Delaware Department of Correction
Restrictive Housing Assessment

Baylor Women's Correctional Institution (BWCI)
Howard R. Young Correctional Institution (HRYCI)
James T. Vaughn Correctional Center (JTVCC)
Sussex Correctional Institution (SCI)

Assessment Conducted By:
American Correctional Association

March 17, 2016

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DEFINITIONS:

ACA: American Correctional Association

BCHS: Bureau of Correctional Health Services

BOP: Bureau of Prisons

BSN: Bachelors of Science Degree in Nursing

BWCI: Baylor Women's Correctional Institution

DDOC: Delaware Department of Correction

FTE: Full Time Employee

HIPPA: The Health Insurance Portability and Accountability Act

HRYCI**:** Howard R. Young Correctional Institution

IOP: Institutional Operating Procedures

JTVCC: James T. Vaughn Correctional Center

MH: Mental Health

MSN Masters of Science Degree in Nursing

Psy.D Doctor of Clinical Psychology

QA: Quality Assurance

CQI: Continuous Quality Improvement

RTU: Residential Treatment Unit

RH: Restrictive Housing or Restricted Housing

SCI: Sussex Correctional Institution

SMI: Serious Mental Illness

INTRODUCTION

There has been extensive writing on the subject of Restrictive Housing (RH) units designed with the specific purpose of incarcerating inmates/detainees under highly isolated conditions. Restrictive Housing units have very limited access to programs, exercise, staff, or other inmates/detainees. When it is determined that an inmate is unable and/or unwilling to adhere to the rules governing conduct in the general population, they are confined in RH units usually locked in a cell for 23 hours per day for weeks, months, and sometimes even years. With nearly 20% of inmates/detainees having a diagnosed mental disorder, there is extensive writing about the exponential growth in the mentally ill population in America's jails and prisons. (Haney, 2003) As the RH population and mentally ill population converged, it became clear that mentally ill inmates/detainees were disproportionally represented in RH. These mentally ill inmates/detainees were being placed in RH at over twice the rate of those without mental illness. (Metzner & Fellner, 2010) As a result, litigation addressing the disproportionate number of mentally ill inmates/detainees in RH proliferated throughout America's correctional systems.

The standard of care for mentally ill inmates/detainees in RH continues evolving as consent decrees and settlement agreements guide correctional policy development. Sustained by the generally accepted understanding that, when people are subjected to social isolation and reduced environmental stimulation, they may decompensate mentally and, in some cases develop psychiatric symptoms, the court system has upheld rulings that certain subgroups of the prison population, including the mentally ill, are especially vulnerable with prolonged incarceration in RH. (Grassian, 2006) Prison and jail systems, therefore, have had to respond by developing specialized mental health programs and multidisciplinary policies that can remediate the critical clinical and legal issues germane to the management and treatment of mentally ill inmates/detainees in RH. (Aufderheide, 2013) The critical components advanced for specialized mental health programs in RH include, but are not limited to: [1]

1. Pre-placement and post-placement mental health screening evaluation;
2. Written and verbal orientation to mental health services;
3. Access to structured mental health services and treatment;
4. Individualized treatment and services plan developed with the inmate by a multidisciplinary services team;
5. Weekly rounds of all inmates/detainees by qualified mental health staff;
6. Ongoing evaluation and monitoring;
7. At least quarterly monitoring of compliance with program requirements;
8. Sufficient staff resources for mental health and security;
9. Specialized mental health training;
10. Open lines of communication between security and mental health;
11. Definition of serious mental illness (SMI); mental health classification system;
12. Established levels of care;
13. Input by mental health staff in the disciplinary process;
14. Therapeutic environment/space to provide treatment and afford confidentiality; and
15. A step-down unit for transitioning inmates from RH status.

[1] Aufderheide, Dean (2013). Mental Illness in Administrative Segregation: How to Bulletproof Your Program Against Litigation. Correct Care, Spring, Vol. 27, No. 2: 14-16.

The Delaware Department of Correction statewide population characteristics for mental illness/treatment related statistics appear to be consistent with other state correctional systems incarcerating inmates and detainees. The Department's total inmate/detainee population as of December 1, 2015 was 5615. Of that number, 1374 were receiving some type of mental health treatment, which represents about 24 percent of the total population. There were 816 who were identified as having a serious mental illness (SMI), which represents about 15 percent of the total inmate/detainee population. Of the 1374 inmates/detainees receiving mental health treatment, 1091 were prescribed one or more psychotropic medications, which represent about 79 percent of the mentally ill population statewide.

The statewide population characteristics for mental illness/treatment related statistics in RH also appear to be consistent with other state correctional systems incarcerating inmates and detainees. There were 453 inmates/detainees who were in some type of restrictive housing, which is 8 percent of the total inmate/detainee population. 141 were receiving some type of mental health treatment, which represents about 31 percent of the restrictive housing population. There were 89 identified as having a serious mental illness (SMI), which represents about 20 percent of the inmate/detainee population in restrictive housing. Of the 141 inmates/detainees receiving mental health treatment in restrictive housing, 99 were prescribed one or more psychotropic medications, which represent about 70 percent of the mentally ill population in restrictive housing.

PURPOSE OF CONSULTATION

Restrictive housing is a vital and necessary tool used in the corrections profession to maintain order and control of a facility, to ensure safety, to prevent violence, and to protect inmates who may be in danger. Restrictive housing can help to reduce gang influence, and control inmates who may be an escape risk. Restrictive housing may have benefits for most individuals within the corrections environment yet its use must be in a proper and controlled manner so as to not cause long term negative effects on the individual involved. The American Correctional Association is proud to partner with the Delaware Department of Correction to address the issue of restrictive housing and improve behavioral health. The purpose of this project design and implementation was to conduct the following:

Objective 1: Review current policies and procedures

Objective 2: ACA will conduct site visits to the four restrictive housing units of Baylor Women's Correctional Institution (BWCI), Howard R. Young Correctional Institution (HRYCI), James T. Vaughn Correctional Center (JTVCC) and Sussex Correctional Institution (SCI).

Objective 3: The ACA team will complete an analysis and will complete a literature review on the use of restrictive housing. ACA will make recommendations on possible alternatives to the use of restrictive housing.

The team conducted site visits to the restrictive housing units BWCI, HRYCI, JTVCC, and SCI. The visits were on November 18 and 19, 2015, with a follow-up assessment discussion on November 20, 2015, in the ACA Headquarters. There was an additional on-site assessment and review on December 14 and 15, 2015, with follow-up assessments and discussions in the

ACA Headquarters. The ACA Team consisted of Dr. Elizabeth Gondles, Dr. Dean Aufderheide, Doreen Efeti, Adam Willhite, Mel Williams and Tony Wilkes. The team assessed the restrictive housing policies and practices in order to make recommendations regarding operation and possibly statutory changes relating to the Delaware Department of Correction's use of restrictive housing.

METHODOLOGY

The following sources of information were utilized in accomplishing the review:

1) Visual examination of each RH unit at Baylor Women's Correctional Institution (BWCI), Howard R. Young Correctional Institution (HRYCI), James T. Vaughan T. Vaughn Correctional Center (JTVCC) and Sussex Correctional Institution (SCI);

2) Review of the following Institutional Operating Procedures (IOP) governing RH:

   A. BWCI: Post Order B-4.9 MAXIMUM SECURITY AND ISOLATION HOUSING UNIT 8, with effective date of 3/11/10;

   B. HRYCI: DEPARTMENT Policy Number 110.03 SPECIAL MANAGEMENT OFFENDERS, with effective date of 1/1/01;

   C. JTVCC: Policy Number 3.3 AD-SEG AND MAX REVIEW, with effective date of 12/1/15;

   D. SCI: DEPARTMENT Policy Number 3.38 YOUTHFUL CRIMINAL OFFENDERS PROGRAM, with effective date of 7/6/15.

3) Group structured interviews using the *Structured Assessment Instrument for Behavioral Health Programs in Restrictive Housing.* Participants included the institutional leadership, representatives from the Department's Bureau of Correctional Healthcare Systems and representatives from the Department's contracted provider (hereafter referred to as "Connections") for health and mental services.

