Disability Law Center, Inc. vs Massachusetts Department of Correction, et al.
Civil Action No. 07-10463 (MLW)

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Date(s) of Site Visit: September 10-12, 2012
Date of Report: October 22, 2012

Sites toured:
Souza Baranowski Correctional Center (SBCC)
- Special Management Unit (segregation)
- Secure Treatment Program (STP)

MCI-Cedar Junction (MCI-CJ)
- Special Management Unit (10 Block, segregation)
- Behavioral Management Unit (BMU)
- Departmental Disciplinary Unit (DDU)

This first site visit consisted of touring segregation and high security treatment units at SBCC and MCI-CJ; rounding in some of the Special Management Units (SMU); meeting with select inmates housed in segregation units individually and group meetings with inmates in the high security treatment units. Inmates confined in Special Management Units were selected for interview based upon their being on a waitlist for STP or BMU and in segregation for 30-days or longer; inmates with an MH3 classification and/or prescribed antipsychotic medication or more than three psychotropic medications though not considered SMI by the DOC and its vendor, MHM.

Superintendents, prison administrative staff, institutional custody and mental health staff in addition to representatives from the central office and the legal office were very helpful and accommodating to these visits.

Souza-Baranowski Correctional Center (SBCC)

Special Management Unit (SMU)

The SBCC SMU, visited on September 10, was orderly, quiet and clean. During our rounds on the South SMU (J wing), all inmates affirmed that mental health staff conduct rounds regularly. Inmates also identified other ways to get mental health care including calling an emergency situation ("Medic 5") or submitting a written request.

Five inmates were interviewed individually. Four of them had been identified as SMI and in segregation for 30-days or longer; one had been on the STP waitlist for eight months and one was on a watch in the HSU and was to be transferred to the BMU at the end of the month. Transfer to the STP for the waitlisted inmate had been delayed to accommodate STP admissions for inmates believed more acutely in need of transfer. Those inmates identified as SMI and in segregation for more than 30 days reported being offered the opportunity for a weekly 1:1 out-of-cell counseling opportunity; most

take advantage of it. One inmate appeared psychotic but was not prescribed any antipsychotic medication at the time of the site visit although he was identified as SMI and had seen the psychiatrist. This case was brought to the attention of institutional staff for assessment/follow-up.

Secure Treatment Program (STP)

The STP was fully operational. The census on the day of the site visit was 19 although two inmates were at Bridgewater State Hospital and one was out-to-court. The housing unit was clean and quiet. A significant amount of retrofitting of the housing unit was completed allowing two areas of secure group treatment space (one with desks and another with treatment modules) in addition to the open dayroom equipped with metal tables permitting inmates to interact and socialize with one another during unstructured out-of-cell time.

Two groups of inmate program participants were interviewed. For the most part, all of them (10 inmates) related positive treatment experiences in the STP and expressed regard for treatment staff and appreciation for having been provided the opportunity for participation in the program. They raised three areas of constructive criticism that are worthy of further consideration:

1. Accountability cells - With a change in the management staff in the STP, the function of the accountability cells had also recently been modified to serve as an immediate consequence for an accusation of a disciplinary infraction in addition to placement for safety reasons and/or after a finding of guilt for an infraction. Prior to this change, involvement in behavior that could lead to a disciplinary infraction was assessed on a case-by-case basis and incorporated into the individual's overall treatment plan. Not every infraction resulted in a return to Phase 1. Current utilization amounts to punishment (drop of privilege level, restriction of property) without a finding of guilt. The inmates objected to the lack of due process and to the perceived lack of proportionality in accountability cell confinement. (Similar complaints about accountability cells voiced in the BMU are described below.) Staff affirmed the change in use of the accountability cells as an immediate consequence to some behavior.

2. Discharge planning – No mechanism for graduation/discharge from the program based on improved and stable clinical condition. Discharge is based solely on completion of the time required to be served as a result of a DDU sanction. (Although there is a mechanism to receive some reductions in the DDU sanction for good behavior, some inmates are in the STP for years and years in spite of improvement and clinical stability. This is going to represent a challenge not only for the inmates but also for the treatment staff to provide on-going, new and additional types of treatment interventions to this group of inmates and simultaneously address the treatment needs of inmates newly admitted. Additionally, this appears to be an inappropriate use of valuable and quite limited treatment space for those who no longer require such an intensive level of care.)

