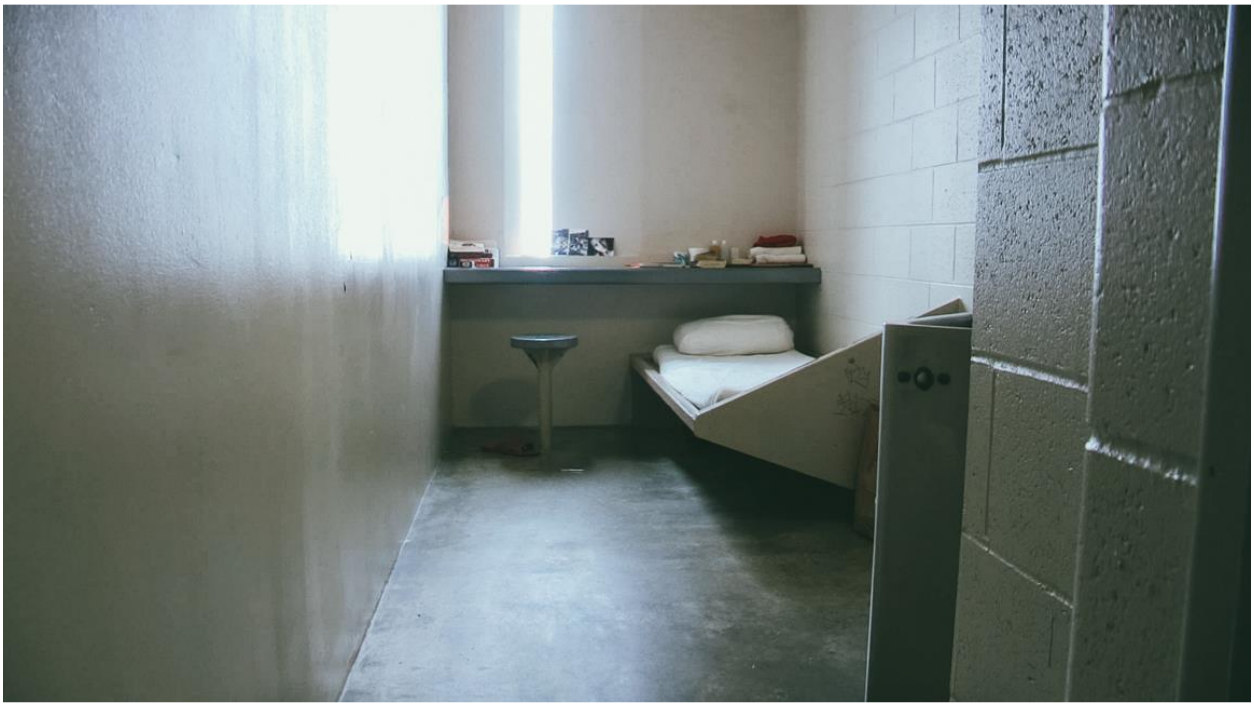
Beyond Incarceration:

Lock Down for Persons with Disabilities

An Investigation by Disability Rights Maryland
2017



Segregation: twenty-two hours or more in a cell, with or without a cellmate, in a space that is smaller than an average parking space.

This report was prepared by Disability Rights Maryland (DRM).

DRM, a non-profit legal advocacy organization, is Maryland's designated Protection & Advocacy agency (formerly known as "Maryland Disability Law Center"), charged with advancing the rights of people with disabilities. DRM uses an array of strategies, including individual and class representation, outreach and education, information and referral, technical assistance and self-advocacy support, policy and coalition work and abuse and neglect investigations. . DRM is federally mandated. Information about DRM and its services, and a copy of this Report can be found at: https://DisabilityRightsMD.org.

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Investigative Summary

Violations of Rights

Disability Rights Maryland, pursuant to an investigation into conditions for incarcerated persons with disabilities at North Branch Correctional Institution, **finds violations of: the 8th Amendment of the U.S. Constitution's prohibition against cruel and unusual punishment; Article 25 of the Maryland Constitution; and the Americans with Disabilities Act.**

The violations relate to the use of segregation, inadequate services, the failure to accommodate persons with disabilities, and discriminatory practices. The failures are magnified by insufficient policies and resources, and have plagued the Department of Public Safety and Correctional Services (DPSCS) for years. Reforms planned by DPSCS do not adequately address the findings herein. Better correctional practices, as instituted in other jurisdictions, can be implemented to prevent the harm and continued risk of injury observed by DRM for person with disabilities.

Why this Investigation

As the designated Protection and Advocacy system (P&A) for Maryland, Disability Rights Maryland (DRM) has authority under federal law to protect the rights of people with disabilities[1] and to conduct investigations of abuse and neglect incidents, including within prisons.[2] After receiving complaints related to segregation; inadequate mental health care; use of force; failure to prevent harm; and discrimination against people with disabilities, DRM initiated an investigation into conditions at North Branch Correctional Institution (NBCI). NBCI is a super-maximum prison near Cumberland, Maryland. This report is the result of DRM's investigation.

For purposes of this report, "segregation" is characterized by 22 or more hours in a cell with or without a cellmate. In disciplinary segregation there is generally no access to a phone, television, or radio; limited personal property and often no visitation. Meals are eaten in the cell. Frequently referred to as "solitary", incarcerated persons in segregation are usually housed two in a cell, with both individuals on segregation status. Double-celling became necessary as prison populations increased. (NBCI was designed to operate at a capacity of 675[3] persons in 2008, but had 1,297 persons incarcerated in August, 2015[4].) Double-celling in segregation means that there are two individuals in a cell space no larger than an average parking space. The practice can be equally or more problematic than 'solitary'.[5] Due to the harm associated with segregation, multiple sources have condemned its practice regardless of whether there are one or two individuals in a cell (discussed herein).

This report is based on review of thousands of pages of information related to NBCI operations, records of incarcerated persons, and Department of Public Safety and Correctional Services (DPSCS) policies. DRM interviewed individuals incarcerated at NBCI and researched applicable law and social science material. DRM met with Warden Frank Bishop and staff and, accompanied by their attorney, toured restrictive housing units, segregation tiers, and the Special Needs Unit (SNU). DRM also observed areas available for individual and group programs. DRM engaged an expert consultant to assist in its review.[6] DRM appreciates the conversations with Warden Bishop, the staff and those incarcerated individuals with whom we met.

Summary of Findings

Segregation practices like those at NBCI are harmful. National medical and correctional organizations have taken positions against its use. Court decisions and changing correctional practices across the country reflect the consensus that harm from segregation practices, such as those observed by DRM, violate the law and principles of basic human dignity.

Several of DRM's findings are consistent with other reviews of DPSCS, which have called for major reform and operational changes in DPSCS' segregation practices. A summary of DRM's findings, detailed in this report, is listed below.

General Findings	
Harm from Segregation is well-established – leading to limitations and bans on it use, new standards and calls for reforms	• Experts find confinement in a cell for 22 or more hours a day causes harm, trauma and risk of harm to individuals with disabilities • Numerous national organizations have adopted standards to limit segregation, including the National Commission on Correctional Health Care • Lawsuits and legislation have limited the use of segregation • Courts have found prolonged segregation of individuals with serious mental illness is cruel and unusual punishment • Numerous prison systems have banned or imposed time limits on segregation of individuals with serious disabilities
Segregation ≠ Safety	• Segregation can increase negative behaviors as well as cause harm • Segregation has not been shown to keep prison safer or deter violence

Maryland-Specific Findings	
Individuals in Maryland prisons are harmed by confinement in segregation	• Individuals with mental illness in segregation drank from their toilets, smeared feces, banged their heads, cut themselves, heard voices, attempted suicide, were subjected to use of force, and do not get access to needed programs.
Maryland uses segregation excessively	• DPSCS and NBCI place a higher percentage of prisoners in segregation than most states and at rates above the national average • Total segregation time is not limited, and individuals can spend years confined in segregation status without meaningful review
Individuals with mental illness are disproportionately placed in segregation	• Individuals with mental illness are placed into segregation at rates much higher than, and spend much longer in, segregation than persons without disabilities.
DPSCS under-identifies disability	• Individuals with serious mental illness are identified at prevalence rates that are significantly lower than indicated by research and reported by most state prison systems • DPSCS practices and identification of disabilities vary among facilities • NBCI does not diagnose brain injury and intellectual disabilities • Failure to identify results in failure to provide services
Individuals with disabilities are subject to discrimination	• Policies and practices do not accommodate disabilities in disciplinary proceedings and in providing equal access to services. • Policies permit punishment and lengthy segregation for incidents related to self-harm: records show multiple charges to individuals for failing to comply with orders to: cease cutting themselves or to disengage from a noose around the neck, even though the individuals involved were known to have serious mental health disabilities
Insufficient mental health and correctional staffing & programming contribute to reliance on segregation	• DPSCS returned over $30 million of its budget because of vacancies last fiscal year and has significant staffing shortages • NBCI psychology department positions mostly vacant • NBCI has no recreation therapists or substance abuse counselors • Lack of programs leads to increased reliance on solitary
NBCI Special Needs Unit requires significant improvement	• Created to serve some individuals with disabilities and has positive elements, but suffers from insufficient staffing, treatment and programming • Found excessive use of segregation and abusive practices.