4) Review of Policy Number E-09 SEGREGATED OFFENDERS, promulgated by the Department's Bureau of Correctional Healthcare Systems on 11/14/07 and revised on 5/5/11;

5) Group setting interviews with inmates/detainees identified with a serious mental illness (SMI) and residing in RH at BWCI, HRYCI and JTVCC;

6) Review of various documents provided by the Connections leadership to include, but not limited to, mental health staffing matrix, staff training records and a recent audit report and;

7) Informal discussion with line staff.

FACILITY SITE VISIT AND ASSESSMENT

The ACA team conducted a review of the Delaware Department of Correction's (DDOC) current restrictive housing policies and programming of the Bureau of Prisons (BOP) and Bureau of Correctional Healthcare Systems (BCHS) in order to provide recommendations related to operational protocol, programming, placement and review, medical and mental health treatment issues, metrics, monitoring and training. ACA conducted a review of policies provided by DDOC Central Office (see attachment 2 of this report).

As a result of the initial review, the ACA assessment team found the following:

- The DDOC policies need to be reviewed and revised as necessary in order to remain current and useful to the staff. As one example the BOP Policy 4.3 has an effective date of December 16, 2010. The ACA team recommends that there is written documentation that policies are reviewed and revised as necessary on an annual basis.

- The ACA team recommends that policies address specific needs. A revision of policies should include: an objective of the policy, identifiable directions to staff, a systematic approach toward practical applications and it should reflect the subject matter of restrictive housing.

- In reviewing the classification/inmate housing assignment process, there are several levels of approval required to assign housing and classification. Although the information reveals that the DDOC uses an "objective" classification system; embedded in all the different approval levels, we believe that inmate housing assignments are "subjective" and currently not "objective". This classification and housing assignment currently applies to restrictive housing and to any possible future step-down housing program. We recommend that a systematic process and procedure be developed when it comes to housing assignments as well as to classification.

- The ACA team recommends that custody levels be considered in the housing assignment process. In both the documentation provided and in observation during the tour of the facilities, we believe that the warden in one prison used discretion in determining an inmate's classification assignment. This type of housing assignment procedure may create liability issues for the State of Delaware. A mandated custody level process must be followed for correct classification procedures.

- An "objective classification system" should be managed by the employees who are considered the subject-matter experts for the DDOC and the final decision should be a reflection of that system.

The ACA team found that centralized policy and procedures exist on restrictive housing. However, during our visits in the institutions we noticed that the centralized directives were not adhered to. Howard R. Young Correctional Institution (HRYCI), James T Vaughn Correctional Center (JTVCC) and Sussex Correctional Institution (SCI) have developed their restrictive housing policies and have implemented them. When we asked at each institution if the staff has been trained on the restrictive housing policies and procedures we were told they had not. Baylor Women's Correctional Institution (BWCI) does not follow a restrictive housing policy nor does it have a written procedure. The ACA team concluded that all of the four institutions do

not follow nor has staff been trained on the Bureau of Prisons and Health Services central office policies and procedures on restrictive housing. Additionally each of the four institutions addresses restrictive housing per the warden's directives. There needs to be increased monitoring, oversight and training for the field by Central Office on the use of restrictive housing. All BOP and BCHS policies and procedures on restrictive housing should be revised to include standardized forms for a centralized comprehensive program and adequate training of staff for all institutions.

Baylor Women's Correctional Institution

On Wednesday, November 19, 2015, at 0745 hours the ACA team arrived to review and assess the Baylor Women's Correctional Institution (BWCI). BWCI is the only women's prison in the state, which opened December 29, 2001. The facility houses both pre-trial and sentenced adult females in minimum, medium and maximum security levels.
At 0835, the ACA was welcomed and escorted to the conference area to begin an in-brief with the BWCI leadership team. Dr. Elizabeth Gondles introduced the ACA assessment team and reviewed the task and objectives.

Warden Capel introduced Major Emig (Director of Security), Judith Caprio (BOHS, director of behavior health), Dr. Timme (Chief Psychologist for Connection) and Franny Carlin (Director of Mental Health, Connection). The Warden then gave a general overview of the facility and its mission.

During the in-brief, there was a group discussion concerning inmates in restrictive housing and the project objectives. The warden stated that there were severe staffing shortages in uniform and non-uniform staff. During the discussion on restrictive housing, there appeared to be a difference between the BWCI leadership and the BOHS division in terms of procedures and practices. After a discussion the ACA team went on a tour of the BWCI restrictive housing unit (Unit 8) and the Medical Services Area. It was apparent to the ACA team that the treatment and security staff are concerned about the welfare of the inmates. An unusual practice was observed in that the psych techs were on duty observing inmates who are on watch instead of using correctional officers (although this is not noted as a "wrong" practice). Staff was very open and cooperative when questioned about operations and policy.

The team made the following observations and recommendations in regards to BWCI:

1. Observation/Assessment:

   Inmates revealed, and staff concur, that inmates get out-of-cell time less than one hour per day and even less time on weekends. In addition, inmates are not allowed outdoor recreation though there is a recreation area right outside the unit. The team was informed if an inmate is held in Unit 8 longer than 14 days they receive access to the activities director 2-3 days a week for 45 minutes.

Recommendations:

A. *(Ref: ACA Ad Hoc Committee on Restrictive Housing ACI Standard 4-4270)*[2]

All inmates in Unit 8 should receive a minimum of 1 hour of out-of-cell time daily. It is current policy in many state correctional facilities throughout the United States to get all inmates in restrictive housing out of their cells at least for one hour per day. ACA has formed a nationwide Restrictive Housing Committee which is updating and developing new standards for restrictive housing. Recommendations include getting all inmates out of their cells every day for at least one hour.

B. *(Ref: ACA, ACI Standards 4-4154 and-4-4155)*

All inmates in Unit 8 should have the option of outdoor recreation. There is an outdoor recreation area adjacent to Unit 8 which could be used to ensure all inmates housed there have access to fresh air and natural light (weather permitting). NOTE: Outside cleaning and showering do not count toward any out-side recreation time, whether in-door out-of-cell, or out-door.

2. Observation/Assessment:

The ACA team found several environmental conditions of concern including: obstructed cell vents, cleanliness, obstruction of cell door glazing and inoperable showers.

Recommendations:

(Ref: ACA, ACI Standard 4-4333)

A. Conduct regular cell inspections to ensure safety, security and proper sanitation.

B. Unit supervisor should ensure repair, cleaning, and operational issues are addressed in a timely manner.

3. Observation/Assessment:

There is lack of programing for inmates in Unit 8.

Recommendation:

(Ref: ACA Standard 4-4273 and proposed new step-down standard RH Ad-Hoc committee)

Develop structured daily dayroom activities and instructional programs. ACA can site several model programs in other states which could serve as a model to review.

4. Observation /Assessment:

The ACA team believes there is confusion on how many inmates are under mental health care and how many inmates are receiving mental health medications.

[2] Haney, C. (2003). Mental Health Issues in Long-Term Solitary and "Supermax" Confinement. *Crime and Delinquency*, 124-156.

Recommendations:

Develop protocol to identify all inmates in need of, or receiving mental health services. All protocol must include written documentation.

Howard R. Young Correctional Institution

On Wednesday, November 19, 2015, at 1200 hours the ACA team arrived at HRYCI. The Howard R Young Correctional Institution (also known as Gander Hill Prison due to the neighborhood in which it is located) is a Level 5 facility in the northeast section of Wilmington, Delaware. The original facility, now called the West Wing, was designed to hold 360 detainees, individuals who are awaiting trial or sentencing or who are unable to make bail. The facility now averages 1,500 offenders.

Upon arrival into the institution, the team was greeted by Lt. Silhouette (Medical Liaison). Warden Wesley introduced himself and his leadership team. After all introductions were made, Dr. Elizabeth Gondles introduced the ACA assessment team and reviewed the task and objectives for the visit.

The ACA team noted that the warden appeared to be genuinely interested in the mission of the team. He communicated his willingness to be transparent and responsive to recommendations for improvement. The facility is well organized and staff was alert and attentive.

The team went into the restrictive housing unit 2L (Disciplinary Detention) and 2M (Administrative Segregation). The ACA team noted that during the tour both treatment and security staff are concerned about the welfare of the inmates. A unique procedure was observed in that the psych techs were on duty observing inmates who require a 24 hour watch. Staff was very open and honest when asked questions about operations and policy.

The ACA team made the following observations and recommendations for HRYCI:

1. Observation/Assessment:

   Inmates revealed, and staff concur, that inmates get out of cell time less than one hour per day and less on weekends. In addition, inmates are not allowed outdoor recreation.

