CCLP REPORT ON CAUSES OF RECENT DISTURBANCES AT LONG CREEK YOUTH DEVELOPMENT CENTER

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INTRODUCTION

In September of this year, the Maine Department of Corrections (MDOC) requested that the Center for Children's Law and Policy (CCLP) conduct an assessment of seven incidents involving group disturbances at the Long Creek Youth Development Center, in South Portland, Maine, on August 2, 9, and 30, and September 11, 13, 16 and 18. The focus of the assessment was not to be on the minute details of each incident but, rather, on understanding underlying causes of the incidents and how the incidents are or may be related to policies, practices, and programs at Long Creek.

In order to carry out the investigation, MDOC requested that CCLP:

1. Review all reports, reviews, and other documentary materials, including all videos, of the incidents;
2. Visit Long Creek on October 5 and 6 and interview unit staff, supervisors, facility administrators, and youth who were involved directly in the incidents or witnessed or otherwise had knowledge of the incidents;
3. Review CCLP's 2017 assessment of policies, practices, and conditions at Long Creek, and consider how recommendations that were or were not implemented are or may be related to the incidents;
4. Develop recommendations for MDOC and other agencies to address problems related to the incidents, including recommendations related to incident responses and incident investigative protocols;
5. Provide a verbal report to MDOC administrators on the findings of the assessment;
6. Provide a written report to MDOC on the findings of the assessment, with the understanding that MDOC will make the report available to appropriate executive branch agencies, the legislature, and the other necessary external stakeholders on a timeline and in a matter determined by MDOC; and
7. Provide for post-report implementation review or technical assistance to ensure that recommendations pursued by MDOC are implemented with fidelity, where MDOC will be responsible for ensuring that a review and update of the implementation of findings is conducted no later than six months following the release of the report.

CCLP previously conducted two assessments related to the juvenile justice system in Maine. In 2017, with support from the Maine Juvenile Justice Advisory Group (JJAG), CCLP conducted a comprehensive assessment of policies, practices, and conditions in the Long Creek Youth Development Center using the standards in the Juvenile Detention Facility Assessment Standard

Instrument that were developed for the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative (JDAI Standards). The 2017 report included extensive recommendations for reforming policies and practices that did not conform to the JDAI Standards.

In 2019 and 2020, with support from the JJAG and in conjunction with the Maine Juvenile Justice System Assessment and Reinvestment Task Force, CCLP conducted a statewide assessment of Maine's juvenile justice system. The comprehensive report was released in 2020 and contained wide-ranging recommendations for reforms in the system.

This assessment is not an investigation of the precise details of each of the seven incidents that occurred in August and September. MDOC has already conducted such investigations of each incident and law enforcement agencies are investigating for possible criminal violations.

Instead, this assessment is focused on looking at underlying conditions, policies, and practices that may have led to the disturbances or that contributed to them. We wanted to know: Why did these disturbances occur? Are there common characteristics of the incidents? Most importantly, how can MDOC and the Long Creek administration reduce the likelihood of similar disturbances in the future?

EXECUTIVE SUMMARY

At the request of the Maine Department of Corrections, the Center for Children's Law and Policy conducted an investigation of seven group disturbances that occurred at the Long Creek Youth Development Center during August and September of 2021. The focus of the assessment was not to be on the minute details of each incident but, rather, on understanding underlying causes of the incidents and how the incidents are or may be related to policies, practices, and programs at Long Creek.

Prior to an on-site visit, for each of the seven incidents, MDOC provided the team with Critical Incident Reviews, staff reports, videos, and, as available, medical reports and photographs. On October 5 and 6, the CCLP team met with Commissioner Randall Liberty and Acting Superintendent Amanda Wolford and her staff, toured Long Creek, and interviewed many of the youth and staff who were involved in the seven incidents. Members of the CCLP team conducted phone or online interviews with some staff, and with the Acting Superintendent, subsequent to the on-site visit.

The CCLP team made the following findings:

1. Boredom has been one of the main reasons behind much of the acting-out behavior by youth. With little to do during the day and no staff presence on the pods, youth are left to their own devices and engage in disruptive behavior.

2. Severe and chronic staffing shortages have been toxic to operations at Long Creek. At last report, there were 5 teacher vacancies, 19 vacancies in Juvenile Program Worker (unit staff) positions, a vacancy in the Deputy Superintendent position, and vacancies in

administrative positions. Staff shortages have undermined all areas of operation at the facility.

3. Youth behavior contributes to the problems. Most residents acknowledge that they have made poor decisions and continue to engage in risky behavior. They want attention and admit to following the crowd, without thinking about the potential consequences of their behavior. Acting out provides excitement, a way to relieve stress, and immediate attention to their needs.

4. Staff behavior also contributes to the problems. The staff practice of group punishment -- holding everyone accountable for one person's actions -- is counterproductive. Bedtimes are too early for teenagers and, occurring when staff resources are at their lowest, are a constant source of friction.

5. Physical plant issues require replacements of door locks, sprinklers, and furniture in the living units.

6. MDOC should revise the behavior management level system and the grievance system. The behavior management system has a strong focus on rules and sanctions with little attention to rewards for positive behavior. Youth feel that it is too difficult to reach Levels 3 and 4 (where the incentives are), too easy for staff to drop them to a lower level, and it takes too long to get back to a higher level. Thus, the system is ineffective. The grievance system has built-in disincentives for residents to use it, and when they do use it, they feel that it doesn't work.

7. MDOC should clarify the policy on responses to disruptive behavior. MDOC policy on Use of Force is confusing, leading many staff to be unsure of what they can and cannot do.

8. Mental health clinicians should be directly involved in conflict situations from the beginning, and clinicians need to develop effective Intensive Behavior Management Plans. At present, clinicians are not directly involved in disturbances. Intensive Behavior Treatment Plans are largely about sanctions for inappropriate behavior and do not spell out the behaviors to be extinguished, the new behaviors to be substituted, and the incentives for positive behavior development.

9. External conditions such as inadequate MH services in community add to the difficulties. Maine still does not have a secure psychiatric facility where youth with mental health problems can go and psychiatric programs in the community still do not accept, or quickly eject, youth who engage in violent behavior.

10. The process for Critical Incident Review should be expanded. It does not include the underlying issues in the incident or the youth's point of view of the incident. It does not look at broader issues in the facility that may be related to the incident. It accepts as appropriate MDOC interventions used in state prisons such as chemical restraints and

tasers, and, on rare occasions, intervention by the Special Operations Group (SOG), the tactical team trained to quell prison riots.

The report discusses each finding in detail and provides multiple recommendations for remedying the problem.

METHODOLOGY

A. Assessment Team Members

Three CCLP staff members conducted this assessment:

- Mark Soler, J.D., is the Executive Director of the Center for Children's Law and Policy and the founder of the organization in 2006. From 1978 until 2006, Mark was Senior Staff Attorney, Executive Director, then President of the Youth Law Center, a national public interest law firm located in San Francisco. At the Youth Law Center, he and his colleagues worked in more than 40 states on juvenile justice, child welfare, health, mental health, and education issues, and litigated successfully in 16 states on behalf of children whose rights have been violated in juvenile justice and child welfare systems.

- Regina Mitchell, M.A., is the Director of Systems Innovation at the Center for Children's Law and Policy. In this capacity, Regina coordinates and manages the Juvenile Detention Alternatives Initiative (JDAI) and Probation Transformation portfolio and partnership with the Annie E Casey Foundation (AECF) Juvenile Justice Strategy Group (JJSG). Prior to joining CCLP, Regina served as a Program Administrator for the Ohio Department of Youth Services, with responsibility for JDAI in Ohio's JDAI sites. Regina also worked as a Juvenile Parole Officer and Probation Officer.

- Lisa Macaluso, M.A., is the Senior Juvenile Justice Policy Advisor at the Center for Children's Law and Policy. Prior to joining the CCLP, Lisa was the Deputy Director of Crime Prevention for the New Jersey Attorney General's Office implementing New Jersey's Strategy for Safe Streets and Neighborhoods. She also served as the Director of the Office of Local Programs and Services with the New Jersey Juvenile Justice Commission, where she led the development and implementation of a number of innovative policies and practices including the state-level replication of the Juvenile Detention Alternatives Initiative.

Mark Soler worked on both the 2017 conditions assessment of Long Creek and the 2020 statewide juvenile justice system assessment. Lisa Macaluso worked on the 2020 statewide system assessment.

