THE STATE OF SOLITARY:

RESTRICTIVE HOUSING AND TREATMENT OF INCARCERATED DELAWAREANS WITH MENTAL ILLNESS

COMMUNITY LEGAL AID SOCIETY, INC.

DISABILITIES LAW PROGRAM

SEPTEMBER 2024

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EXECUTIVE SUMMARY

The Disabilities Law Program (DLP) of Community Legal Aid Society, Inc. (CLASI) serves as Delaware's Protection and Advocacy (P&A) system, charged with protecting the legal rights of people with physical and mental disabilities. Under federal law, P&A systems have the authority to conduct monitoring and investigative activities in a variety of settings where people with disabilities live and receive services, including correctional facilities.

Conditions in correctional facilities are of great concern to CLASI and to other P&A systems around the country, due to the overrepresentation of people with disabilities, including mental illness, in correctional settings. Research also suggests that the experience of incarceration, and of segregation or solitary confinement in particular, can cause mental health problems and also exacerbate existing mental illness.

History of CLASI's Interventions on Behalf of Incarcerated People with Mental Illness Held in Solitary Confinement

In 2013, CLASI and the ACLU of Delaware became troubled by reports they were receiving about the placement of individuals with serious mental illness in solitary confinement, meaning that they were confined to cells for at least 22 hours per day, often for extended periods of time. After investigation, in 2015 CLASI, the ACLU, and Pepper Hamilton LLP filed a federal lawsuit, *CLASI v. Coupe*, against the Delaware Department of Correction (DDOC), which detailed concerns about the treatment of individuals with mental illness placed in restrictive housing environments, including solitary confinement. These concerns included minimal out-of-cell time, lack of access to mental health treatment, and conditions for individuals placed on suicide watch.

The parties settled the suit in 2016, and DDOC agreed to make several changes related to the use of restrictive housing. These included: increased mental health staffing; minimum requirements for out-of-cell time; establishing that individuals could not be placed in disciplinary detention for more than 15 consecutive days; requiring a break of at least 15 days between disciplinary detention sanctions; and that no individual classified as seriously mentally ill could be placed in disciplinary detention for any period of time unless they presented an immediate danger and there was no reasonable alternative.

The terms of the settlement were effective for five years and concluded in 2021. While the settlement was in effect, CLASI monitored DDOC's progress by reviewing data, meeting regularly with DDOC leadership, and conducting on-site facility visits with an expert monitor.

CLASI's Recent Monitoring of Correctional Facilities and Treatment of Individuals with Mental Illness

In the spring of 2023, CLASI retained two experts to assist its staff in conducting updated monitoring, in order to assess current conditions at DDOC facilities with a specific focus on restrictive housing units, including designated mental health units and units housing individuals in disciplinary detention.

CLASI's monitoring found areas where DDOC appeared to remain in compliance with the policy changes agreed to as part of the *CLASI v. Coupe* settlement. It also found areas where additional progress had been made, particularly in the implementation of Residential Treatment Units (RTUs) for individuals with mental illness at two facilities.

However, the monitoring also identified several major areas of concern. These areas included: suicide

prevention practices, the need to expand RTUs, the continuum of mental health services and crisis intervention practices, substance abuse treatment protocols, and the use of punitive point and classification systems and privilege sanctions as "backdoor" methods to restrict and isolate incarcerated individuals, now that more traditional disciplinary detention practices, such as solitary confinement, have been reformed.

CLASI is particularly concerned with the need for increased transparency and data sharing to enable it to effectively assess current conditions and carry out its obligations as the P&A. During the monitoring process, DDOC unfortunately denied many of CLASI's requests for more specific data and information, which made it difficult to assess how DDOC's current practices compare with those reported while the *CLASI v. Coupe* settlement was in effect. There is a particular need for more transparency with respect to DDOC's practices surrounding the use of points-based classification, privilege restrictions, and administrative segregation.

CLASI urges DDOC to review the findings and specific recommendations in this report, summarized below, to ensure that incarcerated Delawareans with mental illness are treated fairly and humanely. We also urge DDOC to increase transparency by collecting and making available data regarding the length of restrictions, use of point-based classification, privilege restrictions, and administrative segregation in its facilities.

