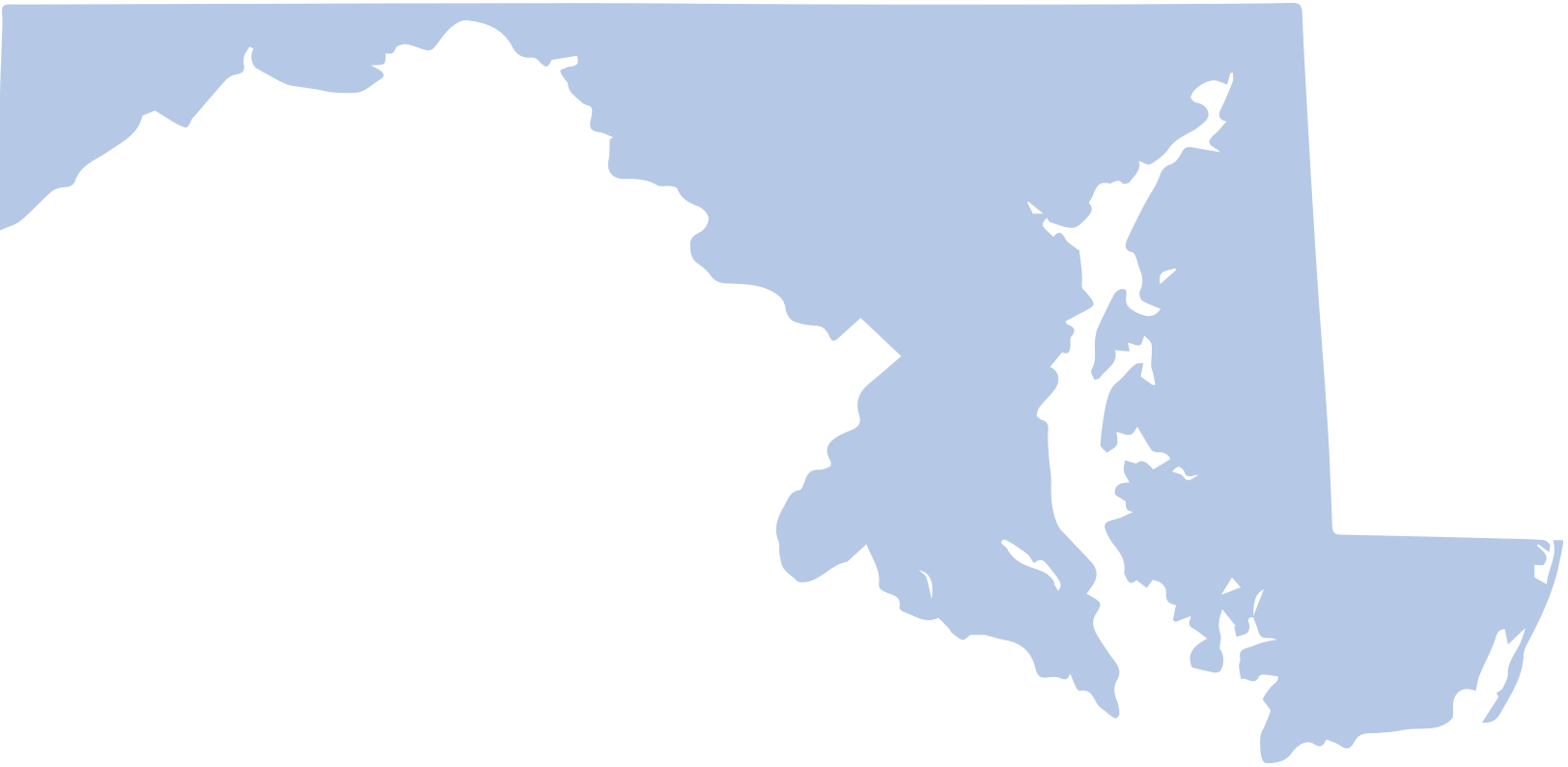
SEGREGATION AND SUICIDE:
CONFINEMENT AT THE MARYLAND CORRECTIONAL INSTITUTION FOR WOMEN

Conducted by Disability Rights Maryland

Disability Rights Maryland



This report was prepared by Disability Rights Maryland (DRM) and Munib Lohrasbi, a Community Fellow with the Open Society Institute (OSI) of Baltimore. DRM is a non-profit organization and is Maryland's designated Protection and Advocacy agency mandated to advance the civil rights of people with disabilities. OSI-Baltimore promotes reforms of social inequities in our criminal justice systems and supports Fellowships to individuals working on issues affecting underserved communities of Baltimore.

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I. STATEMENT OF AUTHORITY AND SCOPE OF 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 and to investigate allegations of abuse and neglect, including within prisons.[1]

DRM, working with an OSI-Baltimore Community Fellow, launched a review of conditions at the Maryland Correctional Institution for Women (MCIW) after receiving several complaints relating to the suicide of Emily Butler, a young woman in segregation, lack of adequate health care, use of segregation, and neglect and abuse of individuals with disabilities in restrictive housing.[2] For the purposes of this report, "segregation" or "restrictive housing" may be used interchangeably and refers to the isolation of an individual in a cell, with or without a cell mate, for 22 hours or more per day.[3]

This Report is based on site visits, review of records, information provided by MCIW Warden Chippendale, health care contractors for the Department of Public Safety and Correctional Services (DPSCS), discussions with individuals who provide programming or advocacy, and interviews and correspondence with women incarcerated at the facility. The findings related to the suicide investigation are based on interviews with women who were in the segregation unit at the time of Ms. Butler's death; review of video security tape of the segregation unit; review of segregation log sheets; and extensive review of individual and MCIW records. DRM also spoke with Ms. Butler's family, who graciously shared their perspectives. The family's desire for change compelled their decision to permit DRM to share details of her story. The cooperation of all involved is appreciated.

II. INTRODUCTION

MCIW is the only women's prison in Maryland and serves an average daily population of 775 individuals of all security classifications and pre-trial detainees.[4] Warden Margaret Chippendale prides herself on offering the women over 70 programs, generally regardless of their security classifications. Sharing the belief adopted by many in her profession, Warden Chippendale commented that keeping people engaged and busy - "fighting idleness"- assists those

[1] 42 U.S.C. 10801; 42 U.S.C. 10802(3); 29 U.S.C. 794e(f).

[2] "Abuse" is defined as any act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with mental illness. "Neglect" means a negligent act or omission by any individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to an individual with mental illness or which placed an individual with mental illness at risk of injury or death, and includes an act or omission such as the failure to establish or carry out an appropriate individual program plan or treatment plan for an individual with mental illness, the failure to provide adequate nutrition, clothing, or health care to an individual with mental illness, or the failure to provide a safe environment for an individual with mental illness, including the failure to maintain adequate numbers of appropriately trained staff. 42 U.S.C. 10802(1); (5).

[3] Double-celling can be equally, or more problematic than solitary segregation. See, Joseph Shapiro & Christine Thompson, *The Deadly Consequences of Solitary with a Cellmate*, The Marshall Project (March 24, 2016), https://www.themarshallproject.org/2016/03/24/the-deadly-consequences-of-solitary-with-a-cellmate.

[4] Facility Summary, DPSCS Fiscal Year 2019 Operating Budget, http://www.dbm.maryland.gov/budget/Documents/operbudget/2019/agency/Q00-DPSCS-Facility-Summaries.pdf.

incarcerated and helps to keep the prison calm and safe. This philosophy, however, is not extended to numerous women with serious disabilities who are placed in restrictive housing and experience conditions of extreme isolation. These severe conditions result in harm and safety risks and are a focus of this Report.

III. SUMMARY OF FINDINGS

This Report highlights the **conditions in the segregation, infirmary, and mental health units at MCIW, which are the most restrictive in the facility.** DRM finds the restrictive conditions, applied to individuals with serious disabilities, violates the 8th Amendment of the United States Constitution, which prohibits cruel and unusual punishment, including deliberate indifference to the health care needs of incarcerated individuals; Article 25 of the Maryland Constitution; the Americans with Disabilities Act (ADA); and Section 504 of the Rehabilitation Act.

The harm from prison segregation practices is pointedly evidenced by the death of Ms. Butler, a young woman in segregation with serious mental health issues. DRM's investigation finds that MCIW failed to exercise reasonable standards of care during events surrounding her suicide. DRM also finds that facility responses to the suicide are not sufficient to prevent future harm. A review into the circumstances of her death offers an opportunity to reform restrictive housing practices. By doing so, DPSCS could adopt better and safer correctional practices, conform to professional standards and comply with our laws. (*See*, **Sections VIII and IX**). Finally, this Report offers information on the harms of segregation, alternative correctional practices, and a series of recommendations.

IV. MCIW GENERAL POPULATION CONDITIONS

MCIW is comprised of six buildings in active use surrounding an open area. The Administrative Building adjacent to the gatehouse contains a cafeteria, computer lab, gymnasium, and a small number of classrooms and office space for the Warden and Chief of Security. A multi-purpose building contains a larger computer lab, more classroom space, case management offices, and facility records. There is also a library that is available at least once per week to women in general population units.[5] Women in general population visit the medical building to receive their prescribed medication. Sick calls and requests for dental, medical, and mental health services are processed in this building as well.[6] The remaining two buildings serve as housing cell blocks.

MCIW has three housing units for the general population: A, B, and D wings located in two adjacent buildings. Generally, two women are assigned to each cell roughly the size of a parking space, but some women are housed in single cells. Cells are generally furnished with a bunk bed, two mattresses, and a sink attached to a toilet. Women are allowed to have limited personal property in their cell and radios or televisions if they are able to afford them. Every general population unit surrounds a common indoor area with tables, board games, a microwave, and

[5] Women in segregation, infirmary, or the mental health unit are not given time in the library.
[6] DPSCS has contracted with Wexford Health Sources, Inc. (Wexford) to provide medical services and MHM Services, Inc. (MHM) to provide mental health services statewide to individuals in their custody.

two showers.[7] There is open space at the center of the prison with some seating and an area for the gardening club. Women in general population are allowed to leave their units to participate in programming, recreation, educational opportunities, medical visits or job assignments. Women in restrictive housing – administrative and disciplinary segregation; the inpatient mental health treatment unit; and the infirmary- are generally prohibited from such opportunities.

V. DISCIPLINARY AND ADMINISTRATIVE SEGREGATION

A. Conditions

C wing, the designated segregation unit at MCIW, is located in one of the oldest buildings in the prison. C wing houses women on administrative and disciplinary segregation. The unit shows evidence of disrepair; several windows were cracked or broken, contributing to cold conditions in the winter and excessively warm conditions in the summer. One cell had electrical wires hanging from the ceiling. Other cells had exposed vents in the ceilings. Ms. Butler and another individual whose records were reviewed, were able to tie a sheet through the vent openings in the cell ceiling, make a noose, and place it around their necks.

As in all cells at MCIW, metal beds are bolted into the concrete floor. The toilets and sinks are stainless steel. There are no toilet seats and no privacy for using the bathroom. Cell doors are thick and door windows are made of Plexiglas. The doors have cuff ports, or slots, that can be opened to provide meal trays or medications and to allow for handcuffing individuals before they exit the cell.

"Helen" was placed in administrative segregation pending an investigation. She was ultimately cleared of any wrong doing. However, "Helen" reported that she lost her job and spot in "Toastmasters," a program designed to improve public speaking and self-confidence.

"Linda" was placed in C wing and had her phone and visitation privileges taken away for a disciplinary infraction. Her mother drove from North Carolina the following week to visit her but was turned away at the gatehouse. "Linda" has asked her family not to visit her anymore to save them the hassle.

Placement in administrative segregation most commonly occurs after an individual has been accused of committing an infraction but prior to an investigation or hearing on the alleged rule violation. It can also be used if an individual is determined to pose a safety risk to the facility or others, or to protect the individual.[8] Once placed on administrative segregation, the individual is removed from participation in vocational or job programming opportunities and is generally relegated to the bottom of long waiting lists upon their return to general population. Women on administrative segregation are allowed to keep personal property.

[7] There is no specific time designated for showers in general population. The women are free to shower every day if they are willing to wait in line during recreation periods and pay for the necessary hygiene products.
[8] DPSCS Case Management Manual 2(B)(2).

Meals are eaten in the cell within feet of the toilet. Showers are offered at least twice a week. Most often individuals are double celled. Periods of administrative segregation vary, but the Warden is required to approve any stay over a year.

Conditions in disciplinary segregation are similar to administrative segregation except that there is no access to a telephone, television, or radio; and any personal property is very limited.[9] Visitation is often restricted as part of the underlying disciplinary sanction.