Further, even when inmates are "discharged" at the expiration of DDU sanction, they are generally released, with little preparation, to a maximum security and chaotic environment that is the same or similar to that which led to the behaviors and DDU sanction initially. By contrast, in the past some inmates were discharged from the STP to medium security. In addition, some transitional housing/programming or step-down planning occurred in the past permitting some inmates to go to an RTU, even temporarily, to assist in the discharge process.

3. Second shift custody staff - Virtually all STP inmates reported problematic officers on the second shift, particularly relief officers, without adequate supervision. Problems reported included verbal disrespect by the officers up to and including perceived harassment and provocation in addition to failure to call a mental health emergency on an inmate's behalf.

MCI-Cedar Junction

Special Management Unit (SMU) - 10 Block

The SMU has the capacity to house 60 inmates. The census was 33 at the time of the site visit. The unit appeared to be functioning in an orderly manner. It was clean and the inmates were quiet; some were out in the recreation yards, some sleeping and one mental health worker was seeing caseload inmates outside of their cells for individual counseling sessions. During our rounds of the unit, inmates affirmed seeing mental health staff routinely conduct rounds twice weekly.

Six inmates were interviewed privately in an interview room located just off the housing unit. They were selected for interview from the roster provided by the institution: four inmates were identified as SMI, two of them having been in segregation more than 30 days; and another was identified as prescribed haloperidol but was not on the mental health caseload. This process revealed that there were some transcription errors on the institutional rosters in terms of accurate labeling as SMI and current medication prescriptions. SMI inmates in segregation were being provided a weekly out-of-cell individual contact with their mental health counselor. Institutional staff reported that one inmate on the roster and interviewed was mistakenly reported as SMI, his diagnosis was some sort of affective disorder Not Otherwise Specified (NOS). However, there were significant indications of bipolar disorder (and hence, SMI) during the interview and this inmate requires reconsideration following a comprehensive mental health assessment. Another SMI inmate on the unit longer than 30 days was on the waitlist for STP admission. Out-of-state placement was being pursued in another case of an SMI inmate in SMU for more than 30 days. One SMI inmate that arrived in the unit recently had a profound hearing impairment that seriously compromised meaningful spoken communication – and may have contributed to the behavior which led to his being charged with staff assault.

Behavioral Management Unit (BMU)

The BMU has a capacity of 10 and had a full census at the time of the site visit. The unit appeared clean and quiet; most of the inmates were at outdoor recreation when we arrived although a few had declined. Inmates are housed in single cells on the first floor of the unit. Group treatment rooms, one containing secure desks and the other with therapeutic modules, are also on the first floor. The "accountability cells" are located on the second story of the housing unit.

Nine of the ten inmates assigned to the BMU were interviewed in group settings. (One group contained four inmates and the other group, five.) Some inmates had been in the program virtually since the opening of the unit; five inmates had been there for a year or longer; three had been there for longer than six months but less than a year; and two inmates were relatively recent admissions having been there for one to three months. (One of the more recently admitted inmates had been in the unit on a prior occasion.) One inmate had been transferred from the STP to BMU presumably as a result of a physical altercation with a correctional officer in STP.

Although specific data was not shared with us, institutional and mental health staff reported that the BMU outcomes measured across a variety of metrics were quite positive. Some of these measures included a decreased need for use of force, fewer rule violations/disciplinary infractions, dramatic reductions in inmate-self injury and crisis care and a very low re-admission rate. It was therefore, particularly disconcerting to observe the degree of anger, hostility and frustration expressed by the inmates during our group meetings with them. Additionally, in spite of the use of groups to provide virtually all programming in the unit, the inmates themselves had developed no group skills whatsoever, yelling and talking over one another, cutting one another off, failing to listen to one another, etc. (This is in stark contrast to the group meetings and inmate behaviors in the STP. The contrast is not just a reflection of psychopathology inasmuch as both units contain SMI inmates with significant Axis II co-morbidities.)

