders are overrepresented in prisons across the United States, systems and facilities have categorized a sub-group of clinical presentations as representing SMI. Individuals with SMI are not only disproportionately represented in jails and prisons, but once incarcerated, they are more likely to be housed in Restrictive Housing where they are particularly vulnerable to decompensation, exacerbated psychiatric disturbance, self-injury, and suicide. For this reason, tracking of the SMI population in the disciplinary process is critical to effectively providing the clinical safeguards to which those with SMI are entitled and deserving.

The designation of SMI generally refers to a sub-group of psychiatric disorders and/or level of functional impairment that requires greater clinical services to address higher levels of acuity. These conditions generally reflect breaks with reality (i.e., psychotic distortions, hallucinations, delusions), severe depression or suicidality, extreme affective states (i.e., manic or hypo-manic episodes), and other symptoms that create substantial impairment in one’s ability to maintain their safety, the safety of others, or to maintain their own health and basic activities of daily living. Across the country, and indeed between community and correctional jurisdictions, the definitions of SMI vary tremendously, and how the term is defined has important ramifications; in most cases, being classified as having an SMI entitles an individual to financial or social program benefits, clinical services, housing locations, and state-funded community-based programs like Assertive Community Treatment (ACT) and other ‘deep-end’ mental health services.

The CJRA of 2018 specifically defined SMI in MADOC as follows:

A current or recent diagnosis by a QMHP of one or more of the following disorders described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:

- a. Schizophrenia and other psychotic disorders
- b. Major depressive disorders
- c. All types of bipolar disorders
- d. A neurodevelopmental disorder, dementia or other cognitive disorder
- e. Any disorder commonly characterized by breaks with reality or perceptions of reality
- f. All types of anxiety disorders
- g. Trauma and stress related disorders
- h. Severe personality disorders; or a finding by a QMHP that the inmate is at serious risk of substantially deteriorating mentally or emotionally while confined in Restrictive Housing, or already has so deteriorated while confined in Restrictive Housing, such that diversion or removal is deemed to be clinically appropriate by a QMHP.

CJRA and policy, affords substantial entitlements and protections, but also dilutes the clinical impact of that designation. No longer does the designation carry the clinical connotation, for example, that the person requires a higher level of care, presents with greater acuity, necessitating more significant clinical services.

Reflecting on the community standard, the Substance Abuse and Mental Health Services Administration (SAMHSA) states that SMI is, “defined by someone over 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities.”¹¹ The Centers for Medicaid Studies (CMS) notes that “... states define SMI in different ways depending on the entity, context, and purpose for which it is being used (e.g., legal, clinical, epidemiological, or operations).”¹² In sum, the definitional parameters of a construct like SMI have intended and unintended consequences, and the implications ripple through systems of care. In the community, casting a wider definitional net entitles those who may not require deep-end services and supports to valuable and often scarce clinical, financial, and other social supports, while reducing personal independence and autonomy. Meanwhile, to restrict the definition disqualifies people who otherwise would have received potentially critical supports prior to the imposition of a more restrictive definition.

As a result of this greatly expanded definition of SMI within MADOC facilities, the number of inmates diagnosed with SMI grew exponentially. The CJRA was implemented on January 1, 2019, and overnight the caseload of inmates designated SMI nearly quadrupled, from 660 to 2,493. Having a designation of SMI in MADOC, according to the

The CJRA was implemented on January 1, 2019, and overnight the caseload of inmates designated SMI nearly quadrupled, from 660 to 2,493.

¹¹ www.samhsa.gov/find-help/disorders.
¹² As an example, see Arizona Revised Statutes 36-551.

Some states take a more subjective approach to the definitional issue, allowing for clinical judgment and impairments in functional capacities to drive the designation of SMI.¹³ These states do not list required diagnoses, such as psychotic disorders, depressive disorders, or affective disorders, while other states are more specific in requiring a threshold diagnosis and evidence of impaired role functioning.¹⁴ Still others take an even more restrictive approach to designation of SMI, listing very specific diagnoses that are necessary and sufficient for a designation of SMI; for example, in Idaho, SMI, “means any of the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) incorporated in Section 004 of these rules: (7-1-15):

- a. Schizophrenia spectrum and other psychotic disorders
- b. Bipolar disorders (mixed, manic and depressive)
- c. Major depressive disorders (single episode or recurrent)
- d. Obsessive-compulsive disorders¹⁵

The Commonwealth of Massachusetts has set a narrower definition for SMI in the community than in the Department of Correction, specifically identifying non-qualifying disorders that would qualify under the MADOC definition.¹⁶

Additionally, the Commonwealth of Massachusetts identifies qualifying mental disorders that further limit the scope of the definition of SMI, which must be diagnosed to qualify for those services in the community.

The impact of this expanded definition under the CJRA has been felt throughout the correctional system, and staff and inmates are very aware of it. Correctional Officers reported feeling frustrated that SMI had lost its meaning in their purview, and that so many people seemed to be designated SMI now that the protections and services required for the population seemed to apply inappropriately to a great many inmates.

Similarly, clinical staff at each facility are now forced to create their own work-arounds to manage their caseloads and triage the patients who are of the highest acuity levels. For example, under the new definition of SMI, an inmate diagnosed with Attention-Deficit Hyperactivity Disorder (ADHD) qualifies as having a SMI.¹⁷ Meanwhile, an inmate diagnosed with Schizophrenia, hearing command hallucinations and falsely believing people are trying to harm him, is designated as having a SMI. The two are very likely to have different treatment needs, require differing levels of care, but are categorized together under the CJRA definition. As a result, mental health departments were noted to maintain their own lists of what might be called acute and sub-acute populations, further segmentation of the SMI population to restore the clinical relevance to the term.

Lastly, it was observed through interviews with staff and patients that the definition of SMI under the CJRA resulted in increased dependence on the State, a loss of autonomy, and a sense of entitlement to enhanced mental health services and social supports in the community following release. As articulated previously, the definition of SMI in MADOC is very different than that in the Massachusetts Department of Mental Health (DMH), and for many of these people returning to the community, they simply will not qualify for those deep-end services once they are released.

¹³ As an example, see Arizona Revised Statutes 36-551.

¹⁴ As an example, see Maryland Priority Populations: https://maryland.optum.com/content/dam/ops-maryland/documents/provider/providermanual/Maryland_ASO_MNC_BH2564_71.20.pdf.

¹⁵ Idaho Administrative Code IDAPA 16.07.33 Section 100, Page 5.

¹⁶ 104 CMR 29.00.

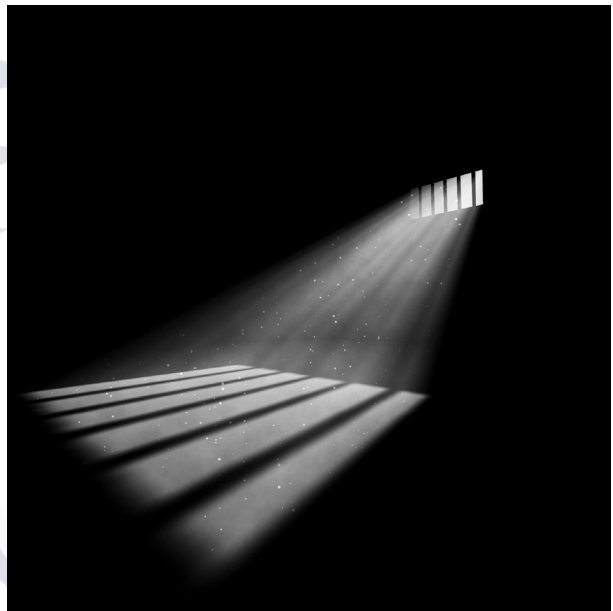
¹⁷ ADHD is categorized as a Neurodevelopmental Disorder in the DSM-5.

Defining MADOC's Current Restrictive Housing System and Due Process

The Restrictive Housing System exists within the larger context of prison discipline, housing, classification, and administrative responses to alleged rule violations. These concrete aspects of operations reflect the philosophical mission of a prison system, influencing and reflecting organizational culture, interdisciplinary training, and the built environment, in addition to ideals of deterrence, incapacitation, rehabilitation, and retribution that are often unwritten. It should be noted that there is no Restrictive Housing placement in MCI – Framingham, nor is there a female DDU in MADOC, having eliminated the practice among the female population entirely. What follows applies to the male population residing in MADOC facilities.

When an individual residing in GP is alleged to have committed an infraction warranting removal from GP for investigation and potential discipline, he is immediately taken to a Health Services Unit (HSU) for evaluation by a Qualified Health Professional (QHP) and QMHP who make the clinical determination as to whether placement in Restrictive Housing is contraindicated. Although the HSU is the most common location for these evaluations by QHPs and QMHPs, in certain locations the evaluations take place in examination rooms just outside the sallyport for entry into the RHU. This was observed by the Consulting Team at MCI – Shirley. The individual is placed into one of these spaces and the evaluations occur here prior to admission to the RHU, consistent with MADOC policy.¹⁸ Clinical contraindications to placement in Restrictive Housing may include injury sustained in the immediate incident, unstable medical conditions requiring further assessment or intervention in the HSU, as well

as identification of elevated risk for self-directed violence, psychiatric decompensation, and the opportunity to immediately triage someone experiencing an acute psychiatric emergency on to Mental Health Watch for further evaluation, stabilization, and treatment planning. Completion of these evaluations prior to placement in a RHU affords a clinical safety net by which QHPs and QMHPs can exercise medical autonomy,¹⁹ delaying or avoiding placement in RHU for those with unacceptably high levels of clinical risk, to refer appropriate individuals for placement in one of the STUs, and to advocate for diversion to RTUs when indicated. In practice, this is often an opportunity for members of the interdisciplinary team to ensure patient safety while deliberately consulting on potential risk, review the events leading to the alleged infraction, and to share information regarding the appropriateness of various interventions and housing placements.