Records sampled by DRM indicate that Warden Chippendale made rounds in the segregation unit less than twice per month in the time under review. She reported attending weekly segregation team meetings to review the status of women living in the unit. A nurse conducts medication rounds three times per day. A health professional conducts weekly rounds. These encounters are conducted cell side with a heavy door and thick Plexiglas separating the parties. Significantly, the cell side encounters prohibit confidential health and mental health communications.

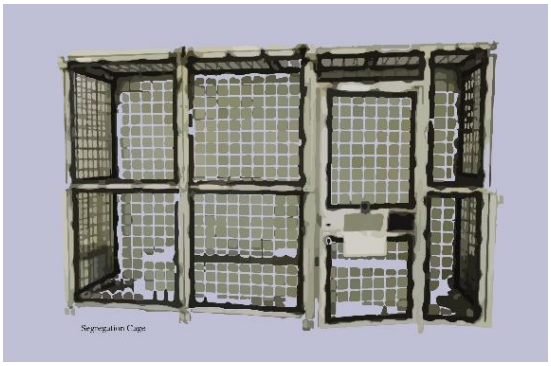
"Zoey" claimed that she was not offered any recreation time for over a week. There was no Record of Segregation Confinement on file from any custody shift, demonstrating that any recreation time was provided.

"Erin" recently spent the majority of four months in restrictive housing. Her Records of Segregation Confinement are only filled in for a few days each month. Thus, there is no record of her being offered required recreation or showers for most of that time.

Out of cell recreation time is to be offered five times a week for an hour. Recreation time takes place in outdoor segregation cages, weather permitting. The outdoor cages are stark, empty fenced-in areas. Cellmates may be offered time in the cages together, which can compound the inability to be away from a cellmate with whom one is housed for 22-24 hours per day. The idle time, close quarters, and lack of diversion can generate additional stress and disputes.[10] The segregation unit can be loud as individuals may yell to one another, to staff, or because they are not stable. The unit is colorless and evidences little to promote hope, health, or wellness.

Correctional officers are required to maintain records of out of cell time for each individual housed in disciplinary segregation (segregation sheets).[11] DRM reviewed records demonstrating that women have gone for two weeks without being offered recreation opportunities. Several segregation sheets reviewed by DRM were incomplete or were missing entirely; in one case, for an entire month. MCIW has no day room for indoor activity on the segregation unit.[12] Some women reported having to choose between recreation time and taking a shower, thus further

[9] The Warden reported that a working television was added to the unit after DRM's visit.
[10] Joseph Shapiro & Christine Thompson, *The Deadly Consequences of Solitary with a Cellmate*, The Marshall Project (March 24, 2016), https://www.themarshallproject.org/2016/03/24/the-deadly-consequences-of-solitary-with-a-cellmate.
[11] DPSCS Division of Correction Directive 110-6(VI)(A)(2).
[12] Prison facilities for men visited by DRM have day rooms or indoor recreation areas on the segregation units.



limiting out of cell time. There are ***usually no out of cell opportunities during weekends or holidays and no mental health rounds***. Ms. Butler committed suicide in segregation on a weekend.

A review of MCIW records for January through October of 2018 demonstrates that the Warden, perhaps in recognition of the perils of segregation, used her discretion to reduce the amount of time on many disciplinary sentences. The reduced segregation time brings MCIW closer to meeting standards promoted by many national organizations, but still allows some women to spend months in disciplinary segregation, longer than recommended by numerous professional groups. As discussed later in this Report, Maryland's use of segregation is out of step with national averages and practices. (*See*, **Section IX**). Moreover, the Warden's actions as applied to individuals with serious disabilities do not reflect the standards endorsed by many organizations and adopted in several jurisdictions, which limit or prohibit the use of segregation for individuals with serious disabilities due to the known harms and risk of harms for such individuals that the United Nations has equated to torture.[13] (*See*, **Section VIII**).

B. Suicide In Segregation

The death by hanging of Emily Butler, a young woman in segregation at MCIW, provides tragic evidence of the harms and dangers of segregation, especially for individuals with disabilities. In reviewing facility records, DRM discovered an incident of attempted suicide that also involved a woman with serious disabilities in segregation that occurred less than six weeks prior to Ms. Butler's death.

"Elaine" spent five months on disciplinary segregation for throwing urine at staff.[14] Elaine's infraction occurred when she was on the inpatient mental health treatment unit (IMHTU) and threw urine through her cell slot out onto staff. The IMHTU is a small unit for individuals experiencing acute behavioral health crisis and is staffed by medical personnel. Elaine is diagnosed with post-traumatic stress disorder, major depressive disorder and borderline personality disorder. Her treatment plan, in place at the time of her infraction, noted that she has repeated incidents of self-injurious behaviors, aggression and poor tolerance for stress. She is prescribed psychotropic medications to treat her mental health conditions. Elaine has spent years in accumulated time on the IMHTU and has a history of psychiatric hospitalizations.

According to her records, after Elaine was transferred from the IMHTU to disciplinary segregation, she was observed in her cell standing on the sink and tying a sheet to the vent in the

[13] A review of Segregation Probation Logs from January 2018 to October 2018 demonstrated that women known to DRM as seriously mentally ill were sentenced to approximately double the amount of days in segregation than others but had a lower percentage of that time probated by the Warden. Only 40.2% as compared to 47.7% for the MCIW population and 51.4% for the institutional population that includes pre-trial detainees; Juan Ernesto Méndez, *Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*. Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, p. 21 (2011).

[14] DRM is using the name "Elaine" so that this individual may remain anonymous.

ceiling and around her neck. An officer intervened and stopped Elaine's actions. Elaine's records reveal that she wanted to harm herself because she was scared about pending criminal assault charges for throwing the urine and that she had other stresses related to her family. Elaine's records also state that she was upset that staff on the segregation unit did not take her seriously when she said that she was suicidal and wanted to speak with mental health staff. Records note that **she said she attempted to hang herself after getting no response to her request for help.** Elaine spent a few days on the IMHTU after this incident, and was then *returned* to the disciplinary segregation unit despite her evidenced need for mental health services. After completing her punishment in segregation, she was again returned to the IMHTU.

Less than six weeks after Elaine was discovered with a sheet tied to the vent and around her neck, Emily Butler was discovered, also in the segregation unit, hanging from a sheet tied to a vent in her cell.

Ms. Butler's extensive mental health history was known to MCIW. It was detailed in her prison psychiatric evaluation upon her admission in 2015. She had been receiving mental health services in the community since 2008 for depressive, bipolar, and post-traumatic stress disorders. Records note her feelings of sadness, anger, irritability, hopelessness, and a lack of self-worth. Her family states that Ms. Butler was a bright and charismatic young woman when she received clinical attention and medication for her mental health issues. She had enrolled in an office management class and completed a few group courses during her time at MCIW. She was prescribed psychiatric medications to address her anxiety and depression, but never received regular individual counseling.

Ms. Butler was sent to segregation after tossing coffee on a friend during a dispute on Friday, November 10, 2017. She spent Friday, Saturday and part of Sunday in segregation before taking her life on November 12, 2017. According to women interviewed by DRM, Ms. Butler was distraught over her argument with her friend, and that her disciplinary charges would affect her chance for parole, for which she would have been eligible in April 2018. She was reportedly crying a great deal and asking to call her father **and to see mental health.** Neither request was granted. These events were reported separately and corroborated by numerous women interviewed by DRM. According to several women, Ms. Butler asked for mental health help repeatedly on Friday and on Saturday. Some women gave statements affirming their observations. Aside from the opportunity to shower, she was not offered any time out of her cell.

Ms. Butler's records reveal that during a previous placement in segregation, she affirmed that she knew to "tell somebody" if she felt like hurting herself because there were mental health professionals available for help. In this instance, reports of her "telling somebody" did not produce help.

Ms. Butler was not screened or evaluated for mental health concerns prior to being placed in segregation. Had that occurred, several risk factors should have been identified. Ms. Butler had a history of serious mental illness. She was diagnosed with depression, bipolar disorder, and post-traumatic stress disorder. She had a history of multiple self-injury or suicide attempts prior to her incarceration. This background was documented in her prison medical records. In prison she was on medications to treat her anxiety and depression. **A week prior to her death, her depression medications were changed to address her increased depression symptoms**. She

reported lacking motivation to get out of bed, being irritable, sleeping most of the day, and isolating herself. An evaluation could also have noted aggravating stress factors, such as the dispute with her friend and her worry that she would be found ineligible for parole.

According to an Institutional Order governing practices at MCIW, staff assigned to the segregation unit must "supervise and monitor inmate's behavior and note all actions in the segregation confinement binder and the special confinement sheets." The Order further dictates that "security rounds will be made every 30 minutes and noted in the log book."[15] These directives were ignored. While Ms. Butler was accounted for during the Sunday morning count at 7:30 AM, rounds did not happen until she was found hanging in her cell when lunch trays were delivered around 10:15 AM.

Several women from the unit described the trauma of watching officers bring Ms. Butler out of her cell and attempt CPR, watching medical staff appear and then seeing Anne Arundel County paramedics arrive. Ms. Butler was declared dead around 11:00 AM, but her body lay on the floor in the middle of the segregation unit for hours until the medical examiner arrived that afternoon. Emily Butler was only 28 years old when she died. She was sentenced to MCIW for a non-violent offense. She left notes for her friend and for her father.

C. Investigative Findings: Failure to Exercise Reasonable Care

DRM finds that MCIW failed to exercise reasonable care in the segregation unit. There were failures in security and supervision in the officers' responses to Ms. Butler's behaviors and requests for mental health assistance, and in accommodating her disabilities. Security rounds were not adequate or not performed; interactions with Ms. Butler were absent; anti-ligature strategies were not implemented to prevent hanging, even though another woman was reported to have tied a sheet from the vent in her cell ceiling and around her neck just a few weeks prior to Ms. Butler's suicide; mental health pre-placement screening was not provided and her reported requests for interventions were ignored despite documented mental health risk factors; connections to mental health staff were not made; and MCIW failed to mitigate the known risks of harm in restrictive housing.

Ms. Butler was not a danger to herself or others in MCIW because she acted impulsively and threw coffee on her friend during a dispute. Her friend was not injured and did not want to see Ms. Butler placed in segregation. Her segregation sentence was about punishment, not safety. Ms. Butler only became a danger to herself after she was placed in segregation.

MCIW knew of the mental health history, diagnoses, and risk factors impacting Ms. Butler. Had Ms. Butler received consideration prior to being placed in segregation she could have received alternative sanctions and interventions in response to her documented increased mental health symptoms and her actions. She should have been diverted from segregation. Had she developed a meaningful clinical relationship or received other out of cell supports she may have had resources to better cope with her circumstances. Increased isolation for individuals with serious disabilities, including Ms. Butler who was being treated for depression, is not appropriate.

[15] Post Order 110-1-31a, applicable to all officers on MCIW's segregation wing effective September 1, 2016.

DRM saw no evidence that a robust review of the mental health factors that contributed to Ms. Butler's suicide was conducted.[16] There should have been documented consideration of her mental health issues and the lack of mental health staff or out of cell time in segregation, especially during the weekends. There was no connection between Elaine's actions in segregation and Ms. Butler's, even though the actions were close in time; both women used ceiling vents to tie sheets to the ceiling and around their necks; both women had known serious mental health histories; both were in segregation; and both were reported to be asking for mental health assistance prior to their actions of self-harm. The limited internal review observed by DRM will not produce sufficient actions to prevent future harm.

D. MCIW's Response To Ms. Butler's Death.

According to Warden Chippendale, several actions were taken subsequent to Ms. Butler's death including that the Chaplain was asked to visit the segregation unit and an expert on trauma-informed care was invited to speak with some staff. The Warden also reported that she increased her participation in segregation reviews and visits to the unit, and developed anti-ligature plans for the segregation unit; although the anti-ligature plans had not been completed at the time of DRM's visit in March 2018.[17]

DRM was not privy to personnel actions that may have been taken but the officers on the segregation unit at the time of Ms. Butler's death remain at MCIW and were observed working at the facility when DRM visited.

E. DRM Finds More Corrective Actions Are Necessary

Further action should be taken to prevent harms such as those demonstrated by the records of Elaine and Ms. Butler.

DPSCS should adopt standards endorsed by the National Commission on Correctional Health Care (NCCHC),[18] and supported by other organizations, that prohibit placement of individuals with serious disabilities in segregation, except in limited exigent circumstances when alternatives are not available. Further, those ultimately placed in restrictive housing must be offered more time out of cell and programming opportunities.

Mental health services must be available in crisis situations, especially when individuals with serious mental health histories face known stressors and are asking for help.