In terms of content, inmates reported that the BMU programming was not helpful to them; they found it punitive rather than therapeutic and expressed grave concerns about the perceived lack of confidentiality. They pointed to the use of the "accountability cells" for many purposes as an example of the punitive nature of the BMU. The inmates reported that these cells are being used as an immediate consequence to accusations of rule violations (without any finding of guilt), as punishment after a finding of guilt for a rule violation, as crisis watch/suicide prevention cells and, most recently, as a threatened consequence to refusing program participation. Regardless of the reason for placement in the accountability cells, the consequences and conditions are the same: loss of level/privileges and property; removal of clothing and undergarments with issue of safety smock; no soap or toothpaste; no access to shower; and all meals are finger foods. (These complaints are similar to ones voiced by STP inmates, although in the STP inmates are apparently given basic hygiene items.)

As another example of the punitive nature of the BMU, inmates also complained of multiple, repeated strip searching in spite of the numbers and locations of multiple cameras (including views into each cell.) In yet another example, there is only one potential inmate job assignment in the BMU. It is that of an inmate runner and the position is filled by one of the BMU residents. However, he is made to perform his job duties (cleaning showers, mopping, etc.) with one hand cuffed and attached to a belly chain. (Both the fact of there being only one potential job assignment and the manner in which the inmate is restrained while completing his duties were offered as evidence of the punitive rather than therapeutic nature of the BMU.) There was also a great deal of frustration and boredom expressed concerning group activities, particularly among inmates who had been housed in the BMU for years – the curriculum has not varied or programming kept pace to prevent boredom given the duration of time some inmates are confined in BMU. (The group activity that was interrupted by our usurping the time on the day of the visit was to watch a DVD of a television show about modern day prospecting for gold in Alaska. The relevance of such an activity and/or therapeutic value was not clear.) It is not surprising that the MHM monthly reports indicate that the group attendance rate in the BMU dropped from 84% in April to 44% in July.

Inmate groups expressed similar concerns to those of STP inmate regarding no "graduation" from BMU regardless of improvement or attainment of treatment plan goals. Inmates are only released at the expiration of their DDU sanction. (One inmate reported that he had been returned to BMU even though he had no DDU sanction. He said he didn't receive an explanation as to why nor was he given a BMU release date.)

DDU

The environment itself and "tone" of the unit was much improved over prior visits. The unit appeared to be running orderly and smoothly without the noise, chaos and inmate agitation levels observed during other site visits. The institutional staff acknowledged as much and attributed the improvements to the transfers of some of the DDU population into the BMU and STP units.

According to the DDU roster (both initial and updated), there are no SMI inmates housed in DDU. It appears that the pre-placement screenings are completed but only a small sample of records was reviewed. However, in the recently admitted cases reviewed, there appears to be an over-reliance on pre-existing diagnoses made while inmates are in DOC custody, regardless of diagnostic accuracy or adequacy rather than an actual screening or evaluation of current condition. (For example, although the use of "rule out" diagnoses has been addressed, the "Not Otherwise Specified" (NOS) modifier is over-represented. It does not appear that a NOS diagnosis is re-visited to determine its veracity and there is no documentation to explain just what makes the case "NOS" or "atypical" or why the condition doesn't meet the usual diagnostic criteria. The use of certain NOS diagnoses, such as mood disorder NOS, may have a profound impact on whether an inmate is consider SMI or not and must be addressed.)

Inmates were chosen for an individual out-of-cell interview based upon information contained on the roster; that is, having an MH3 classification, prescription of antipsychotic medication or prescription of three or more psychotropic medications regardless of type. Eight inmates were interviewed. There were indications that at least three of them required a more comprehensive mental health assessment and precise diagnostic clarification (one with an NOS diagnosis, one diagnosed with primary insomnia in prison though outside treatment records and current presentation consistent with psychotic disorder; another diagnosed in prison with Mood Disorder NOS but outside providers, history and current medication consistent with Bipolar Disorder.) One inmate was mistakenly listed as taking an antipsychotic medication though it had been discontinued many months prior and there were no indications of psychosis. One inmate had been offered BMU participation but declined due to serious past issues with other inmates on the unit.

All inmates acknowledged seeing mental health staff on rounds and caseload inmates were offered individual out-of-cell counseling sessions about once a month. There were issues with respect to the frequency, duration and location of appointments with psychiatry. (One recently arriving inmate had his medication dose cut substantially without ever having met the psychiatrist or being told of the dose reduction. This precipitated some behavioral problems and placement on a crisis watch. The dose reduction, absence of a psychiatric assessment and crisis as reported by the inmate were all verified by documentation in the medical record.)