Case for Reform

Alternatives to Segregation are Necessary & Effective	• Independent reviews of DPSCS practices have called for reform • Other prisons systems have reduced segregation & increased prison safety • Increased out-of-cell time, alternative housing, incentive programs & changed policies can replace segregation & benefit prisons and incarcerated individuals • DPSCS acknowledges that segregation is counterproductive, but reforms to date are insufficient
RECOMMENDATIONS PROVIDED AT END OF REPORT	

Segregation:

Harm, Overuse and Disproportionate Use

Description of Segregation

Segregation is characterized by 22 or more hours in a cell with or without a cellmate, in a cell that is smaller than an average parking space. The beds are bolted into the concrete. The toilets and sinks are stainless steel. Cell door windows are small and are made of ballistic-resistant glass. The cell doors have cuff ports that can be opened to provide meals and to allow for handcuffing individuals before exiting.

Segregation can take many forms including administrative segregation, disciplinary segregation, cell restriction and other special housing.

Individuals in disciplinary segregation are rarely out of their cells: typically, twice a week for 15-minute showers and up to five hours a week for recreation, which may be cancelled for assorted reasons (weather or security concerns).[7]

When individuals are offered outside recreation, it is typically in recreation "cages" designed for only one person.

Television, radio, phone calls, and personal property are not permitted in disciplinary segregation. Visitation can be prohibited. There is no limit on the amount of segregation time that can be accumulated.

*"Adam" has been diagnosed with Schizophrenia, Borderline Intellectual Functioning and Neurological Disorders. He has been in segregation for **six years.** He has been observed drinking from the toilet, eating feces, hearing voices and banging his head against the wall.*

*"William" has a history of Schizophrenia and Bipolar Disorder. Records indicate while in segregation he reported seeing fires in his cell and hearing voices. He has **cut his wrists and neck**, explaining the voices told him to do so.*

*"Calvin" is diagnosed with Bipolar Disorder and Antisocial Personality Disorder. He was abused as a child. He has been observed exhibiting paranoia, hearing voices, smearing his blood, making suicide attempts. DPSCS records state that **his segregation time prevents him from accessing the treatment services available to individuals in the general prison population.***

Segregation Harms People

Research links segregation to harm.[8] Segregation for individuals with disabilities can produce trauma, anxiety, dysphoria and depression, exacerbate mental illness, and prevent recovery. Two Supreme Court cases, both decided in 2015, gave Justices the occasion to note the psychological harm caused by segregation.[9] And as explained by the Third Circuit Court of Appeals:

> [t]he empirical record compels an unmistakable conclusion: this experience is psychologically painful, can be traumatic and harmful, and puts many of those who have been subjected to it at risk…Anxiety and panic are common side effects. Depression, post-traumatic stress disorder, psychosis, hallucinations, paranoia, claustrophobia, and suicidal ideation are also frequent results.[10]

While the Eighth Amendment "does not mandate comfortable prisons . . . neither does it permit inhumane ones." *Farmer v. Brennan*, 511 U.S. 825, 832 (1994). Courts cases have limited the use of segregation for persons with disabilities and litigation has established standards for minimally adequate treatment.[11] Three states bar any placement of individuals with serious mental illness in segregation, and other states have imposed 30-day limits.[12] State legislatures have also limited segregation.[13]

Consensus Against Segregation

In recognition of the harms of segregated confinement, the following entities have adopted positions strictly limiting its use:

National Commission on Correctional Health Care: Exclude individuals with mental illness from segregation for any length of time. (2016)[14]

American Public Health Association: Individuals with serious mental illness should not be placed in segregation. (2014)[15]

U.S. Department of Justice: Individuals with serious mental illness should not be in segregation, absent defined exigent circumstances, and require more programs and out-of-cell time if segregation is used. (2016)[16]

American Psychiatric Association: Avoid prolonged segregation for persons with serious mental illness and, if used, ensure adequate out-of-cell time. (2012)[17]

American College of Correctional Physicians: Avoid any prolonged use for persons with serious mental illness and provide out-of-cell time. (2013)[18]

American Correctional Association: Limit use of restricted housing for persons with serious mental illness. (2017)[19]

Overuse in Maryland

Maryland continues to rely on segregation more than most states. Maryland uses segregation at nearly twice the national average.

- Analyses of Maryland corrections data have repeatedly shown that at any given moment, between 7.7% - 9.8% of Maryland prisoners are in segregated confinement.[20]
- This is nearly **twice the average rate of most states (4.9%)[21] and nearly twice the national rate (4.4%) identified by the Bureau of Justice Statistics.**[22]

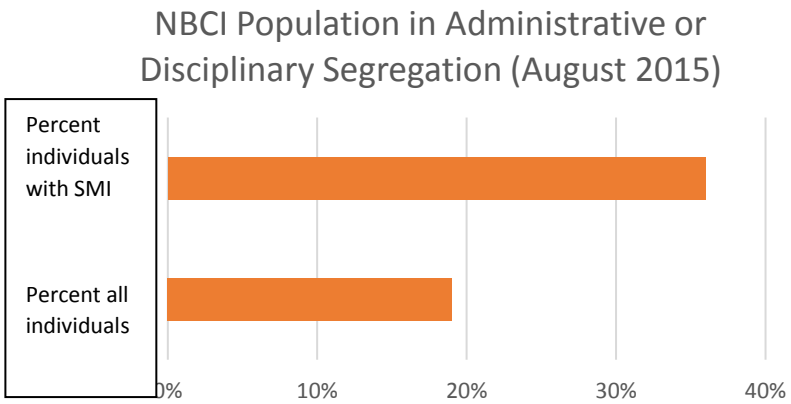
7.8% of incarcerated males at DPSCS were held in segregation for more than 15 consecutive days (2015 data).[23]

The Already-High Rates of Segregation are Even Worse for People with Mental Illness

Disproportionate Use & Disparate Impact

Persons with serious mental illness, who are most likely to suffer harm from segregation, are disproportionately placed in such housing and remain there, on average, for longer periods of time than do persons without serious mental illness.

Snapshot data from September 2015 shows that across Maryland prisons 16% of individuals with serious mental illness (SMI) were in segregation – compared with the system-wide average of 8% for all individuals.[24]



The disparities are even worse at North Branch Correctional Institution, the focus of DRM's investigation. At NBCI, of all individuals identified with SMI, on average **36%** were in disciplinary or administrative segregation (2015 & 2016 data).[25]

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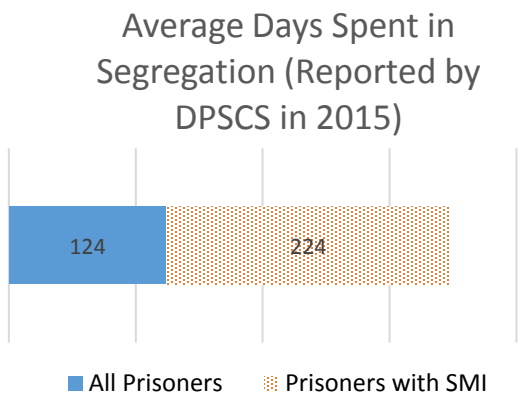


Individuals with serious mental illness (SMI) in DPSCS custody spend almost twice as much time in disciplinary segregation compared to all individuals in segregation – an average of 224 days (nearly eight months), compared to an average of 124 days (about four months).[27]

Actual disproportionality for individuals with serious mental illness is likely worse than the data show, as DPSCS and NBCI under-identify serious mental health and other disabilities.

Segregation Does Not Mean Safety

Segregation can exacerbate problems

Segregated confinement is not the solution to institutional security and safety: it can *increase* problems:

- Experts report that due to boredom, deprivations and isolation, rule infractions by individuals in segregation can increase.[28]
- Segregation has not been shown to be effective at improving institutional behavior and can lead individuals to become more, not less violent.[29]
- Segregation status can prevent individuals from accessing needed programs, which is especially significant for persons with serious disabilities.
- Segregation, even for a short amount of time, can significantly impacts a person's mental health.[30]

While segregated housing may have little influence on improving behaviors and may exacerbate violence, **alternatives** to segregation can lead to improved safety. [31]

Individuals at NBCI have been convicted of serious crimes and can present challenging behaviors. Alternatives to segregation must be implemented to provide safety and security to everyone in the institution. Implemented properly, alternatives should reduce reliance on segregated confinement, reduce rule infractions, reduce legal liability, reduce harm to individuals with disabilities and provide benefits of social skill adaptation to incarcerated individuals.

Before examining such alternatives, this report discusses factors that contribute to the use of segregation of NBCI. By examining the use of segregation, steps to decrease the practice can be identified.

Drivers of Segregation in Maryland Prison

Under Identifcation of Individuals with Disabilities

Correctional facilities have a constitutional duty to provide necessary care to individuals in their custody. Elements of adequate care include adequate staffing, proper diagnosis and a continuum of treatment modalities. DPSCS and NBCI under-identify individuals with disabilities and fail to provide needed treatment, programming or accommodations for such individuals.