   Recommendations:

   A. *(Ref: Restrictive Housing Ad Hoc committee proposed changes ACA Standard 4-4270)*[3]

      Inmates in restrictive housing should receive a minimum of one hour of out-of-cell time daily. Of note, on the second visit on December 4, the warden advised the ACA team he has arranged for the inmates to have outdoor recreation,

[3] O'Keefe, M. L., Klebe, K. J., Metzner, J., Dvoskin, J., Fellner, J., & Stucker, A. (2013). A Longitudinal Study of Administrative Segregation. *Joutnal of the American Academy of Psychiatry and the Law*, 49-60.

although this was not personally observed. (The ACA Team) It is current policy in many state correctional facilities throughout the United States to get all inmates in restrictive housing out of their cells at least for one hour per day. ACA has formed a nationwide Restrictive Housing Committee which is updating and developing new standards for restrictive housing. Recommendations include getting all inmates out of their cells every day for at least one hour.

B. (Ref: ACA, ACI Standards 4-4157 and 4-4155)

All inmates in restrictive housing should have the option of indoor or outdoor recreation (weather permitting). There is an outdoor recreation area, which is adjacent to restrictive housing, which could be utilized for outside recreation.

2. Observation /Assessment:

The ACA team found several environmental conditions or concerns, including obstructed cell vents, cleanliness, and attention to unit sanitation.

Recommendations:

(Ref: ACA, ACI Standard 4-4333)

A. Conduct and document regular cell inspections to ensure safety, security and sanitation.

B. Unit supervisor should address repair, cleaning and operational issues in a timely manner.

3. Observation/Assessment:

Inmates revealed, and staff concur, that inmates get out-of-cell time less than one hour per day and even less time on weekends. In addition, at the time of our visit inmates in 2L were not allowed outdoor recreation while 2M could access outdoor recreation.

Recommendations:

A. All inmates in restrictive housing should receive a minimum of one hour of out-of-cell time daily. Cleaning and showering should not be counted toward out-of-cell time.

B. All inmates in restrictive housing should have the option of indoor or outdoor recreation (weather permitting). There is an outdoor recreation area adjacent to 2L which could be utilized for outside recreation.

C. Develop structured daily dayroom activities and programs.

4. Observation/Assessment:

Inmates are in full restraints when removed from their cells for the purpose for dayroom access.

Recommendation:

Central Office should develop security procedures in order to allow inmates out of cell time without restraints.

5. Observation/Assessment:

   A step down program does not exist for inmates who have been in restrictive housing for an extended period of time.

   Recommendation:

   (Ref: Proposed new ACA Standard from Ad Hoc committee on Restrictive Housing)[4]

   Central Office should create a department wide step down program to integrate inmates back into general population. ACA can site several model programs in other states which could serve as a model to review.

James T. Vaughn Correctional Center

On Thursday, November 19, 2015, at 0730 hours, the ACA team arrived at James T. Vaughn Correctional Center (JTVCC). JTVCC is a Level 5 prison for men in Smyrna, Delaware. The facility is the state's largest adult male correctional institution. JTVCC houses approximately 2,500 inmates with minimum, medium, and maximum security levels. This facility is the primary facility for housing the Kent County pre-trial (detainee) population. The ACA Team observed that the warden was not completely open to change in regards to restrictive housing objectives and classification concerning the mentally ill. In several instances he alluded to the "Delaware Code" that allowed him to over-ride decisions on classification and/or mentally ill treatment issues. However, the warden did, on occasion, state that he needed to make changes in regards to these issues.

1. Observation/Assessment:

   Inmates and staff call restrictive housing "the hole". This is a negative connotation for inmates, staff and the community and does nothing to advance the idea of restoration of an inmate's preparation to return to the free world.

   Recommendation:

   Train staff and inmates on the appropriate name of the unit and require them to refer to it by the proper name.

2. Observation/Assessment:

   Inmates in disciplinary housing receive one hour of out-of-cell time three times a week. Inmates are not allowed recreation outside.

[4] Aufderheide, Dean (2013). Mental Illness in Administrative Segregation: How to Bulletproof Your Program Against Litigation. Correct Care, Spring, Vol. 27, No. 2: 14-16.

Recommendation:

(*Ref: Proposed Standard change from Ad Hoc Committee on Restrictive Housing, ACI Standard 4-4270*)

Ensure all inmates receive at least one hour of out-of-cell time including recreation outside (weather permitting) seven days a week. Cleaning and showering should not be counted toward any out-of-cell time. It is current policy in many state correctional facilities throughout the United States to get all inmates in restrictive housing out of their cells at least for one hour per day. ACA has formed a nationwide Restrictive Housing Committee which is updating and developing new standards for restrictive housing. Recommendations include getting all inmates out of their cells every day for at least one hour.

3. Observation/Assessment:

   There was confusion by staff as to how many suicide attempts there have been.

   Recommendation:

   A. Review all suicide attempts and keep accurate records of them in order to find underlying causes for future preventive measures.

   B. Central Office should develop department wide policy and procedures to document suicide attempts and enact prevention strategies, including staff training.

4. Observation/Assessment:

   There appears to be a lack of a plan and implementation for annual staff training.

   Recommendation:[5]

   (Ref: ACA, ACI Standards 4-4083 through 4-4089)

   Develop and monitor a mandatory staff department wide training plan for annual training including in particular the areas of staff/inmate communication, suicide prevention, and treatment of mentally ill inmates.

5. Observation/Assessment:

   Contract staff only receives a four hour initial facility orientation training with no additional training.

   Recommendation:

   (Ref: ACA, ACI Standards 4-4083 through 4-4089)

   Ensure contract staff receives annual facility training with an emphasis in the area of security.

[5] Applebaum, K. L., Hickey, J. M., & Pacer, I. (2001). The Role of Correctional Officers in Multidisciplinary Mental Health Care in Prisons. *Psychiatric Services*, 1343-1347.

6. Observation/Assessment:

   The ACA team found staff members stating they cannot force medication on inmates while in other facilities visited staff stated they could force medicate.

   Recommendation:

   (Ref: ACA, ACI Standards 4-4083 through 4-4401)

   Review state wide policy and procedures and consistently adhere to them on the subject of forced medication.

7. Observation/Assessment:

   Restricted housing inmates have a small space inside where they walk around for recreation.

   Recommendation:

   Provide for recreational activities which might include table games, cards, sports equipment and other activities for inmate recreation.

8. Observation/Assessment:

   Information was provided to the ACA Team that the warden has statutory authority to override someone based on his opinion of an inmate's actions. There also exists an apparent mandatory override based on custody level.

   Recommendation:

   Develop policy and procedure to provide more transparency and give less authority to any one individual. Make overrides and classification more consistent, transparent, and used as little as possible.

Sussex Correctional Institution

On Thursday, November 19, 2015, at 1200 hours, the ACA team arrived at Sussex Correctional Institution (SCI). SCI is located in Georgetown, Delaware. Opened in 1931 Sussex is the oldest correctional facility in Delaware. SCI houses all custody levels and youthful offenders. Between 1997 and 2000, 760 beds were added to the facility for a capacity level of 1109 beds.

The staff members of the facility are recognized for the care, time, detail in preparation and cleanliness of the institution for its first ACA accreditation audit. It was apparent to the ACA Team that the Sussex correctional staff was aware of national standards and exemplary practices within their profession. The observations and recommendations the ACA Team makes will assist them to continue improving their institution.

1. Observation/Assessment:

   Restrictive housing units in one building had no natural light and no indoor recreation equipment.

Recommendations:[6]

A. Explore ways to maximize natural lighting in cells that do not have it or have very little lighting.

B. Add indoor recreational equipment in restrictive housing unit.

2. Observation/Assessment:

Policies adopted by the Sussex facility do not appear to have higher authority review.

Recommendation:

A. Document and require review by higher authority.

B. Ensure policies to not contradict the state- wide policy.

Youthful Offender Unit- Restrictive Housing-SCI

Observation/Assessment

There is an absence of a Central Office policy for youthful offenders. Other than security rounds there appears to be a lack of human contact. We only observed education programming and do not know if it other programming exists because there is no written policy from the Central Office. The youthful offender unit has an austere environment with readily apparent sensory deprivation and a lack of access to any natural lighting.