Assessment

Because this was only the very first site visit, only two institutions were visited, and other data on which to base a conclusion is limited at this early stage, I am refraining from articulating an opinion with regard to the Department's compliance with the terms of the Settlement Agreement at this time. However, it is clear that to date, the Department has put forth good faith efforts in many respects including but not necessarily limited to: retrofitting high security environments to permit out-of-cell individual and group contacts; revising security policy to permit congregate activity; developing the software mechanisms and processes to ensure the collection of vast amounts of data not previously collected; and facilitating ready access to inmates and information cooperatively and efficiently during this first site visit. I am putting forth a number of recommendations that are intended to be offered in the same cooperative and collegial spirit as that demonstrated by the Department in preparing for and participating with the actual site visit.

Recommendations

1. Ensure that information contained in the housing unit rosters is up to date and accurate. Clearly, it is difficult if not impossible to track movement, monitor trends and patterns and ensure compliance with proposed treatment interventions if the most basic of information is not reliable. (This

recommendation is being offered with the understanding that the roster inaccuracies were truly unintentional and undiscovered until the actual site visit. Staff were apologetic and worked diligently to correct the information while we were on site. They recognized the need to establish processes to ensure and verify the accuracy of the rosters.)

2. Ensure that inmates awaiting placement in an STU are labeled as MH-4 and are provided the requisite amount of structured out-of-cell individual or group activities, out of cell leisure activity and clinical sessions as provided in the agreement. There appeared to be some confusion about the mental health classification of inmates on the waiting list for an STU with regard to whether they can be designated as MH-4, with staff inadvertently failing to reclassify inmates to MH-4, and consequently not increasing out-of-cell time accordingly.

3. Review STP admission waitlist management. Acuity is certainly a factor but the duration of time spent in segregation while on the waitlist should also be given some consideration.

4. Review mission/use of accountability cells in both STP and BMU. There appears to have been some mission creep evidenced by the use of the cells for multiple and mixed purposes: sanction for unproven behavior, safety/suicide prevention, punishment or threat for non-participation in programming.

5. Review STP length of stay and discharge planning. Length of stay should be related to achieving treatment goals in addition to DDU sanction time so as not to retain individuals at a higher/more expensive and highly limited level of care than required for their condition and the safety of the institution. It was my understanding that the STP was designed so that inmates could graduate from the program before completing the DDU sentence, with the balance of the DDU sentence held in abeyance, but this no longer appears to be the case. Consideration should also be given to returning to better transitional/step down placement and planning when discharged from the STP, whether as a result of completing DDU time or as a step in clinical care.

6. Encourage further investigation of STP second shift custody staff and supervision.

7. Consider implementing a weekly STP inmates and staff unit meeting during which concerns and suggestions can be addressed informally and a sense of community fostered.

8. Review BMU admission criteria and programming. The recent re-admission of an inmate with no DDU sanction and the transfer of an inmate with a serious Axis I disorder from STP to BMU suggest that there has been significant drift away from the unit's initially planned mission and target population. Programming/curriculum are also likely due for review/revision in light of mission creep and the duration of time some of the inmates have been in BMU to

address repeating treatment modules multiple times and the resulting boredom that ensues.

9. BMU evaluation metrics: A number of variables are currently measured and are reported to demonstrate good results. Nevertheless, given the duration of time that some of the inmates have been in BMU and the overall level of expressed dissatisfaction, unrest and anger, consider exploring some additional ways to define success, measure outcomes. Without access to knowing the variables currently being measured, it is difficult to offer accurate or meaningful suggestions as to what these could or should be but a comparison of post-release functioning of inmates released from BMU, STP and DDU may be illustrative if not already done in addition to some objective measures of improvement and sustained stability in clinical condition during BMU treatment and after release may provide additional useful information that could be incorporated into programming.

10. Comprehensive diagnostic assessments are recommended for a number of inmates in the DDU and SMUs. Brief interviews suggested pathology in excess of that reflected in the diagnosis listed on the rosters and chart reviews did not provide documented rationale for assigned diagnoses. Unjustified use of the NOS modifier may directly impact the conclusion of whether or not an inmate is SMI and entitled to the additional programs and services agreed upon in the Settlement Agreement.