Under such conditions, segregation can become a substitute for proper care.
Respected expert organizations, such as the American Psychiatric Association (APA), the National Commission on Correction Health Care and Human Rights Watch have estimated that that close to 20% of individuals in U.S. prisons have serious mental illness. The APA further estimates that about 5% are actively psychotic at any given time.[32]

DPSCS reports varying rates of prevalence of serious mental illness (SMI) in its prisons[33], but consistently reports rates of SMI that are drastically lower than well-accepted baselines:

- A DPSCS report from 2015, identified 435 men and 14 women, or 2.3% and 1.5% of the male and female prison populations, as having serious mental illness.[34]

- A DPSCS report indicated that during 2016, 1,468 prisoners out of 20,274 (7.2%) were identified with SMI.[35] Another report puts the average at 6.1%.[36]

- And in a request for proposals for health services in 2011, DPSCS indicated that there were only 280 individuals with SMI in its prisons. [37]

In a recent national study by the Association of State Correctional Administrators, *only five states identified a lower rate of prevalence of serious mental illness among men in prison than Maryland*. And only four states identified a lower rate of prevalence for women.[38]

Remarkably, the count of individuals with SMI at NBCI **dropped by nearly 40% in less than two years** (from 161 people, or 13% of all incarcerated individuals in January 2015, to about 85 people or 7% of all incarcerated individuals in December 2016). [39] This staggering drop partially coincides with the inability of NBCI to provide required mental health services to individuals identified with SMI due to a loss of staff.

NBCI stated that some prisoner diagnoses have been changed from SMI because of "over diagnosing" of individuals in the community. But the prevalence rates of persons identified as SMI at NBCI was already low, especially given that NBCI, a super max facility, can receive transfers of prisoners with behavior challenges from other state prisons. Moreover, those individuals with a history of mental illness in the community are particularly in need of supports when incarcerated. DRM finds under-identification of SMI at within DPSCS and at NBCI.

Failure to Identify Intellectual Disability and Traumatic Brain Injury

Studies have found that individuals with intellectual disabilities make up between 4-10% of a prison's population.[40] The U.S. Center for Disease Control identified traumatic brain injury (TBI) as common in the prison population, and that TBI is associated with health and cognitive challenges requiring specialized supports.[41]

NBCI did **not identify** a single individual with **intellectual disability**. The facility identified only **two people with traumatic brain injuries**.

NBCI reported that it is **not able to provide testing** for either intellectual disabilities or TBI.

DRM conducted record reviews of prisoners who had evidence of brain injuries and cognitive impairments. **Neither treatment plans nor accommodations were provided to address such disabilities.** Some individuals with such histories were subjected to excessive segregation, including years. Failure to identify disabilities is inconsistent with DPSCS policies and American Correctional Association standards.[42]

Major Gaps in Mental Health and Other Services

Insufficient staffing leads to inadequate mental health services and other programmatic gaps

Lack of Mental Health Staffing

In December 2016 **three of the four** direct mental healthcare positions in NBCI's psychology department were vacant. One position has been vacant for over two years.[43] These vacancies clearly impact treatment. DRM's record reviews demonstrate that treatment plans do not comply with prison policies; individuals are not receiving counseling consistent with policies; and access to programs is limited: A psychiatrist was available, but only part-time.

- There were no treatment plans in the mental health records of some prisoners with SMI.
- Prison policy provides that persons with SMI on segregation are to receive, at minimum, monthly sessions with mental health care professionals, however, such session do not always occur or were not documented.[44]
- Mental health interventions are insufficient, and NBCI has no recreation therapist or addictions counselor, and insufficient indoor space.

Lack of Correctional Staffing

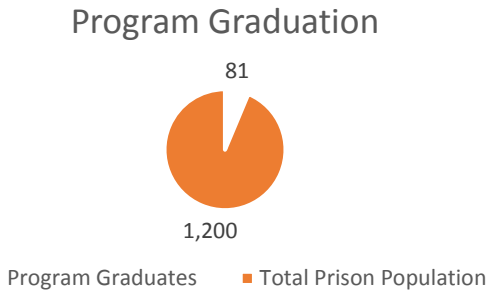
In addition to health care professional shortages, hiring, vacancies and overtime remain a severe problem for correctional staff. DPSCS **reverted more than $30 million** in general funds last fiscal year. The largest reversion was for salaries associated with the department's high staff vacancy rate. Union representatives indicated DPSCS vacancies in correctional facilities may be as high as 1,000 positions, which has been contested by DPSC. [45] The Department of Legislative Services (DLS) recently identified 1,750 vacancies at DPSCS.[46] DLS also identified DPSCS as having a turnover rate of 9.1%, the highest rate of all state agencies.[47] Staffing issues are critical.

Limited Group Treatment and Program Access

Group programs can provide tremendous value, help manage distress and boredom that leads to rule infractions and segregation, and increase socialization skills.

But group programming is very limited at NBCI due to staffing and physical plant issues. Several programs did not meet in 2016, and one served as few as 3 individuals. Wait lists can be long – more than 400 people.

Benefits of Group Programming
Accrue good time credits / reduce disciplinary time
Enhance social skills
Combat detrimental effects of isolation
Provide needed mental health therapies
Provide out-of-cell activity



In 2016, only 81 individuals out of NBCI's 1,200 people were able to graduate from a program.

Some programs provided to persons in segregation, are offered as workbooks that individuals complete in their cells. The value of one such program reviewed by DRM is seriously limited as no instructor is available and no class or group discussion occurs. Developing improved social skills through us of workbooks is far from the 'national best practices' to which DPSCS has pledged it is committed.[48]

Failure to Accommodate Disability in Alleged Rule Infractions

DPSCS and NBCI do not reasonably accommodate disabilities in disciplinary policies and practices or consider how a person's disabilities impacts behavior. Individuals with disabilities are over sanctioned for their behaviors.

> *"**Jay**" threw liquid, possibly urine, at officers while on **suicide watch**.*
>
> *He was in disciplinary segregation at the time and **on numerous antipsychotic medications.** No treatment or behavioral plan was observed in his records.*
>
> *Jay was sanctioned to **365 days of disciplinary segregation, suspension of visits and revocation of good time credits. revocation**.*

According to the World Health Organization: "People who suffer mental problems are grossly overrepresented in prisons, in general, and in segregation units … They may also behave in ways that … are interpreted as violations of rules rather than a manifestation of their mental problems. … [T]his can … lead to a vicious cycle which results in prolonged stay in isolation, where these very conditions make them worse and less able to abide by the rules and regulations."[49]

DPSCS policy acknowledges: **"punishment is ineffective in modifying the behavior of the mentally ill."**[50]

Yet neither DSPCS' hearing process nor the disciplinary matrix prescribing punishment adjust for the role of disability in an incident, or the ineffectiveness or potential harm of punishing individuals with disabilities.

> *"**Nathaniel**" is seriously mentally ill.*
>
> *He was given **180 days** of disciplinary segregation for **sticking his arm through the cell** security slot and refusing to remove it during breakfast.*
>
> *His segregation time spans several years.*

Other than competency determinations, which are rare, there are no mechanisms in the disciplinary process for hearing officers or staff to accommodate individuals with disabilities and to consider the effect of an individual's illness or disability on their behavior, nor whether segregation as punishment will cause harm.[51] No policies instruct staff that there are instances when an individual with a disability should not be charged. DRM reviewed instances when repetitive behaviors, known to mental health staff to be related to an individual's disability, resulted in repetitive charges for rule infractions and more and more accumulated segregation time.

Disciplinary sentences imposed by DPSCS set mandatory minimum sanctions that are overly harsh, lack alternatives and permit subjectivity. Moreover, a separate committee can add further cell restriction to sanctions imposed, after the hearing process. DRM reviewed numerous files where additional cell confinement was added.[52]

Disciplinary Sanction Examples	
Threatening staff/ Throwing liquid or feces	One year
Cursing/Refusing to provide urine samples	200 days
Refusing to remove arm from the cell food slot	Six months

More than one record reviewed by DRM indicated that the individual would benefit from treatment services that would be available if he were not in segregation. Despite the acknowledgement that an individual's health care needs were not being met, no change in conditions or status occurred.

Many jurisdictions consider the disability of a person before imposing disciplinary segregation. Several jurisdictions limit the use of segregation for persons with serious mental illness; others require more hours per day of out-of-cell time in structured and unstructured activities if serious safety issues require that individuals be removed from the general population.

DRM finds failure to accommodate disabilities violates the Americans with Disabilities Act.

Punishment for Activity Related to Self-Harm Behaviors

Records demonstrate that incidents of self-harm can result in punishment**.**

*"**Anthony**" has a **known mental illness.** A guard stated that he observed Anthony with cuts on both wrists.*

Anthony reportedly raised a razor to his own neck and refused to comply with the officer's instructions to drop the razor and to present his hands to be cuffed.

*Guards **depleted two cans of pepper spray** until Anthony complied. He was charged with a rule violation and **received six months of segregation** time for possessing a weapon and **45 days for each violation of disobeying an order.***

*"**Gerald**" has a **known mental health diagnosis.** He is observed with one end of his jumpsuit tied around his neck and the other secured to a piece of metal on the ceiling.*

He did not comply when officers told him to untie the jumpsuit.

*Officers **sprayed Gerald in the face with pepper spray**. He was charged with interfering with or resisting the performance of staff duties and disobeying an order.*

DPSCS's Office of Treatment Services, Suicide Prevention Activities Manual, requires individual treatment plans when individuals are mentally ill and suicidal, but does not prohibit punishment for related activity. [53] "For offenders who are not mentally ill, the personality pathology producing goal directed self-injurious behavior will be identified and behavior management plan implemented. This plan may include a disciplinary component."[54] DRM did **not** see evidence of sufficient behavior plans.