Recommendations[7],[8]

A. Lack of policy that governs the management of youthful offenders;

B. Size of living space (unencumbered)

C. DDOC should establish a multidisciplinary team to develop a Central Office policy to specifically address the treatment and programming needs of youthful offenders. In addition to treatment and programming for youthful offenders with a diagnosed mental disorder, there should be specific mental health services for youthful offenders at risk for developing SMI.

D. Youthful offenders with SMI should be admitted to a specialized residential treatment unit.

E. The entire youthful offender unit should be located on a wing with more natural light available.

[6] Grassian, S. (2006). Psychiatric Effects of Solitary Confinment. *Washington University Journal of Law and Policy*, 325-383.

[7] ACA's Proposed Restrictive Housing standards on Youthful Offenders and the size of the cell

[8] Rovner, L. (2015). Dignity and the Eight Amendment: A new Approach to Challenging Solitary Confinement. *American Constitution Society for Law and Policy*, 1-20.

F. It was noted that there was a teacher on the unit, however; there is a need for programming that identifies and assesses trauma history which develops trauma - informed care principles and practices.

BEHAVORIAL HEALTH PROGRAM ASSESSMENTS

The observations and recommendations for the Delaware DOC's Behavioral Health Program were based on pertinent ACA standards; proposed ACA standards for mentally ill inmates in Restrictive Housing; pertinent Correctional Jurisdictions Restrictive Housing Policies in Attachment 1; Literature Review in Attachment 2; pertinent Delaware Restrictive Housing Project Documents that were made available; group interviews of inmates/detainees; individuals attending the group structured interview at each institution; review of legal precedents in jurisdictions involving the mentally ill in restrictive housing, including but not limited to, California, Colorado, Florida, Pennsylvania, Ohio, Mississippi, Illinois, and Arizona; review and consultation with other jurisdictions.

Baylor Women's Correctional Institution

The site visit at BWCI was conducted on December 14, 2015. As of December 1, 2015, 18 inmates/detainees were in some type of restrictive housing, which is 4 percent of the total inmate/detainee population. There were 12 receiving some type of mental health treatment, which represents about 67 percent of BWCI's restrictive housing population. There were 11 persons identified as having a serious mental illness (SMI), which represents about 61 percent of BWCI's inmate/detainee population in restrictive housing. Of the 12 inmates/detainees receiving mental health treatment in its restrictive housing unit(s), 9 were prescribed one or more psychotropic medications, which represent about 75 percent of BWCI's mentally ill population in restrictive housing.

Tour and visual inspection of RH units included Unit 8. Five inmates/detainees were interviewed in a group setting. Individuals attending the group structured interview included:

Wendi Caple, Warden, BWCI
Mark Richman, Ph.D., Chief, Bureau of Correctional Healthcare Services,
Brian Emig, Major, BWCI
Chris Devaney, Chief Operating Officer, *Connections*
James Johnson, State Representative, Delaware House of Representatives
Patti Harding, R.N., Director of Nursing, *Connections,* BWCI
Frances Carlin, Statewide Director of Behavioral Health, *Connections*
Tracy Fitzpatrick, Mental Health Director, *Connections*, BWCI
Robin Timme, Statewide Chief Psychologist, *Connections*
James Gondles, Executive Director, American Correctional Association (ACA)
Elizabeth Gondles, Ph.D. Director, ACA Office of Health Services
Dean Aufderheide, Ph.D., Clinical & Forensic Psychologist, ACA MH Consultant

Howard R. Young Correctional Institution

The site visit at HYRCI was conducted on December 14, 2015. As of December 1, 2015, 17 inmates/detainees were in some type of restrictive housing, which is 4 percent of the total population. There were 9 persons receiving some type of mental health treatment, which represents about 53 percent of HRYCI's restrictive housing population. Six persons were identified as having a serious mental illness (SMI), which represents about 35 percent of HRYCI's inmate/detainee population in restrictive housing. Of the 9 inmates/detainees receiving mental health treatment in its restrictive housing unit(s), 6 were prescribed one or more psychotropic medications, which represent about 67percent of HRYCI's mentally ill population in restrictive housing. The percentage of HYRCI's mentally ill population in RH is higher than the statewide percentage, probably because of its correspondingly larger detainee population.

Tour and visual inspection of RH units included Unit 2L and Unit 2M. Five inmates/detainees were interviewed in a group setting. Individuals attending the group structured interview included:

Steven Wesley, Warden, HYRCI
Mark Richman, Ph.D., Chief, Bureau of Correctional Healthcare Services,
Tracy Crews, R.N., Director of Nursing, Connections, HYRCI
Chris Devaney, Chief Operating Officer, *Connections*
Frances Carlin, Statewide Director of Behavioral Health, *Connections*
Mark Richardson, Mental Health Director, *Connections*, HYRCI
Christine Claudio
Elizabeth Gondles, Ph.D. Director, ACA Office of Health Services
Dean Aufderheide, Ph.D., Clinical & Forensic Psychologist, ACA MH Consultant

James T. Vaughan T. Vaughn Correctional Center

The site visit at JTVCC was conducted on December 15, 2015. As of December 1, 2015, 400 inmates/detainees were in some type of restrictive housing, which is 88 percent of the total statewide population. There were 118 persons receiving some type of mental health treatment, which represents about 30 percent of JTVCC's restrictive housing population. There were 71 identified as having a serious mental illness (SMI), which represents about 18 percent of JTVCC's inmate/detainee population in restrictive housing. Of the 118 inmates/detainees receiving mental health treatment in its restrictive housing unit(s), 82 were prescribed one or more psychotropic medications, which represent about 69 percent of JTVCC's mentally ill population in restrictive housing.

Tour and visual inspection of RH units included Unit #17, Unit #18, Unit #19, Unit #21, and Unit #23. Five inmates/detainees were interviewed in a group setting. Individuals attending the group structured interview included:

David Pierce, Warden, JTVCC
Mark Richman, Ph.D., Chief, Bureau of Correctional Healthcare Services
Chris Devaney, Chief Operating Officer, *Connections*

Frances Carlin, Statewide Director of Behavioral Health, *Connections*
Robin Timme, Statewide Chief Psychologist, *Connections*
Christine Francis, Health Services Administrator, *Connections,* JTVCC
Heidi Collier, Re-Entry/IADAPT, JTVCC
Lezley Sexton, Mental Health Director, *Connections*, JTVCC
Judith Caprio, Director of Behavioral Health, DEPARTMENT
James Gondles, Executive Director, American Correctional Association (ACA)
Elizabeth Gondles, Ph.D. Director, ACA Office of Health Services
Dean Aufderheide, Ph.D., Clinical & Forensic Psychologist, ACA MH Consultant

Sussex Correctional Institution

The site visit at SCI was conducted on December 15, 2015. As of December 1, 2015, 18 inmates/detainees were in some type of restrictive housing, which is 4 percent of the total population. Two were receiving some type of mental health treatment, which represents about 11 percent of SCI's restrictive housing population. One was identified as having a serious mental illness (SMI), which represents about 5 percent of SCI's inmate/detainee population in restrictive housing. Of the 2 inmates/detainees receiving mental health treatment in its restrictive housing unit(s), both were prescribed one or more psychotropic medications, which represent 100 percent of SCI's mentally ill population in restrictive housing. The percentage of SCI's mentally ill population in RH is lower than the statewide percentage, probably because of its general population characteristics.

Tour and visual inspection of RH units included Unit #4 and Tier Island 2 where the Youthful Offenders are housed. Since no inmates/detainees/youthful offenders with a diagnosed mental disorder were in RH on the day of the tour, no inmates/detainees/youthful offenders were interviewed. Individuals attending the group structured interview included:

Mark Richman, Ph.D., Chief, Bureau of Correctional Healthcare Services
Linda Valentino, SCI
Frances Carlin, Statewide Director of Behavioral Health, *Connections*
Tracy Coleman, Mental Health Director, *Connections*, SCI
Jill Mosser, Health Services Administrator, *Connections*, SCI
Tracey Harris, Disciplinary Hearing Officer, SCI
Truman Mears, SCI
Judith Caprio, Director of Behavioral Health, DEPARTMENT
James Gondles, Executive Director, American Correctional Association (ACA)
Elizabeth Gondles, Ph.D. Director, ACA Office of Health Services
Dean Aufderheide, Ph.D., Clinical & Forensic Psychologist, ACA MH Consultant

The team made the following observations and recommendations in regards to the Behavioral Health Program at Delaware Department of Correction.