2023 MONITORING: KEY FINDINGS AND RECOMMENDATIONS

1. Overhaul Psychiatric Close Observation and Suicide Prevention Practices

Individuals are placed on Psychiatric Close Observation (PCO) status when they are assessed to be at risk for suicide or self-injury, and are placed in suicide precaution cells where they are monitored by staff. CLASI's monitoring found problems with PCO practices, including individuals in PCO status being placed in inappropriate medical infirmary settings, and PCO status being unnecessarily punitive and restrictive.

PCO Status in Medical Infirmary Settings

The report notes that placing individuals who are in mental health crisis and on PCO status in the same area as medical infirmary patients can compromise their treatment. For example, infirmary cells do not generally allow for regular out-of-cell contact with mental health staff. DDOC should:

- Ensure adequate care for people on PCO status, by not intermingling their cells with those of medical infirmary patients; instead there should be a separate set of cells for mental health watch or PCO;
- Ensure that PCO cells in proximity to the medical infirmary have space for out-of-cell encounters with mental health staff.

PCO Is Unnecessarily Punitive and Restrictive

Currently, individuals on PCO status are placed in locked isolation cells, which can exacerbate symptoms and make clinical engagement extremely challenging. The practice of removing clothing, leaving the individual naked except for a suicide smock, is another barrier to mental health care. DDOC should:

- Provide individuals on PCO status with confidential clinical encounters outside of their cells;
- Give individuals on PCO status access to recreation and group therapy, programming, and video visitation;

- Consider creating dorm settings for individuals on PCO status, so they don't face locked cell isolation just for having a mental health crisis;
- Transfer individuals into and out of PCO status based on clinical decisions and ensure that any patient placed on PCO status as the result of an on-call or remote encounter is seen in a face-to-face encounter within 6 hours.

2. Expand the Use of Residential Treatment Units

Two of the correctional facilities monitored had a separate Residential Treatment Unit (RTU) with mental health staff, services, and programming for individuals requiring that level of care for a mental health condition, while two did not. The experts found that the RTUs had many strengths as therapeutic housing areas, and recommended they be expanded. DDOC should:

- Create at least one RTU in each facility, with a priority placed on opening adequate RTUs to allow for some clinical specialization and reduction of inter-facility transfers;
- Collect and track data on fights, uses of force, medication compliance, self-harm, and other basic metrics across facilities as more RTUs are implemented, and make the data publicly available;
- Provide dedicated nursing staff to each RTU, given the high medical acuity of patients with serious mental illness.

3. Improve the Continuum of Mental Health Services and Crisis Intervention Processes

The report finds that more mental health services of variable intensity must be available to individuals across settings within the correctional facilities. For example, there is a sharp drop-off in mental health services after leaving an RTU. A continuum of care must be developed; because there is no intermediate level of care, such as an intensive outpatient model, individuals who leave the RTU can quickly deteriorate, and either end up back in the RTU or in disciplinary detention because of behaviors. DDOC should:

- Ensure that each facility has at least one RTU area;
- Provide on-site programs in step-down units, including group therapy;
- Develop an intensive outpatient model of care that can identify and support patients who are able to live in general population settings, but who require additional support and more frequent care;
- Enable patients in all settings to speak with a mental health professional during a mental health crisis, at any time.

4. Reform Substance Abuse Treatment Practices

The report finds that individuals on medications for an opiate use disorder (MOUD) are not consistently getting treatment when they go through intake. DDOC policies on MOUD from 2023 do not reflect basic clinical standards of care, by time-limiting access to buprenorphine to the first six months of incarceration. Naloxone should be distributed in housing areas and discharge planning units and not stored away from where incarcerated people are likely to be, and staff need to be better educated on its use. DDOC should:

- Screen all individuals currently in DDOC custody and all new arrivals for a substance use disorder;
- Offer evidence-based care including medications for opiate use disorders;

- Consider placing intranasal naloxone in all housing areas with direct access by incarcerated people and placing intranasal naloxone in all discharge planning kits.