DPSCS should require a more transparent review process following a suicide examining all potential causes, and including voices of incarcerated individuals. Inclusion of external entities in

[16] DRM specifically requested such information.
[17] MCIW reported that anti-ligature equipment had been implemented in the segregation unit when DRM followed up in October 2018 but that reinforcement screws still needed to be installed.
[18] NCCHC is an independent, non-profit organization. NCCHC works with the major national organizations representing the fields of health, law and corrections to improve the quality of health care in jails, prisons, and juvenile confinement facilities. NCCHC has adopted the position that individuals with serious disabilities should be prohibited from placement in segregation due to resulting harms.

the processes can be useful. Such reviews move beyond assigning potential blame and examine what might have been done in order to make meaningful changes and prevent future incidents.

DPSCS polices should include pre-screening evaluation processes to ensure that individuals with serious disabilities are identified and diverted from segregation. Alternative sanctions or programs, consistent with individual treatment plans should be developed. This process is manageable given the small number of individuals with serious disabilities sent to segregation.[19] Such actions would mitigate harm and the risk of harm that segregation causes for persons with disabilities. Many jurisdictions that have decreased their reliance on segregation report improved safety in the facility or no increase in incidents. (*See*, **Section VIII**). One Corrections Commissioner reported that banning segregation for individuals with serious mental illness and increasing programming resulted in a dramatic decrease in assaults, a safer facility and fewer incidents of self-harm and suicide, potentially due to not exacerbating mental illness through use of segregation.[20] Numerous jurisdictions have developed programs to address the needs of incarcerated individuals with serious disabilities and to avoid use of segregation. (*See*, **Section VIII**). The IMHTU at MCIW, described below, does not meet the need for an alternative housing program to disciplinary segregation. Conditions in the IMHTU are more restrictive and isolating than in disciplinary segregation and are in need of urgent reform. (*See*, **Section VI**).

VI. INPATIENT MENTAL HEALTH TREATMENT UNIT (IMHTU)

The IMHTU consists of fourteen cells and is operated under contract by DPSCS to MHM Services, Inc. (MHM). The purpose of the unit is to stabilize individuals in crisis. The most restrictive conditions at MCIW were observed in the IMHTU, which is a segregated housing unit.

As discussed below, segregation can impact or aggravate existing mental health conditions resulting in regression, deterioration, decompensation, and intensified mental health symptoms. The risks of harm can include lessened ability to conform behaviors, distorted realities, and self-harm.[21] General acceptance of the harmful effects of segregation for individuals with mental illness has led numerous corrections and professional groups to prohibit segregation for individuals with serious disabilities, or to limit its use to a last resort when absolutely necessary and to mitigate its effects by providing significant time out of cell, increasing access to services, and minimizing the harshness of conditions and periods of time in segregation.

[19] DPSCS identified only 98 individuals at MCIW with a serious mental illness in 2015. Only 6 of these individuals had been sent to administrative or disciplinary segregation as of August 31st of that year. Letter from Stephen Moyer, Secretary of DPSCS to Amy Cruice, Legal Program Administrator at ACLU-MD, Public Information Act Request-Segregated Confinement (September 21, 2015).

[20] Rick Raemisch, Executive Director, Colorado Department of Corrections, *Colorado Reforms: What Do You Mean "Culture?,* cited in *Reforming Restrictive Housing: The 2018 ASCA-Linman Nationwide Survey of Time-in-Cell*, Association of State Correctional Administrators and Liman Center for Public Interest Law at Yale Law School, October 2018 at 68.

[21] *Id*. at 84

The conditions in the IMHTU exacerbate the effects of segregation. Additionally, conditions are antithetical to principles of trauma informed care, which is significant as most of the women incarcerated at MCIW have histories of trauma, including trauma from sexual abuse.[22]

According to her records, "Elaine" doesn't believe that men should work in the IMHTU because "men just like to use people and rape people". She complained of her father being in her cell. Shortly after these statements were made, a male officer came on the unit to confirm that the women were in their cells (count). "Elaine" began screaming, banging and refused to cover up. The officer left the unit. A nurse called a doctor and received permission to give "Elaine" forced injections of medications to control her and calm her down. "Elaine" is diagnosed with post-traumatic stress disorder.

A. Conditions In The Unit

Women placed in the IMHTU are not allowed to keep any items or materials with them. They are stripped and given a "safety smock."[23] They are not permitted to retain underwear; neither tops nor bottoms. They are not allowed shoes or socks. Individuals interviewed expressed discomfort being without underwear and barefoot in cement cells.

Cells on the unit have a bed frame, a toilet (without a toilet seat), and a sink. When placed on the unit, the women are not allowed to have a mattress or any bedding. The light in each cell remains on 24 hours a day and cannot be controlled from within the cell.[24]

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[22] Barbara Bloom, Barbara Owen, & Stephanie Covington, *Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders*, National Institute of Corrections (June 2003); Warden Chippendale estimated that 85% of the women at MCIW have trauma histories (March 27, 2018). The Federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Association of State Mental Health Program Directors (NASMHPD) agree that principles of trauma-informed care include that clients need to feel connected, valued and hopeful of recovery; the connection between childhood trauma and adult psychopathology is understood by all staff; and staff work in mindful and empowering ways with individuals to promote and protect the autonomy of that individual. Physical and psychological safety of staff and patients, building and maintaining trust, peer support and mutual self-help are important. SAMHSA News, *Guiding Principles of Trauma-Informed Care,* Volume 22 (Spring 2014). https://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_2/trauma_tip/guiding_principles.html; Andrea Blanch, Cathy Cave Beth Filson, and Darby Penney, *Engaging Women in Trauma-Informed Peer Support: A Guidebook*, NASMHPD (April 2012).

[23] A safety smock is a quilted, collarless, sleeveless gown with a thickness that makes it impossible to roll or fold so it cannot be used as a noose.

[24] In an action brought by individuals housed at the Washington State Penitentiary against the State of Washington corrections system for conditions allegedly violating the 8th Amendment, the court held that, "Adequate lighting is one of the fundamental attributes of 'adequate shelter' required by the Eighth Amendment." *Hoptowit v. Spellman*, 753 F.2d 779, 783 (9th Cir. 1985). In a separate case brought by an individual plaintiff in Oregon for conditions in a disciplinary segregation unit, the court held that, "There is no legitimate penological justification for requiring plaintiff to suffer physical and psychological harm by living in constant illumination. This practice is unconstitutional." *LeMaire v. Maass,* 745 F. Supp. 623, 636 (D. Or. 1990), vacated, *LeMaire v. Maass,* 12 F.3d 1444 (9th Cir. 1993) (vacated in part after the State agreed to a modified lighting policy).

An individual interviewed by DRM reported that she does not speak with any medical or mental health providers during rounds anymore after other women in her unit overheard her discussing a sensitive matter and began harassing her about the incident.

Women from general population units act as observation aids for women in the IMHTU who are determined to be a suicide risk. Observation aids monitor the at risk individual at 15 or 30 minute intervals.

Women are **initially permitted only 15 minutes out-of-cell per day** until they conform to certain behaviors, and then they may earn a maximum of two hours per day out of cell. There are no opportunities for outdoor recreation on the unit. The indoor recreation area is a fenced cage area without any windows or access to natural light. There is a room on the unit that can be used as a day room for those individuals who earn the privilege, but there is no working television and no radio.

The IMHTU restricts out of cell time more than any other unit at MCIW.

The IMHTU has an incentive program that allows individuals to "earn" a mattress or a blanket, but individuals with continued severe mental health symptoms may not receive either. Multiple individuals complained of the cold temperatures in the unit, which they experience in the smock, without socks or a blanket. When DRM visited, the unit was cold. Blankets are occasionally approved by a doctor. Telephone access is prohibited unless access is earned by improved behavior.[25] Meals are provided in cell, where women must eat within a foot or two of the toilet. Some women are not provided eating utensils, but must eat with their fingers when they are initially placed in the unit. The lack of clothing, mattresses, and blankets should be revisited. If an individual is identified to be a suicide risk, the facility could use suicide resistant mattresses and blankets such as the one pictured here.[26]

In addition to serving women at MCIW in crisis, whenever a woman is transferred to a state psychiatric hospital for treatment and is then returned to MCIW, they are placed in the IMHTU, regardless of their status or stability upon return. The IMHTU also receives individuals who were in jail including women on pre-trial status, who have been determined to be a threat or at risk of harm due to their mental health status. When DRM visited, a young woman on the unit had been charged with violating a peace order and was transferred from jail.[27] The young woman interviewed was visibly scared, cold and wanted to contact her mother.

[25] Legal calls are not prohibited.
[26] Ferguson Safety Products provides suicide proof products and bedding to several state correctional departments around the country. These products include suicide proof mattresses, blankets, pillows, and slippers. https://docs.wixstatic.com/ugd/b201ff_7102e10f25024b50b0552c6e60173059.pdf.
[27] MCIW receives pre-trial detainees due to the closure of the Baltimore City Detention Center.

B. Services In The Unit

The women interviewed by DRM did not attend groups or engage in programming on the unit. There were descriptions on the fronts of cells identifying the level system or what behaviors were needed to earn more time out of cell or to be discharged from the unit. Record reviews did not demonstrate implementation of adequate individual treatment plans. The Regional Director of Mental Health Services explained that treatment plans were not generally required as DPSCS policy only requires a treatment plan if an individual is seen by mental health staff four times or more in a two month period.[28] Similarly, the Regional Director explained that there were not mental health groups on the unit since it is designed for short term stays. According to the Regional Director, women rarely stay on the unit for more than ten days. DRM finds that the IMHTU should operate consistent with community standards of care, and if women experiencing a crisis are placed in the unit, services and treatment plans should be implemented immediately as part of the treatment unit protocol. Moreover, at least three women had significantly longer stays, spanning hundreds of days.

These few individuals had prolonged periods of time when they were clearly not well and spent excessive time in segregation and/or the IMHTU. Some of the women were transferred to a state psychiatric hospital, some repeatedly, but were ultimately returned to MCIW where they do not receive needed services and decompensate.

> *"Kara" is an individual with a serious mental illness who has spent 405 days in administrative and disciplinary segregation since 2012. She has been referred to the Clifton T. Perkins Hospital Center for treatment several times over the years but invariably deteriorates after returning to MCIW. "Kara" has spent more than 900 days in the IMHTU and 723 days institutionalized since 2012 compared to just 137 days in general population during that time.*

MHM provides a registered nurse and a licensed practical nurse to supervise the unit. DPSCS provides a correctional officer for each shift. MCIW reported that the following changes were to occur in the IMHTU: a part-time activity specialist and an overnight nurse would be added and the part-time Assistant Clinical Director serving MCIW will be a psychologist.[29] Not all of these changes had occurred when DRM visited, although the new DPSCS mental health contract was to be fully staffed by April 1, 2018.[30]

Daily rounds are conducted in the hallway outside of the cells. The cells have thick Plexiglas windows, several of which are badly scratched making it difficult to view inside the cell. It is difficult to communicate through the thick cell doors. These structures limit monitoring and precludes any individual confidential discussion. Individual counseling is generally not provided and there was a lack of consistent group therapy. More treatment services and qualified personnel are needed.

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[28] DPSCS Directive # 124-425 Mental Health Services, Individual Treatment Plans. Issued 12.20, 2000.
[29] Instead of a licensed mental health professional counselor.
[30] The State of Maryland DPSCS entered into a new contract with MHM Services, Inc. to provide services for inmate mental health services from January 1, 2018 through December 31, 2023.

DRM reviewed records involving the use of five point restraint on women experiencing a behavioral health crisis. Nurses or other staff make regular notations during the period of restraint. In some instances, five point restraints continued for the maximum time period permitted with a physician's authorization; up to four or six hours. Restraint logs reviewed demonstrated that the five point restraint continued even when the woman became calm or quiet.

> *"Elaine" was placed in five point restraints from 8:00 PM to midnight after she was observed scratching her forearm with a staple pin in the IMHTU and refused to stop. She was also given forced injections of Haldol and Cogentin when the restraint was ordered. She talked to officers, nurses, and observation aids during this time and was described as being calm throughout the four hour period, which is the time period allowed in the restraint order.*

Records also showed that chemical sedatives such as Haldol and Cogentin were often administered to the individual in crisis, in addition to the physical restraints. The chemical restraints are injected intramuscularly and usually induce calm and drowsiness quickly. The prolonged use of restraints after an individual is no longer agitated is not reflective of best practices. Restraints should be removed quickly when an individual calms down or has regained self-control. DRM reviewed restraint records that documented the individual was calm for a considerable period, but the restraints were continued. **The restraint use reviewed at MCIW would be illegal if used in either Federal or State psychiatric hospitals.**[31]

The conditions in the IMHTU are extreme and grim. They are in sharp contrast to a setting which would allow individuals to regain some of their social skills and improve their ability to function with others. The lack of individualized mental health support belies the purpose of the unit. Insufficient confidential and out of cell contacts limit the opportunity to meaningfully assess individual mental health conditions and symptoms, a necessary predicate for offering adequate treatment. The lack of treatment does not meet professional standards of care. Additionally, services should be provided in the least restrictive and most integrated setting, should employ the least intrusive response to an apparent need for mental health services, and should be trauma informed.