The majority of the observations/assessments pertinent to the issues and concerns with the mentally ill in Delaware DOC's RH units are applicable to all four of the institutions. Some issues, such as policy development and monitoring, involve the Bureau of Correctional Healthcare Services and will be referenced accordingly. Identified issues and concerns that

are exclusive to an institution, such as the youthful offenders at SCI, will be addressed with a specific corresponding observation/assessment and recommendation. Therefore, the observations/assessments and recommendations will address both issues and concerns that are both systemic and institution specific.

1. Observation/Assessment
   At present, the Department does not have an established definition of Serious Mental Illness (SMI). Although it is in a draft policy revision and there has been at least one training provided, it has not been officially promulgated. Almost none of the institutional staff or the Department's Director of Behavioral Health knew the draft definition of SMI, which is an intricate definition derived from the Disability Law Center, Inc. v. Massachusetts Department of Correction, et. al., Civil Action No. 07-10463. Although establishing a working definition of SMI is critical, there also needs to be a working definition of "mental illness" to adequately address the clinical needs of those inmates/ detainees who may be in RH, but do not have SMI. Without these definitions, it will be problematic in determining what resources are needed and where to put them.

   Recommendation:
   In consultation with a nationally recognized correctional mental health expert(s), the Department should establish in policy, and promulgate from its Central Office, definitions of mental illness and serious mental illness (SMI). These definitions should be applicable at all institutions. An example of a definition for consideration is "Psychotic, Bipolar, and Major Depressive Disorders and any other diagnosed mental disorder (excluding substance use disorders) associated with serious behavioral impairment, as evidenced by acute de-compensation, self-injurious behaviors, multiple major rule infractions or mental health emergencies, that requires an individualized treatment plan as determined by a qualified mental health professional.[9]" (American Correctional Association, 2015)

2. Observation/Assessment
   The Department does not have a defined mental health classification system to determine needed levels of care. A mental health classification system is essential in order to know what mental health treatment services are needed for whom, and when, where and how they will be delivered. As the starting point to ensure access to necessary care in RH, inmates/detainees should be classified in accordance with their identified mental health needs and assigned the clinically appropriate level of care to meet those needs.

   Recommendation
   In consultation with a nationally recognized correctional mental health expert(s), the Department should develop and establish a mental health classification system that is applicable to all institutions. Each institution should be classified according to the mental health grades that it can house. For example, an institution classified as MH-1/MH-2 can house inmates/detainees classified as MH-1/MH-2. This classification system helps ensure that adequate treatment resources will be available to inmates/detainees commensurate with

[9] American Correctional Association's proposed definition for Serious Mental Illness for the corrections field. Reference Adult Ad-Hoc Restrictive Housing Committee proposed expected practices.

their clinical needs. The system also facilitates consistency across institutions so the Department can reliably measure and compare outcomes for developing best practices. The classification system should include at least the following mental health designator grades:[10]

A. MH-1 = Demonstrates no significant impairment in the ability to adjust within an institutional environment and does not exhibit symptoms of a mental disorder (which includes intellectual disability). Although inmates/detainees classified as MH-1 do not require ongoing mental health treatment, they have access to routine mental health services (sick call, emergencies, confinement evaluations, etc.).

B. MH-2 = Exhibits impairment associated with a diagnosed mental disorder. The impairment is not so severe as to prevent satisfactory adjustment in general inmate housing with the assistance of mental health case management, psychological services, and counseling.

C. MH-3 = Shows impairment in behavioral functioning due to a diagnosed mental disorder. The impairment is not so severe as to prevent satisfactory adjustment in general inmate housing with the assistance of mental health case management, psychological services, counseling, and psychiatric consultation for psychotropic medication. MH-3 is also assigned routinely to an inmate who is determined to need psychotropic medication, even if the inmate may be exercising the right to refuse such medication.

D. MH-4 = Is assigned to a residential unit (RTU), which is an intensive outpatient/assisted living level of mental health care with augmented treatment and services. The mental health classification MH-4 can only be assigned or changed at an RTU.

E. MH-5 = Is assigned to a crisis stabilization unit (CSU), which is an inpatient level of mental health care. This classification can only be assigned or changed at a CSU.

F. S-6 = is in the reception process and is scheduled to be evaluated by psychology and psychiatry staff.

3. Observation/Assessment

Other than outpatient level of care and psychiatric close observation, the Department does not have defined levels of care to provide access to necessary treatment in accordance with the inmates/detainees assessed mental health needs. Depending upon the seriousness of their mental symptoms and associated behavioral impairment, the inmates/detainees need to be able to move between the levels of care in accordance with their identified mental health needs and assessed level of behavioral functioning.

Recommendation

In consultation with a nationally recognized correctional mental health expert(s), the Department should develop and establish levels of care to ensure inmates/detainees have unimpeded access to necessary mental health treatment and services.

[10] Florida Department of Corrections Restrictive Housing Policies

A. Outpatient. This level of care involves regular monitoring, evaluation group counseling individual counseling and psychotropic medications, when clinically indicated. Inmates/detainees generally reside in the prison community and report to the institutional mental health clinic to receive medications or other mental health services. Outpatient care is appropriate for inmates/detainees classified as MH-2 or MH-3.

B. Infirmary Mental Health Care. This level of care is the less restrictive of two levels of inpatient mental health care and consists of a brief admission to the institutional infirmary for inmates/detainees residing in the general prison community. Infirmary mental health care is indicated whenever mental health staff determines that an inmate/detainee that is residing in the general prison community presents mental health problems or conditions that cannot be safely or effectively managed on an outpatient basis. Admission to infirmary mental health care is often precipitated by a mental health crisis involving an assessed risk of self-injurious behavior. An inmate/detainee may be transferred to a crisis stabilization unit or "CSU", if clinically indicated. Infirmary Mental Health Care is appropriate for inmates/detainees classified as MH-1/MH-2/MH-3.

C. A residential treatment unit is appropriate for inmates/detainees that require more intensive services than those that can be provided in outpatient or infirmary mental health care, but whose condition is not so acute as to require care in a crisis stabilization unit. Inmates/detainees in a residential care unit are classified as MH-4 and they typically remain in the unit for extended periods. Some remain for years because their level of functioning does not reach the threshold required for discharge to outpatient care.

D. Inmates/detainees requiring crisis stabilization services receive care at a crisis stabilization unit. This involves admission to a secure highly structured, mental health unit that is separate from the general prison community. Inmates/detainees in a crisis stabilization unit are classified as MH-5. After inmates/detainees are stabilized, they can be safely discharged to either a residential treatment unit or outpatient level of care.

E. There is a need for programming that identifies and assesses trauma history and develops trauma-informed care principles and practices.

4. Observation/Assessment

There is a general consensus among clinicians that the conditions and duration of confinement in administrative segregation are associated with potential psychological harm for many inmates with a serious mental illness. Without access to necessary mental health care, some inmates may experience symptoms of depression, paranoia, perceptual distortions, delusional thinking, impaired problem-solving ability and problems with impulse control. In other words, the harsher the conditions and the longer the duration of the confinement, the more likely deterioration may occur, or at least be resistant to improvement. Although the RH units that were visually examined during the December visit appeared clean there did not appear to be sufficient space allocated to provide access to care in a therapeutic and confidentiality setting or for programming. In one unit, the lights were turned off and in another unit for youthful offenders; there was a single small area for congregation. Based on our observations,

inmate interviews and informal discussions with line staff, inmates/detainees in the restrictive housing units are locked down 22-24 hours.

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Recommendation

All inmates with a diagnosed mental disorder in the Department's RH units should have unimpeded access to augmented mental health services and programming that is commensurate with their identified mental health needs. Inmates with an identified serious mental illness should be placed in a secure residential treatment unit and receive at least 10 hours of out-of-cell structured therapeutic activities and at least 10 hours of out-of-cell exercise weekly.

5. Observation/Assessment

Although the Department has a process in place to evaluate inmates/detainees within 24 hours of placement in RH, the evaluation does not appear to be a process in place for pre-screening evaluations that are conducted by a qualified mental health professional. Such evaluations are necessary to determine not who can be placed in RH, but rather to identify mental and behavioral impairment in inmates/detainees that should preclude placement in RH. The input into the disciplinary process by mental health staff does not constitute a credible pre-placement screening evaluation.