¹⁸ 103 CMR 423.08 Restrictive Housing Placement and Limitations on Placement in Restrictive Housing.

¹⁹ Medical Autonomy refers to the clinical independence of qualified health care professionals to practice medical and behavioral health services without interference from custody staff. With clinical independence comes the responsibility to practice according to one's legal and ethical mandates, consistent with the laws of the local jurisdiction (usually professional regulation bodies), as well as the Hippocratic mandate to 'do no harm.' NCCHC describes Medical Autonomy in essential Standard P-A-03 Medical Autonomy, and rightfully places oversight and accountability on the Responsible Health Authority (RHA) for monitoring and Continuous Quality Improvement (CQI) rather than on the custodial component of operations.

If the person is determined to require additional clinical services prior to placement into the RHU, he is transferred to the HSU until medically cleared by a QHP and QMHP. In this way, the Restrictive Housing System meets the standard for Suicide Prevention and Intervention as promulgated by NCCHC, as the QMHP conducts suicide risk screening and assessment, diverting the individual onto Mental Health Watch as indicated. NCCHC Standards state that these processes are clinical in nature, and fall under the purview of health care professionals, noting, “Although many suicides are unpredictable, a suicide prevention program can help reduce risks. Inmates may become suicidal at any point during their stay, but high-risk periods include... [c.] After admittance to segregation or single-cell housing.”

Compliance indicators,^{20 21} for this standard include the following criteria, among others:

1. The responsible health authority and facility administrator approve the facility’s suicide prevention program.
2. A suicide prevention program includes the following:
 - Facility staff identify suicidal inmates and immediately initiate precautions.
 - Suicidal inmates are evaluated promptly by the designated health professional, who directs the intervention and ensures follow-up as needed.
 - Acutely suicidal inmates²² are monitored by facility staff via constant observation.
 - Non-acutely suicidal inmates²³ are monitored by facility staff at unpredictable intervals with no more than 15 minutes between checks.

The best practice guidelines were followed by MADOC as demonstrated in our facility tours, process studies, and interviews. These evaluations provide QHPs and QMHPs an opportunity to prevent placement of an individual into Restrictive Housing when certain clinical contraindications are present, including when an inmate is potentially suicidal and to identify and evaluate any inmate diagnosed with a SMI. During site visits, officers, inmates, patients, and clinicians corroborated the practices reflected in policy, and the Consulting Team conducted mental status examinations of patients being placed on Mental Health Watch, some receiving treatment while on Mental Health Watch, and many who had accessed the Mental Health Watch System.

Once clinical emergencies or contraindications are ruled out by QHPs or QMHPs, the individual is admitted to the RHU on pre-hearing detention status, pending investigation, and potentially referred for placement in the DDU due to the severity of alleged infractions. Because a DDU referral can result in placement into the DDU for up to ten years, additional due process protections are afforded to the individual, although those procedural components can result in prolonged stays in the RHU awaiting adjudication of the DDU referral. What was clear in policy, procedure, and practice was that reviews of these individuals happen both formally and informally, and if an individual is to remain in the RHU or DDU for lengthy periods of time he is considered for early release, tracked, and reported to the RHOC on a quarterly basis.

²⁰ National Commission on Correctional Health Care (NCCHC). (2018). Standard P-B-05 Essential. Standards for health services in prisons. NCCHC.

²¹ National Commission on Correctional Health Care (NCCHC). (2015). Standard MH-G-04 Essential. Standards for mental health services in correctional facilities. NCCHC.

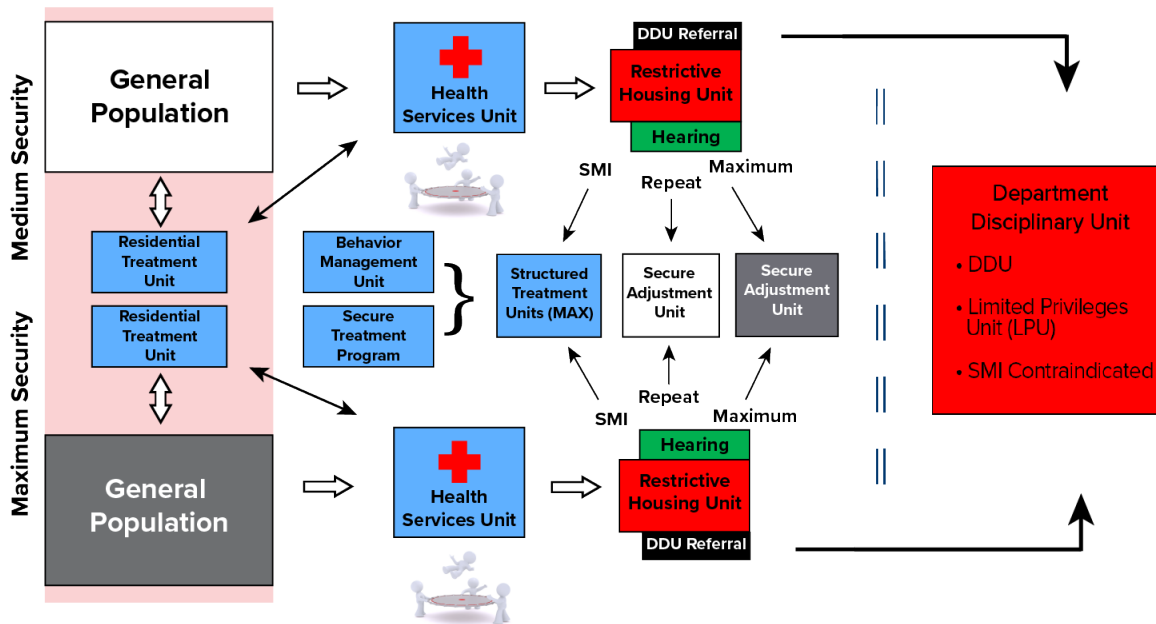
²² Acutely suicidal (active) inmates are those who are actively engaging in self-injurious behavior and/or threaten suicide with a specific plan (NCCHC P-B-05 [pp. 39]).

²³ Non-acutely suicidal (potential or inactive) inmates are those who express current suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or have a recent history of self-destructive behavior (NCCHC P-B-05 [pp. 39]).

Operationally, administratively, and legally, the DDU is identified as separate and distinct from the RHUs. The Consulting Team quickly recognized that it was helpful to separate the system into 'pre-DDU' and 'DDU' components, understanding that the DDU is a relatively unique, small, but critical component to the disciplinary system. In the experience of the Consulting Team, these long-term segregation

units are becoming less common, while the 'pre-DDU' components are closer to the emerging standard of penological practice. Considering the operational definition utilized in this study, the Consulting Team considered those housed in any RHU or in the DDU to be housed in conditions of confinement that reflect a Restrictive Housing status.

Current Restrictive Housing Process:



Focused Population Study

To complete this assessment, the Consulting Team requested and was provided with access to individual and aggregated data regarding the population placed in Restrictive Housing, including specific demographic indicators, length of stay, and additional relevant information as requested. Monthly, quarterly, and bi-annual reports to the RHOC were instrumental in compiling this focused population study. Those reports, issued by the Executive Office of Public Safety and Security (EOPSS) were observed to be outstanding in the experience of the Consulting Team, unmatched in our experience, providing useful data pertinent to common concerns regarding restrictive housing practices, such as reasons for placement in Restrictive Housing, length of stay, placement reviews and early releases, mental health status, self-injurious behavior and suicide, and additional aggregate and individual-level data presented in a manner that allows for others to conduct ad hoc analyses. While the team did hear complaints from advocacy groups regarding delays in the production of these reports, their quality and utility appear to be unquestionable.²⁴

According to the organization of the data provided by EOPSS, the RHOC also considers those housed in RHUs separately from those housed in the DDU and considers those in the Restrictive Housing Unit serving Disciplinary Detention (RHU-DD) separately from those held in RHU for other reasons (i.e., awaiting hearings, unwilling to leave, verified safety needs, etc.).

Based on a review of data from the 2019 calendar year reporting period, the following calculations and observations were particularly relevant and contributory to key observations and subsequent recommendations:

- The Total Average Daily Population has steadily trended downward in recent years²⁵. The corresponding chart represents that decline.
- MADOC had an operational capacity of 561 beds for males in Restrictive Housing until July 2019, when they closed units, resulting in a reduction to 501 beds, followed by a reduction in beds to 481 in October of 2019, and reduction to current number of 450 beds.²⁶
- In all, MADOC has reduced its number of beds in Restrictive Housing by 111 or 20% since July of 2019, continuing to remain below 65% of capacity even as the number of beds decreased substantially.