Several states provide accommodations for individuals with disabilities and recognize the harm that may attach to applying physical force or disciplinary sanctions to individuals with disabilities. Other jurisdictions **prohibit** disciplinary action for behavior related to self-harm, for behaviors related to cell extractions or placement in mental health cells, and limit the use of restraints for incidents related to mental health or disability.[55]

Denial of Medications for Rule Violations

DRM reviewed records of **"**Evan**"** an individual in segregation with a mental health diagnosis who requested to be seen by psychology for help with "being tormented by demons."

"Evan" was not seen until nine days after his request.

When he was seen by psychiatry, he was started on additional medications. Shortly thereafter, these medications were not provided "due to misconduct."

Evan was denied medication four times in one-month due to misconduct and received additional disciplinary segregation time for his behavior.[56]

Records report he claimed being

"tormented by demons"

and had

"demons wanting to take over his body."

There is no indication that his psychiatrist was aware of the decision not to provide his medications. DRM reported this incident to the Warden and his attorney, with a request to end such practice and for a reply. No response was received.

Failure to Track Time in Segregation and Absence of Meaningful Review

NBCI requires that there be a monthly review of individuals on segregation.

DRM review of records found monthly reviews that were not meaningful for moving individuals out of segregation.

*Some individuals had over **thirty** segregation reviews that simply noted "no change."*

The National Institute of Corrections reviewed DPSCS' segregation practices in 2015 and identified the practice of segregation review as needing reform.

There is no clear path out of segregation for individuals who cannot conform their behaviors and who repeatedly violate rules, even when their behaviors are related to a disability. Instead, segregation time, and its related harm and risk of harm, continues to increase as the disciplinary system requires longer sanctions for individuals who have repeated violations.

No one appears accountable for the continued and excessive reliance on segregation.

Special Housing Units-in Need of Reform

Special Needs Unit (SNU) at NBCI

NBCI operates a "Special Needs Unit" with a capacity for 40 individuals. According to DPSCS, a SNU is a "[h]ousing status designed to manage inmates with a serious mental illness in the least restrictive environment as possible, with the goal of returning the inmate to general population and providing aftercare support…These units offer more intensive mental health services." [57]

SNU was quieter than segregation tiers and has more trappings of humanity. The program was described as including a level system that allows those incarcerated to advance to using a small dining room on the tier and ultimately integrating into the dining hall used by those in the general population. When DRM visited, however, no individual was permitted out of their cell to eat and group programming was limited. Restrictions were enforced after a murder at the prison, which occurred several months prior to DRM's visit and in another portion of the facility. The SNU is subjected to general lock down policies. The SNU also permits lengthy segregation of individuals with serious disabilities, lacks sufficient treatment and programming, and uses aversive punishment, all of which the SNU should be created to avoid.

NBCI does not collect information to demonstrate how the SNU tracks program results or success.[58] DRM finds that the SNU needs significant improvement. The promise of intensive mental health services is compromised by lack of staff and programming.

Mental Health Support and Services

The level of mental health services available to individuals in the SNU is inadequate to meet the level of need that exits, and does not conform to community standards of care:

Record review indicates the frequency of individual sessions with a mental health counselor varies and does not follow the prison's policies for minimum frequency.	According to the SNU Manual, weekly individual sessions with a mental health professional are required, but can be satisfied by a psychiatric nurse making daily 'rounds' or by a medication review by a psychiatrist. [59] Such interventions are not the equivalent of individual counseling sessions.

Mental health services need be more robust to meet the needs of individuals with serious disabilities.

Segregation in the SNU

The use of continued segregation in SNU exposes individuals to harms that the SNU is designed to prevent.

Some individuals transfer to SNU and remain on disciplinary segregation for months on end. Four and six months of segregation were noted- in some cases much longer. One person had two years of segregation in the SNU.

The SNU appears guided by conflicting philosophies, which is apparent in the outcomes for individuals housed in the unit. As set forth in the SNU manual itself:

"Consequences for prisoner's behavior are to be developed as part of a prisoner's treatment plan and are designed to promote recovery."	"If a prisoner receives an infraction while in SNU, he shall be maintained on the most secure status until he completes any segregation sentence that is imposed." [60]

Individuals housed in the SNU unit can become trapped in segregation status:

*"**Darren**" has a serious disability and a history of loud and disruptive behavior. His therapist and doctor report that he has trouble understanding his behaviors due to his disabilities. Nonetheless, Darren receives long segregation sanctions. His behavior in segregation escalates. He is temporarily transferred to a state psychiatric hospital where he has access to treatment and is not in segregation. His behavior improves. Darren returns to NBCI and is placed on segregation in the SNU. He deteriorates. His SNU treatment team discussed a forced cell extraction;, shackles; use of a holding cell (bare cell, mattress on the floor); and restraining him to a metal D ring in the middle of the cell floor in response to continued disruptive behavior.*

The SNU, like other restricted housing units, has no requirement to ensure that each person receives a minimum amount of out-of-cell time.

*"**Walter**" spent five months where individual therapy was not offered or recorded. During his two-plus years (25 months) of segregation, he spent only 62 hours out of his cell for recreation—far less than even one hour per week. His records also show that there was a fourteen-month period when he left his cell one time or less each month.*

Behavior Management Program (BMP) at NBCI

The Behavior Management Program (BMP) was established to allow individuals with aggressive behavior to move through a level system, designed to be completed in a year. The BMP program seemed barely functioning when DRM visited. DPSCS announced plans to revise the program, which was recommended by the National Institute of Corrections following its review in 2015.[61]

Modifications to this program were in planned to be implemented in July 2017 when DRM conducted its inspection, thus DRM declines to comment further on the specifics of the BMP except to note that: 1) the overall lack of resources at NBCI appears to limit the revised program design and promise, and 2) other general comments in this report remain applicable to this program (lack of identification of individuals with disabilities, lack of accommodations, lack of out-of-cell time etc.)

Other Issues of Concern: Lockdowns, Use of Force, Racial Tension, and Disability Animus

Lockdowns at NBCI

When DRM visited in December 2016, the prison was on lockdown stemming from a prisoner murder that occurred several months prior. The lockdown interfered with the provision of mental health counseling and programming.

DRM objected to the prolonged lockdown. DRM also reviewed several records indicating that counseling or other activities were canceled due to use of force incidents occurring in the prison. The frequency of denials of health care services is of concern especially in segregated housing. Lack of health services and programming can result in deterioration, and contribute to increased segregation time as individuals are less able to reduce their time by completing programs or making progress, or due to increased incidents of non-compliance. No policies appear to limit or track the various and cumulative effect of lock-down or service cancellations.

Use of Force

DRM received multiple complaints from prisoners about rough physical treatment from certain correctional officers.

Use of Force Reports Written by NBCI	
Year	**Number of Reports**
2012	166
2015	29
August-November 2016	8 involving prisoners with SMI

Data provided by NBCI show a significant decrease in the use of force since 2012. More review is warranted related to disproportionate use of force on prisoners with disabilities and of those incidents. Warden Bishop attributed the decrease to better communications and knowledge of incarcerated individuals.

Based on review of 8 records, DRM identifies the need for more de-escalation and alternative efforts prior to use of force. Sometimes de-escalation attempts were evident, but they were observed to be not consistently used. Use of pepper spray directed towards the face of an individuals was also noted in records. Pepper spray was also reportedly used on individuals with asthma, which is generally contraindicated.

Chaining a prisoner in restraints to a metal ring in the middle of the cement cell floor (D ring) should be prohibited as inhumane and an excessive use of force. Compounding the inhumanity is the implicit racism involved in the use of chains by white persons on persons of color in custody.

Race

Almost 80% of the individuals housed at NBCI are Black. In stark contrast, about 6% of the surrounding community in Cumberland is Black, and prison staff is almost 100% white. Several prisoners complained of the use of racial slurs, force and hostility by select staff.[62]
Racial tensions are palpable. NBCI houses individuals associated with Aryan Nation or white supremacist groups as well as gangs that are predominantly of color. Given that the composition of staff and other professionals is nearly all white, the prison would benefit from involvement of external and diverse community resources.

Disability Animus

The staff note below, which was documented in records from 2012, is an example of disability animus.

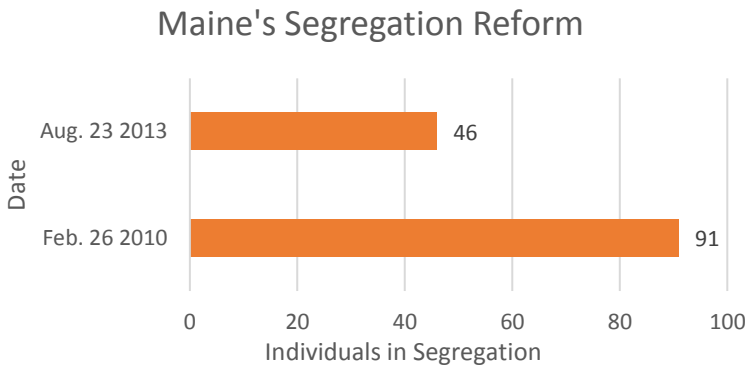
"Dear [name deleted], on behalf of the State of Maryland, we would like to inform you that you are a brain damaged retard!! Only a st bag like yourself… live like a total r****d everyday!!... And don't get me started on the stuttering. State of Maryland= 10. [Name deleted] = 0**

Reforms to Replace Segregation

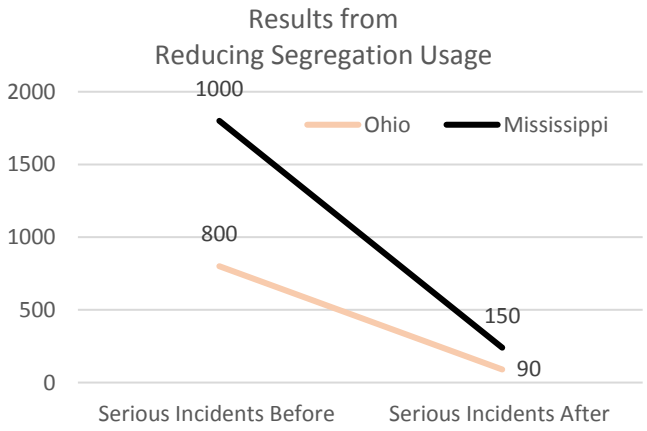
Separation of individuals to promote safety and well-being need not be accompanied by the deprivation and harms of segregation. Excluding people with mental illness, intellectual disabilities or brain injuries from segregation and reforming segregation practices can increase safety for staff and incarcerated persons, and increase compliance with legal and professional standards.