Recommendation

After defining what types of mental illness/neurocognitive deficits and associated impairment in behavioral functioning are not suitable for placement in RH, the Department should promulgate a policy with standardized mental health evaluation forms for pre-placement screening evaluations. Inmates/detainees that are determined by qualified mental health staff to be not suitable for placement in RH based on their mental illness and/or cognitive impairment should be diverted to a secure residential treatment unit.

6. Observation/Assessment

It is crucial that inmates/detainees know how to access necessary mental health services while in restrictive housing. Providing a written orientation to someone who has difficulty with reading comprehension or a verbal orientation to inmate/detainees that have impairments in concentration, attention, orientation, etc. is unacceptable. Moreover, written and verbal orientation should be provided by mental health staff to ensure the inmate has a sufficient understanding and to answer any questions regarding access to care issues.

Recommendation

Based on the interviews, several of the inmates/detainees reported they were not aware of what treatment and services mental health staffs were required to provide. Some disclosed that mental health staff "sees us sometimes when they can" and others stated they are seen "when the officers let them". Too ensure inmates/detainees know how to access necessary mental health services while in restrictive housing, mental health staff should document the inmate/detainee's understanding in their periodic evaluations to assess mental and behavioral functioning.

7. Observations/Assessment

It is imperative that all inmates in restrictive housing have access to necessary mental health treatment and that the appropriate level of care is provided according to their identified mental health needs. There does not appear to be a uniform policy promulgated by the Department's Central Office to ensure a coherent and consistent approach to access to necessary mental health treatment and providing the appropriate level of care for inmates/detainees in RH. There were several institutional operating procedures (IOP) from BWCI that were possibly derived from a Central Office directive(s), but none were made available for JTVCC, HRYCI or SCI. Nevertheless, based on the group structured interview responses and inmate interviews, it appears that the inmates/detainees are locked up 23-24 hours a day. Mentally ill inmates may have access to some mental health treatment, but it appears insufficient for those inmates with SMI. There is a treatment plan form, but it lacks the specificity to meet the criteria of a behaviorally written plan with measurable outcomes, achievable objectives and appropriate reinforcement.

Recommendation

Treatment and services, such as individual/group therapy, case management, medication management and other therapeutic activities, must be structured in such a way to alleviate disabling symptoms of an inmate's mental disorder. A minimum of ten out-of-cell structured therapeutic activities and ten hours of exercise weekly should be offered to inmates/detainees in RH. Therapeutic programming should include, but not limited to, groups that focus on anger management, stress management, psychoeducation, social skills training, step-down planning, substance abuse and current events (local and national news), medication management, etc. Treatment and therapeutic programming should be offered in an area that affords confidentiality and, when necessary, with the use of therapeutic modules, "restart" chairs or modified spider tables.

8. Observations/Assessment

Treatment plans need to be behaviorally written, reviewed and revised as needed, and have clear and measurable outcomes. They should be developed with input from the inmate and by a multidisciplinary services team with members from psychology, psychiatry, nursing, security and classification, at minimum. The plans should also include, step-down planning, step-down units and re-entry planning for continuity of care as clinically indicated must be individualized, reviewed, and revised in response to the changing clinical needs of the mentally ill inmate. Although there is a reference to a multidisciplinary team ("MDT") in IOP G-04.1 for BWCI, there does not appear to be Central Office policy governing the initiation, development, implementation, time frames and criteria for revisions, nor the required staff and processes for a multidisciplinary treatment team.

Recommendation

A Central Office policy is necessary to ensure all treatment plans are behaviorally written, reviewed, and revised as needed, have clear and measurable outcomes and achievable goals. Treatment plans should be developed with input from the inmate and by a multidisciplinary services team with members from psychology, psychiatry, nursing, security, at minimum, which comprises the treatment team. The plans should include

goals that are linked directly to the identified mental health problems and needs of the inmate/detainee, and be reviewed at regular intervals (e.g. 14 days after implementation, 90 days, and 180 days thereafter) depending on behavioral impairment. Any significant event should be discussed by the MDST to determine whether revision to the treatment is warranted even if the event occurs sooner than the next planned treatment team meeting. “Significant events” may include, but are not limited to, serious self-injury or suicide attempt, refusing psychotropic medications for more than five consecutive days, receipt of a disciplinary report, a use of force, refusing more than 50% of their out-of-cell structured therapeutic services. Step-down planning should be an integral component of the treatment plan.

9. Observations/Assessment

Weekly rounds are a very important mechanism to proactively identify any issues that may exacerbate symptoms associated with a diagnosed mental illness. For non-mentally ill inmates, weekly rounds are important for identifying any emergent symptoms associated with impairment in mental and/or adaptive functioning (e.g., risk factors associated with self-injurious behaviors. According to Connections staff and the form provided for review, it appears rounds are being conducted three days weekly for all inmates/detainees in the RH units. The form includes questions pertinent to the inmate’s mental health status and behavioral impairment and, as such may risk compromising confidentiality.

Recommendation

A Central Office policy delineating the procedure, documentation and compliance monitoring of weekly rounds should be promulgated with input from a multidisciplinary team.

10. Observations/Assessment

It is of critical importance that there are scheduled evaluations of all inmates in RH in order to closely monitor any changes in mental status and associated impairment in adaptive functioning. Behavioral risk assessments should be completed periodically for mentally ill inmates by the multidisciplinary treatment team and especially after a critical incident such as a use of force, threats to the safety of others or institutional security, etc. There should be defined criteria and clinical protocols to help staff know when a referral to a higher level of care (residential treatment unit, inpatient care, etc.) There does not appear to be a Central Office policy delineating these important processes.

Recommendation

A Central Office policy should be developed that delineates the time frames for evaluations of mental and behavioral functioning for inmates/detainees in RH as well as the criteria for referral to a higher level of care when clinically indicated. The evaluations and clinical protocols should be standardized and conducted by a qualified mental health professional.

11. Observations/Assessment

It is imperative that there is a regular schedule for monitoring compliance with the key components of the mental health program and treatment requirements in RH. Other than an audit report for June–November 2015 by *Connections*, there did not appear to be any systematic monitoring of the mental health program and treatment requirements for inmates/detainees in RH at either the Central Office or institutional level.

Recommendation

Central Office should develop and implement a standardized monitoring tool that assesses compliance for specific requirements within each of the key components of the mental health program and treatment requirements for mentally ill inmates in RH. The mental health director at each institution should use the monitoring tool monthly as an ongoing assessment of the institution's compliance. The Central Office staff should use the tool to evaluate overall compliance by reviewing a random selection of institutional compliance in each of the program components at least quarterly. Monitoring by Central Office should be conducted by the Director of Behavioral Health, who should be a qualified mental health professional. The results of the quarterly audits should be distributed to the *Connections* leadership, the institutional wardens and designated Central Office leadership. Corrective Action Plans (CAP) should be developed by institutional staff, approved by the Director of Behavioral Health and monitored accordingly. Early identification of any deficiencies allows for quick corrective action to be implemented and will ensure proactive preparation for subsequent audits.

12. Observations/Assessment

With nearly one-third of the beds in RH occupied by inmates/detainees with mental illness, these units tend to be staff intensive. Access to necessary mental health treatment and programming should be the metric that determines staff resources.

Recommendation

A multidisciplinary workgroup comprising Central Office and institutional staff should develop an analysis of staffing needs for each RH unit. The critical criterion should be sufficient and qualified staff resources to ensure access to necessary mental health treatment commensurate with the identified mental health needs of inmates/detainees in RH.

13. Observations/Assessment

The mental health training provided to staff assigned to the RH units does not appear adequate to equip them with the tools necessary to effectively manage this high risk/needs population, especially those inmates/detainees with SMI.

Recommendation

Security staff assigned to institutions with RH units should receive specialized mental health training both initially at time of hire and annually thereafter. The training should focus on the demand characteristics and risk factors associated with managing inmates in RH. Topics should include, but not be limited to, suicide and self-injury prevention, understanding mental illness, recognizing symptoms of major mental disorders, detecting signs of deterioration, crisis response, indicators for referrals and preparation

guidelines for step-down units. All training modules should be reviewed and approved by the Director of Behavioral Health annually.

14. Observations/Assessment

There did not appear to be any requirements for institutional mental health leadership to meet with the warden to address emergent or potential concerns pertinent to access to care and the management of the RH units. Accordingly, there were no apparent requirements for senior mental health staff assigned to the RH units to meet with their senior security, classification and medical staff counterparts.