B. Review of materials and interviews

Prior to the on-site visit, for each of the seven incidents, MDOC provided the team with Critical Incident Reviews, staff reports, videos, and, as available, medical reports and photographs.

On October 5 and 6, the CCLP team met with Commissioner Liberty and Acting Superintendent Amanda Wolford and her staff, toured Long Creek, and interviewed many of the youth and staff who were involved in the seven incidents. There were 37 youth at Long Creek on October 5. The Pine unit was closed and the Cedar unit was being repaired for damage caused in a disturbance. At the conclusion of the site visit, the CCLP team met with Acting Superintendent Wolford and her staff to discuss the team's preliminary observations and findings.

Following the site visit, MDOC arranged for the CCLP team to conduct online interviews with some staff who were on vacation or otherwise unavailable during the October visit.

The CCLP team recognizes that some young people fail to remember accurately in describing a situation, some exaggerate in their descriptions, and some do not tell the truth about a particular event. The team also recognizes that some staff in a youth facility fail to remember accurately, some exaggerate, and some do not tell the truth about a particular incident. A single account, especially of alleged abuse or neglect, is important for the team to consider, but the team generally avoids drawing conclusions based on the words of a single individual. Instead, the team generally looks for similar descriptions from several individuals, common patterns of behavior, and descriptions that match videos and witness reports in ascertaining what actually happened.

C. Acknowledgements

CCLP deeply appreciates the cooperation by MDOC throughout this assessment, particularly MDOC Commissioner Randall Liberty, Deputy Commissioner Ryan Thornell, and Acting Long Creek Superintendent Amanda Woolford. The agency provided us with reports of internal investigations and other relevant documents, as well as multiple videos of each incident. The agency also arranged for CCLP's team to meet with administrators, staff, and young people during the site visit on October 5 and 6, 2021, and to conduct subsequent online interviews with staff who were on vacation or otherwise unavailable during the site visit.

By the nature of this assessment, this report focuses on current challenges and difficulties at Long Creek. It does not include all reforms at the facility since the 2017 assessment and the 2020 assessment of the Maine juvenile justice system. This report also does not include the many efforts to improve the juvenile justice system in Maine by MDOC, the Office of Child and Family Services, the Legislature, and many advocates for young people in the state, particularly during the past two years.

We also understand, from conversations with Amanda Woolford subsequent to our on-site visit, that she has made a number of significant changes at the facility. Where changes have been made, we will report our observations as of the dates of our visit and the subsequent changes that have been made.

FINDINGS

1. Boredom has been one of the main reasons behind much of the acting-out behavior by youth.

The most frequent thing the CCLP team heard from residents and staff was that there has been little for youth do at Long Creek. Organized programming has been lacking. In the past, residents were kept busy with school, recreation, staff-led groups, and activities led by volunteers who came to the facility. Due to staff shortages, discussed below, there has been little interaction between staff and youth in some units. School has often been canceled. When school has been in session, some youth have had only two classes per day. Due to COVID-19 restrictions, volunteer services essentially came to a halt. Youth at the facility have had far too much idle time.

Classes have often been canceled. Classes were canceled on October 5, when the CCLP team was on site, because teachers called out. When residents are not in class, they are given school packets to complete. This causes problems for young people who are academically challenged and have no individual instruction or help when the work is difficult.

Every youth we interviewed reported they want more structure during the day. An efficient and safe facility environment must include a variety of structured programming to keep youth engaged and occupied. Much of adolescence is about testing boundaries and "hands on" learning. Adolescents need activity, and risk-taking is attractive to them. Because the critical decision-making parts of their brains are not fully developed, young people often make thinking errors and bad decisions. With no structured programs and little staff interaction at Long Creek, they get into mischief, property damage, horseplay, and aggressive behavior toward other youth. With no immediate intervention by staff or consequences for their behavior unless there is a direct assault or group disturbance, the youth continue their disruptive behavior. Some see it as a game, an activity to keep them occupied until they find something else to do. They say they are looking for "amusement" and "entertainment." They see their behavior as having fun. Some youth are remorseful afterwards, some are not. Many youth think that the disruptions are a means to an end of getting their "demands" met for more things to do.

The population at Long Creek is smaller than before the pandemic, but the youth there have more needs and are more challenging for staff. More youth have problems such as conduct disorder and PTSD. More youth have higher ACEs scores (Adverse Childhood Experiences) and more previous delinquent behavior. Some youth cognitively have lower processing speeds for information, which makes it harder to get their attention during incidents.

Residents reported that they were restricted to their rooms or in their pods unsupervised for the majority of the time. After a day of idleness, they have to go to bed early. The current bedtime schedule consists of Level 1 – 8:00pm, Level 2 - 8:30pm, and Level 3 at 9:00pm. For adolescents, 8:00pm is too early for bedtime, too different from a normal day for a teenager, so it is not surprising when they rebel. With the addition of structured programming, the CCLP team feels the bedtime can be adjusted.

The COVID pandemic also affected visitation and made in-person visits impossible. Youth receive 15 minutes per week of free calls. Phone calls are good but no substitute for face-to-face, in-person visits. Young people need contact with their families on a regular basis.

Recommendations

1. Provide a full education program to every youth in a classroom every weekday.

2. Return to a robust volunteer services program. With volunteer programs, there is the opportunity for development of varied programs to meet the varied needs and interests of youth. Surveying the residents for their interests would allow a coordinator to reach out to the community, local colleges and religious organizations to provide no- or low-cost activities. Several residents recommended basketball and corn hole tournaments. Staff members may also be an untapped source for programming. There may be staff who have a passion and skill in a certain area and who would be willing to facilitate a group with youth on music, calisthenics, cooking, or a variety of other topics.

3. Close the pods during the day and conduct all activities in the dayrooms. This would allow staff to interact directly with youth to keep them engaged in meaningful activities during the day.

4. Bedtimes should be adjusted and moved at least a half-hour later.

5. The facility should return to in-person visitation as soon as possible, possibly requiring proof of vaccination.

6. Continue to add interesting and engaging activities. Since the CCLP team was on-site, there have been several programs and opportunities put in place. Staff and youth recognize a clear shift with the new administration at Long Creek. The addition of the Saturday movie and the Bear's Den has been welcomed by the residents and staff. So has the addition of the Wednesday evening activities, Bear Fit, Noon Ball, and bringing back the Unit Sponsors. Adding additional items to the Bear's Den that youth requested, such as the punching bag, has also led to improved morale and positive culture.

7. Provide more time for youth on Levels 3 and 4 to use Play Station 4. When the team was on site, PS4 was only available on units for one hour per day.

8. Allow more youth to have music in their rooms via MP3 players. Music is the lifeblood of many adolescents, an important part of their culture and a calming and enjoyable activity.

2. Severe and chronic staffing shortages have been toxic to operations at Long Creek.

a. Causes of staff shortages

The primary reason for the lack of supervision and structured activities at Long Creek is the significant shortage of staff in all categories. As of November 12, there were 5 teacher vacancies, 19 vacancies in Juvenile Program Worker (unit staff) positions, a vacancy in the Deputy Superintendent position, and vacancies in administrative positions. In October, when the CCLP team was on site, there were 4 teacher vacancies and 19 JPW vacancies.

There are multiple causes for the staff shortages. Some staff have been out because they have had COVID-19 or other illnesses. Staff are allowed up to 80 hours of sick leave for COVID-19 reasons. Some staff have reportedly abused the sick leave allowance, taking all of the time available when it was actually safe for them to work.

Some staff feel strong disincentives to going to work. Administrators and staff told the CCLP team that staff feel fear from several sources. They fear being accused by advocates of mistreating youth. They fear being criticized in the press. They fear putting hands on youth, even in situations requiring physical interventions, because that can lead to accusations from advocates and being criticized in the press. Many are afraid of being sued.

Some staff are physically afraid of the youth in Long Creek. Staff have seen youth commit physical violence against other youth and staff and cause significant damage to property and living units. They believe that some youth have no fear of staff, and our interviews confirm that they are correct, at least with respect to some youth.

In addition, the staffing shortages have meant that there are few if any additional staff in the units if a disturbance occurs, so unit staff may not be able to expect immediate reinforcements. Backup staff are able to respond to units, but they are not around when the disturbance starts.