Decreased Use of Segregation & Implemented Alternatives in Prison Systems across the Country [63]

From 2011-2012, **Maine** transformed segregation: decreased individuals in seg., decreased time in seg., improved conditions, provided access to more care and saw no increase in incidents of violence.[64]



Ohio and Mississippi reduced their super-max segregation populations by 89 and 85 percent respectively. Both states saw a reduction in the number of serious prison infractions. Mississippi went from 1,000 prisoners in segregation to 150 (-85%) and saw almost a **70% drop in serious incidents.**[65]



Utah does not place individuals with SMI in segregation; offers programming and 20 hours a week minimum out-of-cell time (10 structured: 10 unstructured).[66]

Colorado banned segregation for prisoners with SMI and intellectual disabilities and offers 20 hours a week minimum out-of-cell time (10 structured, 10 unstructured). From 2015-2016, staff assaults reduced by half, and forced cell entries reduced by 79%.[67]

Pennsylvania has limited the use of segregation for individuals with serious mental illness and provides programming and 20 hours a week minimum out-of-cell time (10 structured: 10 unstructured).[68]

Virginia developed a program that decreased the number of people in administrative segregation by 53% and the number of prison infractions by 56%.[69]

Washington and New Mexico have reduced the use of segregated housing and increased the use of alternative programs. New Mexico caps disciplinary segregation at 30 days.[70]

Massachusetts created specialized units as alternatives to segregation resulting in a reduction in on-site and off-site medical visits, disciplinary reports and self-injurious behavior.[71]

South Dakota dropped its use of segregation for individuals determined to present threats of violence by 18% and its violent incident rate reach its lowest point.[72]

North Dakota reduced its use of segregation and reported a reduction in use of force and no increase in incidents of violence.[74]

Kansas greatly reduced the use of segregated housing and reported little or no adverse impact on facility safety.[73]

Michigan reformed administrative segregation practices through incentive programs that reduced the length of stays in isolation, the number of prisoners in isolation and the number of incidents of violence and other misconduct.[75]

In the many court cases challenging segregated confinement of individuals with mental illness, the following remedies are commonly identified:

- Diverting persons with disabilities from segregation through alternative sanctions
- Developing alternative housing programs for persons with disabilities whose behaviors require separation from the general population
- Increasing opportunities for out-of-cell time
- Enhancing mental health services
- Adopting measures to accommodate (and do not punish) behaviors related to disabilities and to provide equal access to programs and opportunities

Individuals at NBCI can present challenging behaviors. DRM recognizes that alternatives to segregation must provide safety to the entire institution, but the case for reform is clear.

DPSCS Acknowledges Its Restrictive Housing Practices are Counterproductive

In February 2016, DPSCS acknowledged that alternative programming can reduce incidents of violence in prisons.

"Through the use of evidenced based programming, which has been shown to be effective in changing behavior, violent behavior and can be reduced, making our facilities safer for staff and offenders."[76]

Reducing reliance on segregation and use of evidence based practices requires more programming and staffing, as well as proper identification of individuals with serious disabilities – all of which is challenging at NBCI.

2015 - 2 years ago

Secretary of Public Safety and Correctional Services, noting that use of segregation is under scrutiny, asks National Institute of Corrections (NIC) for recommendations to meet national standards and improve operations.[77]

NIC recommends limiting offenses sanctionable with segregation; reducing length of segregation; and developing alternate housing programs for persons with serious behaviors and for individuals with serious mental illness.[78]

2016 – 1 year ago

DPSCS reports it intends to adopt NIC's recommendations.

DPCSC and NBCI's Plans for Reform are Not Sufficient

The Secretary reported that he intended to use NIC's evaluation to:

- Cap disciplinary segregation at 60 days and modify the disciplinary sanction and matrix system;
- Develop a behavior management program at NBCI for prisoners with serious aggressive behaviors; and
- Develop a new program for prisoners with serious mental illness.[79]

These initiatives have been in the planning stages since 2015 and were not implemented when DRM investigated NBCI. DRM is aware that some NBCI staff have received crisis intervention training, and DPSCS staff, including Warden Bishop, have learned about reform efforts initiated in other state prison systems and received training from NIC. Proposed regulations regarding DPSCS' disciplinary system does <u>not</u> cap segregation at 60 days. The proposed regulations permit six months of segregation for certain infractions, place no limit on cumulative segregation and do not modify segregation for individuals with disabilities who are at risk of harm. Many issues raised in this report are not addressed by the plans announced by the Secretary. Moreover,

the limitations of staffing and programming must be decidedly dealt with to offer safe, new housing programs that offer more than a different name.

DPSCS' decision to develop a housing program for individuals with serious mental illness at Western Correctional Institution (WCI), which prison has such significant program and staff deficiencies, should be re-evaluated. The Vera Institute of Justice report on DPSCS's use of segregation recommended that correctional units serving persons with disabilities should be relocated to areas where related community resources are more plentiful.[80] DRM seconds that recommendation. WCI has been plagued with staffing shortages.

NBCI's new behavior management program "Max II", began July 1, 2017. On paper, it makes improvements to the prior behavior program, which was barely functional, but it fails to limit segregation or to set adequate minimum out-of-cell standards; instead, it sets *maximum* out-of-cell time, which remains limited. Additionally, while the new Max II program is to exclude persons with serious mental illness, such exclusionary criteria will not be adequate until DPSCS and NBCI can properly identify such individuals (and individuals with intellectual and other disabilities who should not be in the program). In sum, more supports and actions are necessary to accomplish needed reforms.

Conclusion and Recommendations

NBCI is not unique in its function. Numerous prisons across the country have been reforming segregation practices and the delivery of mental health services and programs to achieve dual goals of constitutionally adequate care and a safe, secure setting. Prisons are tough environments. Ensuring successful reform requires significant attention to staffing, programming and policy changes. Such attention is warranted given the conditions observed at NBCI. **DRM finds those conditions harm, and put at risk of harm, incarcerated persons with disabilities; and violate the 8th Amendment of the U.S. Constitution, Article 25 of the Maryland Constitution and the Americans with Disabilities Act.**

Secretary Moyer, Warden Bishop and their attorney were provided a copy of DRM's investigation on June 1, 2017. DRM offered to discuss the report and any responses. Secretary Moyer wrote to DRM in mid-June stating that he read the report, noted its "very troubling findings", and requested an internal review, and; that he would reach out to schedule a meeting with DRM to work in 'partnership'. DRM contacted Secretary Moyer several times to ask for a meeting date but received no follow-up**. DRM determined to issue this report to the public. Serious reforms are needed.**

Recommendations

1. Exclude individuals with serious disabilities from disciplinary segregation with defined, limited exceptions for use of restrictive housing based on clear and present threats of violence; with additional oversight and reporting for such exceptional cases.

2. End discrimination and modify policies and practices to accommodate individuals with disabilities in access to programs, housing and discipline proceedings.

3. Engage experts to ensure proper identification of individuals with disabilities, review and modify definitions, standardize evaluations, and offer recommendations for provision of disability services.

4. Provide individual plans for movement to less restrictive settings for those individuals with serious disabilities who are not in the general population.

5. Significantly increase daily out-of-cell time with set minimum hours for social interactions and appropriate programming for individuals with serious disabilities and for those individuals not in the general population.

6. Limit disciplinary segregation to the most violent infractions or threats of credible violence, drastically reduce use of segregation, length of segregation, and consecutive segregation time. Establish measurable outcomes.

7. Establish procedures to remove individuals from segregation if their medical or mental health deteriorates or if necessary services cannot be provided.

8. Permit isolation for clinical purposes only upon order and on-going review of health care professional, in a supervised area and under the least restrictive conditions possible.

9. Provide transparency and accountability for use of segregation and restricted housing by tracking and reporting on out-of-cell time hours per person and total time in any restricted housing.

10. Revise policies to limit loss of phone and visitations to short term sanctions and alternatives to segregation. Loosen restrictions on loss of property to short term sanctions or based on genuine safety rationale. Permit individuals in restricted housing or segregation greater access to phone calls and visitation.

11. Increase mental health, correctional and program staff. Substance abuse and recreation staff are needed. Wait lists for programs need to be reduced and standards established to ensure access.

12. End punishment for incidents related to self-harm; end use of D ring – where an individual is shackled and then restrained to iron ring in floor; restrict staff denial of medications authorized by health professionals.

13. Modify policies so health care services and programs are canceled less frequently; develop standards for cancellations with reporting & review systems.