DRM recognizes that MCIW serves some individuals with extremely challenging behaviors. The IMHTU is not able to adequately meet their needs. Given the harsh conditions of the IMHTU that include sensory deprivation, social isolation, enforced idleness, and lack of health care interventions; this unit may well aggravate the very problems it was created to resolve. **The IMHTU amounts to segregation and effectively punishes women with severe or chronic mental health issues by restricting their privileges without providing meaningful access to mental health services.**

[31] Regulations governing the use of restraints in Maryland State psychiatric hospitals allow for the use of restraints only to the extent necessary and consistent with the individual's treatment needs and applicable legal requirements DURING an emergency in which the behavior of the individual places the individual or others at serious threat of violence or injury. MD. Health-General Code Ann. 10-701(c). Federal regulations require that restraints be discontinued at the earliest possible time. 42 C.F.R. 482.13(e).

VII. INFIRMARY

Wexford Health Sources (Wexford), under contract with DPSCS, manages MCIW's infirmary to provide a skilled level of care. The infirmary has 24 cells, of which only ten were in use during DRM's tour of the facility.[32] Conditions in the infirmary qualify as restrictive housing. Women in the infirmary are single celled and are permitted out of their cell for "recreation" 60-90 minutes per day. Labeling this time as "recreation" is a misnomer. There is no day room or outdoor recreation area.[33] The out of cell time at MCIW permits individuals access to the infirmary hallways, and perhaps a microwave, although nobody may use their commissary privileges to purchase supplemental food while in the infirmary.[34] There is no access to a working radio or television in the hallways.

Neither the cells nor hallways have exposure to any natural light. DRM observed that half of the lights in two inspected cells were not operable. Access to some personal property is permitted so individuals who are able to purchase a television or radio can have those items in their cell. One individual, who has been housed on the infirmary for several *years,* had no such amenities in her cell and reported no access to funds.

"Sara" recently spent 147 consecutive days in the infirmary because she refuses to eat most of the food offered at MCIW. She was discharged from the infirmary after staff ruled out medical reasons for her refusal to eat and she was stable. "Sara" has repeated admissions related to her refusal to eat. Her records demonstrate a history of mental health issues and an eating disorder. DRM found no treatment plan to address her mental health or her eating issues. She had no access to outdoor recreation during her months in the infirmary.

Daily rounds are conducted by a medical professional. These encounters frequently take place inside individual cells, which are larger than cells in disciplinary segregation or in the IMHTU, and allow for confidential health care visits. A nurse creates an entry in every individual's records each shift describing the individual's mood, behavior, and any significant event.

One woman commented that she felt she was being punished when in the infirmary. Another individual complained that the infirmary depressed her due to the idleness, restricted confinement, and lack of social contact. She was a short term resident with no known mental health diagnosis. A few women with serious mental health conditions have had prolonged stays in the infirmary. A review of records for two such women did not demonstrate adequate individual treatment plans to address their mental health needs.

One individual in the infirmary has somatic issues, which have stabilized, and a serious mental illness with active auditory hallucinations. While her treatment plan provides a goal for decreasing hallucinations, her only interventions relate to taking psychotropic medications. No psychosocial interventions or cognitive therapy is provided to address the hallucinations or

[32] MCIW personnel confirmed that the infirmary regularly operates below capacity.
[33] This is in contrast to the infirmary at Western Correctional Institute (WCI) for men, which has both indoor and outdoor recreation areas for people in the infirmary.
[34] This practice also contrasts with that of the WCI infirmary.

"Melissa" has spent years in the infirmary. She uses a wheelchair for mobility. She told DRM that spending time outdoors and feeling the warmth of the sun is what she misses the most. She also misses a former Chaplin who would come to talk with her and a women who was friendly with her in general population. She has no visitors or phone calls.

coping with them. Her physician notes that she is not receiving individual counseling. Her medical records reflect that at times she has poor hygiene and is not taking care of herself. One comment states that it is not clear whether her condition is the result of her mental illness or a lack of motivation. The observation did not trigger further interventions for such concerns. In a recent 16 month period, she was visited by a licensed professional counselor 6 times. No interventions are identified or noted to be targeted during or subsequent to such visits. She has occasionally been offered or participates in a group session. Her isolation is extreme and she reportedly spends most of her time sleeping.

The continued presence in the infirmary of this individual appears to be largely due to her inability to care for herself. She expressed a desire for more human contact; to be able to see the sky and birds; that she had benefited from another incarcerated individual providing her with assistance with daily living activities, which does not occur in the infirmary; and when a former Chaplin made weekly visits to the infirmary. Given this individual's advanced age, reliance on a wheelchair, and fragility, she does not appear to be a safety risk and may be a candidate for medical parole. Regardless of that option, her housing status appears to violate the mandate of the Americans with Disabilities Act (ADA) to administer services, programs, and activities in the most integrated setting appropriate to the needs of the individual.[35]

In FY 2017 the average annual cost per person incarcerated was nearly $41,000.[36] Costs for individuals housed in the infirmary greatly exceed that amount given the additional clinical attention provided in the unit. As health care costs are a source of considerable spending in the DPSCS budget, fully utilizing medical parole could have a significant impact on corrections spending, even with the release of a small number of people.[37] Alternative placements outside of prison may enable the State to bill Medicaid and receive federal reimbursement for provision of health care services. While thirty requests are reported to be pending review for medical parole, DRM could find no public information related to how many medical paroles have been granted.[38]

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[35] 28 C.F.R. 35.130(D).

[36] Department of Legislative Services Office of Policy Analysis, Analysis of the FY 2019 Maryland Executive Budget, DPSCS, January 2018, at 9.

[37] Justice Policy Institute, *The Release Valve, Parole in Maryland, a Justice Policy Institute Report,* February 2009. Available at: http://www.justicepolicy.org/uploads/justicepolicy/documents/maryland_parole.pdf . According to this Report, Maryland could save more than $13 million (in 2009 dollars) in one year by paroling half of the prison population over age 60. The Report found that the state's cost for an individual age 60 or older is a conservative $60,000 yearly, compared with $1,422 for a person on parole or $35,000 for a younger inmate (in 2009 dollars).

[38] DPSCS Joint Chairmen's Report to Honorable Edward J. Kasemeyer and Maggie McIntosh Maryland –Inmate Mental Health Contract Report – Q00A, August 1, 2018.

The infirmary also houses pregnant women approaching their last trimester or due date. DPSCS considers pregnancy as a medical condition warranting placement in the infirmary.[39] Placement is not limited to high risk pregnancies or individualized assessments. Thus all pregnant women are subjected to a more restrictive environment than in general population, with less time out of their cells and fewer programming and socialization opportunities. All individuals in the infirmary are barred from buying commissary food products so pregnant women cannot supplement their diets, even if they are willing to pay to do so and had been using the commissary prior to placement in the infirmary.

The Baltimore Doula Project organizes volunteers to provide support to pregnant incarcerated women at MCIW.[40] Both the Baltimore Doula Project and NARAL Pro-Choice Maryland express concerns over the restrictive conditions that pregnant women endure in the MCIW infirmary. The lack of socialization and forced isolation can be problematic.

DRM was pleased to learn that, conforming to numerous corrections and health care recommendations and standards, women are never transported to the hospital in restraints. After child birth at a local hospital, the women return to the infirmary for post-natal care until they receive a clinical recommendation for discharge from the unit.[41] Returning to the restrictive conditions in the infirmary is not based on hospital discharge recommendations or choice of the individual.

VIII. ESTABLISHED HARM AND RISK FROM SEGREGATION

A. Consensus For Limiting Segregation

Social science research demonstrates that exposing individuals with serious mental illness to segregation causes them harm and puts them at risk of serious harm.[42] As a result, numerous organizations have strongly condemned the practice.

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[39] DPSCS policy requires placement in the infirmary when the expectant mother is at least two weeks away from their due date but according to numerous sources and observations, placement in the infirmary can occur as early as the 30 week mark of the pregnancy in practice. DPSCS Clinical Services & Inmate Health Pregnancy Management Manual, 2(II)(k), at 10.

[40] The Baltimore Doula Project offers education during the prenatal period, presence in the hospital throughout birthing, and postpartum visits in the prison. The program also facilitates support groups for women who are pregnant and newly parenting.

[41] DPSCS Pregnancy Management Manual, *supra* at 4(II)(C)(1); Mother–infant attachment can be crucial for the mother's mental health, especially in the immediate postpartum period. However, most women who give birth while in custody are forced to separate from their infants within 1 to 2 days of giving birth. Contact visits with the newborn can enhance mother–infant bonding and have a positive impact on the inmate's well-being. Several correctional facilities have instituted nursery programs that allow the infant to live with the mother in a specially supervised wing, with parenting support for the inmate. Such programs have been shown to improve women's feelings of attachment to their children, and to reduce recidivism; one study found that 86% of women in a prison nursery program remained in the community 3 years after release (Goshin, Byrne, & Henninger, 2013). MCIW has a visitation nursery to permit contact visits between mothers and their children which can be scheduled for regular visitation times and subject to normal restrictions. The room is brightly painted and has rocking chairs, making it less institutional than other visitation areas.

[42] One study found that nearly every inquiry into the effects of solitary confinement over the past 150 years has concluded that subjecting an individual to involuntary segregation results in a distinct set of emotional, cognitive,

In 2012, the United Nations Special Rapporteur on Torture stated that solitary confinement lasting more than 15 days should be banned.[43] In 2015, the United Nations clarified and codified this recommendation, defining solitary confinement as "confinement of prisoners for 22 hours or more a day" and calling for the prohibition entirely of solitary confinement of women, children, and "prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures."[44]

In 2012, the American Psychiatric Association's (APA) issued a position statement on segregation states:

> "Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates. If an inmate with serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space and adequate unstructured out-of-cell time should be permitted. Correctional mental health authorities should work closely with administrative custody staff to maximize access to clinically indicated programming and recreation for these individuals."[45]

The Society of Correctional Physicians published a position statement similar to that of the APA.[46]

The American Public Health Association (APHA) has also endorsed limiting the use of segregation.[47] The APHA has called for the elimination of prolonged restrictive housing practices as a means of punishment and for excluding individuals with serious mental illnesses from such housing of any duration.[48]

The World Health Organization (WHO) has recognized, "Those with pre-existing mental illness are particularly vulnerable to the effects of solitary confinement."[49]

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social, and physical pathologies. David H. Cloud, Ernest Drucker, Angela Browne, and Jim Parsons, *Public Health and Solitary Confinement in the United States,* American Journal of Public Health, 105, no.1 (2015): 18-26.

[43] Juan Ernesto Méndez, *Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*. Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, p. 21 (2011).

[44] *United Nations Standard Minimum Rules for the Treatment of Prisoners* (Mandela Rules) May 21, 2015, Rule 44; 45.

[45] American Psychiatric Association, *Position Statement on Segregation of Prisoners with Mental Illness*, Approved by the Board of Trustees, December 2012.

[46] Society of Correctional Physicians, *Position Statement on Restricted Housing of Mentally Ill Inmates* (2013).

[47] American Public Health Association, *Solitary confinement as a public health issue*. Washington, DC: American Public Health Association, November 5, 2013, Policy 201310. http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/14/13/30/solitary-confinement-as-a-public-health-issue.

[48] *Id*.

[49] "Prisons and Health", edited by Stefan Enggist, Lars Moller, Gauden Galea and Caroline Udesen, World Health Organization, Regional Office for Europe, 2014, at 29. http://www.euro.who.int/__data/assets/pdf_file/0011/249194/Prisons-and-Health,-5-Solitary-confinement-as-a-prison-health-issue.pdf.