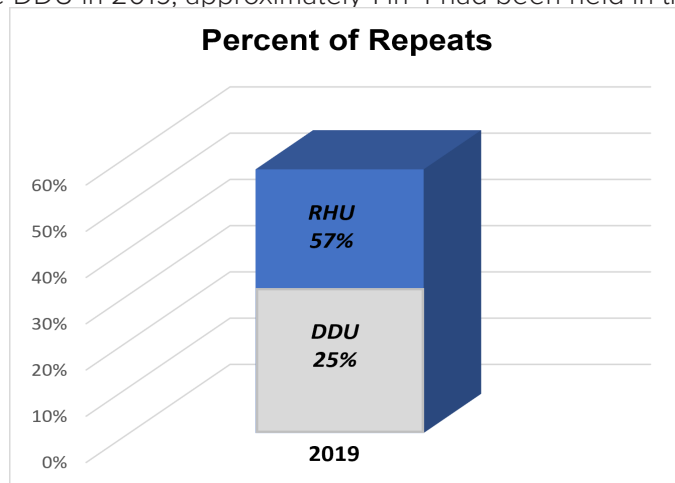
²⁴ For additional information, statistics, membership, and further guidance, see: <https://www.mass.gov/restrictive-housing-oversight-committee>.

²⁵ MADOC. January 1, Snapshot 2011-2020.

²⁶ MADOC. Number of inmates held in Restrictive Housing Units within each state correctional facility. Monthly Restrictive Housing Report to the Restrictive Housing Oversight Committee.

- On January 7, 2019, 328 male inmates were housed in RHUs: 3.73% of the inmate population at that time, and 58.5% of capacity.
- On April 1, 2019, 298 male inmates were housed in RHUs (53.1% of capacity).
- On July 1, 2019, 298 male inmates were housed in RHUs (59.4% of capacity after reduction by 60 beds).
- On October 1, 2019, 312 male inmates were housed in RHUs (64.9% of capacity after reduction by 30 beds).
- On January 6, 2020, 308 male inmates were housed in RHUs: 3.71% of the inmate population at that time, and 64.3% of capacity).
- On April 6, 2020, 290 male inmates were housed in RHUs (64% of capacity).
- The Average Length Of Stay (ALOS) in RHUs in 2019 was 18 days, while the Median ALOS was 10 days.
- The ALOS in RHUs for an individual on the mental health caseload was 19 days, while the Median ALOS was 9 days.
- In 2019, just under 50% of those housed in a RHU (non-disciplinary) met the definition of having SMI.
- In 2019, approximately 57% of those housed in the DDU were on the mental health caseload.
- In 2019, 142 male inmates were placed in Restrictive Housing for using or possessing illicit substances, having a UDS that was positive for illicit substances, or for consuming or producing alcohol.²⁷
- Of those held in Restrictive Housing in 2019, approximately 57% had been placed in Restrictive Housing previously.
- Of those held in the DDU in 2019, approximately 1 in 4 had been held in the DDU previously.

Date	Males Housed	Capacity Percent
1/7/2019	328	58.5
4/1/2019	298	53.1
7/1/2019	298	59.4
10/1/2019	312	64.9
1/6/2020	308	64.3
4/6/2019	290	64



²⁷ Class 2 Offenses, including 2-11, 2-14, and 2-19. Introduction and dealing in illicit substances, a Class 1 Offense (1-15), was not included in this analysis.

Experiences of the System

During the study period, the Consulting Team had the opportunity to interact with an estimated 200 stakeholders, including those currently incarcerated, those formerly incarcerated with lived experience, those employed by MADOC and its contracted providers, those formerly employed by MADOC and contracted providers, and those representing advocacy and legislative efforts on behalf of incarcerated populations and the people of the Commonwealth. These interactions occurred in scheduled workshops, small focus

groups, individual meetings, public hearings, and during site visits on August 18th and 19th. The team conducted interviews in GP, RTUs, HSU, RHUs,

Bridgewater State Hospital “annex” units [Intensive Stabilization and Observation Unit (ISOU) and Recovery Unit (RU)], the STUs [Secure Treatment Program (STP) and Behavior Management Unit (BMU)], and the DDU. Those site visits were attended by two of Falcon’s Senior Consultants, one former state Secretary of Corrections and one psychologist, who obtained temporary licensure to practice in the Commonwealth of Massachusetts. The psychologist provided MADOC and Wellpath with names of all those interviewed, and clinicians then provided immediate follow-up with the inmate in accordance with agency protocol. What follows is summary material from these conversations and themes observed by the on-site Consulting Team.

Stakeholders:

- Currently Incarcerated
- Formerly Incarcerated
- MADOC Employees and Contractors
- Former MADOC Employees and Contractors
- Advocacy representatives
- Legislative representatives
- People of the Commonwealth of Massachusetts

Process Observations

To further assess the practices in place within the Restrictive Housing System, the Consulting Team observed each relevant step in the disciplinary process. Consultants witnessed intervention by staff responding to conflicts, the use of clinical staff or specific MADOC staff to establish rapport, the immediate resolution of that conflict through restraint, and the placement of the individual into restrictive conditions of confinement that protected

himself and others from imminent danger.

Additionally, staff described these procedures as routine, incorporating multidisciplinary responses to reduce uses of force and arrive at alternatives to more restrictive interventions. The

Consulting Team also observed the role of nursing and mental health clinicians who conducted evaluations in the HSU following an incident, and prior to placement into an RHU. While touring the RHUs, the consultants observed clinical staff conducting wellness checks and individual out-of-cell therapy sessions in the RHUs and in the DDU. The team observed groups occurring in the STP and an RTU, and toured various classrooms dedicated to the SAU. Additionally, the Consulting Team observed first-hand the interdisciplinary communication occurring around those housed in the RHUs and the DDU, noting that all members of the interdisciplinary treatment teams had clear familiarity with patients.

From our observations, the processes observed during the site visits reflected the policies promulgated by MADOC and its contracted providers of healthcare services, which in turn are representative of the standard of practice as described by relevant professional organizations.

Professional Experiences

Core Working Group

The Consulting Team kicked off this study with a series of workshops and focus groups with a Core Working Group, as well as additional leadership from MADOC and contracted providers of healthcare and programs. At the statewide level, the Commissioner participated in several of the workshops along with Deputy Commissioners overseeing prisons, healthcare, programs, re-entry, and human resources, along with strong representation from the legal department. These leaders were joined by several additional regional and facility-level administrators who assisted with organizing smaller focus groups to include those providing care and custody inside housing units, specialized treatment programs, and specifically within RHUs and the DDU.

In general, MADOC leadership was well-versed in national standards of correctional practice, specifically accredited by the ACA and citing the NCCHC Standards for Prisons in their policies. MADOC leadership includes multiple ACA auditors and those who work on accreditation issues and it was clear that MADOC policies were developed based on the requirements put forth in the standards of both

professional bodies. Consistent with best practices, policies aligned with those standards, and processes observed in facilities reflected consistency with the policies of the agency.

MADOC leaders were equally as familiar with the history of their agency, including the statutory and legal influence on operations in recent decades, often citing case law, quoting statutes, and otherwise adept at explaining not only what the policy is, but why it is that way. The Core Working Group described a deep sense of obligation and pride in the delivery of services, feeling responsible not only to the incarcerated population, but also to the staff working within facilities and the constituents beyond the walls. This sense of obligation was matched by intense frustration expressed to the consultants regarding the level of adversary and animosity perceived from outside advocacy groups and legislators. This group of leaders was among the most educated and articulate we have seen, with notable strengths observed in those who work in data collection, synthesis, and presentation; legal affairs; and the design and delivery of mental health services.

Site-Level Interviews

The Consulting Team met with site-level MADOC employees and contracted providers of healthcare and programs during initial workshops, follow-up focus groups, and during site visits. In general, a close partnership was observed between custody and healthcare staff yet maintaining clear boundaries between those responsible for treatment and those responsible for security.



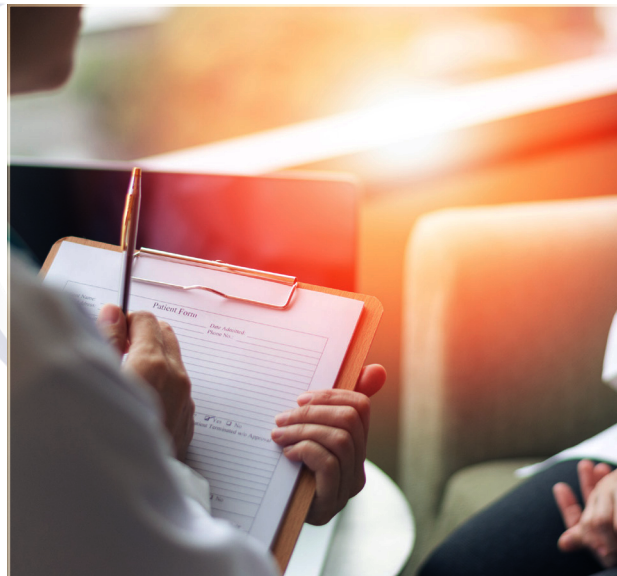
Custody personnel who were responsible for overseeing and working within specialized housing units like the STUs, the RTUs, and the DDU used the same language and rehabilitative messaging that was observed in statewide leadership meetings, with notable awareness and rehabilitative ideals reflected at the Superintendent and Captain levels of the facilities. Furthermore, correctional officers working on housing units were aware of the CJRA and its language, clearly trained in the requirements of the new law. In that vein, several officers expressed frustration at the revised definition of SMI, describing it as less helpful for them in determining urgency of referrals, need for advocacy or diversion, and the sense that those who are “SMI by statute” are somehow attempting to manipulate the system to avoid unpleasant consequences for their actions.