There has also been considerable turnover among staff at Long Creek. For new staff, who are not used to working with challenging young people, these fears can be exacerbated. For veteran staff, there is concern that new staff have not developed sufficient skills to handle themselves or help other staff when conflicts occur. Staff are questioning whether they want to work at Long Creek.

None of this is to say that the fears of staff are fully justified, or that they justify neglecting or abusing young people at Long Creek. It is to say that these concerns are very strong among many staff at the facility, and some staff have responded by not going to work. Long Creek staff have more absenteeism than staff in any other MDOC facility.

b. Effects of staff shortages

The effects of the staff shortages are significant and of great concern. Living units at Long Creek generally consist of a dayroom with one or more offices and three pods coming off the dayroom. Each pod has rooms for youth on two sides and an open area between.

Because of the staff vacancies, the administration has not stationed staff in the pods. Instead, staff are stationed in the dayrooms. In some living units, the youth spend much of their time in the dayrooms, where staff can supervise them. But in some units, youth spend much of their time on the pods, where they have little to do and little contact with staff other than staff checks every 15 minutes. One boy told the team that he had an Individual Behavior Management Plan – meant to help him curb disruptive behavior -- to sit in his pod at a table, with no staff present, and read, write, and draw. We saw videos of youth in pods without staff present, where youth with nothing to do gradually escalated their behavior until they began kicking doors and looking to do property damage.

If youth begin to cause a disturbance, staff must decide whether to intervene themselves or call for backup. With the staff shortages, some stay out of the pods until supervisors or administrators arrive.

Absence of staff in the pods and delays in staff entering the pods has resulted in escalation of aggressive behavior by youth that could have been averted by early staff intervention. We saw videos of situations in which youth self-escalated in their pod for several minutes while staff remained in the dayroom. One staff voiced his frustration by saying, "When we get to de-escalation, we're already losing."

Staff shortages affect every area of facility operations. Exercise activities have been curtailed due to lack of available staff supervision. Youth get fewer phone calls. Teachers have called out, leading to canceled school. Behavioral health clinicians have also been absent or have left employment at the facility, and they are hard to replace.

The staff shortages are directly related to the disturbances in August and September. Several of the disturbances occurred between 6pm and 8pm. This is the period of shift change, when the facility has its lowest number of staff in place, and the number of staff is already depleted by vacancies. When the disturbance occurred on August 3, there were 7 staff in the facility, responsible for 37 youth.

Moreover, the clinicians generally leave work at the facility at 6pm. With 12-hour work shifts, unit staff are tired and ready to go home, and don't hang around at the end of their shifts. There is no overlap between the shifts, so there is limited time for the members of one shift to brief the next shift about potential problems in the unit or with individual youth. When a disturbance occurs during these hours, it is very difficult to have an incident review or immediate debrief because staff and clinicians are not there or are there and want to get home.

In the wake of the staff shortages, some staff volunteer for overtime, and some staff do double shifts. Staff appreciate the overtime pay, but a single shift is 12 hours long, and a double shift is 24 hours. Working in any youth facility is challenging. Working in Long Creek is especially challenging under present circumstances. It is difficult to expect staff to remain alert, patient, and effective for a full 8-hour shift, let alone a 12-hour shift. It is not reasonable to expect staff to remain alert, patient, and effective for 24 hours straight.

Finally, the materials indicate that outreach to hire new staff has been traditional and limited. MDOC was slow to open an Indeed account. Limited outreach has been done outside of the DOC website and localized job fairs, in neighboring states, and to colleges and universities in Maine, particularly to students of criminology and other social sciences. As a first job out of college, working at Long Creek can be a valuable introduction to the challenges to corrections and criminal and juvenile justice principles in the real world.

Unfortunately, Maine has plenty of company in experiencing staff shortages in juvenile facilities. Cities, counties and states all over the country are experiencing similar shortages, with similar consequences. In South Carolina and Cuyahoga County (Cleveland), Ohio, there have been highly-publicized disturbances in youth facilities that are directly attributable to staff shortages.

At the same time, what we wrote in our 2017 assessment of Long Creek is still true today, four years later:

> **Staffing shortages at Long Creek are hindering the ability to supervise youth in a safe and humane manner, and they are jeopardizing the safety of staff as well.** The team was alarmed at the staffing shortages at Long Creek, which have led to a number of very concerning conditions and practices, outlined below. Overall vacancy rates for the facility have nearly doubled since the same time last year, and there are many vacancies among direct care staff and supervisors. The team understood the staffing shortage as being a product of many interrelated factors. These include (1) many resignations resulting from low staff morale and high levels of stress, (2) an influx of new staff who lack the same level of experience and skill in working with youth and who often do not last longer than two years at the facility, (3) the frequent and significant use of forced overtime, which contributes to low morale and staff member exhaustion, (4) a significant number of staff being out for extended periods on some form of medical or administrative leave, (5) a relative lack of mental health resources at the facility given the profound mental health problems of so many youth at the facility, and (6) high rates of youth engaging in self-harming behavior, which pull staff away from supervision of other youth. There are other contributors to the current staffing shortages at Long Creek, but there is no understating the seriousness of the problem. Notwithstanding the new hiring efforts that are underway, the facility is at a serious risk of continuing to lose staff at a rate that will make it impossible to run the institution safely for youth and staff.

Recommendations

Many of the recommendations we made in 2017 are also appropriate today:

1. Hire enough JPWs to maintain a staff to youth ratio of 1:8 or less in each housing unit during waking hours, as required by the PREA standards and the JDAI standards without forced overtime.

2. Require staff who have direct contact with youth to have at least 2 years of college or a high school diploma or the equivalent and 2 years' experience working with youth.

3. Create a recruitment plan involving internship and recruiting programs through schools of social work, psychology programs, and local colleges. Involve testimonials from youth who benefitted from the help and guidance that Long Creek staff provided to them.

4. Re-name positions to reflect an emphasis on working closely with youth on behavior change and skill development, such as Youth Development Specialist or Youth Behavior Specialist. Consider creating additional positions that allow staff opportunities for professional advancement, such as staff positions with special focus on specialized programming or trauma.

5. Explore options to increase the salaries of staff to improve hiring and retention. Although base wages increased during the past three years, current salaries still hinder the ability of the facility to attract and retain quality staff.

6. Develop a rotating shift schedule that allows overlap between senior and junior staff. Compensate senior staff who serve as mentors or "specialists" on less desirable weekend and evening shifts. The integration of senior and junior staff is essential to developing consistency for youth. It would also allow Long Creek to maximize existing and limited resources – dedicated and experienced staff – to share their knowledge with newer staff.

7. Maintain consistency with assignments of staff to housing units.

8. Provide on-going positive feedback and recognition to staff on all shifts. Use the employee recognition committee to help cultivate and sustain incentives described above.

3. Youth behavior contributes to the problems.

Most residents acknowledge that they have made poor decisions and continue to engage in risky behavior. They want attention and admit to following the crowd, without thinking about the potential consequences of their behavior.

Residents reported that disrupting and damaging the unit is a way to get the stress out. Some reported that they get hyped when the incidents begin. Disruptions on the unit are an adrenaline rush, usually a build up during the day when staff don't intervene.

Youth noted that acting out has been a way to get their needs met. They try to ask for the things they need through proper channels. When they think their requests fall on deaf ears, they act out and damage property. Youth reported that, at times, staff antagonize residents, call them names, and treat them like animals.

Youth reported a lack of trust and connection with staff. One youth reported that there is an extreme lack of connection for youth who are at Long Creek long term. He indicated this is one of the reasons why he acts out. When he exhibits positive behavior, his treatment by staff is no different than at other times.

Some youth bring hometown rivalries into Long Creek, such as Lewiston vs. Portland. Some are gang members, who feel a duty to attack members of rival gangs.

Several youth reported feeling unsafe, especially during disturbances. Some doors have broken locks and other youth open doors, even if residents want to stay out of the fray. Once the door is "popped" there is no safe space for uninvolved youth to retreat.

Staff and youth identified two youth who have been ringleaders in the disturbances. They were together in Cedar during the disturbances. They have assaulted youth who have not gone along with them, as captured by multiple videos. Since the CCLP team was on site, the administration has split these youth up and moved them to different units.

The group disturbances and the property damage were wrong. That does not mean that youth at Long Creek are especially violent. On the days the CCLP team was on-site, some youth were charged with felonies, including some A-level felonies, but many of the detained and committed youth were charged with D level offenses, i.e., misdemeanors such as simple assault or theft of less than $1,000.