In January 2016, the Department of Justice recommended that individuals with serious mental illnesses should not be placed in restricted housing absent exceptional circumstances, and that if such individuals have to be in segregation, time out of cell and programming should be increased.[50]

The Association of Correctional Administrators (ACA) defined restrictive housing as a practice for use only when necessary and for as short a time as possible and recently approved standards that limit the use of restrictive housing for people with serious mental illnesses.[51]

> *Addressing the use of segregation in prison, the Third Circuit Court of Appeals stated that, "[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."* Craig Williams v Secretary Pennsylvania Department of Corrections, *No. 14-1469, No. 15-1390, 2017 WL 526483 (3d Cir. 2017).*

In 2016, the National Commission on Correctional Health Care (NCCHC), established by the American Medical Association, adopted a position against segregating individuals with mental illness for any length of time.[52] The NCCHC recommended limiting segregation to no more than fifteen days for anyone and limiting the practice altogether for juveniles and people with mental illness. The NCCHC noted it was well established that segregation can result in the exacerbation of mental illness, anxiety, dysphoria and depression.[53]

Constitutional litigation challenging the lack of treatment for persons with serious mental illness in segregation has led to court settlements and orders excluding such individuals from restrictive housing.[54] 21 state correctional systems reported that they do not place people with serious mental illnesses in segregation for over 30 days.[55] Numerous correctional systems are developing alternative responses to segregation, some of which are highlighted below.

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[50] Department of Justice, *Report and Recommendations Concerning the Use Of Restrictive Housing*, Jan. 2016 at 113. https://www.justice.gov/dag/file/815551/download.

[51] *ACA Restrictive Housing Standards 2016*, approved Aug. 2016 4-RH-0031; 4-RH-0028; 4-RH-0012; 4-RH-0010; 4-RH-0004; 4-RH-0006. Extended restricted housing is defined as restricting an individual to a cell for at least 22 hours a day for more than 30 days. ACA 4-RH-0031 standard states that a person with serious mental illness should not be placed in Extended Restrictive Housing, defined as more than 30 days.

[52] Solitary Confinement (Isolation), National Commission on Correctional Health Care (April 2016). https://www.ncchc.org/solitary-confinement.

[53] *Id*.

[54] For a compilation of extant orders, see *Special Collection: Solitary Confinement*, CIVIL RIGHTS LITIG. CLEARINGHOUSE, http://www.clearinghouse.net/results.php?searchSpecialCollection=40.

[55] 2018 ASCA-Liman Nationwide Survey, *supra* at 64.

B. Alternative Treatment Options

Alternative disciplinary measures have been demonstrated to improve safety. Alternatives can reduce reliance on segregation, reduce rule infractions, reduce legal liability, reduce harm to individuals with disabilities, and help incarcerated individuals better develop social skill adaptation.[56] States such as Ohio, Kansas, Maine, Mississippi and North Dakota reduced their use of segregation and have not seen significant rises in violent incidents.[57] Reform in Virginia reduced the number of people in administrative segregation by 53% and resulted in a 56% decrease in prison incidents.[58] Several other jurisdictions have taken steps to keep people with serious mental illnesses out of segregation, often paired with diversionary programming that provides needed services and time out of cell in less restrictive environments.

> The Colorado Department of Corrections broadly limits the use of restrictive housing to 15 days for all individuals in their custody.[59] Individuals with serious mental illnesses are referred for a mental health evaluation and placement in a Residential Treatment Program that allows people to work and participate in programming including individual therapy and groups focused on developing cognitive behavioral skills, anger management, and self-care. Staff in these programs encourage participation through activities that are tailored to individual interests such as art or therapy dogs.[60] Colorado saw significant reductions in staff assaults and forced cell entries following implementation of these policies.[61]

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[56] Vera Institute 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.*

[57] *Id*. at note 21, p. 66; 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; 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); Amanda Seitz, *Violence, Use of Force Down at Lebanon Prison*, Dayton Daily News (March 11, 2015).

[58] Alison Shames, Jessa Wilcox, and Ram Subramanian, *Solitary Confinement: Common Misconceptions and Emerging Safe Alternatives*, Vera Institute of Justice, p. 12 (May 2015). https://storage.googleapis.com/vera-web-assets/downloads/Publications/solitary-confinement-common-misconceptions-and-emerging-safe-alternatives/legacy_downloads/solitary-confinement-misconceptions-safe-alternatives-report_1.pdf.

[59] Applies to disciplinary segregation, protective custody, and placements pending reclassification or transfer; Colorado Administrative Regulation (AR) 650-03(IV)(2);3); 650-04((IV)(4).

[60] Jean Casella and Aviva Stahl, *Opening the Door: What Will It Take To End Long-Term Solitary Confinement In America's Prisons? Colorado Could Be The First To Find Out*, Solitary Watch (April 29, 2016). http://solitarywatch.com/2016/04/29/opening-the-door/.

[61] Exact figures vary by facility. Forced cell entries decreased by 77% and staff assaults by 46% at the San Carlos Correctional Facility. Forced cell entries decreased by 81% and staff assaults by 50% at the Centennial Correctional Facility. 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.

In 2016, New York City (NYC) Health and Hospitals, the largest public health care system in the country, took direct control of the care of people in the NYC corrections system.[62] NYC Health and Hospitals operate intensive therapeutic housing units in the jails for people with serious mental health disorders. The enhanced staffing and professional care available in these units has led to the lowest incidence of injuries per incarcerated individual of any housing unit in City jails, major reduction of violent incidents and decrease in use of force rates compared to rates had these same individuals been housed with general population. The units serve individuals returning from inpatient hospitalization, those who may require hospitalization, those with complex diagnostic challenges, and those returning from court-based competency evaluations. Individual therapy, group therapy, art therapy and other activities are part of the programming. Ping-pong tables and colorful walls exist in some units.

The Pennsylvania Department of Corrections categorically bans the placement of individuals with serious mental illnesses in restrictive housing. This population serves any disciplinary segregation assignments in a Diversionary Treatment Unit that is designed to provide increased access to programming and professional care.[63] People housed in this unit are offered an out of cell encounter with psychology staff once per week and are afforded more privileges and time outside of their cells than they would receive in disciplinary segregation. The walls in these units are covered with art and messages related to recovery rather than the bleak environments that are common in traditional restrictive housing units.[64]

Delaware caps the use of disciplinary segregation at 15 days for all individuals in their custody.[65] Delaware does not allow for the placement of individuals with a serious mental illness in disciplinary segregation for any time at all unless they present an immediate danger and there is no reasonable alternative.[66]

The Alabama Department of Corrections recently agreed to create a Structured Living Unit to serve as "a diversionary outpatient unit for persons with serious mental illness or who are otherwise found to be inappropriate for a restrictive housing placement in lieu of a restrictive housing placement."[67]

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[62] Previously administered by a for-profit private contractor of medical services to jails and prisons. https://www.nychealthandhospitals.org/oversight-hearing-evaluating-recent-changes-in-healthcare-in-new-york-city-correctional-facilities.

[63] Pennsylvania Department of Corrections Policy (PA DC-ADM) 801(6)(B); 13.8.1(10)(A)(2).

[64] Rich Lord, *Pennsylvania Prison System Develops Separate Housing For Mentally Ill Inmates*, Pittsburgh Post-Gazette (January 6, 2015). http://www.post-gazette.com/news/state/2015/01/06/Pennsylvania-prison-system-develops-separate-housing-for-mentally-ill-inmates/stories/201501060042; Dan Simmons-Ritchie, *PA. State Prisons Transform Mental Health Care, But Is It Working?*, Pennsylvania Real-Time News (November 6, 2015). https://www.pennlive.com/news/2015/11/mental_health_care_pennsylvani.html.

[65] Delaware Department of Corrections, Bureau of Prisons Policy 4.3(VI)(C)(3).

[66] Delaware also forbids the placement of juveniles and pregnant women in any form of restrictive housing. *Id*. at (VI)(B)(5); (6); (7).

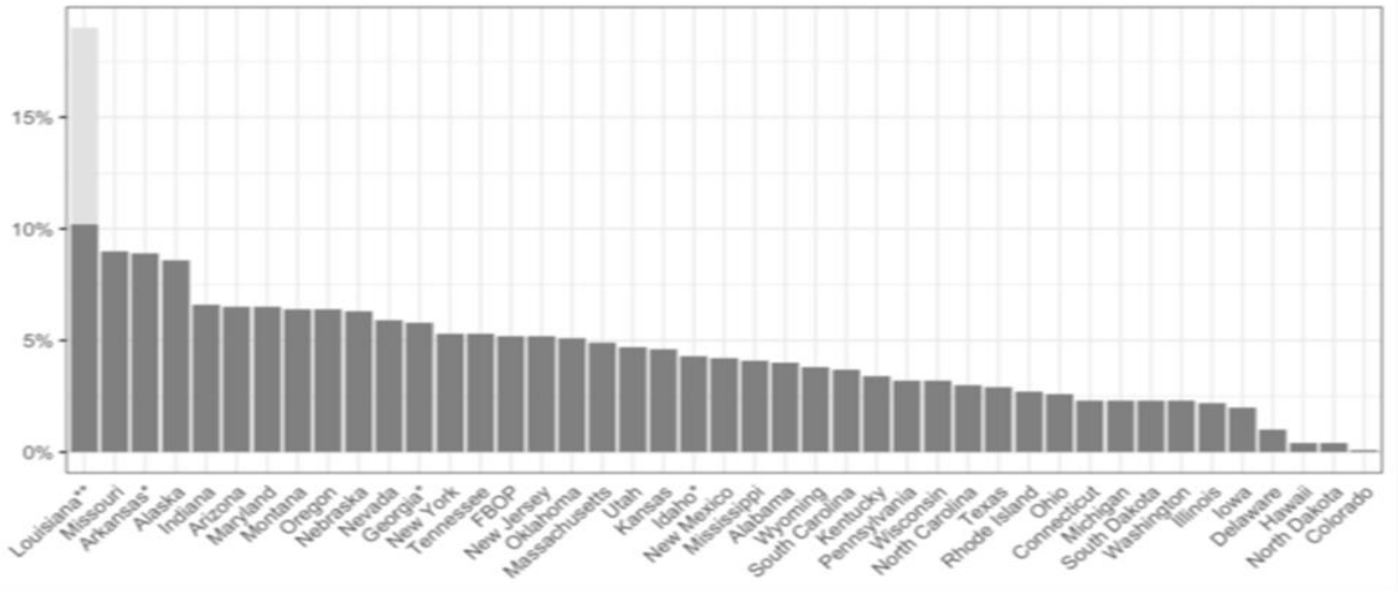
[67] *Braggs v. Dunn*, 2:14cv601-MHT (M.D. Ala 2018).

IX. MARYLAND'S OVERUSE OF SEGREGATION

A. Maryland Disproportionally Relies On Segregation

Maryland utilizes segregation more than the vast majority of states. In a 2018 report from the Association of State Correctional Administrators and the Liman Center for Public Interest Law at Yale Law School, Maryland ranked 7th out of 43 state prison systems in its use of segregation, defined as separating individuals from general population and holding them in their cells for an average of 22 hours or more per day for 15 continuous days or more.[68] States with large urban populations, such as Illinois, Michigan, Massachusetts, Pennsylvania, Texas, Ohio, New York, Tennessee, North Carolina, and Georgia all relied on segregation less than Maryland.[69] Los Angeles County Jail, which houses over 17,000 persons also uses segregation substantially less than Maryland and limits segregation for certain individuals with mental illness.[70] DPSCS reported that in 2017, **49.8% of the population in 2017 spent some time in segregation**.[71]

Maryland Ranked 7th In Its Use of Segregation For At Least 15 Consecutive Days[72]



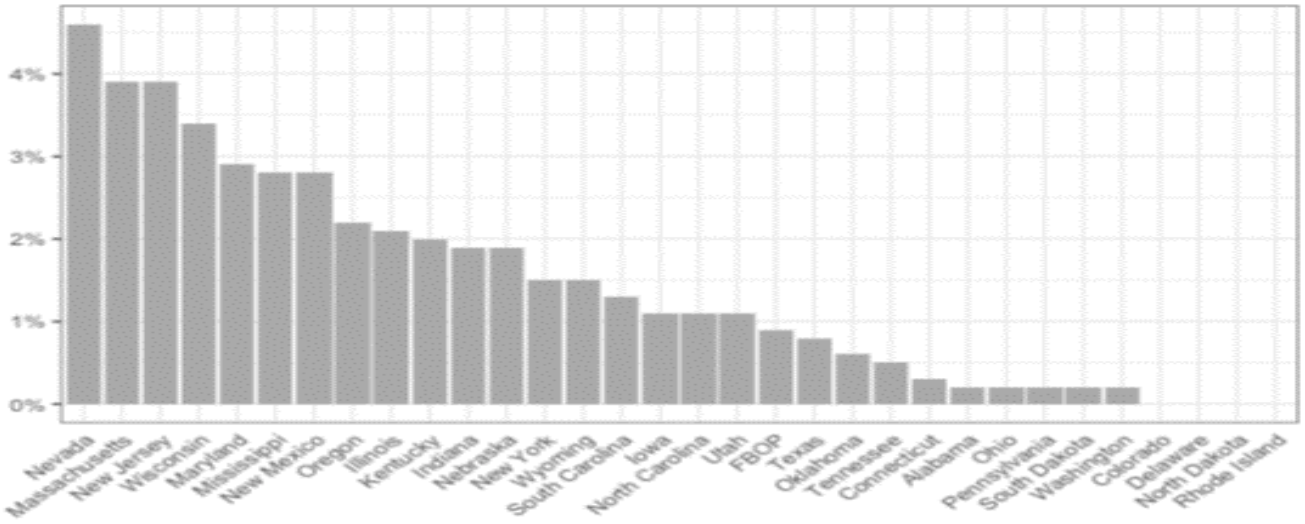
Reviews of DPSCS' use of segregation conducted by the National Institute of Corrections (NIC) and the Vera Institute of Justice were critical of Maryland's practices relating to the lack of alternatives, the frequency of its use, and the length of segregation sentences.[73] The Vera Institute of Justice noted a **"startling" lack of mental health staff to respond to the needs of**