In general, correctional officers were aware of the procedures and policies related to Restrictive Housing, including the rights afforded to those with SMI specific to time-out-of-cell. Officers agreed with inmates interviewed that the quality of programming while out-of-cell could be improved, specifically in the DDU, and even the Captain of that area was aware that MADOC and its contracted provider were working to enhance the quality of those services.

With respect to mental health staff, consultants interviewed regional and site-level directors, along with mental health clinicians within various facilities. The working relationship between the contracted providers and the MADOC healthcare leadership team was obvious, and several of those interviewed had worked for both employers throughout their careers. Site directors were clearly invested in patient care and were able to readily discuss the clinical presentations of their more acute patients after those patients were interviewed by the consulting psychologist. Directors, clinical supervisors, and clinicians were all able to articulate the policies germane to Restrictive

Housing practices, as well as those involving the triaging of patients to the HSU, on to Mental Health Watch, or for referral through Court-Order to the Bridgewater State Hospital annex units.

Mental health clinicians described having access to their patients and not feeling that issues of dual loyalty²⁸ negatively impacted their delivery of care. Clinicians were observed conducting individual therapy sessions in the DDU, and the process for moving patients and arranging private visits appeared to be adequate. They stated that there are times when their requests to see a patient face-to-face in Restrictive Housing or in the DDU are denied, but those denied requests are temporary due to exigent circumstances of risk. The clinicians stated that they are still able to see the patient cell-side, and once deemed no longer an imminent risk, the patient is presented to the clinician in a private setting. Clinicians were aware of some of the more complicated ethical dilemmas encountered in correctional healthcare, such as not ‘clearing’ a patient to enter Restrictive Housing, but rather evaluating for urgent or imminent risk that would warrant a higher level of care in the HSU or on Mental Health Watch.



²⁸ Dual loyalty is an ethical dilemma encountered by healthcare providers working within settings of confinement that create a conflict between professional duties to the patient, and the interests of another party, such as that accompanying delivering care in a setting consecrated to security (i.e., the State). See: Pont, J., Stover, H. & Wolff, H. (2012). Dual loyalty in prison health care. *American Journal of Public Health*, 102(3), 475-480. DOI: 10.2105/AJPH.2011.300374.

Of note, clinical staff at each facility described a complicated response to the revised definition of SMI under the CJRA; at once appreciating the reduction of reliance on Restrictive Housing for more inmates and patients, while also feeling frustrated by the dilution of the clinical importance of the SMI designation. Each mental health department had developed its own improvisational tracking method to clinically triage the more acute patients to ensure that those with the highest clinical needs received the greatest level of service.

Currently Incarcerated Persons

The Consulting Team interviewed approximately 100 inmates across five MADOC facilities, conducting formal and informal interviews. Interviews occurred in group and individual settings, and in private spaces when requested. Because this study was conducted during a global pandemic that highlighted the epidemiological dangers of correctional facilities, the experiences of inmates and staff were impacted by recent emergency policies that limited movement, programming, and interaction with others. Just as the free world had been in quarantine and community lock down, MADOC prisons had initiated several emergency measures to limit the introduction and transmission of COVID-19. At the time of the site visits, MADOC facilities had no known positive cases in any of the facilities toured, and inmates were beginning to realize a slow but steady return to some sense of normalcy in facility operations. While some inmates took the opportunity to convey a sense of distrust associated with the measures taken by MADOC to limit movement and programming, most commended the department for the steps taken and the communication received from leadership, and all stated that they had not been denied medical or mental health treatment because of the lock down and quarantine measures. It was apparent that the agency was effectively communicating with the population to ensure that they were aware of the existing and evolving safety precautions.

Restricted Housing Unit (RHU)

The RHUs visited were each obviously below capacity, one at SBCC with just three inmates, relatively clean and quiet in the experience of

the Consulting Team. Inmates housed in these units described a variety of reasons for their segregation from GP, each verified with MADOC leadership. Reasons encountered included: pre-hearing detention, disciplinary detention of less than 15 days, awaiting the outcome of a DDU referral and investigation process, awaiting transfer to the DDU. Several of those interviewed had been in the RHU for more than 30 days, one inmate more than 60 days, each of them navigating the due process afforded in the DDU referral and investigation procedures. It should also be noted that those few inmates awaiting transfer to the DDU had not been moved because of restrictions on inter-facility transfers due to the global pandemic (according to MADOC personnel). Those housed in RHUs commonly complained of procedural ambiguity around their reasons for remaining in RHU, describing frustration and exhaustion with what felt like indefinite placements to them. Two described not knowing why they were in RHU, producing incident reports and paperwork that seemed to suggest both were the subject of ongoing investigations, which was confirmed with MADOC leadership.

Clinically, those housed in the RHU reported that they were able to access medical and mental health services as requested or as expected, consistent with their treatment plans, although some complained they were not getting their preferred treatment or medications. During mental status examinations of those housed in RHUs, there were no active symptoms of acute mental illness reported or observed. None of those housed in the RHUs reported psychotic symptoms, such as hallucinations or delusional beliefs, and there were no signs of the same observed. None of those interviewed reported active or passive suicidal ideation, intent, or plan, and although some described feeling mild anxiety or depressed mood, these reports were either linked directly with their placement in RHU, the nature of the ongoing pandemic and resultant restrictions on movement and visitation, and clinical staff were aware of those experiences. Despite no evidence of acute symptoms of mental illness observed in those living in RHUs, several were designated as having SMI. These individuals reported diagnoses of Post-traumatic Stress Disorder (PTSD) and “anxiety,” and each was known to clinical staff.

Secure Treatment Program (STP)

The STP is a 19-bed treatment unit at SBCC that offers diversion from the DDU for inmates who are designated with SMI based on traditional conceptualizations of the clinical term (i.e., more acute diagnoses like psychotic disorders or bipolar disorders). There is discretion for inmates not in the DDU referral process to be admitted, as well. Due to their propensity for rule violations and violence, this group of inmates receives enhanced residential mental health treatment while ensuring the safety of self and others.

Patients residing in the STP were generally diagnosed with major mental illnesses, including psychotic disorders, major mood disorders, and personality disorders that included the potential for breaks with reality and possible imminent danger to self and others as a result. The visit included observation of two simultaneous group therapy sessions, which were then turned over to the consultants for private group and individual meetings. The inmates here appeared to be appropriately identified and housed, and treatment was obviously occurring. There were no complaints regarding time-out-of-cell, and some conveyed that they were grateful to be in the STP rather than the DDU, appreciative of the conditions of confinement in the STP and the access to more intensive treatment. Several of the inmates on this unit, however, were relatively incoherent in speech, demonstrating active symptoms of psychosis, but not imminently dangerous, reaffirming appropriate placement in this level of care. One inmate described feeling bored by the material offered in programming, stating that he had been in the STP for years and felt that the manualized components were repetitive and a

more relational or interpersonal approach to therapy would be beneficial. The diagnostic heterogeneity in the STP, including for example Schizophrenia and Borderline Personality Disorder, makes selection of treatment materials challenging given the varying treatment packages appropriate for the differing presentations.

Behavior Management Unit (BMU)

The BMU is a 10-bed unit at MCI – Cedar Junction that offers diversion from the DDU for inmates who are designated as SMI due to significant character pathology and/or co-morbid diagnoses (i.e., Personality Disorders). Opened in July of 2010, the BMU provides an incentive-based model of treatment that includes prosocial activities that are specifically designed to address individualized behaviors that contributed to the disciplinary sanction. Similar to the STP, interdisciplinary treatment teams can refer individuals to the BMU who are not necessarily designated as SMI, or who are not currently in the DDU referral process.

Patients residing in the BMU were generally diagnosed with a combination of major mental illnesses and severe personality disorders, primarily elevated levels of Cluster B Personality Disorder like Antisocial, Narcissistic, and Borderline Personality Disorders. While these inmates were noted to have presentations of such severity that breaks with reality were possible and danger could be imminent, interviews revealed an instrumentality or conditionality to threats of self-harm or harm to others that was not apparent in the STP population. In our experience, the population housed in the BMU is the most treatment-refractory and challenging clinical population, generally due to a pervasive history



of physical and psychological trauma and a lifelong history of intractable interpersonal conflicts. This population challenges the traditional models of mad versus bad, as they do not fit neatly into categorical models of diagnoses but certainly have a SMI that warrants intensive clinical attention. Risk for self- and other-directed violence in this population is very high generally. The Consulting Team witnessed a patient being removed and isolated in a therapeutic module to prevent imminent harm to self or others. In the time the Consulting Team completed its tour, the patient had been approved for Court-Ordered admission to the ISOU at Bridgewater State Hospital. The BMU had exceptionally high levels of staffing, including two officers on each floor, two sergeants, a lieutenant, three mental health clinicians, and a clinical supervisor, for a total of ten patients. Patients in the BMU generally did not want to participate in the treatment programming available, and some felt they would have preferred to remain in the DDU, despite obvious risks that this population poses if placed in Restrictive Housing.