Recommendations

1. Build honest and mutually respectful relationships with youth. Recognize that this is a difficult population and their cognitive reasoning capacity is still developing. Provide adolescent brain development training.

2. Provide stronger incentives for good behavior. Make bedtime one hour later than normal an earned reward for good behavior. Consider other desirable incentives such as takeout meals from a local fast food establishment or restaurant.

4. Staff behavior also contributes to the problems.

One of the most important relationships at Long Creek is the relationship between staff on the unit and the residents. Residents reported that "most kids have one trusted staff member here." The behavior management process assigns one staff person as a coach to each resident. This practice was regarded very highly by the residents. At the same time, residents and staff alike reported that there are times where they are "in a pissing match." As in the 2017 report, staff in 2021 all reported that staff cutbacks and vacancies have hurt staff morale and have left fewer staff available at the facility to intervene before small issues become big confrontations. When exhausted staff tell frustrated residents to go to their room, the residents see this as unfair and uncaring. Staff may respond in a sarcastic way, out of their own frustration, to get residents to comply. This sets up a tit-for-tat scenario, where residents feel justified in acting out. As one resident said, "Staff get excessive with everything, then when incidents happen, they don't want to get involved. They need to realize that kids in here have a lot of trauma with adults."

Residents also reported that the practice of holding everyone accountable for one person's actions is counterproductive, as it sends the message that "even if you are doing the right thing,

you will still get punished." One resident put it this way, "When one or two kids do something, we all get held accountable. That's frustrating. So instead of taking our frustration out on the kids who caused the punishment, we take it out on the staff."

One staff noted, "The adult system has less punishment than Long Creek. Adults in prison get tablets and television in their rooms. In Long Creek, youth have nothing in their rooms."

There was also consensus among those interviewed that bedtimes are a daily issue for residents and staff, even though residents know what time they must go into their rooms. As one staff member said, "They know what to expect … they have the same bedtime every night." Residents believe that their bedtime is too early for their age, and that this is a reason why some kick open their doors. One of the biggest triggers for residents come when all residents on the unit are held accountable for one youth's misconduct, especially before bedtime. Residents explained that, if an incident happens near bedtime, the residents are locked down earlier than usual and stay in their rooms until the morning. Resident think that staff purposely delay their response to misbehavior until it's reasonably close to bedtime so that they can lock the residents down early and keep them in their rooms until the morning.

Residents have noticed that responses to incidents take a long time. They reported that some staff are afraid of the residents and make it clear that they don't trust them. Residents see this lack of trust as a sign of disrespect. If the staff don't trust them, then they don't trust the staff. Staff noted that many of the line staff are new JPWs who are still learning the ropes. Additionally, staff noted that when an incident occurs, staff from other units must get involved due to short staffing.

Some residents acknowledged that the staff can get into more trouble than they can. The youth have noticed that the staff are "very picky and choosy about what they will do to a kid," which leads to incidents lasting for an hour or more while the staff call in the SOG team and try to negotiate with kids to stop what they are doing. Some residents see the delay in response time as an indicator that the staff don't care about them or what they are doing, especially when staff are passively watching an incident unfold.

Recommendations

1. Put senior staff on the units, watching how new staff interact with youth and how they respond to incidents. Senior staff should provide newer staff with coaching, support, and feedback so they can learn how to appropriately interact with and correct residents.

2. Hold staff accountable for their misconduct. Review videos of incidents immediately with an interdisciplinary team from Long Creek to identify problem behaviors by staff and needs for additional training or transfer to other duties.

3. Prohibit unit lockdowns for misbehavior by one youth. That is the essence of unfairness, and youth treat it as such.

5. **Physical plant issues require replacements of door locks, sprinklers, and furniture.**

As noted in the 2017 Long Creek assessment, the physical plant suffers from significant shortcomings that are exacerbated by incidents that cause major property damage to the units. Administrators, staff, and residents have been familiar with the challenges presented by the facility, including chronic maintenance problems, inconsistent air and water temperatures, accessible sprinkler heads, lighting problems and other problematic conditions.

During our visit in October, we saw that many of the same issues continue to plague the facility. Sprinkler heads in individual rooms are easy for youth to reach and set off. Several of the recent incidents involved setting off sprinkler heads, which is very disruptive to facility operations.

Doors with defective locks are of particular concern. Residents and staff reported that when an incident happens on the pod, residents know that some of the room doors are defective. This means that the youth participating in the incident can try all the closed doors to seek out additional residents to participate. Residents reported that when an incident is happening, there is no safe space for them to go, even when they don't want to participate. Staying locked in the room is often not an option. Residents reported that this causes stress for those on the unit who do not want to act out. Staff also reported that the locks issue takes away another tool for them to use in working with residents. Sending a youth to their room when the lock is broken is not an effective control strategy.

Furniture on the unit is another concern. The furnishings on the units do not provide anything like a homelike environment. Sometimes the entire furnishing on a pod is one plastic chair. This communicates a message to residents that the people in charge don't care about the conditions that youth live in. Unit furnishings in either the pod or the day room should set a homelike tone, be of better quality, and be secured to the floor and unmovable so that they cannot be used to damage property or hurt others during an incident.

Recommendations

1. Permanently fix the door locks to ensure that residents cannot pull doors open or, if this is not feasible, do not use rooms where locks are compromised.

2. Replace sprinkler heads with a flat version that is harder to access and trigger. In lieu of full replacement, work with experts to identify and install sprinkler head covers that are designed to restrict access to the sprinkler head while still allowing for water flow during a fire emergency. Ensure that sprinkler head cover design does not provide ligature points to prevent resident suicide attempts.

3. Provide better quality correctional grade furnishings on the units, including carpet on floors. Ensure that chairs, tables, beds, and other furnishings are secured (either too heavy to move or bolted down to the floor) to reduce the potential to use in incidents.

4. Secure additional resources for preventative and corrective maintenance and develop a prioritized list of chronic maintenance issues to be addressed to their relation to the life, health, and safety of youth and staff at the facility.

5. Change outdoor recreation time so that one unit is out at a time, to avoid the problems that led to the August 3 group disturbance. Alternatively, place temporary barrier between outdoor recreation areas so that youth cannot see others from different pods during recreation time.

6. MDOC should revise the behavior management level system and the grievance system.

According to the 2019 Resident Handbook, Long Creek's behavior management policy consists of a phase system to monitor progress through the facility's treatment programs and a level system to track behavior.

The treatment phases include assessment and orientation, self-awareness, self-control, off grounds approval and community reintegration preparation. The criteria for moving from one treatment phase to the next seems relatively broad and discretionary. New residents start at Phase 1: assessment and orientation where staff identify the areas that cause problems for the resident and orient youth to the facility. The self-awareness phase requires residents to show awareness of the problems created by certain behavior choices. Phase 3 is self-control, where the resident shows that they can gain control of negative behaviors and engage in more positive behaviors and includes the possibility of off-grounds approval where the resident has completed the steps necessary to be able to go off-grounds to work or on passes. Phase 4 is community reintegration preparation where a resident is prepared for release and staff identifies community supports to be included in a re-entry or after care plan. As residents demonstrate expected behaviors for each phase, they are moved to the next phase. Daily behavior is measured using behavior cards. Once a resident has earned by behavior, and once Classification has approved a resident for Phase 3, the resident can apply to the Unit Treatment Team to discontinue the daily behavior card. However, the privilege of no longer using a behavior card only comes when Classification approves the resident for Phase 4. Only the Superintendent or their designee can drop a resident from their current phase to a lower phase.

The boys' behavior management system consists of four levels. Girls follow a three-level system: bronze, silver, and gold. The current behavior management system for boys makes it very difficult to advance through the levels by creating several hoops to jump through, especially for residents with mental health issues. At the same time, it very easy for staff to drop residents a level or levels. Residents consistently noted that it is very difficult to advance in levels and very easy to lose levels. They agreed that the current behavior management rules are a disincentive to progress because levels are too hard to achieve and too easy to lose. The Assessment Team agrees with the resident's assessment. According to the Resident Handbook, residents on level 1 are expected to follow the basic facility rules for safety and security. Residents are also eligible for basic privileges such as phone calls, recreation time, unit activities and "others." The Resident Handbook does not list additional expected behaviors for each level, but the text does

explain that residents must demonstrate expected behaviors to move to the next level where the resident will be expected to show even more responsibility as well as receive more privileges.