[68] 2018 ASCA-Liman Nationwide Survey, *supra* at 4.
[69] Maryland reported that 7.5% of their custodial population in 2015 spent more than 15 days in restrictive housing and 6.5% in 2017. *Id.* at 96.
[70] *Id*. note 64, at 56-59.
[71] *Report on Restrictive Housing – Fiscal Year 2017 Fulfilling Reporting Requirements of SB 946*, DPSCS. (Dec. 2017).
[72] Maryland reported 6.5% of their total prison population in restrictive housing for at least 15 consecutive days. 2018 ASCA-Liman Nationwide Survey, *supra* at 12, Figure 2.
[73] *Review of Maryland DPSCS Use of Segregation in Adult Prisons*, Vera Institute of Justice, 2012; *Report on Implementation of National Institute of Corrections Recommendations*, DPSCS, February 2016.

special populations in segregation and also noted the severe lack of programming in DPSCS facilities. The Vera review also found that the lack of mental health staffing and interventions contribute to the numbers of individuals on segregation and restricted housing status. Other jurisdictions have dramatically reduced the use of segregation and increased access to mental health services, especially for seriously mentally ill populations.[74]

MCIW relies on segregation less than other DPSCS facilities. In September of 2017, 2.9% of incarcerated women were in restrictive housing for more than 15 days compared to 7.4% of incarcerated men.[75] However, MCIW's use of restrictive housing is high compared to other jurisdictions' use of restrictive housing for women. Maryland ranks 5th out of 32 responding state correctional systems on the percentage of incarcerated women in restrictive housing.

Maryland Ranks 5th In Its Use of Segregation For Women For At Least 15 Consecutive Days[76]



B. DPSCS' Response To Calls For Reducing Segregation

DPSCS issued revisions to their disciplinary regulations that became effective on July 2, 2018 in an attempt to reduce the disproportionate reliance on segregation.[77] While the new regulations represent progress, they **remain far short of reforms needed, especially for individuals with serious disabilities**. Numerous jurisdictions recognize that segregation is especially harmful for individuals with serious disabilities and impose limits on disciplinary segregation for such individuals. DPSCS' regulations do not.

[74] In 2014, 10 states announced or implemented policy changes to reduce the number of adults or juveniles held in segregated housing, improve the conditions in segregation units, or facilitate the return of segregated people to a prison's general population. Eli Hager and Gerald Rich, *Shifting Away from Solitary*, The Marshall Project, December 23, 2014; Colorado passed legislation that removed entirely those with SMI—from being housed in long-term segregation. Colorado Revised Statute, 17-1-113.8 (2014); 2018 ASCA-Liman Nationwide Survey, *supra* at 64.

[75] *Id*. at 21, Table 5.

[76] Maryland reported 2.9% of their female prison population in restrictive housing for at least 15 consecutive days. *Id.* at 20, Figure 7.

[77] Code of Maryland Regulations (COMAR) 12.03.01.

Segregation sanctions have been reduced under the new matrix governing disciplinary sanctions, but segregation may be imposed for up to 180 days.[78] If an individual commits an infraction while in segregation, any additional segregation sentence becomes concurrent, but the total segregation time may be extended. The regulations have not been applied retroactively, thus individuals with years of disciplinary segregation time have not been offered relief, which DPSCS could accomplish through use of Warden Directives. The list of infractions resulting in segregation have been narrowed, but segregation is still permitted for actions that do not present actual or imminent risk of harm. Alternative sanctions are identified for less serious infractions.

Additional sanctions can be imposed as punishment in addition to segregation. These sanctions are imposed on a more subjective basis.[79] For example, a segregation sentence can be bundled with other sanctions such as limiting access to appliances or commissary or restricting visitation from family, friends, or others. Visitation can be limited for up to six months.[80]

While the revised disciplinary regulations make improvements in reducing the use of segregation sentences and expanding alternative disciplinary options, they fail to adequately address the recommendations of the National Institute for Corrections, (NIC), which was asked by DPSCS to review its use of segregation. NIC recommended that no segregation sanction be imposed for more than 60 days. DPSCS stated in writing that it intended to adopt such recommendations, ---- but then did not.[81]

The failure of the new regulations to address the harm for individuals with serious disabilities is a critical omission, for which DRM urges remediation.

C. Attempts To Reduce The Use Of Restrictive Housing At MCIW

MCIW's use of segregation for women is lower than DPSCS' use of segregation for men.[82] However, MCIW's use is high compared to the national rate of segregation for incarcerated women.[83] The Warden also uses her authority to reduce the length of some segregation sentences. DRM reviewed segregation logs from January 2018 to October 2018 in which 116 segregation sentences were reduced as noted above. However, numerous individuals serve segregation sentences longer than that endorsed by corrections and health care organizations. (*See*, **Section VIII**). Some women spend several months in segregation under conditions DRM finds unconscionable. The impact on women with disabilities is severe, and is not addressed.

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[78] *Id*. at (.27).
[79] *Id*. at (.28)(A)(2);(B)(4).
[80] Id. at (.28)(C);(D). A facility could theoretically impose all of these sanctions for a single infraction. "An alternative disciplinary sanction may be imposed independently or in conjunction with another alternative disciplinary sanction." (.28)(B)(4)(a).
[81] DPSCS expressed their intent to conform to ACA standards following the NIC review. More recently, DPSCS claimed that they relied on ACA standards when making policies in their response to the Liman survey. 2018 ASCA-Liman Nationwide Survey, *supra* at 64; Former DPSCS Deputy Secretary for Operations Mary Livers is quoted in a 2006 report on restrictive housing that, "We're moving away from having that feeling of being safe when offenders are all locked up, to one where we're actually safer because we have inmates out of their cells, involved in something hopeful and productive." John Gibbons & Nicholas Katzenbach, *Confronting Confinement: A Report of the Commission on Safety and Abuse in America's Prisons,* Vera Institute of Justice (June 2006).
[82] The percent of individuals subjected to segregation is lower at MCIW that other facilities DRM has visited.
[83] 2018 ASCA-Liman Nationwide Survey, *supra* at 20.

Rather than limiting time in segregation for women with serious mental health issues, a number of women serving the longest segregation sentences are women with serious mental health disabilities. DRM was particularly disturbed to see that some women, such as Elaine, were moved from the infirmary or IMHTU, where they were deemed to need a medical level of care, to serve disciplinary segregation punishment in units where there is a lesser degree of health care available. Sometimes after punishments were served, the women were returned to the medical units. Withdrawing needed medical attention in order to mete out a disciplinary sentence is improper and may constitute violations of the ADA and Rehabilitation Act.[84] Such transfers call into question either the need for placement on a restrictive treatment unit or the efficacy of placement on the segregation unit. MCIW has not demonstrated that it is equipped to provide the care necessary for women such as Elaine who continue to deteriorate and are exposed to extended stays in restrictive housing units. It is imperative that these individuals receive mental health services that adequately address their needs, which may only be available in a treatment setting with the resources needed to provide more focused care.

MCIW recently initiated a substance abuse program for women sent to segregation for infractions related to substance abuse issues. Women are offered a reduction of their segregation sentence as an incentive to participate in a unit focused on substance abuse.[85] Those who opt to participate are moved to D wing, a general population unit, following their release from segregation. Participants in the program must attend weekly group meetings led by community volunteers and daily peer driven meetings for six months.[86] Women are given the option to remain in the unit following completion of the program but may opt out after the mandatory six month period. This unit was not observed by DRM. As described, it is mostly peer run, which certainly has value. The reported absence of any certified substance abuse counselors is lamentable, however, especially given the intentions of the Maryland Justice Reinvestment Act and the addictions and abuse histories of the prison population.

[84] The stressful conditions of 23-hour isolated confinement have a particularly severe effect upon prisoners with serious mental illness, and are a principal cause of deteriorated mental health for many such prisoners. Failure to provide viable alternatives to limit the suffering of prisoners with mental illness in isolated confinement is a direct violation of the ADA and Rehabilitation Act. *Disability Advocates, Inc. v. New York State Office of Mental Health*, 1:02-cv-04002-GEL (S.D.N.Y. 2007); An investigation into a state correctional institution conducted by the Civil Rights Division of the Department of Justice found that denying prisoners with serious mental illness and intellectual disabilities the opportunity to participate in and benefit from general population housing and subsequent benefits such as time out of cell and interaction with other prisoners through routine and unnecessary isolation constitutes unlawful discrimination under Title II of the ADA. *Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation*, United States Department of Justice (May 31, 2013) https://www.justice.gov/sites/default/files/crt/legacy/2013/06/03/cresson_findings_5-31-13.pdf.

[85] Sentence reductions are generally from thirty days to ten or fifteen days for first time offenders.

[86] Women in the program who fail to attend meetings or who are found guilty of subsequent infractions for substance abuse issues are sent back to segregation and start over.

X. UNDER-IDENTIFICATION, INCONSISTENT REPORTING AND LACK OF TREATMENT OF INDIVIDUALS WITH SERIOUS MENTAL ILLNESS

A. Under-Identification And Inconsistent Reporting

There can be no doubt that persons with mental illness are over represented in prison populations.[87] The American Psychiatric Association (APA) has estimated that about 20% of individuals in U.S. prisons have a serious mental illness (SMI).[88] The National Commission on Correctional Health Care (NCCHC) issued a report to Congress in which it estimated that 17.5% of individuals in state prisons had schizophrenia, bipolar disorder, or major depression. Reports commissioned by NCCHC estimate that on any given day between 2.3% and 3.9% of individuals in state prisons are estimated to have schizophrenia or other psychotic disorder, between 13.1% and 18.6% major depression, and between 2.1% and 4.3% bipolar disorder.[89] A study conducted by the California Policy Research Center found that between 4% and 10% of the prison population has an intellectual disability.[90] The United States Center for Disease Control identified traumatic brain injuries as common in the prison population and associated these injuries with health and cognitive challenges requiring specialized support.[91] Human Rights Watch estimated that approximately 20% of individuals in state prisons were SMI based on interviews and visits to state and federal prisons.[92] These figures have been confirmed by other studies.[93]

DPSCS has reported inconsistent numbers of individuals with SMI. In 2011, DPSCS reported that only 1.2% of the State prison population experienced SMI.[94] DPSCS provided a report to the Maryland General Assembly in the fall of 2015 that identified 947 of their incarcerated population as SMI.[95] In a response to a survey conducted by the Association of State

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[87] Seth Prins, *Prevalence of Mental Illnesses in U.S. State Prisons: A Systematic Review*, Psychiatric Services Vol. 65 No. 7 (July 2014). https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201300166.

[88] American Psychiatric Association, *Psychiatric Services in Jails and Prisons*, 2nd ed. (Washington, D.C.: American Psychiatric Association, 200), Introduction, xix.

[89] National Commission on Correctional Health Care, *The Health Status of Soon-to-be-Released Inmates, A Report to Congress*, March 2002, https://www.ncjrs.gov/pdffiles1/nij/gr vol.1, p.22; April 2002, vol.2. http://www.ncchc.org/pubs/pubs_stbr.vol1.html; http://www.ncchc.org/pubs/pubs_stbr.vol2.html.

[90] 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.

[91] 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.

[92] Human Rights Watch, *Ill Equipped: U.S. Prisons and Offenders with Mental Illness* (Washington, D.C.: Human Rights Watch, 2003).

[93] H. J. Steadman, F. C. Osher, P. C. Robbins et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, Psychiatric Services Vol. 60 No. 6 (June 2009); C. Cosmos, *Mentally Ill Behind Bars on the Rise; D.C. Tackles a Trend*, [Washington DC] Street Sense, January 10, 2005, http://www.streetsense.org/article_mentalillness.jsp.