Secure Adjustment Unit (SAU)

Inmates in the SAU were generally those who had repeat low- to mid-level infractions and were clearly not appropriate for or benefiting from Restrictive Housing to modify behaviors. The three-tiered unit lends itself to having 20 out of cell together, enhancing the availability of socialization and interaction. Interviews revealed a sense of frustration with placement in the program, with some reporting that they were only there because they feared returning to their original facilities due to conflicts with other inmates. Mental status examinations did not reveal any active psychosis or major mood instability, although the program did appear to be capable of serving individuals with SMI and more acute diagnostic categories.

Department Disciplinary Unit (DDU)

Inmates in the DDU were the most vocal about their conditions of confinement and perception that they were being warehoused and unfairly punished. The DDU is designed as a facility whose aim was punitive long-term super-maximum confinement. Interviews revealed deep anger and resentment toward correctional staff and the facilities in which they were housed. "If you treat me like an animal, I'm going to act like an animal," said one inmate. The Consulting Team conducted dozens of interviews in the DDU, focusing specifically on the SMI Contraindicated population, those with diagnosed SMI awaiting bed space in the STUs. Of those with whom the Consulting Team spoke, none were diagnosed with major mental illnesses like psychotic disorders or bipolar disorders, and most described diagnoses of Posttraumatic Stress Disorder or "anxiety." Several were not prescribed medications. Mental status examinations did not reveal active symptoms of psychosis or major mood instability, neither reported nor observed, and no inmates were identified as being in any acute distress. Inmates in the DDU complained that their time out of cell could be more productive and meaningful, describing programming as shackling them to a Restart chair "and staring at a wall." They described high rates of turnover in the programming staff, and several chose not to leave their cells to attend groups as a result.

Formerly Incarcerated Persons

On October 6, 2020, the Consulting Team met with three formerly-incarcerated persons, arranged by PLS. Their perspectives were incredibly valuable in developing an appreciation of the culture inside facilities, and how Restrictive Housing plays a role in perpetuating a harsh and punitive climate. What follows is a summary of the themes heard during the focus group with respect for the privacy of those who shared their stories.

- Those interviewed described serving substantial multi-year sentences in MADOC prisons, including repeated or lengthy stays in Restrictive Housing in general, and the DDU specifically. It was reported that Restrictive Housing had been used as an administrative tool to protect vulnerable inmates from others, despite the person's objection.
- Interviewees noted that things appear to have improved slightly in recent years, specifically with the introduction of tablets and tablet-based programming.
- People articulated a frustration that Restrictive Housing and the DDU did not address the root causes of the conflicts that led them to the disciplinary system, but rather served as an attempt to incapacitate and punish further.
- Interviewees described serving sanction time without notice of their alleged infraction, but due to ongoing conflicts in GP, being unable to return to less restrictive housing.
- One interviewee described serving five years in the DDU prior to the more recent reforms, noting that it was "lock-in-a-box" then, with no programming, indicating improvement in recent years.



Key Observations

1. Senior leaders recognize the evolving nature of correctional practices, lean into the issue of Restrictive Housing reforms, and are flexible and adaptable.

Across the country, we are witnessing a social movement for criminal justice reform with sweeping implications throughout the justice system. While the outcry for reform today focuses on issues of mass incarceration, institutional racism, and the intersection of public safety and public health, restrictive housing reforms have been at the forefront of systemic evolution for many years. In fact, the modern movement toward more humane practices was spearheaded by the Settlement Agreement reached in Massachusetts in 2012.²⁹

In fact, the modern movement toward more humane practices was spearheaded by the Settlement Agreement reached in Massachusetts in 2012.

The intervening years have seen that case cited in many subsequent legal and legislative efforts to reform the practice of restrictive housing, and those efforts have had a profound impact on penological practices across the country. In many ways, it is not surprising that the same system that reached that Settlement Agreement is now circling back to revisit the issue nearly a decade later. While the 2012 Settlement Agreement applied specifically to inmates with SMIs, the intervening years have seen steady declines in the reliance on restrictive housing to manage the larger population, reducing the number of beds in restrictive housing areas, and successfully eliminating the practice altogether in the female facility.

MADOC invited this independent assessment knowing that changes would be imminent and requested that the Consulting Team identify strengths and opportunities for improvement, a relatively rare example of proactive leadership in our experience. For decades, correctional policy has been shaped by legal action, or the threat of the same, and in recent years we are seeing a new generation of leadership that no longer believes that lawsuits are necessary for enhancements and implementation of improved practices. This was clear with this project, and MADOC leadership was eager to learn and share with us their ideas, seeing this as an opportunity to improve their system. This study builds upon reforms already underway including creation of the Central Office Restrictive Housing Oversight Committee developed in recent years to review all inmates in Restrictive Housing on a monthly basis.

Additionally, this study was conducted during a global pandemic, with all meetings, workshops, focus groups, and presentations, with the exception of the on-site visits were conducted virtually, as the pandemic remained a global threat.

These unique and unprecedented challenges notwithstanding, the Consulting Team found in MADOC a Core Working Group of unmatched leadership in our experience. The core group included Commissioner Carol Mici, several of her Deputy Commissioners and their Assistant Deputy Commissioners, superintendents from all over the Commonwealth, and strong and impressive involvement from those responsible for overseeing medical, behavioral health, and criminogenic programming. Access to necessary data and documents was granted without question or delay, often receiving hundreds of pages of documents just days after requesting them. Similarly, access to various

²⁹ Disability Law Center v. Massachusetts Department of Correction, et al. 960 F.Supp.2d 271 (D.Mass 2012).

stakeholder groups was provided in a transparent and collaborative manner, inviting the Consulting Team to work directly with PLS to interface with formerly incarcerated persons, former employees, and even arranging a meeting with the CJRC. While on site visits, consultants were provided with unfettered access to inmates and staff without question, and consultants were able to engage in individual and group meetings.

Worthy of specific attention in this regard was the use of technology and data we witnessed during the study. The community-facing image of MADOC represented on its website, including an extensive series of user-friendly dashboards, and easy access to research statistics and reports is exemplary. In addition to the helpful content, user guides and instructions assist the user with accessing and interpreting desired data and statistics. Linking to the RHOC and associated reports, statutes, and documents made assessing the system unusually efficient during a very challenging time. Lastly, the Consulting Team's contacts with Operations Analyst Manager, the MADOC Data Analytics Unit, and the Research and Planning Division were invaluable and unmatched in our collective experience. Not only did they provide extensive data and documents immediately upon request, but they also participated in instructional sessions to orient to the available data and completed customized studies to facilitate further investigation.

In our collective experience, this level of collaboration and transparency during a study of this type and potential consequence, represents a refreshing and unique strength for this department.

2. There exists a deep mistrust of MADOC from public advocacy groups and the legislative CJRC.

Not uncommon in prison systems across the country, advocacy groups and passionate legislators see prison systems as institutions in need of reform, at a time when reforms are enjoying bipartisan support. The Consulting Team empathizes with MADOC leadership as systems are complicated by a wide array of complexities including budgetary restraints, policy, procedure, organized labor, culture, and of course the mandate for public safety. While this is a common conflict for institutions, in our experience we have seen no more passionate or professional group of advocates. They are influential, well-organized, well-informed by former employees and formerly-incarcerated persons, and even have some statutory mandates to represent the interests of those currently incarcerated.

The Consulting Team heard a perception of general opaqueness from the department, with many calling for increased transparency. More specifically, PLS, the CJRC, and formerly-incarcerated persons advocating for change described a lack of "compliance" with the CJRA of 2018. While the compliance concerns were somewhat vague, there were specific concerns reported regarding delays in the provision of the quarterly and bi-annual data and reports to the RHOC. While the Consulting Team did note that the reports were several months behind, we also recognize the potential ramifications of publicly releasing data of that kind and consequence, the importance of its accuracy and reliability, and the need to establish strong and consistent procedures for collecting, synthesizing, analyzing, and reporting. Delays notwithstanding, the quality and utility of those reports is unquestionable and unprecedented in our experience.

3. MADOC is forced to be reactive to outside pressures in enacting system improvements, policy changes, and reform.

Leadership at MADOC indicated to the Consulting Team that they would like to proactively implement programs and systemic changes but experiences the advocacy and resultant legislation, lawsuits, settlements, etc. as unwavering and all-consuming. This results in inefficient efforts that have unforeseen and undesirable impacts on the preferred strategic goals of the larger system. For example, when new programs are required within the department due to external forces (i.e., Settlement Agreements), they are not efficiently incorporated into the larger system, resulting in operational and fiscal redundancies and inefficiencies. Layered capital and operating costs result in unintended silos of operations and services that ideally could be integrated within existing staffing and operational structures.

4. MADOC experiences outside groups as misinformed and unsympathetic to the challenges faced by those providing care and custody in prisons.

Working in prisons and directing prison systems is very challenging work, consistently identified as some of the most stressful occupational environments in the nation. Unique stressors have been shown to produce rates of PTSD in correctional officer samples many times higher than the general public, and rates of somatic and behavioral health conditions and crises – including suicide – are substantially higher in populations of people who work in correctional settings. And yet, those who choose this profession are committed to public safety, and many have a deep sense of the rehabilitative ideal. When outside entities mandate changes within the department, MADOC is responsible for implementing those changes, and navigating through the unintended consequences.