5. End the Use of Punitive Point and Classification Systems, Privilege Sanctions, and Administrative Segregation as Backdoor Methods to Restrict and Isolate Incarcerated People

The monitoring revealed a number of concerns related to punitive disciplinary practices. While DDOC policies still reflect limits on the imposition of discipline agreed to as part of the *CLASI v. Coupe* settlement —e.g., that placement in disciplinary detention cannot exceed 15 days at one time and stays in disciplinary detention must be separated by a minimum of 15 days—DDOC appears to be using a point system, lengthy privilege restrictions, and administrative segregation as "backdoor" methods to subject individuals to more restrictions outside of the confines of traditional disciplinary detention, and for longer periods of time. DDOC should:

- Evaluate the overall time individuals are spending in any type of maximum or restricted custody level, including disciplinary detention and administrative segregation;
- Analyze sanction data over time to assess whether frequency and duration of privilege restrictions have increased since changes in policy to limit the use of disciplinary detention;
- Create additional due process safeguards for the placement of individuals in administrative segregation.

6. Increase Activities in Restrictive Housing

Programming and group activities appeared to be very limited in many of the restrictive units. Group activities benefit individuals by reducing isolation, and aid correctional professionals in assessing individuals' behavior and interpersonal interactions. Certain programming can also help reduce the likelihood of incarcerated people re-offending. DDOC should:

- Develop a plan to bring more programming and opportunities to restricted housing units;
- Create paths for people to work their way out of restricted housing units sooner.

7. Replace Outdated Inhumane Practices Affecting Wellbeing

The monitors noted that DDOC persists in utilizing interventions that are no longer generally accepted in correctional settings across the country. This includes the use of large, aggressive dogs for security, which is an archaic and inhumane practice, especially for individuals in mental health crisis. DDOC policy also authorizes use of "loaf" meals (ground up food put into a loaf shape) for disruptive behavior. This practice is not favored or used in many other states. DDOC should:

- End the use of security dogs and instead develop a service animal training program for incarcerated people;
- End the use of "loaf" meals for disruptive behavior and use alternatives to feed people who misuse food and related items.

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I. INTRODUCTION

A. The Role of the Protection & Advocacy System

The Disabilities Law Program (DLP) of Community Legal Aid Society, Inc. (CLASI) serves as the Protection and Advocacy (P&A) system for people with disabilities in Delaware. Each state has an organization designated by its governor to act as the P&A. The P&A system was created by federal legislation in the 1970's following public outcry in response to the appalling conditions that were reported in many institutional settings around the country.[1] P&A systems can conduct monitoring and investigative activities in a wide variety of settings where people with disabilities live and receive services including hospitals, group homes, day centers, schools, and correctional facilities. P&A systems are equipped with the legal authority to conduct monitoring at facilities and programs serving people with disabilities as well as to investigate allegations of abuse or neglect in these settings.

Conditions in correctional facilities are of great concern to P&A systems around the country due to the overrepresentation of people with disabilities in carceral settings. According to the Prison Policy Initiative, approximately 40% of people in state prisons nationwide have a disability, compared with 15% of the general population.[2] Similarly it is estimated that the prevalence of mental illness among incarcerated populations is significantly greater than what is present in the community at large, sometimes as much as 12 times greater.[3] Research has also suggested that the experience of incarceration, and of segregation or solitary confinement in particular, can both cause mental health problems and exacerbate existing mental illness.[4]

B. Solitary Confinement in Delaware and the *CLASI v. Coupe* Settlement

Around 2013, CLASI and the ACLU of Delaware became concerned about reports both organizations were receiving related to the placement of individuals with serious mental illness in solitary confinement[5] and the conditions of their confinement. CLASI and the ACLU further investigated these concerns by corresponding with and interviewing incarcerated individuals, reviewing their individual

[1] Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. § 10801. Protection and Advocacy for Individuals with Developmental Disabilities Act, 42 U.S.C. § 15041.

[2] https://www.prisonpolicy.org/reports/chronicpunishment.html.

[3] https://psychiatry.weill.cornell.edu/research-institutes/dewitt-wallace-institute-psychiatry/issues-mental-health-policy/fact-sheet-0.

[4] https://www.prisonpolicy.org/blog/2021/05/13/mentalhealthimpacts/; https://www.psychiatry.org/news-room/apa-blogs/decriminalizing-mental-illness; https://www.nami.org/Blogs/NAMI-Blog/March-2023/How-Solitary-Confinement-Contributes-to-the-Mental-Health-Crisis.