14. Reform SNU: maximize out-of-cell time; enhance mental health & programming; develop program evaluation; decrease harmful use of segregation and restraints; increase oversight, transparency and support for this program.

15. Engage external resources for strengthening programming and opportunities in the facility, consider developing certified peer support programs.

Endnotes

[1] *See*, Developmental Disabilities Assistance and Bill of Rights (DD) Act of 2000, 42 U.S.C. § 15043; Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act of 1986, as amended, 42 U.S.C. § 10801, et seq., and Protection and Advocacy of Individual Rights (PAIR) Program of the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794e(f) incorporating the general authorities, including access authorities, as set forth in the DD Act.
[2] See 42 U.S.C. § 10802(3), which defines facilities wherein DRM may investigate allegations of abuse or neglect to include, but need not be limited to, hospitals, nursing homes, community facilities for individuals with mental illness, board and care homes, homeless shelters, and jails and prisons.
[3] MARYLAND MANUAL ON-LINE, DEPARTMENT OF PUBLIC SAFETY & CORRECTIONAL SERVICES, FUNCTIONS, DIVISION OF CORRECTIONS, North Branch Correctional Institution, http://msa.maryland.gov/msa/mdmanual/22dpscs/html/22agen.html.
[4] Letter from Stephen T. Moyer, Secretary DPSCS, to Amy Cruice, ACLU-MD (Sept. 21, 2015) (on file with DRM).
[5] Joseph Shapiro & Christine Thompson, *The Deadly Consequences of Solitary with a Cellmate*, THE MARSAHLL PROJECT (March 24, 2016), https://www.themarshallproject.org/2016/03/24/the-deadlyconsequences-of-solitary-with-a-cellmate#.
[6] Henry A. Dlugacz is an attorney and psychiatric social worker specializing in mental health disability. His work includes teaching law and monitoring federal class action litigation related to forensic psychiatric hospitals and correctional mental health, where he has been a consultant and court-appointed expert. Mr. Dlugacz has served as Director of Mental Health for the St. Vincent's Hospital Correctional Health Program. He has lectured in national and international forums.
[7] NBCI Policy NBCI.ID.110.0006.1, *Disciplinary Segregation*, effective 23 Dec. 2014.
[8]David H. Cloud, Ernest Drucker, Angela Browne, & Jim Parsons, *Public Health and Solitary Confinement in the United States*, 105 AMER. J. OF PUBLIC HEALTH 1, 18-26 (2015). Kenneth L. Appelbaum, MD, *American Psychiatry Should Join the Call to Abolish Solitary Confinement*, J. Am. Acad. Psychiatry & L. Online 406, 411 43 (Dec. 2015): 406, 411, http://www.jaapl.org/content/43/4/406; Jeffrey L. Metzner, MD, and Jamie Fellner, Esq., *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, J. Am. Acad. Psychiatry & L., 38 (March 2010): 104–08; Haney, Craig. (2017). "Madness" and penal confinement: Some observations on mental illness and prison pain. Punishment & Society. 19. 146247451770538. 10.1177/1462474517705389.
[9] *Glossip v. Gross*, 135 S.Ct. 2726, 2765 (2015) (Breyer, J., dissenting, joined by Ginsburg, J.); Davis v. Ayala, 135 S.Ct. 2187, 2208 (2015) (Kennedy, J., concurring).
[10] *Craig Williams v Secretary Pennsylvania Department of Corrections*, __F.3d__ (2017), 2017 WL 526483.
[11] *Braggs v. Dunn*, No. 2:14 cv 601-MHT, 2017 U.S. Dist. LEXIS 98755, at *95 (M.D. Ala. June 27, 2017) ("Patients housed in ADOC's mental-health units receive very little out-of-cell time. This puts them at a substantial risk of continued pain and suffering, decompensation, and self-harm."); *Disability Rights Network of Pa. v. Wetzel*, No. 1:13-CV-00653-JEJ (M.D. Pa. Jan.9, 2015), ECF No 59. https://www.aclupa.org/download_file/view_inline/2714/677/; *T.R. v. S.C. Dep't of Corr*., No. 4855-6615-1984 v.8 (May 31, 2016), http://www.pandasc.org/wp-content/uploads/2016/06/Settlement-Agreement-May-31-2016.pdf; *Parsons v. Ryan*, 754 F.3d 657,690 (affirming the district court's order that the Arizona Dept. of Corrections develop and implement a plan to remedy, among other things, its constitutionally deficient segregation of individuals with serious mental illness.); *Parsons v. Ryan*, No. CV 12-00601-PHX-DJH (D. Ariz. Oct. 14, 2014), ECF No 1185, settlement agreement filed October 14, 2014, approved by District Court February 18, 2015, mandating out of cell time and services for individuals with mental illness; Stipulation, *Peoples v. Fischer*, No. 11-

cv-2694 (S.D.N.Y. Feb. 19, 2014), ECF No. 124, individuals with cognitive impairments are prohibited from being placed in solitary; *T.R. v. S.C. Dep't of Corr.*, No. 4855-6615-1984 v.8 (May 31, 2016), http://www.pandasc.org/wp-content/uploads/2016/06/Settlement-Agreement-May-31-2016.pdf; Stipulation, Indiana Prot. & Advocacy Serv. V. Comm'r, Indiana Dep't of Corrections, No. 1:08-CV-01317-TWP, (S.D. Ind. Dec. 2012) ECF No. 496.

[12] U.S. Office of the Inspector General, U.S. Dept. of Justice, *Review of the Federal Bureau of Prisons' Use of Restrictive Housing for Inmates with Mental Illness*, *Evaluation and Inspections Division 17-05*, Washington, DC. July 2017; https://oig.justice.gov/reports/2017/e1705.pdf (Massachusetts, Mississippi and New York had at most a 30-day limit, while Colorado, Maine and Pennsylvania no longer placed inmates with SMI in restrictive housing units).

[13] COLO.REV.STAT.ANN. §17-1-113.8(1) (West 2015); MASS.GEN. LAWS.ch.127§ 39A(b) (West 2015); Washington DC introduced, but has not passed "Inmate Segregation Reduction Act of 2015," (More information on the D.C. proposed legislation is available at http://www.safealternativestosegregation.org/app_dev.php/resources/view/dc-segregation-reduction-act.)

[14] National Commission on Correctional Health Care, *Position Statement: Solitary Confinement (Isolation)* (2016). http://www.ncchc.org/filebin/Positions/Solitary-Confinement-Isolation.pdf

[15] Am. Pub. Health Assn, *Solitary Confinement as a Public Health Issue* (2013), https://www.apha.org/policies-andadvocacy/public-health-policy-statements/policy-database/2014/07/14/13/30/solitary-confinement-as-a-publichealth-issue; Statement of the American Public Health Association, Submitted for the record to the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights, *Reassessing Solitary Confinement II: The Human Rights, Fiscal, and Public Safety Consequences* February 20, 2014. https://www.apha.org/~/media/files/pdf/advocacy/letters/2014/140220aphasolitaryconfinementtestimony.ashx.

[16] U.S. Department of Justice, *Report and Recommendations Concerning the Use of Restrictive Housing: Final Report* (Washington, DC: U.S. Department of Justice, January 2016). p.99-102, https://www.justice.gov/dag/file/815551/download; Federal Bureau of Prisons Program Statement 5310.16, Treatment and Care of Inmates with Mental Illness (May 1, 2014), p. 16, recognizing the harm and need t\o limit segregation for incarcerated persons with serious mental illness.

[17] American Psychiatric Association, *Position Statement on Segregation of Prisoners with Mental Illness* (2012).

[18] American College of Correctional Physicians, *Restricted Housing of Mentally Ill Inmates* (2013).

[19] American Correctional Association, *Public Correctional Policies* (2017).

[20] VERA INST. OF JUSTICE, *Review of Maryland DPSCS Use of Segregation in Adult Prisons*, (2012), finding DPSCS had a total prisoner population of 21,931, of whom 1,834 were housed on administrative and disciplinary segregation in 2011, meaning 8.35% of the DPSCS prison population was on administrative or disciplinary segregation, which was **high** compared with other states. (Another 130 prisoners were in segregation in protective custody.); Letter from Stephen T. Moyer, Secretary DPSCS, to Amy Cruice, ACLU-MD (Sept. 21, 2015) reporting that the total prison population was 21,921 and there were 2,055 prisoners in disciplinary and administrative segregation on August 2015, meaning 9.8% of the prison population was in segregation.; Letter from Stephen T. Moyer, Secretary DPSCS, to Senator Robert Zirkin, Chair, Judicial Proceedings Committee (Oct. 1, 2015), *Use of Segregation Confinement in Maryland's Correctional Facilities*, reporting that in September 2015, 8% of the population was in segregation.; *Report on Restrictive Housing – Fiscal Year 2016 Fulfilling Reporting Requirements of SB 946*, DEP'T OF PUBLIC SAFETY & CORR. SERVS. (Dec. 2016), DPSCS stated that for fiscal year 2016, 13,881 prisoners spent time in segregation, and in the month of December 2016 there were 1,878 placements of prisoners in segregation out of an average prison population of 20,374. https://goccp.maryland.gov/wp-content/uploads/dpscs-restrictive-housing-report-2016.pdf.