For example, when the CJRA was implemented on January 1, 2019, it redefined the term SMI to ostensibly encompass all mental illnesses. By expanding the definition of SMI, the CJRA effectively eliminated the use of Restrictive Housing for more than 2,400 inmates who then fell under that definition. Clinically, however, the term has long carried important meaning with respect to the acuity and functional impairment that accompanies traditional diagnoses of psychotic disorders, bipolar disorder, depressive disorders, and other conditions that reflect substantial need for ongoing clinical care. The SMI population generally requires prioritized clinical services, enhanced in both quantity and quality, to maintain an adequate baseline of functioning. In sum, the term SMI now incorporates both acute and non-acute populations, muddying the waters of the term. Additionally, because of the contraindications for SMI in Restrictive Housing, certain conditions must be met for placement therein³⁰. Additionally, the waiting lists for STUs anecdotally went from approximately 8 or 9 to nearly 100.

5. Leadership views this study as an opportunity to confirm what is done well, but also for proactive system change and implementation of best practice correctional and rehabilitative models.

MADOC leadership proactively invited this assessment of the Restrictive Housing System, recognizing that the study would include validation of some components, but could potentially include significant recommendations for enhancement to the system. Throughout the study period, MADOC leadership, line staff, and contracted partners all openly recognized that there are opportunities for improvements, and we found a dedicated workforce eager to implement programmatic enhancements.

³⁰ See M.G.L. c. 127, sec.39A (a) and M.G.L. c. 127 sec 39B (a)-(c)

6. Conceptually, it is helpful to separate 'Pre-DDU' [i.e., Restrictive Housing Units (RHU)] from the DDU itself, which is a place rather than a condition of confinement.

Pre-DDU operations closely approximate the emerging standard of forward-thinking prison systems across the country, but relatively small tweaks to that system are necessary to bring it further in line with best practices in terms of safety and efficacy of the system. Current operations do an excellent job of incapacitating imminent risk for harm to self or others in the emergency response and initial de-escalation following an incident. Emergency clinical diversion into HSU and on to suicide precautions when indicated is an area of strength.³¹ People with acute mental health conditions, such as active symptoms of psychosis or major episodic mood instability, are often deflected back to RTUs, triaged to STUs, and provided with additional clinical support if required to enter RHUs. These clinical safeguards effectively minimize the risk of patients 'falling through the cracks,' and we found no evidence of acute symptomatology in RHUs or the DDU. More importantly, mental health leaders and clinicians are passionate, committed, and creatively balance empathic patient-centered ethics with the need for safe and secure environments, a clear strength in this system.

Although these safeguards were clearly in place, in exceptional cases people do remain in RHUs longer than 30 days. While we recognize that the Commonwealth of Massachusetts Courts have upheld the constitutionality of the conditions of confinement for pre-hearing status and what does or does not constitute the deleterious conditions associated with prolonged solitary confinement,³² we still recognized that there were people held in RHUs for longer than 30 days. In our opinion, these conditions meet the definition of Restricted Housing contemplated in the more qualitative standards such as the position statement on Solitary Confinement (Isolation) from the NCCHC.³³

RTUs and STUs appear to be adequate, well-staffed, with appropriate policies and practices in place, but bed space is insufficient given the wait lists that exist.

7. Conditions of confinement in the DDU result in prolonged periods of Restrictive Housing.

In the DDU, people remain in these conditions of confinement for months or even years, potentially up to ten years although that is a relatively rare exception. Furthermore, the innately punitive culture of the DDU minimizes the interests of rehabilitation or positive behavior change to address the underlying causes of the infraction that led to placement in the DDU.

The LPU does afford more time-out-of-cell, but is permeated by the punitive culture of the DDU more broadly. We believe it meets the definition of Restrictive Housing. While the SMI Contraindicated population may receive additional time out of their cells, we also believe these conditions meet the definition of Restrictive Housing similarly to the LPU. Lastly, the clinical team is very good at triaging the acute population and no acute psychiatric symptoms were observed in the DDU by consultants during site visits, but those designated as SMI under the CJRA are still forced to remain in the DDU awaiting bed space in the BMU or the STP.

³¹The policies governing these operations are outstanding in our collective experience. Specifically, 103 DOC 650, *Mental Health Services* is worthy of highlight.

³²Referencing *LaChance v. Commissioner of Correction*, 463 Mass 767 (2012); *Torres v. Commissioner of Correction*, 427 Mass. 611 (1998); among others.

³³ See ncchc.org/solitary-confinement.

8. Procedural due process afforded to those referred to the DDU can create unpredictable lengths of stay in Restrictive Housing.

Because of the potential for lengthy sanction time associated with DDU referrals, those referred for a DDU hearing are afforded due process rights that are uniquely burdensome and result in extended stays in Restrictive Housing Units awaiting disposition in a quasi-judicial proceeding. Efforts have been made by MADOC administration to address the perceived lack of fairness, for example, by removing DDU Hearing Officers from the facilities where DDU hearings are held. Additionally, we recognize that there is a system of review in place, and that anyone held in non-disciplinary restrictive housing for more than 90 days is entitled to a hearing, notification of the reason for continued placement in the Restrictive Housing Unit, and additional safeguards, due process, and administrative oversight. These lengthier stays can also result in a ‘time-served’ determination at disposition. However, it is a paradox of the entitlement to due process that people remain in Restrictive Housing Units for months pending investigation and hearings, resulting in undefined and unknown periods of time in these conditions of confinement. Inmates who navigate the DDU referral process, as well as those professionals who advocate for them during that process, experience a lack of procedural justice in the investigations and hearings.

9. Programming for criminogenic needs in the DDU should be assessed and enhanced, to improve the quality of time-out-of-cell for meaningful interaction, not only the quantity.

Treatment for those in the DDU, specifically programming for criminogenic thinking, was described by all parties and interviewees as requiring improvement. Just as important as the number of hours a prisoner is out-of-cell is the programming and activity that occurs during that time. In discussing this on-site, staff from the mental health department, MADOC officers, and even the Superintendent were all in agreement that the observation is worthy of additional attention and consideration. They described high rates of staff turnover in the facilitator positions, difficulty filling the positions, and finding candidates who prefer to be correctional officers rather than clinicians.

We also observed that additional efforts were underway to reach this population with programming due to exigent circumstances associated with the global pandemic. These included increased access to tablets as well as educational packets while out-of-cell time has been limited.



Recommendations and Options

1. Identify a team and develop a plan for implementation.

Changing a system requires more than policy directives if it is to have lasting positive impact, and cultural shifts necessitate strong leadership and a demonstrated commitment by people in positions of respect and influence. There are implications for training, health, wellness, creativity in the built environment, and a shift in general philosophy and the interests of justice. In our opinion, MADOC clearly has the competence to make substantial changes and be a leader as criminal justice reforms continue to evolve.

It is recommended that an interdisciplinary implementation team create a strategic and structured road map for enacting system changes, looking not only for substantive changes, but for efficiencies as changes are implemented. For example, this could be a good opportunity to reorganize clinical and criminogenic programming contracts to achieve increased efficiencies. This type of efficiency does not need to be immediate but can be done in preparation for the next cycle of contracts.

It is further recommended that the implementation team reflect representation from multiple disciplines, including MADOC administration, correctional officers, Wellpath medical and mental health, Spectrum, and any other internal stakeholders. Furthermore, it is recommended that a Stakeholder Advisory Group be formed to include advocacy organizations, members of the public, local legislators, and people with lived experience, to invite them into the process and allow them to feel heard and validated.

Good examples of existing implementation teams or models exist, such as those addressing justice-involved females, restrictive housing oversight, LGBTQI populations, data, and training. One of these existing teams may be appropriate for this purpose given resources already allocated to these missions.

2. Develop a transparent communication strategy.

Given the level of interest from a wide array of stakeholders in the community, a communication strategy should be implemented that informs those groups of intentions to enhance the system in a clear and transparent manner. It is recommended that regular updates be provided through the RHOC, as well as through less formal updates and venues specifically eliciting feedback as implementation proceeds. Taking a proactive approach to communication of intended changes and creating channels for feedback from stakeholders will likely yield the most effective, sustainable, and efficient implementation.

3. Dissolve the Department Disciplinary Unit (DDU).

It is recommended that the DDU be dissolved, including the DDU proper, the LPU and the SMI Contraindicated. Those currently serving DDU sanctions should be considered for specific programming or housing in maximum security facilities as appropriate, or otherwise assessed for programs consistent with the criminogenic needs that landed them in the DDU to begin with. If criminal prosecution is warranted, it is recommended that the matter be referred to the appropriate District Attorney or other prosecutorial body outside of MADOC.