Staff measure a resident's behavior daily using a behavior card. The behavior card lists the target behavior and includes a rating system ranging from commendable to acceptable to unacceptable behaviors. Once a resident has earned by behavior, and once Classification has approved the resident for Phase 3, the resident can apply to the Treatment Team to discontinue the daily behavior card. When a resident has been approved for Phase 4 by Classification, the resident no longer needs to use the daily behavior card. Residents can advance through the levels or levels can be taken away. Each week the resident's coach recommends a level for each resident. A coach can recommend movement up a level, staying at the same level or being dropped a level (or levels), based on a resident's behavior during the prior week. If a resident has done something considered to be major misconduct, the resident will immediately be dropped to Level one and remains on Level one until the Unit Team reviews the resident's misconduct and determines an appropriate level. When a resident is ready to advance to the next phase, their coach will give the resident a packet to complete. To advance a level, a resident must gather input from each area of programming, complete a packet, and make a presentation to the Unit Treatment Team. If the Unit Treatment Team approves the resident's advancement to the next level, the JPM or social worker arranges a Phase Advancement Review with the Classification Committee. The resident attends the Phase Advancement Review meeting to discuss phase advancement. If the resident's phase advancement is denied, the Classification Officer will explain what the resident needs to do to advance a level. Residents can be dropped a level by the JPM or the Unit Treatment Team. It is unclear whether staff must document reasons for dropping a resident's level and it is unclear whether staff are required to discuss their decision to drop a level with the resident, and what the resident needs to do to advance.

It is helpful to have input on appropriate levels for youth, but the behavior management system is complicated and confusing. It should be streamlined and clarified.

The revised Resident Handbook does not specifically list privileges associated with each level of the behavior management system though staff identified various privileges associated with higher levels include pizza or Chinese food on Fridays, a movie during the weekend, opportunities to assist with environmental services (e.g., doing unit laundry or cleaning), visiting the Bear Den to play video games or working out Bearfit (crossfit) and the heavy bag. The Resident Handbook lists the facility rules, what is considered minor and major infractions and consequences for these infractions. The Staff may impose a range of sanctions for behavior that constitutes major or minor violations. These sanctions include verbal re-direction, a writing assignment, and "unacceptable" rating on a daily behavior card, activity restriction, unit restriction, and pod restriction. A youth on pod restriction must remain in his or her pod except during off-unit activities and meals. The maximum amount of pod and unit time that a youth may receive is 30 hours.

CCLP's assessment report findings 2017 are applicable today. That report found that the behavior management system had a strong focus on rules and sanctions with no identified rewards for positive behavior, noting that "the current system does not foster a culture of staff recognition of positive youth behavior at all times." The report noted that staff interviewees did

not "intentionally identify or promote positive behavior" and did not "understand the importance of recognizing positive behavior." The 2017 report recommended that Long Creek "incorporate recognition, verbal or otherwise, as a regular part of the behavior management system. Include a list of possible incentives in the Resident Handbook. Establish clear examples of positive behavior. Consider requiring staff to document use of positive re-enforcement to create a culture that recognizes staff who catch youth doing something right."

The 2017 report also recommended that Long Creek create a process to identify new and effective incentives, such as the resident committee, focus groups or a standing item on the agenda at monthly meetings. During our on-site visit, residents identified that the operation of the behavior management system seems unfair, is focused on sanctions and is ineffective in controlling resident behavior. One resident summed it up, "Even when kids are doing good, they don't get the opportunity to go up a level. Staff need to explain why they are taking a level away. They give us something to work towards [that is valuable] to us like early release, different clothes, later bedtime or use of an iPad." Residents also perceive that their voices are not heard when they try to get their needs met through positive channels but acting out gets their needs met quickly. Another resident reported, "Staff don't pay attention to kids when they are doing good. [They] never ask what they need when they are doing well, they only ask after residents act out. [Staff] should ask kids what they need when they are doing well" and follow through to avoid incidents. The perception that needs can only be met after acting out creates an incentive for incidents that can be remedied by making recommended changes from the 2017 report to the behavior management system as soon as possible.

The behavioral level and phase system, as it currently operates, is highly discretionary regarding level raising, taking away levels and earning levels back. The process for earning higher levels is onerous. The process itself was deemed "not worth it" because it is too hard to earn levels and too easy to have levels taken away. Several interviewees noted that they were unsure whether the levels were "applied equally" as levels are decided by the Unit Manager. Staff also said that the levels are harder to earn if a resident is considered "high risk," noting "the higher the risk level, the harder it is to gain a level."

The impact of wide discretion, along with a focus on rule violations and sanctions lead male residents to believe that they cannot reach level 3, where the privileges start. Male residents consistently noted that it was hard, if not impossible, to obtain level 3 or level 4. They felt that even if they worked hard to obtain level 3 it could easily be taken away and not achieved again for days or weeks. One resident noted "the way the level system works most can't really get to level 4 and, even if you get there, it's very easy to lose." Residents we interviewed also noted that the system does not work this way for girls, stating that "Girls lose a level (3 or 4) and get it back in a day, for boys it takes a week or more to get it back." Staff tended to agree with this view.

As one interviewee noted, "if kids go to their room and are let out, the staff have no control. Behavior management helps staff control kids' behavior by moving them toward their goals. However, the girl's system is different than the boy's system. Girls can get their level back quickly; boys will take a week or more to get their level back."

The current staffing shortage may also affect Long Creek's ability to effectively carry out the behavior management system. The behavior management system allows for unit restriction and pod restriction for a maximum of 30 hours. With residents are either in the pod or on the unit for most of the day and evening, these sanctions are not available as part of the behavior management system in an effective way. Moreover, the behavior management system relies on room restriction to work out issues with residents so that they don't lose a level. One resident explained that "kids can't hang out in the pod, they have to be in the day room. If a kid does something wrong, they can get up to 45 minutes of room confinement for de-escalation. The kid has to talk to staff and try to fix the issue to not lose a level." When a unit is short staffed and when youth are not receiving treatment programming, it is unclear whether Long Creek can carry out the behavior management process effectively.

Given the issues around the behavior management system, residents could potentially rely on the grievance system to alert Long Creek leaders of issues. The 2019 revision of the Resident Handbook outlines the procedures for filing a grievance. Residents can file a grievance and request administrative review of any policy, action, decision, or any condition that the resident feels are unfair, in violation of their rights or in violation of departmental policies and procedures, without fear of consequences. The Resident Handbook then proceeds to dissuade residents from filing grievances by noting that the Commissioner, designee, or Superintendent may determine that a resident has abused the grievance process or determines that the grievance is frivolous, he/she may suspend the resident's use of the grievance process for up to 90 days. The Handbook goes on to say that, if the Commissioner suspends the residents use of the grievance process, the resident will be notified in writing. If there is a determination that the resident has made a false statement in a grievance filed, disciplinary action may be taken against the resident. Residents may not file grievances for classification decisions, disciplinary decisions or going on a pass, as there are separate appeal procedures for handling these matters. Finally, the Resident Handbook explains that residents who want to file a grievance will have to fill out appropriate forms with the assistance of the JPM or another staff member, which may also have a chilling effect on a resident's decision to file a grievance.

When asked about the effectiveness of the grievance system to address issues, residents noted that it doesn't work. The inability to have grievances taken seriously leads residents on level 1 and level 2 to the conclusion that they can't use legitimate avenues to voice their issues and therefore, it doesn't matter what they do or what they don't do; once they are in trouble, they will not be able to get to level 3 or 4. Staff interviewees said that a grievance system exists but could not name the Grievance Officer.

Recommendations

1. Streamline and clarify the behavior management system.

2. Revise phase and level policies according to 2017 report recommendations, including a list of incentives and examples of positive behavior. Provide guidelines for decisionmakers and for residents on when levels can be taken away and specify how residents can earn back a level. The ability to earn time off a sentence is the most powerful incentive for inducing good behavior. In Maine, Long Creek has release

authority for committed youth and therefore should consider incorporating an element for earning time off for early release as well as adding time for certain egregious acts.

3. The level system that requires residents to gather information, fill out packets and present to adults is onerous, especially when after all is done, a resident still might not be approved to move up a level. The onerousness of this process is completely unbalanced with the ease that a resident can lose a hard-won level. Revisit the methods for moving up and down levels, perhaps making this a more fluid process, so that it is easier to obtain higher levels and more privileges.