[94] DPSCS stated in a request for proposals (RFP) for the provision of mental health services that it housed approximately 280 individuals with seriously mentally ill out of nearly 23,000 total people. Request for Proposals Inmate Mental Health Care Services, Solicitation No: DPSCS Q001002014, issue date December 7, 2011 at 54; Total End of Fiscal Year Population, Department of Public Safety and Correctional Services, 2011, https://www.hrw.org/reports/2003/usa1003/usa1003.pdf

[95] Letter from Stephen T. Moyer, Secretary DPSCS to Senator Robert Zirkin, "Use of Segregation Confinement in Maryland's Correctional Facilities" dated October 1, 2015.

Correctional Administrators in 2015, DPSCS identified only 1.5% of women in their custody as SMI.[96] In a 2016 letter to the Maryland General Assembly, DPSCS wrote that 1,468 individuals were identified with SMI.[97] In 2017, DPSCS reported that "approximately 1,500" individuals were identified as SMI.[98] These figures would indicate that the SMI population in Maryland prisons has never risen above 8% based on average daily population figures.[99] However, the true percentages of individuals identified as SMI within the state correctional system are certainly lower considering that average daily populations do not reflect the daily fluctuations of people processed by DPSCS facilities. Even the 8% figure would be significantly below the percentages suggested by the APA and NCCHC and other studies.[100]

SMI rates are generally much higher among incarcerated women than incarcerated men. A study conducted by the Bureau of Justice Assistance found that 32% of incarcerated women met SMI criteria within a year of their survey.[101] This study determined that 22% of incarcerated women met criteria for major depression and 4% were on the schizophrenia spectrum within that timeframe. Other studies have confirmed that roughly 1 out of every 3 incarcerated women are SMI.[102] MCIW reported an average of 108 individuals with SMI monthly among their population during 2017.[103] This would translate to 13.9% of MCIW's population based upon the reported average daily population of 775 in 2017. This number represents less than half of the rates identified by the aforementioned studies. While there is some range relating to exact percentages of incarcerated persons with serious mental illness, the percentage of such individuals identified by DPSCS and MCIW appear low. One reason for the under identification is suggested by the inadequate definition used by DPSCS to identify individuals with serious mental illness.

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[96] *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*, The Association of State Correctional Administrators and Arthur Liman Public Interest Program at Yale Law School, Table 16, p. 51 (November 2016), data based on an October 2015 survey where only 14 out of a custodial population of 951 or 1.5 % of females were identified with a SMI.

[97] DPSCS, *Department of Public Safety and Correctional Services Report on Restrictive Housing – Fiscal Year 2016 Fulfilling Reporting Requirements of SB 946*, December 2016 at 4.

[98] August 2018 Mental Health Contract Report, *supra*. The report did not provide an exact number of individuals with SMI. 7.5% figure based off of the 19,882 incarcerated offenders reported by DPSCS in their Fiscal 2019 Budget Overview submitted to the Maryland Department of Legislative Services in January 2018.

[99] Based off of annual average daily populations, these numbers would indicate that less than 4% of incarcerated individuals were identified as SMI in 2015, 7.2% in 2016, and 7.5% in 2017.

[100] Beck, *supra*; *Aiming to Reduce Time-in-Cell, supra*; Austin and McGinnis, *Classification of High-Risk and Special Management Prisoners: supra.* Courts have noted that a state's undercount of SMI population that substantially deviates from national figures means some inmates with SMI are not getting diagnosed or treated and that the undercount contributed to understaffing. *T.R. v. South Carolina Dep't of Corr.*, Order case number 2005-CP-40-2925, (Court of Common Pleas, 5th Judicial Circuit, S.C. 2014). (This court expressly rejected a figure of 12.5% cited by the State in favor of 17%).

[101] Joanne Belknap, Dana DeHart, Bonnie Green, and Shannon Lynch, *Women's Pathways to Jail: The Roles of Intersections of Serious Mental Illness & Trauma*, Bureau of Justice Assistance (September 2012).

[102] Prevalence of Serious Mental Illness Among Jail Inmates, *supra*. [Identifying 31% - 34% of women surveyed as SMI].

[103] 1,296 individuals with SMI total identified, divided by 12 months. *Mental Health Services Monthly Report*, Maryland Correctional Institution for Women, (2017).

B. Inadequate Definition of Serious Mental Illness (SMI)

DPSCS' SMI definition is flawed as it does not properly address criteria related to an individual's level of functioning. SMI is a clinical diagnosis based on a finding that an individual has a particular diagnosis and demonstrates impaired functioning. However, DPSCS' criteria for demonstrating impaired functioning adopts a community behavioral health definition, which is generally not relevant in a correctional setting. The criteria to measure impaired functioning requires that an individual demonstrate 3 of the following over the previous 2 years: (1) an inability to maintain independent employment; (2) social behavior that results in interventions by the mental health system; (3) an inability, due to cognitive disorganization, to procure financial assistance to support community living; (4) a severe inability to establish or maintain a personal support system; or (5) need for assistance with basic living skills.[104] Several of these **requirements do not apply in a correctional setting, impeding a SMI diagnosis**.

To contrast, the Massachusetts Department of Corrections identifies criteria for measuring functional impairment as self-harming behavior, demonstrated difficulty in the ability to engage in activities of daily living, or a demonstrated pattern of dysfunctional or disruptive social interactions.[105] The Delaware Department of Corrections considers functional capacity in a similar manner by examining self-harming behaviors, demonstrated pervasive difficulty in the ability to engage in activities of daily living, or a demonstrated pattern of dysfunctional or disruptive social interactions.[106] These criteria are more applicable within a correctional setting than those used by DPSCS. Some jurisdictions, such as Delaware and Colorado, include intellectual disabilities within their definitions for SMI functional impairment.[107] It is important that this population be identified and considered for provision of accommodations or treatment.

C. Few People Receiving Mental Health Services

The relatively few women who are identified as SMI still struggle to receive mental health services at MCIW. **Records revealed that there were only 19 instances where individuals identified as SMI received mental health services at MCIW in 2017,** or an average of 1.58 instances per month.[108] These figures were presented to DRM without names, meaning that there may be redundancies in individuals identified and treated each month, further depressing the number of individuals with SMI receiving mental health services. Therefore, MCIW identified as many as 13.9% of their overall population as SMI but documented providing mental health services to only 2.5% at most. These percentages are based off of the reported average daily population at MCIW in 2017. However, far more than 775 women pass through MCIW annually, meaning that the percentage of individuals identified as SMI and those receiving mental health services is likely much lower taking into account higher absolute figures for persons with SMI. DRM could not determine an exact figure from the data reviewed but the inapplicable criteria for SMI has likely screened out individuals who should be identified and should be receiving

[104] DPSCS, *Department of Public Safety and Correctional Services Report on the Inmate Mental Health Contract*, August 2018; American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (2013).
[105] 103 CMR 650.01(U)(4).
[106] Delaware Department of Corrections, Bureau of Prisons Policy 4.3(IV).
[107] *Id*; CO Department of Corrections Administrative Regulation 650-03(III)(J).
[108] 2017 Mental Health Services Monthly Report, *supra*.

services. DRM is not confident that the records reviewed from MCIW accurately demonstrate the provision of mental health services. However, as discussed below, inadequate staffing and staff vacancies prevent provision of needed health care service

XI. MCIW STAFFING VACCANCIES PREVENT ADEQUATE PROVISION OF MENTAL HEALTH SERVICES

A. Mental Health Vacancies And Inadequate Staffing

DPSCS has trouble with recruiting employees in several positions that are necessary for operations. The Department reported 937 vacant positions statewide and a vacancy rate that has nearly tripled from 6.4% to 18.2% since 2014.[109] There are 21 vacancies for correctional officers at MCIW alone.[110] MCIW currently has multiple vacancies at positions that are critical for individuals with mental health needs. There are only two DPSCS mental health counselors currently working full time at MCIW, which serves a daily population of approximately 775 women. A third mental health counselor position has remained vacant since 2014. The Regional Director of Mental Health Services who serves at MCIW is also currently vacant. Hiring procedures for both State and contracted employees are centralized through DPSCS.[111] DRM heard complaints that the long hiring process contributes to extended vacancies as applicants accept other positions rather than waiting for several months as the bureaucratic process concludes. This was raised as a particular concern for qualified health care applicants who are in high demand.

> *"Linda" has been diagnosed with an adjustment and borderline personality disorders and she has spent an extended amount of time in segregation. "Linda" has repeatedly asked to be transferred to a special needs unit or to the Patuxent Institution. She believes that MCIW staff are mistreating her by keeping her in segregation despite her mental health diagnoses. "Linda" is offered an individual therapy session every month. Her requests to increase these encounters to daily or weekly sessions have been denied by psychology staff.*

B. Contracted Mental Health Vacancies

MHM has contracted with DPSCS to provide mental health services for several years and recently entered into a new six year agreement.[112] The new contract provided for increased MHM staffing effective April 1, 2018. A number of positions were earmarked to serve the MCIW population, including an activity therapist and at least one more nurse for the IMHTU.

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[109] DPSCS reported these figures in their Fiscal 2019 Budget Overview submitted to the Maryland Department of Legislative Services in January 2018.
[110] DPSCS Positions Budget Fiscal 2017-2019.
[111] DPSCS, *Request for Proposals Inmate Mental Health Care Services Solicitation No. DPSCS Q001002014*, Section 3.7 (December 7, 2011; DPSCS, *Request for Proposals Solicitation No. Q0016026*, Section 3.2.35 (June 22, 2017).
[112] State of Maryland DPSCS Contractual Agreement For Inmate Mental Health Services With MHM Services, Inc., Contract No. DPSCS Q0017059 (November 1, 2017). (Beginning January 1, 2018 and ending December 31, 2023).

However, none of these positions had been filled when DRM inquired several weeks after the April 1st deadline for implementation. Only a third of the newly created positions had been filled when DRM followed up in October 2018.[113] MHM reported a total of 9 vacancies remaining as of October 2018 impacting the MCIW population; including the Regional Clinical Director and Regional Psychiatrist.

C. Impact of Staffing

Histories of trauma, abuse, and mental health issues are common among the MCIW population. Many women interviewed by DRM indicated that speaking with mental health staff improved their temperament and self-confidence. However, staffing ratios preclude a delivery of adequate mental health care services. The lack of correctional officers can also adversely impact delivery of services, especially for women in restrictive housing units who require staff to accompany them during movements out of their cells for showers, recreation, health care appointments, or any activities. It is critical that DPSCS and MHM fill existing vacancies and increase mental health staffing to address the tremendous need for services at MCIW and around the State.

XII. FAILURE TO PROVIDE ACCOMODATIONS AND MODIFICATIONS

Individuals with disabilities at MCIW are protected from disability based discrimination by Title II of the ADA and Section 504 of the Rehabilitation Act.[114] The legal requirements are robust. Prison officials must avoid discrimination; individually accommodate disability; maximize integration of individuals with disabilities with respect to programs, services, and activities; and provide program modifications to ensure that individuals with disabilities have equal access and opportunity to prison program and services.[115]

MCIW's requirement to provide reasonable accommodations and program modifications are subject to limited defenses related to cost and administrative burden.[116] Requests for reasonable accommodations may be made to case management or addressed directly to the DPSCS ADA Coordinator.[117]

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[113] MHM reported vacancy figures directly to DRM in response to a request for information. The Maryland General Assembly requires DPSCS to submit an annual report detailing MHM's performance and compliance with their contract to provide mental health services, including staffing information. However, the report submitted by DPSCS on August 1, 2018 did not contain specifics regarding vacancies. DPSCS Joint Chairmen's Report Inmate Mental Health Contract Report – Q00A, *supra*.

[114] A disability is defined as a physical or mental impairment that substantially limits at least one major life activity. The disability may be established by record or if the individual is generally regarded as having such an impairment. 42 U.S.C. 12102(1); 42 U.S.C. 12131; 29 U.S.C. 794(a). Department of Legislative Services Office of Policy Analysis, *Department of Public Safety and Correctional Services Fiscal 2018 Budget Overview*, 41, Annapolis, Maryland (2017). http://mgaleg.maryland.gov/pubs/budgetfiscal/2018fy-budget-docs-operating-q00-dpscs-overview.pdf.

[115] *Id*.; 28 C.F.R. 35.130(D).

[116] These accommodations must be provided unless the facility is able to establish that the accommodations would constitute an undue burden and hardship due to cost or impracticability. Factors to be considered include the nature and cost of the needed accommodation, the overall financial resources of the facility, and the overall financial resources of the responsible entity. 42 U.S.C. 12111(10); 42 U.S.C. 12132.