[21] *Aiming to Reduce Time-in-Cell: Reports from Correctional Systems on the Numbers of Prisoners in Restricted Housing and on the Potential of Policy Changes to Bring About Reforms*, ASS'N OF STATE CORR. ADM'RS & ARTHUR LIMAN PUB. INTEREST PROGRAM AT YALE LAW SCH., P. 22, TABLE 2, finding that the average percent of persons in segregation among 48 jurisdictions was 4.9%.; James Austin and Kenneth McGinnis, *Classification of High-Risk and Special Management Prisoners: A National Assessment of Current Practices* (Washington, DC: U.S. Department of Justice, National Institute of Corrections, (June 2004) 29-30, finding that among 40 states responding to a survey about incarcerated persons, on average five percent of such persons were housed in administrative and disciplinary custody.

[22] Allen J. Beck, U.S. DEP'T OF JUSTICE BUREAU OF JUSTICE STATISTICS, *Use of Restrictive Housing in U.S. Prisons and Jails, 2011-12* (Oct. 2015), p.1, https://www.bjs.gov/content/pub/pdf/urhuspj1112.pdf.

[23] *Aiming to Reduce Time-in-Cell: Reports from Correctional Systems on the Numbers of Prisoners in Restricted Housing and on the Potential of Policy Changes to Bring About Reforms*, supra note 21, p. 32, TABLE 5.
[24] Letter from Stephen T. Moyer, Secretary DPSCS, to Senator Robert Zirkin, Chair, Judicial Proceedings Committee (Oct. 1, 2015).
[25] Letter from Stephen T. Moyer, Secretary DPSCS, to Amy Cruice, ACLU-MD (Sept. 21, 2015); Data provided to DRM by counsel for DPSCS on March 15, 2017, demonstrating a monthly average of 138 prisoners identified as SMI at NBCI, of whom 51 were, on average monthly, in segregated housing; (on file with DRM).
[26] Letter from Stephen T. Moyer, Secretary DPSCS, to Amy Cruice, ACLU-MD (Sept. 21, 2015) (on file with DRM).
[27] Supra note 25.
[28] D. Jones, Ed., Humane Prisons (Oxford: Radcliffe Publishing, 2006), citing Frank Wood, former Minnesota Commissioner of Correction, "When you take away televisions, when you take away weights, when you take away all forms of recreation, inmates react as normal people would. They become irritable. They become hostile. Hostility breeds violence, and violence breeds fear. And fear is the enemy of rehabilitation."; T.A. Kupers, *"How to Create Madness in Prison*," p.51 D. Jones, Ed., Humane Prisons (Oxford: Radcliffe Publishing, 2006)); John J. Gibbons and Nicholas de B. Katzenbach, *"Confronting Confinement, A Report of the Commission on Safety and Abuse in America's Prisons,* 14 (2006).
http://www.fmhac.net/Assets/Documents/2009/Presentations/Kupers%20Humane%20Prisons.pdf.
[29] Alison Shames et al. *Solitary Confinement: Common Misconceptions and Emerging Safe Alternatives*, New York, NY: VERA INST. OF JUSTICE (May 2015) pp.18-19; Leann K. Bertsch, *The History of Restricted Housing at the ND-DOCR (Mar. 15, 2016),* as cited in ASCA Report, Supra 21,citation at 64 (unpublished manuscript); Jessica Knowles, *The Shameful Wall of Exclusion: How Solitary Confinement for Inmates with Mental Illness Violates the Americans with Disabilities Act*, 90 Wash. L. Rev. 893, 904-05 (2015) (citing several studies).
[30] Jeffery L. Metzner, MD, and Jamie Fellner, Esq., *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, Journal of the American Academy of Psychiatry and the Law", 38 (March 2010): 104-108, as cited in Office of Inspector General report at 1, supra 10.
[31] VERA INST. OF JUSTICE, Resource Center, *Safe Alternatives to Segregation Initiative*, Frequently Asked Questions, *http://www.safealternativestosegregation.org/faq*; *Aiming to Reduce Time-in-Cell: Reports from Correctional Systems on the Numbers of Prisoners in Restricted Housing and on the Potential of Policy Changes to Bring About Reforms*, supra note 21.
[32] American Psychiatric Association, *Psychiatric Services in Jails and Prisons, 2nd ed. (Washington, D.C.:* American Psychiatric Association, 200), Introduction, xix*;* The National Commission on Correctional Health Care estimated that in 2002, 13.1% to 18.6% of prisoners have Major Depression and between 2.1% to 4.3% have Bipolar Disorder (manic episode); National Commission on Correctional Health Care*, "The Health Status of Soon-to-be-Released Inmates, A Report to Congress,"* March 2002, http://www.ncchc.org/filebin/Health_Status_vol_1.pdf. vol. 1; Human Rights Watch estimated that approximately 20% of all prisoners were seriously mentally ill. *Human Rights Watch, Ill Equipped: U.S. Prisons and Offenders with Mental Illness* (Washington, D.C.: Human Rights Watch, 2003).
[33] Governor's Office of Crime Control and Prevention, *Substance Use and Mental Health Disorder Gaps and Needs Analysis*, MSAR#: 10908 (Chapter 151 of 2016, Section 5), December 31, 2016, p. 26, providing a range of rates of persons identified as seriously mentally ill at various DPSCS prisons from 1.4% to 15.5%.
[34] *Aiming to Reduce Time-in-Cell: Reports from Correctional Systems on the Numbers of Prisoners in Restricted Housing and on the Potential of Policy Changes to Bring About Reforms*, supra, note 21, which report used information reported by DPSCS.
[35] *Department of Public Safety and Correctional Services Report on Restrictive Housing – Fiscal Year 2016 Fulfilling Reporting Requirements of SB 946,* December 2016, 4.
[36] Supra, note 33.
[37] DPSCS identifies females in its prison as having significantly less serious mental health issues than do women not in prison, identifies females with serious mental health issues at a rate significantly lower than the vast majority of states, and; identifies females in their prisons to have a rate of SMI lower than that of male prisoners, as cited in *Aiming to Reduce Time-in-Cell: Reports from Correctional Systems on the Numbers of Prisoners in Restricted Housing and on the Potential of Policy Changes to Bring About Reforms*, supra note 21. In contrast, studies reveal that women in prison are more likely than male prisoners and much more likely than women in the general population to have SMI. See, Jennifer Bronson, Ph.D., Bureau of Justice Statistics, *Marcus Berzofsky, Dr.P.H.*, RTI International, *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates*, June 22, 2017.

[38]*Aiming to Reduce Time-in-Cell: Reports from Correctional Systems on the Numbers of Prisoners in Restricted Housing and on the Potential of Policy Changes to Bring About Reforms,* supra note 21, Tables 14 and 15, pp. 50-51, data based on an October 2015 survey. However, other information attributes 15.5% of women incarcerated at DPSCS women's prison as having a serious mental illness, supra, note 33, p. 26.

[39] Data cited in this report is from documentation provided by NBCI to DRM during its investigation. (On file with DRM)

[40] Petersilia, J. (August 2000). *Doing Justice? Criminal Offenders with Developmental Disabilities.* CPRC Brief, 12 (4), California Policy Research Center, University of California. http://files.eric.ed.gov/fulltext/ED465905.pdf

[41] Center for Disease Control, U.S. Department of Health and Human Services, *Traumatic Brain Injury in Prisons and Jails: An Unrecognized Problem*, 2007. https://www.cdc.gov/traumaticbraininjury/pdf/prisoner-tbi-prof-a.pdf

[42] MENTAL HEALTH SERVICES, DPSCSD 124-003, Special Needs Identification, Dec. 20, 2000; ACA Standard 3-4292.

[43] MENTAL HEALTH SERVICES, DPSCSD 124-005.

[44] Some mental health services are offered through a DPSCS contract with MHM Services, Inc., which is responsible for daily segregation "rounds" to check on prisoners. MHM is also required to provide weekly visit by medical personnel (usually a psychiatric nurse) and medication reviews every 90 days. Medication changes and dosages are documented. Medication reviews appear to occur at least every three months as per policy.

[45] In 2016, DPSCS reportedly interviewed 4,000 individuals but hired only 63. According to news reports, union officials have suggested that DPSCS has 1,000 vacancies. Tamela Baker, *Maryland state prisons still face staffing shortage*, HERALD-MAIL MEDIA, July 2, 2017, http://www.heraldmailmedia.com/news/local/maryland-state-prisons-still-face-staffing-shortage/article_298308be-176b-51c6-995e-72282030168f.html.

[46] Department of Legislative Services, Office of Policy Analysis, "Spending Affordability Briefing", Annapolis, Maryland, November 14, 2017.

[47] *Id.*

[48] Letter from Stephen T. Moyer, Secretary DPSCS, to Senator Robert Zirkin, Chair, Judicial Proceedings Committee, Re: *Use of Segregated Confinement in Maryland correctional facilities*, (Oct. 1, 2015) p.1.

[49] *Prisons and Health,* World Health Organization Report, Page 29.

[50] DPSCS Doc. 124.0541, *Special Needs Unit Program Manual*, at 4.

[51] Section 12.02.27.00 of the Code of Maryland Administrative Regulations (COMAR) stipulates the disciplinary process, covering the investigatory process, the hearing procedures, the adjustment history sentencing matrix, and the appeals process. Although DPSCS policies provide prison wardens with the discretion to reduce disciplinary sanctions, there is no written policy addressing consideration of mental health or whether a prisoner's behaviors are related to their disabilities.