4. Organize existing programs and practices that can be considered incentives and create a process to identify new and effective incentives.

5. Help staff to "catch kids doing something right" and to track it so that this information can be used in level determinations.

6. Clarify the grievance procedure and ensure that all residents and staff know who the Grievance Officer is. Ensure that grievances are taken seriously and responded to in a way that can be tracked. Track youth grievances and use this data to improve Long Creek policies and practices.

7. MDOC should clarify the policy on responses to disruptive behavior.

Major misconduct is behavior that creates a substantial threat to the youth or others or the security of the facility. Major misconduct continues to be a serious concern at the facility. Staff responses to major incidents highlight the issues related to a negative "perfect storm" at Long Creek: short staffing, lack of clarity around appropriate responses to disruptive behavior, and a willingness of agency leadership to use adult interventions like chemical restraints and lasers, and on rare occasions, the Special Operations Group (SOG), a corrections tactical team ready to respond to incidents at any MDOC facility, to respond to these types of incidents.

In 2017, the training director for CCG told the assessment team that CCG restraint training does not include retraining youth face down on their stomachs, because pressure on the back can cause asphyxiation, and that any restraint of a youth in that position would be contrary to training. In 2021 we learned that the CCG restraint training begins with staff standing on either side of a resident, then graduates to staff holding a resident against the wall while still allowing for mobility. Staff reported that, if these strategies do not work, the CCG restraint model does allow, as a last resort, for a "therapeutic" hold in prone position that does not allow for pain compliance. When using the therapeutic prone position, staff are taught to constantly talk to the resident, checking to make sure there is no pain or breathing restriction; and allowing the resident to move to the back, sitting or standing position as soon as possible. When the therapeutic prone position is used, it must be done with proper supervision and oversight. The 2017 assessment recommended that facility administrators and the CCG training director clarify the restraint training to explicitly prohibit restraint of youth in prone position with staff putting

pressure on the youth's back and monitor videos of restraint incidents to ensure that staff do not use such physical restraints.

As noted at the beginning of this report, the assessment team interviewed youth and staff and reviewed records of incidents during August and September, including videos of the incidents. Many staff are very patient with youth who are disruptive, trying to engage youth in conversation and working to verbally de-escalate the situation. Staff responses to major misconduct have changed over the years. Staff are willing to try verbal de-escalation but are unwilling to do more to intervene.

Staff gave several reasons for the change. First, several staff reported that current policy on acceptable interventions is unclear. They pointed to a Use of Force directive from October 9, 2020, which states: "When using physical force to effect an arrest, prevent escape from arrest, prevent escape from custody, apprehend an escapee, enforce the rules of a facility, or restrain and individual, or in self-defense or defense of a third person from what he or she reasonably believe to be the imminent use of unlawful nondeadly force, staff shall make *reasonable efforts* to not apply pressure to the neck, chest, and/or spinal area in such a manner as to inhibit the ability to breathe or inhibit blood flow to the brain" (italics added). The directive states that the reasonable efforts requirement "applies regardless of whether the situation is one in which staff may only use nondeadly force or is one in which staff may use deadly force *except… if the staff are taking any necessary actions to defend himself, herself, or a third person from what he or she believes to be the imminent use of unlawful deadly force*" (italics added).

The term "reasonable efforts" does not provide clarity. It is too elastic, and does not provide sufficient direction to staff. Staff should not use the prone restraint, period, and MDOC policy should say so. In this context, "reasonable efforts" provides as much leeway as "all deliberate speed." In addition, the exception is broad enough to swallow the rule. We can appreciate the effort of MDOC to clarify the rule involved, but it seems to exacerbate the problem rather than solve it. The fact that staff are still unclear on what MDOC policy means is a strong indication that the policy needs further clarification.

Staff stated that the directive from leadership is unclear and that they no longer know how to deal with an incident appropriately. Several staff were concerned that this lack of clarity could lead to losing their job, and noted that several staff were "walked out of the building" because of how they responded to major incidents. The circumstances around staff responses to incidents have left them feeling like the administration "cares more about the residents than they do the staff." Staff reported feeling that they "can't do anything with the kids… including putting them in their rooms," that "staff have a hard time defending themselves," and that "staff are under investigation for months at a time."

As one staff noted, "People tell staff they are doing the wrong thing, but they don't tell us what to do instead. What is the proper response… mass hysteria, using mechanical restraints? We don't want to use mechanical restraints [on kids], we want to use de-escalation techniques and our relationships with kids to keep things calm. Staff don't want to hurt the kids, and they don't want to get hurt either."

The 2017 report found that staffing issues contribute to problems with de-escalation. That assessment found that staff cutbacks and vacancies had hurt staff morale, leaving fewer staff available at the facility to work with youth and intervene before small issues became big confrontations. The assessment noted that mandatory double shifts left staff feeling exhausted and lacking in patience when youth acted out, and that staff turnover meant that some staff responsible for youth in the units had limited experience dealing with difficult adolescents.

These issues continue to plague Long Creek in 2021, and they continue to pose a challenge to implementing the de-escalation and restraint techniques with fidelity. These long-term issues were exacerbated by required changes to how staff engage with residents during the COVID pandemic. One staff member put it this way, "During COVID, staff lost their ability to create strong ties with kids. They could no longer eat with the kids or play basketball with kids. At the same time, Long Creek was moving more toward adult responses to poor behavior, and [the leadership had] poor messaging about what staff are supposed to do in event of an incident. The lack of relationships and unclear understanding of the tools staff are supposed to use to intervene in an incident created a vacuum. The adult system looks at the juvenile folks like they are crazy for wanting to use relationships to keep the facility calm. They believe that force is the best way to intervene during an incident. Staff don't want kids to be harmed or traumatized, they [staff] also don't like the idea of mechanical restraints."

Current staffing makes implementing CCG restraint strategies difficult to carry out with fidelity because they require direct supervision of staff to ensure safe restraint. Staff reported that, currently, Long Creek staffing does not allow for supervisors to provide direct supervision of line staff on the unit. Staff explained that a supervisor must be in the room with line staff to observe and coach them during an incident. They also explained that the supervisor plays a critical role in providing feedback to responding staff as they debrief what went well and what did not go well. Staff familiar with the training model also noted that the CCG restraint strategies cannot be modified to allow for fewer staff on the unit.

Prior to the incidents in August and September, the SOG team had not been called to Long Creek since 2014. There was consensus among staff we interviewed that the SOG team became involved in incident responses at Long Creek "because staff stopped responding." The SOG team is the adult facility incident response team. The members of the SOG team receive intensive paramilitary training. One Long Creek staff reported, "The SOG team is very aggressive with gas and other forms of force…. They overdo it." Long Creek staff familiar with SOG team practices noted that they did adjust the force interventions to "just tasers and OC spray" to limit the potential for residents to get hurt.

Long Creek staff noted that there is already access to OC Spray on the units at Long Creek. The spray is reportedly kept by the Juvenile Program Supervisor. It is available as part of a response, but requires the Commissioner's approval to use. Several staff noted that, although OC spray is available, they have not been trained to use it and do not have access to protective gear.

Residents reported that the SOG Team had used the prone position and that they had experienced and complained about not being able to breathe. After incidents using force such as prone position and OC spray, residents noted that they received limited medical attention. This was

also observed on video where medical staff would de-contaminate the resident and ask if he was okay, but did not physically examine him. Residents reported that, once sprayed and wiped down, they were not allowed to shower until the following day.

According to those we interviewed, the chain of command must approve activation of the SOG team. The process for approving SOG team activation and the travel involved for the team to arrive at Long Creek extends response time to an hour or more. As one Long Creek staff stated, "The SOG team is 20 minutes away from Long Creek. They are called when the staff and the FOS determine that they are needed. There's a lot of planning and logistics to contend with, making response time very long. The long response time affects everyone. Kids are in their rooms while the incident is happening, staff don't know what to do in the interim…some staff are afraid to restrain the kids or are afraid of doing anything that might hurt kids."