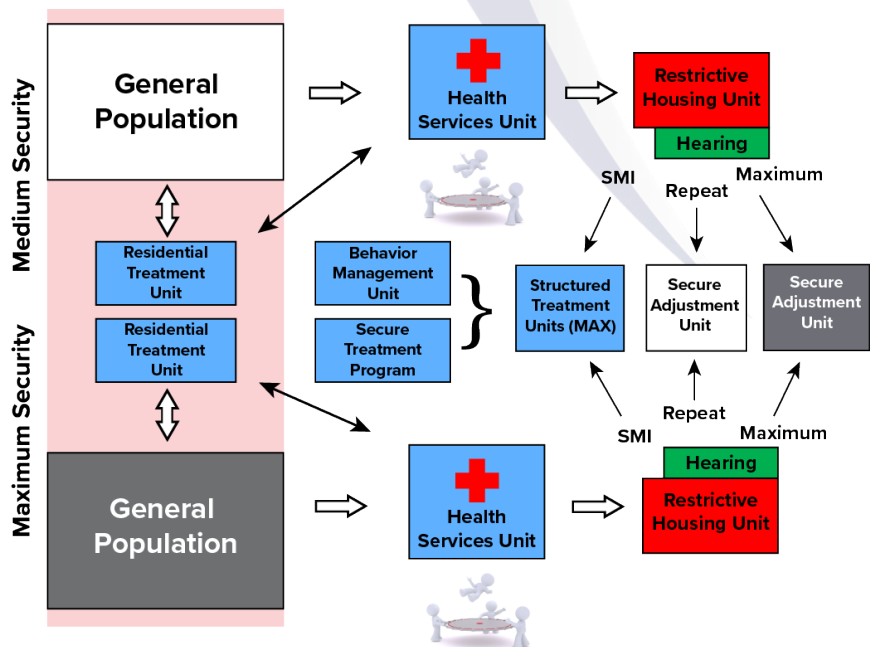
We believe the elimination of the DDU, and the extensive due process afforded those referred for placement in the DDU, could save the department massive resources, reduce the length of stay in RHUs, eliminate delays due to investigations and hearings associated with that process, reduce risk for suicide, and reduce the use of Mental Health Watch to avoid conditions in the DDU. It is recommended that baseline data be collected on each of these indicators and others, such as re-offending (internal recidivism), to be studied on an ongoing basis to assess success of implementation.

The DDU was already expected to move from MCI – Cedar Junction to Souza Baranowski Correctional Center, but no date was set due to the global pandemic. We believe this is an opportune moment in the history of MADOC to implement this meaningful change, elevate correctional practice, and impact the culture within the system in a healthy manner.

Lastly, while we recommend dissolving the DDU as currently operated, it is recommended that the space be reimagined. With some facility and programming upgrades, the space could be valuable for additional services. Specifically, we recognized a need for expanded treatment for Substance Use Disorders, trauma-responsive programming, violence risk reduction, and criminogenic thinking.



Option 1: Evolving Standard



**Option #1
Evolving Standard**

- Department Disciplinary Unit is Dissolved
- No SMI in Restrictive Housing
- No Person in Restrictive Housing >15 Days
- Everyone in Restrictive Housing > 15 Days is Reviewed Every 72 Hours
- Deputy Commissioner of Prisons has Authority for Administrative Override in Exigent Circumstances

4. Consider eliminating all use of Restrictive Housing as currently defined.

In many ways, dissolution of the DDU is a distinct matter from the elimination of Restrictive Housing conditions of confinement, system-wide. Turning to the 'pre-DDU' system, MADOC is well-positioned to make relatively minor tweaks that could potentially eliminate its use altogether. In this model, RHUs would afford everyone more than two hours out-of-cell each day, with a combination of structured and unstructured time, except in exigent circumstances. This is to say that an individual deemed to be imminently dangerous could absolutely be placed into conditions of confinement that maintain safety and security until such time as a less restrictive setting is appropriate. That assessment and process, however, should be clearly documented, with behaviors clearly identified, and should not be punitive but rather protective. Exigent circumstances should be documented and standardized so they are easily accessible for review without undue burden.

This model assumes that no housing unit operates under conditions of confinement that require placement in a cell 22 or more hours per day, by default. Every housing unit, even in the Restrictive Housing Unit, would provide more than two hours out-of-cell per day. This model represents the future of disciplinary and administrative segregation and grew out of the Correctional Service Canada (CSC) Structured Intervention Unit (SIU) model.³⁴ For more information and as one example, see Appendix A.

Based on the Risk-Needs-Responsivity (RNR) model, the SIU operates under an assumption of treatment or programming need, which turns the SIU into an assessment center. The person undergoes an assessment to identify the clinical and criminogenic factors driving the behaviors that led to the infraction or disciplinary intervention, and the person is then programmed into the appropriate intervention to meet those identified needs.

³⁴ For more information on the Correctional Service Canada (CSC) Structured Intervention Unit (SIU) model, see: <https://www.csc-scc.gc.ca/acts-and-regulations/005006-3000-en.shtml>.



5. Study Mental Health Watch and assess the allegations made in the DOJ Report, using the opportunity to enhance safety and quality of healthcare delivery.

The allegations regarding Mental Health Watch presented in the DOJ Report are concerning and warrant attention. It is recommended that MADOC use this opportunity to study its suicide prevention system and the use of Mental Health Watch, recognizing an opportunity to enhance safety and quality in the delivery of this crucial healthcare component

6. Use the disciplinary process to assess clinical and criminogenic needs that contributed to requirement for increased restrictions.

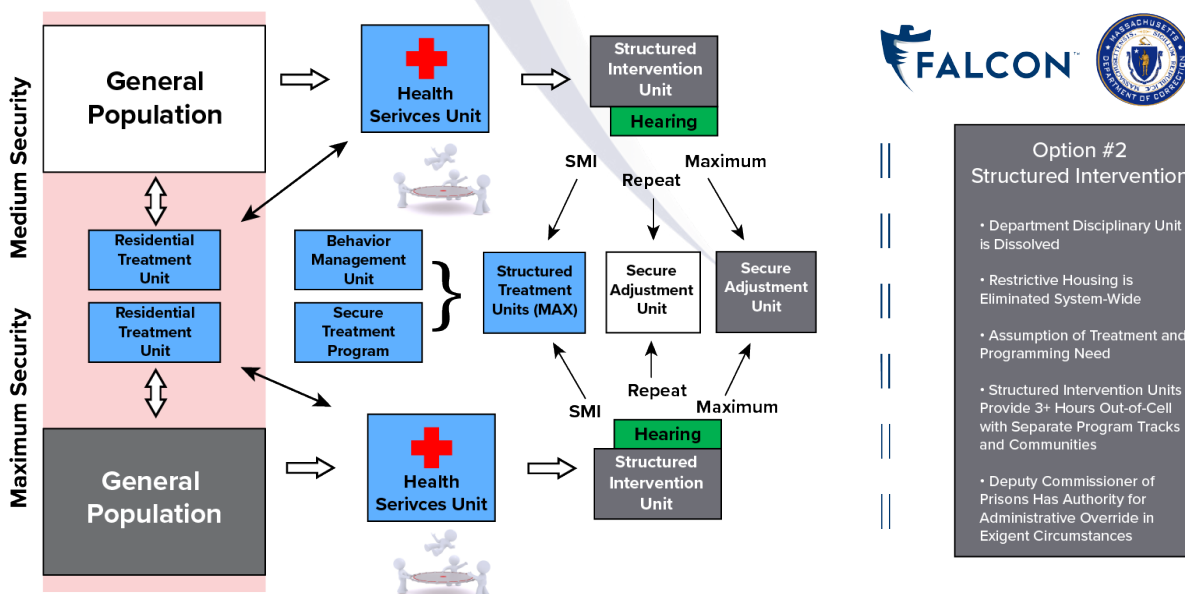
Regardless of the ultimate model selected, a philosophical shift is strongly recommended, to one that assumes some responsibility to identify and respond to the criminogenic and clinical risk factors that contributed to the infraction. In this way, RHUs become assessment centers for development of behavior plans that address the etiology of problematic behavior.

Re-entry from a RHU is accompanied by specific, measurable, attainable goals that reflect behavioral progress, increased safety, and which meet identified clinical and criminogenic needs. It is recommended that interdisciplinary input is invited into the creation of these behavior plans, including from the inmate.

Additionally, note the reduced clinical utility of the SMI designation in this regard, while accepting and appreciating the legal ramifications of the CJRA. This is to say that for clinical purposes, consider creating additional segmentation within the SMI designation to reflect an Acute, Sub-Acute, and Non-Acute³⁵ categorization based on a combination of diagnoses and level of stability or clinical need. These categories allow for triaging clinical needs, assigning resources to those patients most in need of greater services, while still affording all of those with SMI the rights and protections included in the CJRA, consistent with both the letter and the spirit of the law.

³⁵ These are suggested terms we see emerging across the country to reflect clinical need, incorporating the dynamic nature of mental wellness, where a patient may be Acute for a period of crisis before being Sub-Acute at baseline. We also recognize that 103 DOC 650.06, *Mental Health Services* provides for Mental Health Codes and see the "A" Sub Code and the most logical area of policy for including this enhancement..

Option 2: Structured Intervention



7. The SAU has excellent potential - consider expansion, segmentation by risk level, and clinical or criminogenic tracks within the program.

The SAU as policy and program provides a creative needs-driven solution to meet the criminogenic risks of a group of inmates that seems to find themselves repeatedly accessing the disciplinary system within the prison system. Generally, those in the SAU currently have limited histories of violence or Class 1 infractions, but rather include lower-level rule violations that certainly jeopardize the safety and security of an institution, but our experience was that treatment needs were common in the population.