[52] A Reduction in Violence Committee at each facility reviews disciplinary incidents and can recommend increasing housing restrictions, which raises due process concerns as applied in the records reviewed by DRM, where additional sanctions were added to incarcerated persons after their disciplinary hearing process. Executive Directive *OPS.110.0022.*

[53]OFFICE OF TREATMENT SERVICES MENTAL HEALTH SERVICES, SUICIDE PREVENTION ACTIVITIES MANUAL, Inmate Self-Harm and Suicide Prevention, Executive Directive No. OPS.110.0006, p.6.

[54] *Id.*

[55] Pennsylvania eliminated self-injurious behaviors, self-mutilation, other forms of self-injury and behaviors associated with such actions from incidents that can lead to segregation or other sanctions, Settlement Agreement, *Disability Rights Network of Pennsylvania v. Wetzel*, Civil Case No. 1:13-CV-00635 (M.D. Pa. Jan. 5, 2015), ECF No. 59. Vermont and Washington prohibit punishment for self-harming behavior. Vermont's policy on prohibiting punishment for self-harm, Responses to Inmate Self Harm, Security and Supervision #413.11, effective August 21, 2006, also prohibits use of pepper spray relating to such incidents (DRM reviewed records where pepper spray was used on individuals in self-harm or suicide situations at NBCI). See, also *Coleman v. Brown*, No. 2:90-cv-00520-KJM-DAD Document 5298 Filed 04/03/15, Agreement.

[56] The records that indicate his medications were not administered for reason of misconduct were reviewed to see if the medications may have been administered later, but no such notations were identified.

[57] *"Report on Restrictive Housing – Fiscal Year 2016, Fulfilling Reporting Requirements of SB 946",* DPSCS report to Maryland General Assembly, Dec. 2016.

[58] National Commission on Correctional Health Care: Standards for Health Services in Prisons. Chicago, IL: NCCHC, 1996, requiring a comprehensive quality improvement (QI) program involving a multidisciplinary

quality improvement committee of health care providers who meet regularly with correctional administrators to design QI monitoring activities and to review the results.

[59] Special Needs Unit Program Manual (Doc.124.0451), provided to DRM by NBCI on December 16, 2016.

[60] *Id.* pp. 3, 7.

[61] *Report on Implementation of National Institute of Corrections Recommendations,* DPSCS, February 2016, p.5.

[62] This is higher than the 71% of overall DPSCS population and 70% of the population at Western Correctional Institution, adjacent to NBCI. DPSCS's Inmate Characteristics Report for April 2014.

[63] *Aiming to Reduce Time-in-Cell: Reports from Correctional Systems on the Numbers of Prisoners in Restricted Housing and on the Potential of Policy Changes to Bring About Reforms*, supra note 21*; Solitary Confinement: Common Misconceptions and Emerging Safe Alternatives*, supra note 29*; Review of the Federal Bureau of Prisons' Use of Restrictive Housing for Inmates with Mental Illness,* supra note 12; Prisoner Reentry Institute, *Proceeding on Colloquium to further a National Consensus on Ending the Over-Use of Extreme Isolation in Prisons,* October 2015, https://www.prisonlegalnews.org/media/publications/Ending%20the%20Over-Use%20of%20Isolation%20in%20Prisons%2C%20Prisoner%20Reentry%20Institute%20%2C%202015.pdf.; Martin Horn & Ann Jacobs, *Solitary Confinement: Report on a Colloquium to Further a National Consensus on ending the Over-Use of Extreme Isolation in Prisons, JOHN JAY COLLEGE OF CRIM. JUSTICE* (2016); Hager, Eli and Gerald Rich, *Shifting Away from Solitary Confinement*, The Marshall Project, December 23, 2014.

[64]*Change is possible: A Case Study of Solitary Confinement Reform in Maine,* March 2013. https://www.aclu.org/report/change-possible-case-study-solitary-confinement-reform-maine. In addition, for lack of evidence of increased safety, see Natasha Frost and Carlos E. Monteiro, "Administrative Segregation in U.S. Prisons" (Washington, DC:U.S. Department of Justice, National Institute of Justice, March 2016, NCJ 249749R.M), citing Ryan Labrecque, "The Effect of Solitary Confinement on Institutional Misconduct: A Longitudinal Evaluation" (PhD diss., University of Cincinnati, 2015).

[65] Michael Jacobson, President and Director Vera Institute of Justice, Written Testimony Provided for the U.S. Senate Committee on the Judiciary, Subcommittee on the Constitution, Civil Rights and Human Rights, 19 June 2012, p. 2 (citing Terry Kupers et al., "Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs," *Criminal Justice and Behavior 36* (2009): 1037-50, available at http://www.vera.org/files/michael-jacobson-testimony-on-solitary-confinement-2012.pdf (citing James J. Stephan, *Census of State and Federal Correctional Facilities* (Washington, DC: U.S. Bureau of Justice Statistics, National Prisoner Statistics Program, 2008, NCJ 222181).

[66] *Aiming to Reduce Time-in-Cell: Reports from Correctional Systems on the Numbers of Prisoners in Restricted Housing and on the Potential of Policy Changes to Bring About Reforms,* supra note 21 p.70. This document also notes that Alaska, Arizona, Connecticut, Illinois, New Jersey, North Carolina, Oklahoma, South Carolina, Virginia, and Washington, among others, reported implementing or modifying a program for return from segregation to the general prison population.

[67] Rick Raemisch & Kelli Wasko, *Open the Door—Segregation Reforms in Colorado*, Part 2 of 3, *COLORADO DEPARTMENT OF CORRECTIONS* (Jan. 11, 2016), http://www.corrections.com/news/article/-42046-open-the-door-segregation-reforms-in-colorado.

[68] Settlement Agreement, *Disability Rights Network of Pennsylvania v. Wetzel*, Civil Case No.: 1:13-cv-00635-JEJ (M.D. Pa. Jan.9, 2015), ECF No.59.

[69] S*olitary Confinement: Common Misconceptions and Emerging Safe Alternatives,* supra note 29, p. 12. *https://www.vera.org/publications/solitary-confinement-common-misconceptions-and-emerging-safe-alternatives.*

[70] Washington reports reducing the number of prisoners assigned to maximum custody without increases in violence (Washington reports decreasing numbers by 47% from January 2011 to December 2014), VERA INST. OF JUSTICE, Center on Sentencing and Corrections, S*olitary Confinement: Common Misconceptions and Emerging Safe Alternatives,* May 2015, p. 22 citing Bernie Warner, Secretary, Washington Department of Corrections; *Aiming to Reduce Time-in-Cell: Reports from Correctional Systems on the Numbers of Prisoners in Restricted Housing and on the Potential of Policy Changes to Bring About Reforms*, supra, note 19 p.32; *Report and Recommendations Concerning the Use of Restrictive Housing*, supra note 16 p.75-77, discussing changes in Washington and New Mexico prisons.

[71] Massachusetts Department of Corrections, *Specialized Mental Health Units,* describing successful use of alternatives to segregation, http://www.mass.gov/eopss/docs/doc/research-reports/mental-health-brief-finaldoc.pdf.*; Report and Recommendations Concerning the Use of Restrictive Housing*, supra note 16 p.77-78, reporting a 68% decrease in use of segregation in one correctional facility, a better climate and no increase in assaults; Joel Andrade,

PhD, *Mental Health Units as Alternatives to Segregation It Can Be Done,* VERA INST. Of JUSTICE, Think Justice Blog / Addressing the Overuse of Segregation in U.S. Prisons and Jails, June 22, 2017, https://www.vera.org/blog/addressing-the-overuse-of-segregation-in-u-s-prisons-and-jails/mental-health-units-as-alternatives-to-segregation-it-can-be-done

[72] Pierce Parker, Barbara and Michael Kane. *Reshaping Restrictive Housing at the South Dakota State Penitentiary*. Boston, MA: Crime and Justice Institute, December 2015.

[73] U.S. Government Accountability Office (GAO), Bureau of Prisons, *Improvements Needed in Bureau of Prisons' Monitoring and Evaluation of Impact of Segregated Housing*, GAO 13-429, May 2013, pp.34-36; *Aiming to Reduce Time-in-Cell: Reports from Correctional Systems on the Numbers of Prisoners in Restricted Housing and on the Potential of Policy Changes to Bring About Reforms*, supra note 21, p 66.

[74] *Aiming to Reduce Time-in-Cell: Reports from Correctional Systems on the Numbers of Prisoners in Restricted Housing and on the Potential of Policy Changes to Bring About Reforms,* supra note 21, p.64.

[75] Jeff Gerritt, *Pilot Program in UP Tests Alternatives to Traditional Prison Segregation, DETROIT FREE PRESS,* January 1, 2012, www.frep.com/fdcp/?unique=1326226266727.

[76] *DPSCS Report on Implementation of National Institute of Corrections Recommendations,* February 2016, at 9.

[77] Secretary Stephen T. Moyer, DPSCS, letter to Leslie LeMaster, Technical Assistance Coordinator, National Corrections Academy, February 9, 2015.

[78] *DPSCS Report on Implementation of National Institute of Corrections Recommendations, February 2016.*

[79] *Report on Restrictive Housing – Fiscal Year 2016 Fulfilling Reporting Requirements of SB 946*, DEP'T OF PUBLIC SAFETY & CORR. SERVS. (Dec. 2016),

[80] *Review of Maryland DPSCS Use of Segregation in Adult Prisons,* Segregation Reduction Project, VERA INST. OF JUSTICE, New York, NY (2012).