Recommendation

Keeping open the lines of communication between security and mental health staff is one of the most important functions in the care and custody of inmates/detainees in residing in RH units. Central Office should incorporate into an extant policy (or into one which will be developed in the future), the requirement for the institutional mental health director at institutions with RH units to meet weekly with the warden. Current issues germane to access to care and management of the unit should be addressed and proactive solutions considered. The same requirement should be extended to senior mental health staff assigned to the RH units to meet with their senior security, classification and medical staff counterparts.

15. Observation / Assessment:

A lack of physical space to provide an adequate range of programing including group therapy for inmates in restrictive housing.

Recommendation:

The DDOC needs to provide enough space to adequately provide group therapy sessions.

16. Observation/Assessment

Several special need inmates with chronic mental illness are posing challenges. Chronic care programs or special needs housing units are necessary within the correctional setting for inmates with chronic mental illness who do not require inpatient treatment but do require a therapeutic environment due to their inability to function adequately within the general population

Recommendation

The DDOC needs to re-evaluate their special needs population and provide the proper physical environment for these populations.

BUREAU OF CORRECTIONAL HEALTH SERVICES ASSESSMENT

The organizational structure within which a correctional health care delivery system operates directly impacts its ability to attain its goals. In fact, the rank of health services within a correctional agency typically serves as a reflection of the perceived importance of health care in relation to the correctional agency's total mission. In the US correctional healthcare comprised nearly eight billion dollars *(2011 survey by Pew Trust).* This amount accounts for a range of 9–24% of the total operating budget of the agency within the 50 states.

A correctional agency must provide adequate health services to inmates/youth *(1976 Estelle v. Gamble decision, U.S. Supreme Court)*. The correctional administrator has no way to judge the competency of the health staff or adequacy of the delivery system being carried out in the field without an effective organizational system that includes healthcare delivery. A correctional jurisdiction, whether civil service or privatized health services, is ultimately responsible for the delivery of health services. The correctional administrator has the ultimate responsibility of developing and ensuring that the agency's policies and procedures are carried out, including the health services delivery system. To make certain these policies and procedures are developed and implemented, there must be collaboration between correctional administrators, security and health staff. The agency should have a program in place through its central office to conduct oversight and monitoring of the civil service or privatized health services program. A correctional administrator must have the expertise in his or her executive staff to judge the competency of the health staff, the adequacy of the health services being delivered to offenders, and the quality of health services being provided, all within the agency's budget.

Observations and Recommendations

1. Observation/Assessment: Delaware DOC has currently a Bureau/Division of Health Services and a designated health authority. The health authority reports directly to the Commissioner which is a good reporting structure.

   Recommendation: Though the DOC has in place a Bureau of Health Services we recommend a different organizational structure within BCHS (see diagram of proposed reorganization on page 26).

2. Observation/Assessment: There appears to be a disconnect between medical and mental health services both in Central Office and in the field. The Bureau of Health Services executive team does not have a Director of Nursing that reports to the Bureau Chief (Health Authority).

   Recommendation: Create a Director of Nursing position that reports directly to the Health Authority. This should be a FTE with a minimum BSN degree and 3 years of management/supervisory experience, preferably in correctional health. This will greatly improve communication and inmate care within the bureau and with any private providers.

3. Observation / Assessment: There appears to be limited oversight and monitoring of health services private partners.

Recommendation: Develop and implement an oversight and monitoring tool to be implemented and used by the Bureau of Health Services, Director of Administration.

4. Observation / Assessment: No formalized training programs for the field (security, health services staff).

   Recommendation: Formalize an annual training program through the Bureau of Health Services that will work closely with the Bureau of Prisons and the other Bureaus in Central Office.

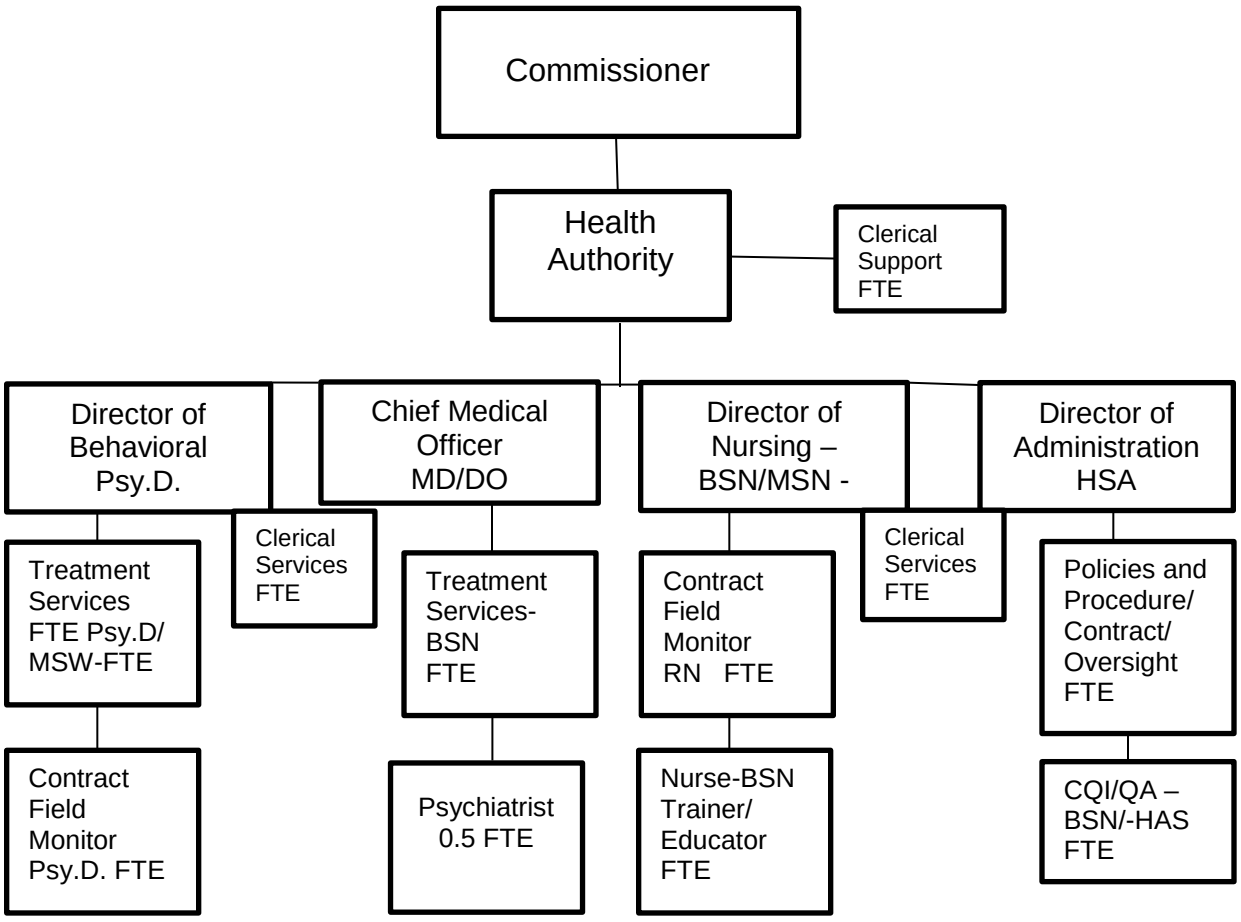
5. Observation/Assessment: There is a need for a Quality Assurance and Continuous Quality Improvement Program.

   Recommendation: Implement a continuous quality improvement program that will improve health care delivery. In addition institute a quality assurance program that involves systematic measurement of the various aspects of the health services operations, comparisons to an objective standard, and modifications of health services policy, procedure, and practices when the standard is not met. Facility staffs have a responsibility to ensure that offenders are protected and that programs and practices are producing the desire outcomes among the correctional population.

Additional Recommendations:

The Delaware Bureau of Health Services Executive Team should consider employing the services of a correctional health care consultant. This consultant could assist the Health Authority to develop and implement a re-organization of the structure of the Bureau of Correctional Health Services. In addition the consultant could assist in developing job positions that fit the needs of the re-organization, the consultant could also assist in developing a monitoring and oversight program to be used in assessing the quality care delivered to the offenders.