Because the SAU takes a RNR³⁶ ³⁷ approach, we recommend further segmenting the criminogenic and clinical treatment and programming to specifically address the needs of this heterogeneous population, programming inmates based on needs, classification, and levels of functioning. Based on our review and study, the following four areas could be worthy 'tracks' within the SAU, and could be further stratified to include both Maximum Security and Medium Security programs:

- Trauma-responsive programming
- Substance Use Disorder treatment and education
- Programming for criminogenic thinking
- Programming for violence risk reduction

8. Evaluate the effectiveness of treatment and programming in the revised specialized housing, including the experiences of those who live and work in those programs, and expand bed capacity with implementing enhancements.

If MADOC decides to make structural changes to the disciplinary system, changes to the CQI monitoring will be necessary. It is recommended that data indicators be redefined to capture those constructs worthy of study for quality, safety, and to demonstrate success as defined. Strong CQI programs can identify problematic trends early and proactively, allowing the implementation team to swiftly make necessary changes to provide care and custody more effectively and efficiently. For example, in the interest of improved safety, you may want to consider monitoring successful staff engagements prior to the application of a planned use of force.

We reviewed the document titled Secure Treatment Units Outcomes: An Analysis of all STU Admissions 2008 to Present, authored by MHM Services, Inc.,³⁸ which is an outstanding example of a process and outcome study for CQI. We understand that MADOC has refined its data collection procedures and organization and plans to create a similar procedure soon. We recommend providing a similar annual update if possible.

Additionally, the BMU and the STP currently exist as a function of the existence of Restrictive Housing. As with any large system of integrated components, altering one component will impact all others. To the point, if the DDU is dissolved and if Restrictive Housing practices are eliminated system-wide, the BMU and the STP are no longer alternatives to Restrictive Housing, but rather become treatment units in Maximum Security settings. Those implications should be examined in terms of time-out-of-cell, treatment modules, programming, and CQI indicators revised as appropriate.

³⁶ Latessa, E., Cullen, F. & Gendreau, P. (2002). Beyond correctional quackery – professionalism and the possibility of effective treatment. *Federal Probation*, 66(2), 43-49.

³⁷ Bonta, J. & Andrews, D. (2007). Risk-Need-Responsivity Model for offender assessment and rehabilitation: 2007-06. Available: sedgwickcounty.org/media/31356/risk_need_2007-06.pdf.

³⁸ MHM Services, Inc. (January 18, 2013). Secure Treatment Units outcomes: An analysis of all STU admissions 2008 to present. Submitted to the Department of Correction Health Services Division.

9. Create a Substance Use Disorder treatment program for those with positive UDSs or who are otherwise entering the disciplinary system secondary to use of drugs or alcohol.

In recent months, MADOC has taken impressive steps to implement Medication Assisted Treatment (MAT) throughout the prison system, and we understand that treatment will soon be available to any inmate for whom it is medically appropriate, regardless of housing location. Consistent with the implementation of that model, which reflects the community standard of care, we recommend developing a comprehensive Substance Use Disorder treatment program specifically for those who use drugs or alcohol while incarcerated.

According to reports to the RHOC, 142 male inmates were placed in Restrictive Housing in 2019 for using or possessing illicit substances, having a UDS that was positive for illicit substances, or for consuming or producing alcohol.³⁹ Again, consistent with the evolving standard of diversion for low-level drug offenses in the community, we recommend developing a diversionary program for Substance Use Disorder treatment. This could be included as a track within the SAU, a component of another program, or could be a standalone treatment program.

10. Expand availability of tablets and tablet-based treatment and programming system-wide.

Consistent with a growing trend across the country, even more so because of the global pandemic, tablet-based treatment and programs in MADOC were very popular among those we interviewed. Not only did inmates speak highly of the access and metaphorical escape provided by this technology. Interestingly, staff described the transaction necessary to charge tablets as creating a prosocial relationship with inmates, who did not have charging stations inside their cells and thus, rely on officers to assist them with charging the tablets.

We recommend expanding the availability of tablets and tablet-based programming. However, we also recommend that tablet-based interventions be adjunctive or complementary to in-person interactions, and that time-out-of-cell not be reduced in any way because of the availability of tablets or other technology. There are important exceptions to this latter point, specifically the growing acceptance of telehealth as meeting the standard of care.

Additionally, programming modules are expanding and improving along with partnerships between content developers and platforms. While Falcon does not receive any compensation for recommending programs, we do review and endorse certain products and delivery systems that reflect best practices in this emerging arena. Two such programs include a prison-specific version of Breaking Free from Substance Use⁴⁰ and Moral Reconciliation Therapy (MRT),⁴¹ both of which have electronic or tablet-based versions.

³⁹ Class 2 Offenses, including 2-11, 2-14, and 2-19. Introduction and dealing in illicit substances, a Class 1 Offense (1-15), was not included in this analysis.

⁴⁰ Available: breakingfreegroup.com/solutions-prisons.

⁴¹ Available: moral-reconciliation-therapy.com.

11. Match staffing and training to specialty programs.

Because of the specialized nature of housing units like RTUs and STUs, we recommend a distinct selection process for correctional officers who work these posts. In other systems, we have seen self-selection, internal training within the unit, and specialized post orders become best practices. We recognize that the new Job Pick system does not allow for that level of consideration, but we believe this is a critical element to success in these specialty housing areas. Interviews with some of the original employees who worked on the Secure Treatment Program described having the right personnel as “the key” to successful operations. Officers were able to self-select, they were trained internally by other officers who had self-selected for the posts, and operations reflected the unique nature of the people housed in these units.

With respect to training, all officers working in specialized housing areas, including the RTU, STP, BMU and SAU should receive specialized training prior to working their first shifts. Now that Job Pick is functioning, post changes can be predicted and training schedule just prior to assuming the posts. Current training materials are very good, and we recommend elevating those materials by incorporating international best practices from European models that support staff and inmates on these specialty units.

Lastly, it was noted that specialized training for units like the RTUs, SAU, and STUs often relies on highly-regarded facilitators who are limited in numbers. When the trainer is on leave, it is disruptive to timely delivery of important training programs. To make these effective training programs sustainable, it is recommended that MADOC leadership invest in expansion of these capabilities, perhaps through mentorship programs within the training department.

Appendix A: Structured Intervention Units (SIU)

STRUCTURED INTERVENTION UNITS (SIUs)

SIUs

Administrative and disciplinary segregation have been eliminated and a new correctional model is in effect.

What does that mean?

Inmates may be transferred to an SIU if they have acted in a way that may, or has, jeopardized the security of an inmate or any other person, including themselves, or the security of an institution, or if they could interfere with an investigation.

How are SIUs **different** from segregation?



Structured interventions are tailored to address inmates' **specific needs**



Inmates have the opportunity to spend a minimum of **four hours** a day **outside their cell**, including two hours a day of **meaningful human contact**



More rigorous and **regular reviews**, including by someone external to CSC



Inmates will be **seen daily** by a healthcare professional



There will be an individualized approach focused on skills-based **interventions** and activities



The goal is to provide inmates with the **tools they need** to return to a mainstream inmate population as soon as possible, and to prevent a return to an SIU



Correctional Service
Canada

Service correctionnel
Canada

Canada

Source: Correctional Service (CSC)

<https://www.csc-scc.gc.ca/acts-and-regulations/005006-3000-en.shtml>

Appendix B: Acronyms

ACA - American Correctional Association	MAT - Medication Assisted Treatment
ACT - Assertive Community Treatment	MRT - Moral Reconciliation Therapy
ADHD - Attention Deficit Hyperactivity Disorder	NCCHC - National Commission on Correctional Health Care
ALOS - Average Length of Stay	OSCC - Old Colony Correctional Center
BMU - Behavior Management Unit	PLS - Prisoners' Legal Services
CJRA - Criminal Justice Reform Act	PTSD - Post-Traumatic Stress Disorder
CJRC - Criminal Justice Reform Caucus	QHP - Qualified Health Professional
CLA - Correctional Leaders of America	QMHP - Qualified Mental Health Professional
CMR - Code of Massachusetts Regulations	RHA - Responsible Health Authority
CMS - Center for Medicaid Studies	RHOC - Restrictive Housing Oversight Committee
CQI - Continuous Quality Improvement	RHU - Restrictive Housing Unit
CRIPA - Civil Rights of Institutionalized Persons Act	RNR - Risk Needs Responsivity
CSC - Correctional Service Canada	RTU - Residential Treatment Unit
DDU - Department Disciplinary Unit	SAMHSA - Substance Abuse and Mental Health Services Administration
DMH - Massachusetts Department of Mental Health	SAU - Secure Adjustment Unit
DOJ - Department of Justice	SBCC - Souza Baranowski Correctional Center
DSM - Diagnostic and Statistical Manual of Mental Disorders	SIU - Structured Intervention Unit
EOPSS - Executive Office of Public Safety and Security	SMI - Serious Mental Illness
GP - General Population	SPMI - Severe and Persistent Mental Illness
HSU - Health Services Unit	STP - Secure Treatment Program
ISOU - Intensive Stabilization and Observation Unit	STU - Secure Treatment Unit
LPU - Limited Privileges Unit	UDS - Urine Drug Screen
MADOC - Massachusetts Department of Correction	WHO - World Health Organization



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