[5] According to the United States Department of Justice, "solitary confinement" or "isolation" means "the state of being confined to one's cell for approximately 22 hours per day or more, alone or with other prisoners, that limits contact with others."

medical records, and consulting with a correctional mental health expert.

This culminated in the filing of a lawsuit in federal court against the Delaware Department of Correction (DDOC), *CLASI v. Coupe*, on August 6, 2015. CLASI was the named plaintiff in this action, suing on behalf of incarcerated individuals with mental illness who had been subject to solitary confinement practices. CLASI's complaint detailed a variety of concerns about the treatment of people with mental illness placed in restrictive housing environments, which included minimal out-of-cell time, lack of access to mental health treatment, and the conditions for individuals placed on suicide watch, which the complaint alleged violated the Eighth Amendment of the United States Constitution.

The parties ultimately reached an agreement to settle the case, which was approved by the District Court on September 1, 2016. To resolve the pending litigation, DDOC agreed to make several changes related to the use of restrictive housing and conditions of confinement. Highlights of this agreement included:

- Implementation of a roster system for tracking individuals with identified behavioral health needs;
- The creation of a Special Needs Unit (SNU) at Baylor Women's Correctional Institution;
- The creation of a Residential Treatment Unit (RTU) at James T. Vaughn Correctional Center;
- Increased mental health staffing;
- Minimum requirements for out-of-cell time for all individuals in restrictive housing;
    - In non-disciplinary restrictive housing:
        - Individuals classified as not mentally ill (NMI) were to receive 17.5 hours of unstructured recreation per week;
        - Individuals classified as mentally ill (MI), as well as individuals classified as seriously mentally ill (SMI) outside of the RTU, were to receive 17.5 hours of unstructured recreation per week plus additional out-of-cell time for structured therapeutic activities as required by the person's individualized mental health treatment plan;
        - Individuals classified as SMI requiring an RTU level of care were to receive 10 hours of structured out-of-cell therapeutic activity and 10 hours of unstructured out-of-cell recreation per week irrespective of their housing unit or security level.
    - In disciplinary detention:
        - Individuals not classified as SMI were to receive at least five hours of unstructured recreation per week.
- Creation of a tracking system for out-of-cell time;
- Establishing that no discipline for a Class 1 violation may be imposed on an individual on the mental health roster without prior consideration of how the individual's mental health issues may have contributed to the behavior and considering the input of a qualified mental health professional;

- Establishing that no individual may serve a disciplinary sanction more than 15 consecutive days in disciplinary detention for any single rule violation, or any series of related rule violations, and requiring a break of at least 15 days between disciplinary detention sanctions;
- Establishing that no individual classified as SMI would be placed in disciplinary detention for any period of time unless the inmate presents an immediate danger and there is no reasonable alternative;
- Revision of DDOC policies to allow for individuals placed on Psychiatric Close Observation (PCO) to have access to reading and writing materials with clinician approval;
- Revision of DDOC policies to ensure female individuals placed on PCO have access to menstrual products and that all individuals have access to toilet paper, absent documented safety or security concerns.

DDOC additionally affirmed its commitment to complying with several existing policies and practices, including but not limited to the completion of mental health evaluations within 72 hours of placement in restrictive housing, the provision of mental health care in accordance with a mental health treatment plan, and providing voluntary evidence-based correspondence programming based on individual needs.

The terms of the settlement were effective for five years and terminated on September 1, 2021. While the settlement was in effect, CLASI monitored DDOC's progress by reviewing data, through regular correspondence and meetings with DDOC leadership, and by conducting on-site facility visits with a monitor in 2018 and 2019.

II. INTRODUCTION OF EXPERTS AND SCOPE OF REVIEW

A. Methods

In the spring of 2023, in order to assess current conditions in DDOC Level V facilities, CLASI retained two highly qualified experts, Dan Pacholke and Dr. Homer Venters, to assist CLASI staff in conducting monitoring visits.[6]

Dan Pacholke

Mr. Pacholke has thirty-five years of experience, related training, and related education in the field of adult institutional corrections, including eight years in administration in the Washington State Department of Corrections (WADOC), including as Secretary, Deputy Secretary, Director of Prisons, and Deputy Director of Prisons, as well as more than twenty years in the following corrections positions: Correctional Officer (2.5 years); Lieutenant (3 years); Captain (6 years); Superintendent (5 years); Chief of Emergency Operations (7 years); Director of Performance Management (4 years). He has performed

[6] CLASI wishes to acknowledge the ACLU of Delaware's assistance in providing financial support to retain these two outstanding experts to accompany CLASI staff on their monitoring visits and provide their observations and recommendations, which are incorporated in this report.

consulting and expert work in over twenty states and six jurisdictions outside of the continental United States.