[117] Questions or complaints containing all relevant information may be sent to the "Inmate ADA Coordinator" at 6776 Reisterstown Road Baltimore, Maryland 21215.

Warden Chippendale served as the ADA Coordinator at MCIW during the period of time reviewed by DRM. None of the incarcerated women with disabilities interviewed for this Report were aware that the facility had an ADA coordinator. Many did not know that they had the right to request reasonable accommodations; let alone the procedure to initiate the process. Multiple staff members, including case managers, were unable to identify the ADA coordinator and were surprised to learn that there was one at the facility. There appeared to be little awareness or education regarding the ADA and the rights of individuals with disabilities.

As an example, the cafeteria and gymnasium at MCIW where many programs are conducted are accessible by staircase. There is a wheelchair lift installed along this staircase, but the lift was not in operation when DRM toured the facility in March 2018. One woman told DRM that she had skipped meals because of how difficult it was for her to climb up and down the stairs. MCIW indicated that the lift had been fixed when DRM followed up in October 2018, however, it was reported to DRM that access could not be extended to the gymnasium due to building code restrictions.

Federal law also requres that services for individuals with disabilities be provided in the most integrated setting appropriate to the individual's needs.[118] As described in this Report, the services provided in the infirmary and mental health restrictive housing units are not provided in the most integrated settings possible. The IMHTU is an extreme response to individuals experiencing a behavioral health crisis. Failure to modify policies to mitigate the established harm of this restrictive housing enviornment runs afoul of the ADA.[119] There is not a defined continuum or array of support services available in the prison that can meet the individualized needs of persons in mental health crisis in more integrated settings. The ADA's integration mandate presumes that such segregation is harmful. While safety issues are a defense to the ADA, the safety risk must be based on an individualized assessment of the risks and of alternative measures. Provision of individualized assessments and alternative responses to segregation is needed for persons with serious disabilities facing restrictive housing. MCIW and DPSCS should modify practices and policies to comform with the ADA. (*See*, **Section XV**).

XIII. COMPLAINTS RELATED TO HYGIENE

DRM received complaints relating to inadequate supplies of blankets, sheets, toilet paper, and soap. Also, multiple women reported that they were not given a mattress when they first arrived at the facility. However, the most pervasive complaint was the shortage of feminine hygiene products. Women may buy more hygiene products from commissary, but only if they have money in a prison account; and many do not.[120] MCIW was soliciting donations of sanitary napkins from the public at one point. To compound the issue, women can go several weeks without laundry. Warden Chippendale assured DRM that a problem with a procurement resulted in the shortage of feminine hygiene products over the summer of 2017, and that issue was resolved. Numerous women continued to complain about this issue to DRM. The complaints were substantiated by NARAL Pro-Choice Maryland, who shared that they were asked by

[118] 28 C.F.R. 35.130(d).
[119] Disability Advocates v. New York State Office of Mental Health, *supra.*
[120] Jobs at the facility pay less than a dollar per day.

MCIW to initiate a donation campaign for menstrual products in September 2018 due to shortages.

The Maryland Legislature recently passed House Bill 797 and Senate Bill 598 requiring all correctional facilities in the State to maintain sufficient supplies of menstrual hygiene products to meet the needs of their populations. Menstrual hygiene products must now be provided on request at no cost to the women in need.[121] Governor Larry Hogan signed the bills into law, which became effective on October 1, 2018. DRM has not had the opportunity to monitor the implementation and effect of this new law but hopes that it will address the shortcomings described in this section.

XIV. MCIW OFFERS PROGRAMMING OPPORTUNITIES TO CERTAIN SEGMENTS OF POPULATION

A. Programming Opportunities At MCIW

Facilities that provide programming opportunities to incarcerated populations produce significant societal and economic benefits. Research supported by the United States Departments of Justice and Education has established that recidivism rates are lower for ex-offenders who participated in academic or occupational programming opportunities while incarcerated.[122] It is also noteworthy that employment rates were higher for this group than their peers who did not receive these opportunities.[123] The study further concluded that investing in educational programming would save money when balanced against the cost of re-incarceration.[124] MCIW offers over 70 programs, groups, and educational opportunities.[125] Women may learn how to grow plants, maintain beehives, and adopt cats to keep in their cells if they are able to sustain clean disciplinary records. The women can enroll in educational or vocational courses including classes on financial literacy and parenting. Yoga classes are offered twice a week.[126] MCIW has a brightly decorated visiting room that permits contact visits between incarcerated women and their young children. There is a Narcotics Anonymous program weekly run by community volunteers. MCIW reported that it offers two afternoon sessions on Alcoholics Anonymous and two such sessions on Narcotics Anonymous annually involving community members.

Most opportunities are limited to a set number of women in general population. Wait lists are long and any substantive opportunities to participate in programming disappear in restrictive

[121] Md. Code Ann., Correctional Services 9-616(C).
[122] "Researchers found that inmates who participate in correctional education programs have 43 percent lower odds of returning to prison than those who do not." Bronner Group, LLC, *Federal Bureau of Prisons Education Program Assessment Final Report* (Nov 29, 2016) (citing RAND Corporation, *Education and Vocational Training in Prisons Reduces Recidivism, Improves Job Outlook* (Aug 22, 2013)). https://www.rand.org/news/press/2013/08/22.html.
[123] "Employment after release was 13 percent higher among individuals who participated in either academic or vocational education programs than those who did not. Those who participated in vocational training were 28 percent more likely to be employed after release from prison than who did not receive such training." *Id*.
[124] "…with a $1 investment in prison education reducing incarceration costs by $4 to $5 during the first three years post-release.…The direct costs of providing education are estimated to be from $1,400 to $1,744 per inmate, with re-incarceration costs being $8,700 to $9,700 less for each inmate who received correctional education as compared to those who did not." *Id*.
[125] 78 programs, groups, and educational opportunities were available to women at MCIW as of April 30, 2018.
[126] Chair yoga is offered once a week for those with limited mobility.

housing units.[127] DRM identified one very small program for individuals with mental illness that appears to have potential if expanded; the Special Needs Unit.

B. Special Needs Unit

DPSCS defines a "special needs unit" (SNU) as a housing status designed to manage individuals with a serious mental illness in the least restrictive environment possible, with the goal of returning the individual to general population and providing aftercare support.[128] The mandate to provide mental health services in the least restrictive environment conforms to legal obligations imposed by the ADA.[129]

There are only four SNU cells in general population at MCIW. Women placed in these cells can be offered the same privileges as those in general population, but with accommodations designed to address specific issues. They are not subject to the dispiriting limitations that exist in other restrictive housing units. They may eat with others in the cafeteria, spend time outdoors every day, participate in programming or job opportunities, use the phone or shower, while receiving individualized care for their mental health issues. Their routines may be adapted to meet their individualized needs or tolerances and to deal with issues that prevent them from being in the general population.

Many walls in general population units are covered with art or painted in bright colors in stark contrast to the grim conditions that are prevalent in segregation, the infirmary, or the IMHTU. The SNU was visited by DRM and was observed to be remarkably calmer than restrictive housing units. This model could be expanded to be an alternative to restrictive housing for women with mental health needs. MCIW might require more or different staff deployment to expand the unit beyond its currently limited scope, but it would be cheaper than the IMHTU or the infirmary, more trauma informed, and less restrictive and less harmful for those in SNU than restrictive housing.

XV. RECOMMENDATIONS

The issues addressed in this report have been discussed with community members, including those who have personal experience with the criminal justice system and who contributed to DRM's understanding and Recommendations. A majority of the Recommendations relate to DRM's findings that the use of restrictive housing for individuals with disabilities needs reform; including the use of disciplinary and administrative segregation, the IMHTU and the infirmary.

People with disabilities frequently have chronic and serious medical and/or mental health treatment needs, which prisons are required to meet. The conditions, lack of services, and failure to accommodate individuals with disabilities leads DRM to conclude that DPSCS practices violate federal statutory law and both the Maryland and United States Constitutions. DPSCS must account for the demonstrated harms of segregation and must modify its practices to

[127] Some women are allowed to continue educational programming through worksheets although there are no interactions with teachers or out of cell time associated with these opportunities.
[128] DPSCS Report on Restrictive Housing FY 2016, supra.
[129] 28 C.F.R. 35.130(D).

accommodate individuals with disabilities and provide services in the most integrated settings appropriate to the individual. DRM recommends that DPSCS:

1. Adopt standards endorsed by the National Commission on Correctional Health Care to prohibit placement of individuals with serious disabilities in restrictive housing, except in limited exigent circumstances when reasonable alternatives are not available and there is actual or threats of imminent harm. For the limited exceptions when a restrictive housing placement occurs, provide more out of cell time and limit the total time in restrictive housing as much as possible based on individualized assessments.

2. Further reduce periods of administrative segregation and disciplinary sanctions; and probate existing segregation time to conform to nationally and clinically endorsed standards, including for persons sanctioned under prior regulatory scheme.

3. Develop alternatives to restrictive housing for individuals with serious disabilities. For example:

    - The MCIW SNU could be further developed to serve as an alternative to restrictive housing. The program is currently comprised of four cells integrated in a general population unit. The program can be developed in other units to offer more program opportunities and more access to mental health supports in an integrated setting.

    - Crisis services, peer supports or voluntary quiet/time out rooms can be offered to help stabilize individuals and prevent restrictive placements. [130]

    - Individualized cell restrictions can be applied temporarily without moving the individual to a restrictive housing unit.

4. Implement a mandatory pre-screening evaluation process before placement in restrictive housing to identify individuals with serious disabilities, divert them from restrictive housing units, and match them to alternatives.

5. Subject treatment plans to external review to ensure they comply with professional standards of care. Treatment plans should include individualized goals, objectives, and substantive intervention strategies.

6. Modify the contract or policies that allow the conditions observed by DRM in the IMHTU including severe restrictions on time out of cell; lack of confidential encounters with health professionals; and inadequate treatment plans. Lack of clothing; lack of bedding; lack of programming or personal property and 24 hour illumination in cells should be used sparingly and only if required based on individualized assessment.

[130] Benefits include that such services are less costly than use of the IMHTU and can promote recovery more quickly. Moreover, for some individuals it is destabilizing to change housing units and concomitantly face a change in cellmates and staff on the new unit.

Plexiglass windows that limit visibility should be replaced and the facility should obtain suicide resistant mattresses and utensils.

7. Modify the contract or policies that allow the conditions observed by DRM in the infirmary including, restrictions on time out of cell, lack of access to natural light, lack of access to recreation and lack of access to commissary food items.[131] Mandate external review of situations requiring extended stays (e.g. a month) or for non-acute care. Revise policies requiring all pregnant women to be placed in the infirmary to decisions based on choice or medical necessity.

8. Re-evaluate the centralized hiring process to permit vacancies to be filled more quickly, especially for health care positions.

9. Develop a method to address the mental health needs of those few women that require intensive services beyond what can be provided at MCIW. A very few women rotate between state hospitals and MCIW or between restrictive housing units at MCIW disciplinary segregation, infirmary and inpatient mental health unit and cannot be stabilized.

10. Provide education to staff and incarcerated women on the ADA and processes for requesting accommodations. Written materials should be posted and distributed.

11. Offer more opportunities for individuals in restrictive housing to get out of cell and to have access to activities when in their cells (e.g. meditation exercises, music or television through tamper resistant products).

12. Consider alternative placements for individuals that continue to deteriorate or have extended time in the IMHTU or infirmary, and who may benefit from services beyond what is available at MCIW, including expanding the use of medical parole.

13. Review policies and use of restraints so that individuals are released once they are calm or have stabilized.

14. Ensure that clinical encounters are offered in a confidential setting.

15. Review segregation and log sheets to establish compliance with record keeping and substantive prison policies.

16. Allow women to copy their health care records at no charge, with narrow exceptions.

17. Complete anti-ligature assessment and implement necessary changes facility wide, not just in the segregation unit.

18. Eliminate physical barriers that prevent persons using wheelchair from accessing the gymnasium, where many activities occur.

[131] Unless Medically Necessary.

As longer term recommendations DRM suggests:

19. Demolishing the older housing units at MCIW, which are problematic for custodial purposes and appear to have ventilation and other maintenance issues. Alternatives to restrictive housing units could be developed with better functional space.

20. Develop contracts with Maryland's anchor health care institutions or universities to run health care operations at its facilities. New York City and Massachusetts may be models for such reforms. Benefits of such changes include more stable staffing, use of existing training opportunities and staff rotations, continued care on release, and access to higher quality care.

Please visit disabilityrightsmd.org for more information or contact Munib Lohrasbi at MunibL@DisabiltiyRightsMD.org with any questions