Delaware Bureau of Health Services
Proposed Organization Structure



Conclusion

There are several opportunities for improvement in the mental health program for mentally ill inmates/detainees in the RH units. Opportunities for improvement include the development and promulgation of policy and procedures by the Department's Central Office Bureau of Correctional Healthcare Systems; implementing adequate monitoring mechanisms, effective oversight; Reviewing and updating policies and procedures; providing sufficient out-of-cell therapeutic activities for inmates/detainees with SMI; instituting an adequate mental health classification system and sufficient levels of care; and providing specialized staff training that targets the demand characteristics and challenges for staff involved with mentally ill inmates/detainees in restrictive housing. Additional opportunities include improving the individualized treatment plans, emphasis on a defined multidisciplinary treatment team approach securing the services of a psychiatric consultant in the Bureau of Correctional Healthcare to provide oversight/monitoring of psychiatric services/practices and a Director of Behavioral Health that is a qualified mental health professional.

Notwithstanding the opportunities for improvement, staff attending the group structured interviews evidenced a limited understanding of the prevailing standard of care requirements for mentally ill inmates in restrictive housing, especially as they relate to recent litigation with SMI inmates/detainees. The majority of the inmates/detainees interviewed exhibited and/or signs and symptoms of serious mental and behavioral impairment. Most displayed psychomotor agitation and reported feelings of anger and frustration, racing thoughts and a sense of learned helplessness. Almost all reported a history of pre-incarceration mental health treatment and many of them acknowledged having received treatment in a psychiatric hospital. It was readily apparent that one inmate/detainee had an intellectual disability and it was confirmed by a mental health staff that she had been in a state hospital prior to incarceration (note: time constraints precluded the opportunity to review patient records and/or interview inmates/detainees or staff individually).

Although there were no psychiatric providers and only one psychologist available for interviews, the *Connections* staff appeared highly motivated, compassionate and committed to providing timely and appropriate care to the mentally ill inmates/detainees in the RH units. The statewide and institutional mental health leadership appeared to have an understanding of the institution's mission requirements and an appreciation for the inherent challenges associated with the provision of care and custody of the inmate/detainee population in RH.

There is no doubt that the mentally ill inmates/detainees are disproportionately represented in the Department's RH units. Although many of these inmates/detainees may be considered a "management problem", identifying care as necessary for those with mental illness establishes legal responsibility to provide access to that care. Accordingly, if the Department is to develop a successful mental health program in its restrictive housing units, it must ensure that inmates/detainees who suffer from serious mental illness, or who are at significant risk for developing such impairment, have unimpeded access to necessary mental health services; and it must develop programming that prevents the development or exacerbation of serious mental and other behavioral adjustment problems. In order to accomplish these objectives, the Department must develop a robust collaborative and multidisciplinary approach to the care and custody of its mentally ill inmates/detainees. Without the promulgation of coherent and binding policies from its Central Office, and authorized by the DDOC Commissioner, the institutional operating procedures will continue to be vulnerable to discontinuity, resulting in

susceptibility to differential access to treatment and services for mentally ill inmates/detainees in the Department's RH units.

Positive aspects of the restrictive housing and mental health program:

- The DDOC Commissioner is open and receptive to recommendations that can improve the delivery of services within corrections that can benefit the citizens of Delaware.

- Generally the wardens are committed to facilitating implementation of the DDOC's mission.

- Staff was very open and cooperative when questioned about operations and policy.

- *Connections* staff appeared highly motivated, compassionate and committed to providing timely and appropriate care and services.

The ACA Team would like to express their appreciation for the opportunity to assist the DDOC and the facilities staff in regards to restrictive housing and behavior health issues. It is our hope that the information obtained from this report will benefit the staff, the inmates in the care of the DDOC, the citizens of Delaware, and will lead to an even more orderly operation within the institutions. The ACA Team believes that this report will also lead to an improved operation of DDOC's restrictive housing program and will ensure that individuals within the restrictive housing program will have opportunities toward advancement. Our hope is that the DDOC will operate even safer professionally administered institutions.

Please feel free to contact the American Correctional Association of we can answer any further questions.

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Dr. Dean Aufderheide is a licensed clinical and forensic psychologist in the state of Florida. He holds a master's degree in Theology, a PH.D. in Clinical Psychology and a master's degree in Public Administration. He has served as past president of the International Association of Correctional and Forensic Psychology and is the ACA's national Mental Health Consultant. He is a member of the ACA's national Ad-Hoc Standards Committee on Restrictive Housing. For the past ten years, "Dr. Dean" has served as the statewide Director of Mental Health Services for 63 major correctional institutions in the Florida Department of Corrections. Dr. Dean has over twenty years of leadership and management of behavior health care systems in military, government and private care systems. He is the author of numerous professional publications and has conducted over fifty peer-reviewed lectures and keynote presentations at national conferences and international forums. A nationally recognized expert on mental health and suicide prevention in the criminal justice system, he has served as a consultant to state correctional systems and the federal government.

Dr. Elizabeth Gondles has served the last nine Presidents of the American Correctional Association as the Healthcare Advisor to the President and currently oversees ACA's Office of Correctional Health. She currently serves in that position for President Mary Livers. Elizabeth has done extensive work on the development of ACA performance-based standards, expected practices and outcome measures for correctional operations for jails, prisons, community corrections, probation and parole, medical and mental health. She is the ACA project director for the development of the ACA's strategic plan on the use of restrictive housing which includes, training, technical assistance, correctional behavioral health certification and ad hoc committee on national and international performance-based standards, expected practice and outcome measures for restrictive housing. Dr. Gondles has performed technical assistance for Ft Lewis, Washington, Confinement Facility including over-all operations and vulnerability assessment. She has performed health care need assessments, technical assistance/trainings/vulnerability assessments in many correctional jurisdictions in U.S. including Indiana, Kansas, Ohio, Louisiana, Texas, Florida, Oklahoma, and many others in

prisons and/or juvenile centers. Her work in jails includes Tulsa County, OK; Hillsboro County, FL; Broward County, FL; and New York City among many other local facilities. She has experience in training of correctional security staff in treatment issues and exemplary security measures. In addition to her many other activities in corrections, she is an active adjunct assistant professor at the University of Maryland.

Mel Williams is an ACA specialist for prison operations and is an ACA certified auditor and trainer. He has over 40 years in a wide range of correctional experience including over 25 years in management of multi-custody facilities. Mr. Williams has a Master of Science in Corrections and is an adjunct professor at Genesee Community College. Before coming to the ACA, his background included a long career with the New York State Department of Correctional Services, where he served in many positions including Superintendent. He is the past President of the North American Association of Wardens and Superintendents (NAAWS) and the New York State Corrections and Youth Association. He has received numerous awards including New York Commissioner's Award, NAAWS Leadership Award, and CAYSA President's Awards.

Chief Tony Wilkes began his career with the Davidson County Sheriff's Office in 1987 as a Correctional Officer and elevated through the ranks to become the first-ever "Chief of Corrections" in the history of the Davidson County Sheriff's Office. Chief Wilkes has served as a representative of large jails for nearly 15 years through the National Institute of Corrections. Chief Wilkes continues to be a catalyst for change through his involvement with the American Correctional Association's Board of Governors, representing adult local detention and is an active member in several ACA committees. He is a certified ACA auditor and trainer. He is a member of the national Ad Hoc Standards Committee on Restrictive Housing for the American Correctional Association.

Doreen Efeti, MPH, MBA, MCHES, is the manager of the Office of Correctional Health at the American Correctional Association. She also works in partnership with all departments in the ACA office to ensure health care remains at the forefront in all ACA activities. Ms. Efeti has over seven years of experience as a public health professional coordinating, planning, and implementing health programs. She has a Bachelor of Science degree in Public and Community Health with a minor in Biological Sciences from the University of Maryland, College Park. She earned a dual Master of Public Health with a concentration in health education and promotion and a Master of Business Administration with a focus in healthcare administration. As a master certified health education specialist, her professional experience has been focused in areas such as chronic disease education and management, community health promotion, health communication, and consulting with various community organizations both in the U.S. and internationally to enhance health outcomes for communities.

Adam Willhite worked for over a decade in the Kentucky Department of Corrections (KYDOC). He held positions in the infirmary, special management unit, assessment and classification center, offender records, policy and procedure development and manager of accreditation. Adam has a Bachelor's degree in Justice Administration from the University of Louisville. Recently he began his career at ACA as an accreditation specialist.

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