As a Correctional Sergeant and Captain, he directly managed segregation units and was responsible for the security management of a maximum, close, and medium security facility. Later, as a Superintendent and Deputy Director, he was responsible for the overall administration of multiple correctional facilities, including all matters of safety and security.

He led efforts to reform the system-wide use of long-term segregation in Washington state, resulting in an over fifty percent decrease in the number of people housed in this setting, while also lowering system-wide violence for eight consecutive years. This reform is described in more detail in a U.S. Department of Justice policy paper co-authored by Mr. Pacholke, *More than Emptying Beds: A Systems Approach to Segregation Reform*.

Mr. Pacholke has published several other articles related to corrections and segregation, including prison safety, restricted housing reform, crisis management, and innovative programs. Following his retirement from WADOC, as a consultant with New York University, he also served as co-director of Segregation Solutions, an initiative that assisted correctional agencies with reducing the use of segregation while also maintaining or improving safety in prison facilities. He is currently a consultant for the U.S. Department of Justice Civil Rights Division advising in its investigations of two state correctional agencies.

Dr. Homer Venters

Dr. Venters is a physician, internist, and epidemiologist with over a decade of experience in providing, improving, and leading health services for incarcerated people. His clinical training includes residence training in internal medicine at Albert Einstein/Montefiore Medical Center (2007) and a fellowship in public health research at the New York University School of Medicine (2009).

His experience in correctional health includes two years during that fellowship visiting detention centers and conducting analyses of physical and mental health policies and procedures for persons detained by the U.S. Department of Homeland Security. He was the Deputy Medical Director of the NYC Jail Correctional Health Service, which included both direct care to persons held in NYC's twelve jails, as well as oversight of medical policies for their care. This role included oversight of chronic care, sick call, specialty referral, and emergency care.

He subsequently was promoted to the positions of Medical Director, Assistant Commissioner, and Chief Medical Officer at NYC Jail Correctional Health Service. In the latter two roles, he was responsible for all aspects of health services including physical and mental health, addiction, quality improvement, re-entry and morbidity and mortality reviews, as well as the training and oversight of physicians, nursing, and pharmacy staff. In these roles, he was also responsible for evaluating and making recommendations on the need for specialized housing units, staffing, and care for vulnerable patients, including those with chronic health problems and those with physical and behavioral health disabilities.

Dr. Venters currently works as a court-appointed monitor regarding health services in jail and prison settings. He is also a consulting expert with the U.S. Department of Justice, Civil Rights Division, and several state Attorneys General regarding health care in jail settings.

With Mr. Pacholke and Dr. Venters, CLASI conducted on-site monitoring visits at all four Level V correctional facilities in Delaware: Baylor Women's, Howard R. Young, and Sussex Correctional Institutions, and James T. Vaughn Correctional Center. There was a specific focus on restrictive housing units, including designated mental health units and units housing individuals in disciplinary detention. These visits occurred between May 16 and 19, 2023. During the course of these visits, in addition to touring specific buildings and housing units, the CLASI team spoke with both DDOC personnel and incarcerated individuals. Additionally, the CLASI team reviewed DDOC policies and individual medical records.

B. Barriers

While a P&A system has the right to "reasonable unaccompanied access" to facilities and individuals, from a practical standpoint it is not possible to have totally unaccompanied access to a correctional facility. This meant not all of the conversations CLASI and our retained experts had with individuals on-site were able to happen in a totally confidential setting. When possible, however, we requested the opportunity to meet privately with individuals instead of or in addition to speaking with them cell-side.

Additionally, DDOC denied many of our requests for more specific data and information, which made it difficult to assess how DDOC's current practices compare with what was reported while the *CLASI v. Coupe* settlement was in effect. For this reason, the conclusions we reached after monitoring are firmer in some areas than in others.