The Acting Superintendent at Long Creek does not plan to rely on the SOG team. She recognizes the multiple reasons not to use the SOG team for disturbances at Long Creek. The amount of time it takes to get approval and for them to arrive at Long Creek means that some incidents will be prolonged, waiting for the SOG team to arrive. Once they do arrive, there may be confusion about who has what authority. In one incident in August, staff received conflicting directions whether to use OC spray. Although SOG team members recently received training on de-escalation for juveniles, it is problematic to have team members use an "adult" level of force in some situations and a "juvenile" level of force in another. Also, at least as of the time of our on-site visit, the SOG team had not received training on other critical areas for working with youth in secure confinement, such as adolescent development, common mental health problems of adolescents, crisis intervention, and active listening. In addition, the use of a prison tactical team significantly undermines efforts to develop trust between youth and staff at Long Creek.

De-escalation strategies and proper restraint practices are critical to the operation of a safe facility. Crisis Consultation Group (CCG) provides de-escalation and restraint training for staff. CCLP's 2017 Long Creek Assessment found that this model would not be geared toward handling adolescents unless the training included more material about adolescent development and how that relates to de-escalation strategies. The 2017 assessment recommended that the training include more role-playing scenarios involving youth who may be attention-seeking, needy, hostile, and aggressive. The team also recommended that the training include competency testing with a specific focus on de-escalating confrontations. Additionally, the 2017 report found that de-escalation protocols do not include mental health clinicians who are trained to work with youth in crisis. The assessment recommended that Long Creek policies ensure mental health clinicians are involved in standoffs between youth and staff and confrontation situations while the incidents are going on, when intervention by the clinicians may help defuse the situation and the safety to the clinicians would not be threatened. Those recommendations have not been implemented.

Recommendations

1. Revise the MDOC October 2020 directive on use of force to clarify the language about what de-escalation techniques staff should use during a major incident. Be clear about the bigger picture regarding developing relationships with residents and utilizing clinicians

before moving to more invasive uses of force. Do not allow a "therapeutic" use of the prone restraint.

2. Do not use of the SOG team to respond to incidents. Develop new training for Long Creek staff or enhance existing training to equip staff to handle group disturbance situations.

3. Long Creek administration recently reported an intense focus on hiring more staff. If staffing continues to be an issue, consider temporarily consolidating detention and commitment populations so that more staff are available for one unit. It may also be appropriate to staff one small unit for residents who cannot be with the larger group of youth due to disciplinary issues.

4. Do not use OC spray at Long Creek.

5. Revise CCG training to include more information about adolescent development and how that relates to de-escalation strategies. The training should include more role-playing scenarios involving youth who may be attention-seeking, needy, hostile, and aggressive. It should also include competency testing on de-escalating confrontations.

6. In-person shift change is a best practice for well-run facilities. Work to build in time for an in-person shift change meeting, where departing staff can talk about what's happening on the unit, who is doing ok and who is not, so that the new shift staff knows how the previous shift went, and what they need to watch out for on their shift.

7. Clarify policy on when staff may use physical force, the type of physical force staff may use, and when staff may not use physical force. Provide training to all staff on the clarified policy.

8. Implement the recommendations in the 2017 Long Creek assessment.

8. Mental health clinicians should be directly involved in conflict situations from the beginning, and clinicians need to develop effective Intensive Behavior Management Plans.

Clinicians have an important role to play when youth in facilities get disruptive. Clinicians are trained and experienced in listening carefully, analyzing behaviors, remaining calm when others are upset, demonstrating empathy, and developing effective individualized behavior plans that extinguish problem behaviors and reinforce positive conduct. Clinicians can intervene at the beginning of a conflict, provide a neutral third-party presence during a time of staff-youth polarization, ask youth about the underlying reasons for the disturbance, and make recommendations for lowering the tension and addressing youth concerns without jeopardizing youth or staff safety. At Long Creek, during August and September, there were few clinicians working in the facility and the ones there were generally not engaged with youth during or immediately after the disturbances.

There was no shortage of stories of inadequate mental health care. One boy reported that he asked to go to the Special Management Unit to be alone because he hears voices. One boy had a neuro-psychiatric evaluation, but the therapeutic services he needs are not available at Long Creek. There were no Intensive Behavior Management Plan for the two residents who had been identified as ringleaders of the disturbances.

There have been shortages of mental health clinicians at Long Creek for some time. When the CCLP team visited the facility during the first week of October, the MDOC Regional Behavioral Health Director had been brought in the previous week because of the shortage of behavioral health clinicians working at the facility. One of the staff said that clinicians had not been involved in the incidents "because we haven't had any." In his memorandum to the Joint Standing Committee on Criminal Justice and Public Safety, dated October 21, 2021, MDOC Commissioner Randall Liberty reported that, as of that date, there was one psychiatrist position filled at .05 FTE (for medication management), one full-time Mental Health Director (the MDOC Regional Behavioral Health Director, who started at the end of September) and one full-time Behavioral Health Technician. There had been two other Behavioral Health Technicians in 2020, but those positions were eliminated when the population at Long Creek decreased significantly due to the pandemic.

To be effective, Intensive Behavior Management Plans must be very specific about the youth behaviors to be changed, the incentives the youth will receive for changing the behaviors, and the sanctions the youth will receive if he or she does not change. Research on adolescent behavior makes it clear that young people are much more likely to change their behavior in response to rewards than to punishments. The optimum ratio is four incentives for each sanction, i.e., youth should be rewarded for doing the right thing four times as often as they are punished for doing the wrong thing. An Intensive Behavior Management Plan that consists of a series of sanctions ("You will not…") will not be effective in changing youth behavior.

In our 2017 assessment of Long Creek, we said the following about IBMPs:

> As written, IBMPs at Long Creek are not effective behavior management plans. Effective behavior management plans outline a structure that encourages youth to develop and use new pro-social replacement behaviors in lieu of problematic behaviors. Skill building is at the core of effective plans, which accomplish this by rewarding the youth when he or she engages in the replacement behaviors. Plans must be written with objective and measurable terms so that staff and youth can assess progress toward achieving the stated goals.
>
> Long Creek's IBMPs focus overwhelmingly on punishing undesirable behavior, not encouraging youth to learn new behaviors. For over 70 years, behavioral psychological research has demonstrated that rewarding desired behavior is much more effective than simply punishing undesirable behavior. Youth must learn what to do, not just what not to do. Rewarded behaviors have a much greater likelihood of being repeated as opposed to behaviors that are not reinforced, which have a tendency to extinguish.

The Intensive Behavior Management Plans that were developed at Long Creek at the time of our visit were not effective. Clinicians and staff recognized this fact. One said, "We haven't had the bandwidth to have plans." Another said, "We haven't done IBMPs well."

The lack of effective IBMPs is of particular concern because we were told that the youth admitted to Long Creek now have greater needs and present more challenging behavior than in the past. As one staff said, there is "a smaller population, but each has more problems." Youth are reportedly more likely to be diagnosed with a conduct disorder, more likely to suffer from PTSD, more likely to be on psychoactive medications, more likely to have very high ACEs score (Adverse Childhood Experiences), and more likely to have longer records of prior offenses. Some youth reportedly have cognitive disabilities in terms of slower processing speeds for information, so that it is hard to get their attention during incidents. In such circumstances, the need for detailed IBMPs with specific and measurable goals is clear.

At the time of our on-site visit, the plan at Long Creek was to give each resident a mini-mental health evaluation, develop individualized treatment plans for each resident, and re-start therapeutic groups in the units. The CCLP team supports these plans, providing that the treatment plans are truly individualized and include positive incentives as well as sanctions.

Recommendations

1. Increase the number of mental health clinicians at Long Creek.

2. Engage mental health clinicians early in disturbances so they can use their skills to talk with residents, identify underlying issues, defuse volatile situations.

3. Develop IBMPs that focus on rewarding skill building and the development of positive pro-social behaviors, with objective and measurable goals and incremental rewards for youth who make progress toward those goals.

4. Implement plans to conduct mini-mental health evaluations on all residents, develop individualized treatment plans for all residents, and re-start therapeutic groups in the units.

9. External conditions such as inadequate mental health services in the community add to the difficulties.

The 2017 assessment of Long Creek noted that there were no secure psychiatric facilities in Maine where youth could go for treatment that is beyond the capacity of clinical staff at Long Creek, and psychiatric programs in the community do not accept or quickly eject youth who engage in violent behavior. The 2020 assessment of the juvenile justice system in Maine discussed this issue at length.