C. Acronyms

The following acronyms will be used in this report:

BWCI – Baylor Women's Correctional Institution
CRU – Classification Review Unit
DDOC – Delaware Department of Correction
HRYCI – Howard R. Young Correctional Institution
JTVCC – James T. Vaughn Correctional Center
PCO – Psychiatric Close Observation
RTU – Residential Treatment Unit
SCI – Sussex Correctional Institution
SHU – Security Housing Unit
SMI – Seriously Mentally Ill

III. FINDINGS AND RECOMMENDATIONS

Our findings, informed by the two experts, can be broken down into observations and recommendations for mental health treatment and for disciplinary procedures, in the following seven areas:

- A. Psychiatric Close Observation Practices
- B. Status of Residential Treatment Units
- C. Continuum of Mental Health Services and Crisis Intervention Processes
- D. Substance Abuse Treatment Practices
- E. Use of Point and Classification Systems and Privilege Sanctions to Restrict and Isolate Incarcerated People
- F. Activities in Restrictive Housing
- G. Other Concerns

A. Psychiatric Close Observation Practices

CLASI is particularly interested in the quality of mental health services for incarcerated people, across settings. Deep concern for the welfare of people subjected to lengthy stays in solitary confinement and restricted settings is what motivated the earlier *CLASI v. Coupe* litigation.

With this in mind, we asked our experts to evaluate Psychiatric Close Observation (PCO), sometimes called suicide watch or prevention practices. Individuals who are threatening self-harm are quickly placed in PCO cells. On our visits, Mr. Pacholke, Dr. Venters, and CLASI staff observed PCO and PCO spaces, and interviewed individuals who had experienced PCO.

A PCO cell at James T. Vaughn Correctional Center

Individuals are placed on PCO when they are assessed to be at risk for suicide or self-injury. While on PCO, the individual is placed in a locked suicide precaution cell where they are monitored by staff. The individual can only have approved items in their cell with them, including a suicide blanket, a mattress, Styrofoam dishes, and an approved eating utensil.

The level of monitoring and whether individuals are able to wear their regular DDOC-issued uniforms while on PCO depends on PCO Tier status, which is based on the assessed level of risk for self-harm. Individuals placed on PCO Tier I, who are assessed to present a more acute risk of suicide, are under constant observation by staff and are only permitted to wear a suicide smock. Individuals placed on

PCO Tier II are observed regularly at intervals not to exceed fifteen minutes and may be permitted to wear their DDOC-issued uniform while on PCO. Clinical staff have the discretion to allow an individual on PCO, regardless of Tier, to have access to reading and writing materials in their cell.[7]

The general conclusion based on our observation is that Psychiatric Close Observation (PCO) or suicide prevention practices need to be overhauled and more nuanced. There were two distinct areas of concern: first, the placement, at times, of people on PCO status in medical infirmary settings, and second, the punitive nature of PCO status.

- **Medical Infirmary Settings and PCO Status**

Having PCO cells located in infirmaries tends to create chaos for everyone, including staff. Consequently, PCO cells should not be intermingled with medical infirmary cells, staff, or patients. Intermingling can also compromise medical treatment. Dr. Venters noted that at Sussex Correctional Institution (SCI), new arrests are initially processed through the infirmary and monitored for intoxication withdrawal; introducing people in acute mental health crisis to the same space could well compromise the ability to monitor either type of patient.

PCO cells in infirmaries do not generally allow for regular out-of-cell contact with mental health staff as there may not be places within the infirmary that are readily available for such contact to occur in a confidential manner. This practice does not allow for confidential interactions with mental health staff. It is not conducive to effective treatment.

- **Recommendations:**
  - In order to ensure adequate care for people on PCO status, the cells they are held in should not be intermingled with those of medical infirmary patients unless there is a need for medical and mental health monitoring. To the extent possible, the facility should have a separate set of cells for mental health watch or PCO, even when these are nearby or connected to the housing area for medical infirmary housing and care.
  - Any space utilized for PCO status in proximity to the medical infirmary should have adequate space for out-of-cell encounters for mental health encounters and tracking of the frequency of these encounters occurring out of cell (as opposed to at the cell side) should occur for individual patients as well as in the aggregate.

- **Punitive and Restrictive Nature of PCO Status**

Both of our experts also expressed concern that the approach to PCO status across settings is unnecessarily restrictive and is counterproductive. Expert monitor Dr. Homer Venters observed: "Whether inside a medical infirmary, an RTU [Residential Treatment Unit] unit or other mental health housing area, the DDOC takes an approach to suicide watch that is punitive, isolating and limits clinical engagement when patients are in crisis."

No units have suicide watch dorm areas on site, requiring all patients to be placed in locked isolation

[7] Further details of DDOC's PCO procedures can be found in DDOC Policy 11-B-05. As noted below, a facility warden or designee may override a clinical determination to allow an individual access to reading and writing materials while on PCO.

> **THE DDOC TAKES AN APPROACH TO SUICIDE WATCH THAT IS PUNITIVE, ISOLATING AND LIMITS CLINICAL ENGAGEMENT WHEN PATIENTS ARE IN CRISIS.**
>
> **-DR. HOMER VENTERS**

cells either located within a housing unit or in the infirmary. This practice can exacerbate symptoms and makes clinical engagement extremely challenging. The removal of clothing, leaving the individual naked except for a suicide smock, is degrading and a barrier to mental health care.

One individual interviewed by Dr. Venters indicated that the experiences in PCO were so humiliating that he stopped reporting being in crisis and learned to "play the game" while on PCO, meaning to tell mental health staff what they wanted to hear so that he would be removed from the PCO cell. Individuals reported that almost all encounters with mental health staff while on PCO were through locked doors. Staff confirmed that this was common practice. SCI does not have any space even available near PCO cells for out-of-cell encounters. At Baylor Women's Correctional Institution (BWCI), there is dedicated space on the disciplinary unit but not at the infirmary.

Isolating individuals in crisis is not therapeutic. One expert noted that a facility warden can override a clinician's decision to allow individuals on PCO to have reading materials. They also noted a lack of ability to communicate with family or participate in group activities. These restrictions inhibit a person's progress toward stability, and do not mirror interventions that are used in inpatient settings. Several individuals reported that they were placed in PCO isolation as a punitive measure after challenging the authority of correctional officers. This is, of course, entirely inappropriate.

Dr. Venters noted that "[i]t is [also] important to recognize the intersection between suicide and substance use withdrawal and other experiences that increase pain and suffering, including periods of high heat and use of solitary confinement as a punishment or for 'administrative' reasons. These extrinsic factors can increase the likelihood of suicide or self-harm."

- **Recommendations:**
  - Patients on PCO status should have confidential clinical encounters outside of their cells unless there is a clinical determination that this is not possible.
  - Each encounter should record whether the encounter was cell-side or in a confidential setting outside the cell, and the frequency of these two types of encounters should be tracked for each individual patient as well as in the aggregate by facility.

- Patients on PCO status should receive recreation and access to group therapy, programming, and video visitation unless clinically contra-indicated.
- Dorm settings for PCO status should be considered so that patients are not faced with locked cell isolation for having a mental health crisis.
- Transfer of patients into and out of PCO status should occur based on clinical decisions, and any patient placed onto PCO status as the result of an on-call or remote encounter should be seen in a face-to-face encounter within 6 hours.
- Examples of these and other innovations in suicide prevention and care for people in mental health crisis include the Washington and California Departments of Correction and the Ventura Sheriff's Department.

Door of locked PCO cell at James T. Vaughn Correctional Center

B. Status of Residential Treatment Units

Two facilities, James T. Vaughn Correctional Center (JTVCC) and Baylor Women's Correctional Institution (BWCI), had a separate Residential Treatment Unit (RTU) for individuals requiring that level of care for a mental health condition. Sussex Correctional Institution (SCI) and Howard R. Young Correctional Institution (HRYCI) do not have Residential Treatment Units; HRYCI has a dedicated mental health unit called the "Transitional Unit," which does not have all of the same programming and staffing elements as the RTU level of care. While the incarcerated individuals and staff interviewed during monitoring indicated that mental health services were readily available in the RTU, our monitors noted a precipitous decline in the mental health services available outside of these units.