There is still no secure psychiatric facility in Maine and psychiatric programs in the community still don't want youth who engage in violent behavior. The Acting Superintendent at Long Creek advised the CCLP team that seven youth at Long Creek could be released if there was a secure psychiatric facility or appropriate mental health programs and services were available in the community.

Recommendations

1. Develop a secure psychiatric facility in Maine that can treat youth who cannot be treated adequately in Long Creek.

2. In contracts with mental health providers in the community, require that providers take youth with histories of acting out.

10. The process for Critical Incident Review should be expanded.

The CCLP team also looked at the MDOC Critical Incident Review procedure. Critical Incident Reviews were conducted by MDOC after each of the disturbances. The review teams for the incidents varied but generally consisted of high-level administrators from MDOC, wardens and/or deputy wardens from other MDOC facilities, the director of the MDOC Special Operations Group (SOG), the MDOC ACA Manager (who manages the audits of MDOC facilities by the American Corrections Association and other entities), the superintendent or acting superintendent of Long Creek, Long Creek operations and security directors, and other MDOC and Long Creek personnel.

The review teams appropriately included the agency officials and facility administrators with the experience to view the disturbances in context and the authority to make necessary changes to policy and practice. One group generally not included in the reviews was mental health clinicians. As noted above, clinicians can and should play critical roles in such incidents. They can also provide valuable observations and insights in incident reviews.

One problem with the incident reports by facility staff, and the Critical Incident Reviews, is that they do not contain any information about what was going on before the incident started. The incident reports begin with a description of who threw the first punch or began the property damage. There is no setting of context: what were the youth doing before the disturbance, where were staff, what activities had the youth engaged in during the day, was the unit short-staffed?

Sometimes incidents are the end point of a process rather than the beginning. A youth may start a disturbance by lashing out after receiving bad news during the day, such as a judge refusing to release the youth from detention or a serious illness in the family. Some incidents may be planned by youth, such as an assault for a previous insult or an effort to establish a power structure among the youth. Some incidents are part of a rolling pattern of misbehavior by a small group of instigators. This kind of information is important to understanding fully why the incident occurred and to developing an intervention that will prevent additional incidents.

Long Creek staff are not trained to include what happened prior to the incident in their incident reports, and the Critical Incident Reviews did not include that information.

In addition, there is no information in the Critical Incident Review about the incident from the youth's point of view. What do the residents involved in the incident say about how and why it started? How does the residents' description of the events differ from staff reports on the events? How do both compare with the video of the incident? Has anyone asked the residents involved why they created this disturbance? Has any clinician talked with them? Do these residents have histories of disturbances or assaults in Long Creek? If so, were they on behavioral management plans? Did any of the residents have identified mental health issues? What medications were they on, if any? What did staff know about these residents?

The Critical Incident Reviews generally frame findings and recommendations in terms of incident command, need for additional training, equipment needs, and suggested policy changes. It is worthwhile to review these issues, but there is a danger that by focusing on these details the review misses the big picture. As discussed earlier, the big problems at Long Creek involve grinding boredom for youth and staffing shortages. Those issues are not mentioned in the Critical Incident Reviews, and following the recommendations that are in the Critical Incident Reviews will not solve or even address those problems.

Looking at broader issues, the Critical Incident Reviews do not question standard MDOC responses to disturbances, which include donning of protective gear, use of chemical restraints (pepper spray), and, on rare occasions, intervention by the Special Operations Group. These responses may or may not be appropriate in state prisons, but they are inappropriate, counterproductive, and dangerous in youth facilities.

CCLP's assessment of Long Creek in 2017 made it clear that chemical restraints are dangerous and counterproductive in youth facilities. The effects of chemical agents on children have never been studied. Therefore, there is no information to determine whether a single or repeated exposure may have long-term consequences for young people's health. The effects of chemical agents are exacerbated in confined spaces with poor ventilation. Staff who use chemical agents may not know which youth in their care are likely to have dangerous and potentially deadly reactions to chemical agents because of pre-existing conditions such as asthma. Moreover, when staff charged with caring for youth spray them with painful and harmful chemicals, they undercut the juvenile justice system's goal of rehabilitating youth, and instead lead youth to feel anger and distrust toward adults, especially facility staff. The use of chemical agents is outside of the mainstream of juvenile justice policy in this country, and few juvenile facilities use them. Use of chemical agent also subjects MDOC to potential liability for civil rights violations. State agencies responsible for juvenile justice in Texas and Wisconsin have been sued successfully for using chemical agents. Litigation has been brought in California over the issue of chemical restraints being used on behavior that is a manifestation of mental illness or developmental disabilities.

In one of the incidents at Long Creek, some staff wanted to use chemical agents even though they had not been trained on the use of such agents and did not have protective gear to wear. Some urged use of a chemical "fogger," which is particularly dangerous because it guarantees

that the chemicals will spread and adversely affect many residents and staff who were not involved in the incident.

As noted above, MDOC has called in the Special Operations Group on a very limited number of occasions and is not planning to use the SOG in the future.

There is a larger point here: if staff know they can rely on chemical restraints or calling on the SOG when youth cause conflict, staff will be much less likely to use their own training on de-escalation and similar strategies. Eventually the most restrictive interventions – what is supposed to be the "last choice" – becomes the first choice. This is of particular concern for staff on the last hours of a 12-hour shift, and all staff on double shifts, who are likely to lose patience due to fatigue. By failing to question the use of chemical restraints and other interventions in disturbances at Long Creek, the Critical Incident Review teams perpetuate the reliance on dangerous and counterproductive interventions.

Finally, the Critical Incident Reviews contain understatements, which is unfortunate. The review of one incident says that video review "revealed that staff may have used unauthorized control techniques during this use of force." In fact, the video shows clear violations of Long Creek policy regarding chokeholds and prone restraints. Another report states that the loss of multiple behavioral health staff and the use of per diem clinicians is "less than ideal." These understatements minimize the severity of the concerns and help to avoid addressing the serious underlying problems.

Recommendations

1. Ensure that incident reports and Critical Incident Reviews include information about what happened before the disturbance began, to identify underlying issues in the conflict.

2. Include information from the youth's point of view in Critical Incident Reports.

3. Do not limit Critical Incident Review findings and recommendations to incident command, need for additional training, equipment needs, and suggested policy changes. Determine whether broader changes are needed in facility operations.

4. Do not accept donning of protective gear, use of chemical or electrical restraints (OC spray and tasers), and intervention by the SOG team, even on rare occasions, as appropriate responses to disturbances by residents at Long Creek. Ban the use of OC spray and tasers at Long Creek. Do not engage the SOG team to intervene in disturbances at the facility, even on rare occasions.

5. Do not use understatements in Critical Incident Reviews. When there are violations of DOC or facility policy by staff, say so. Hold staff accountable for violating such policies.

CONCLUSION

The Acting Superintendent and her colleagues have made a number of important changes to Long Creek since our on-site visit. Many of the changes are in line with the discussion of these issues that we had with the Acting Superintendent and her staff during the closeout session on October 6 and the recommendations in this report. They have provided refresher training on CCG (the de-escalation technique), report writing, and use of force. They have trained the SOG on the de-escalation technique. They have revamped their staff recruiting and retention efforts, including opening an Indeed account. On November 8, five new staff began their training at the Academy. Other new staff are shadowing experienced staff and will subsequently do training at the Academy. The shift commander during two of the incidents no longer works for DOC. Volunteers have begun returning to the facility, bringing structured activities. There is bingo or another structured activity on Wednesday evenings. There are movie nights on weekends. At noon there is Noon Ball and crossfit. They have moved the Bears Den to a different room and added a punching bag. There was a Halloween celebration at the facility. There have been changes in work shifts. They have increased the number of hours that clinicians are available for youth. During waking hours, youth are generally not in the pods and are engaged in activities in the dayrooms. There are at least two staff on each unit, with an additional staff in the unit with the most challenging youth. Program managers and administrative staff are out of their offices and walking around the facility so that they have direct contact with residents and unit staff. The Deputy Commissioner of DOC and the Acting Superintendent review all requests for detention. They have reduced the daily population in the facility to the mid-20s. The Acting Superintendent says that "no idea is off the table" for reform at the facility.

These are very encouraging efforts. Hopefully this report will provide additional ideas for further reforms that will make group disturbances a thing of the past at Long Creek. The Department of Corrections can go a long way toward ensuring that by developing or agreeing to monitoring of these issues on a regular basis, with the results made available to the Legislature, the Executive Branch, and the public.