Dr. Venters noted that the RTU exhibited many strengths as a therapeutic housing area. "Creating a therapeutic setting like the RTU is an evidence-based approach to increasing medication compliance and reducing use of force and other security-related problems," he observed. "It is also a more effective way to prepare people for returning home, by increasing out of cell time, group activities and engagement with care. The RTU model is an important development in DDOC, and ample evidence has been published in other settings showing increased medication compliance, reduction in violence and other clinical and security improvements."[8]

> **CREATING A THERAPEUTIC SETTING LIKE THE RTU IS AN EVIDENCE-BASED APPROACH TO INCREASING MEDICATION COMPLIANCE AND REDUCING USE OF FORCE AND OTHER SECURITY-RELATED PROBLEMS. IT IS ALSO A MORE EFFECTIVE WAY TO PREPARE PEOPLE FOR RETURNING HOME...**
>
> **-DR. HOMER VENTERS**

The RTU at JTVCC has dedicated mental health and security staff. Group therapy and activities and a day room and a gym are provided on site. Both patients and staff reported that the ability for people to have paid jobs, which was made possible fairly recently, was an extremely positive development.[9] The physical space is well-designed. People who were interviewed reported consistent access to medications, better response to sick call requests, and a generally safer environment. Dr. Venters noted that the presence of staff nursing was critical to the unit's success.

An area of concern is the extensive use of lock-in for individuals in the orientation unit of the RTU. Dr. Venters also noted that some incarcerated individuals expressed concern about the lack of coordination between mental health staff and medical staff for individuals with serious medical conditions. Dr. Venters further noted that the RTU at BWCI does not have dedicated nurses.

Both monitors were generally impressed with the environment in the RTU at BWCI, which offers more activities, and makes them available even to individuals who are on restrictions. There appeared to be more supportive, treatment-oriented groups available as well as well-trained staff. BWCI also offers

[8] https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201900405

[9] The placement of the RTU at JTVCC on the maximum security side of the facility has unfortunately made the RTU more restrictive than it needs to, or should, be. Employment opportunities were not available for several years because of these security obstacles.

meaningful vocational activities including CNA training. BWCI should be considered a model. Staff at HRYCI indicated that most of the patients on the Transitional Unit in that facility could benefit from an RTU setting.

Hallway at Howard R. Young Correctional Institution

- **Recommendations:**
  - There is a clear need to broaden the footprint of the RTU in the DDOC, both to provide the ability for some specialization between the RTUs and also to allow for each facility to have the capacity to provide high-level care.
  - Each DDOC facility should have at least one RTU unit, with a priority placed on opening adequate RTUs to allow for some clinical specialization and reduction of inter-facility transfers.
  - Data on fights, uses of force, medication compliance, self-harm, and other basic metrics should be tracked across facilities and the DDOC as more RTUs are implemented and this data should be made publicly available.
  - Each RTU requires dedicated nursing staff given the high medical acuity of patients with serious mental illness. Generally, at least one half of a nursing full-time equivalent (FTE) is required per housing area.

C. Continuum of Mental Health Services and Crisis Intervention Processes

More mental health services of variable intensity need to be made available to individuals across settings within the prisons. At JTVCC, the sharp drop-off in mental health services between the RTU and any other area, including general population or the Security Housing Unit (SHU), which is the maximum security housing area, means people stay at the RTU longer, or in the SHU longer. DDOC should develop an intensive outpatient approach, which will help prevent cycling in and out of the RTU and allow people with mental health disorders to succeed in general population settings.

Many people interviewed during monitoring reported fear and anger at the prospect of leaving the RTU and reported deliberately acting out in order to stay in the RTU or get placed back in the RTU, because of the lack of mental health supports in the general population setting. According to Dr. Venters, this acting out "paradoxically led to new infractions and being placed in punitive segregation."

The lack of more intensive mental health services clearly directs some people with mental illness into the punitive SHU units. However, our experts reported that mental health services on the SHU were minimal and also not confidential. One person reported to Dr. Venters that, when he was having a family-related crisis, he was told the only option to get treatment was to indicate he was suicidal and go to a PCO cell. In comparing the RTU and the SHU, an incarcerated person stated: "If you aren't in the RTU, your mental health care is finished." Correspondence from incarcerated individuals and interviews at SCI indicated similar issues relating to the accessibility and confidentiality of mental health services in the Classification Review Unit (CRU).

Incarcerated individuals also reported lengthy delays in sick call response. In general, the practice of requiring use of sick call prior to filing grievances discourages complaints about mental health and medical care, and suppresses important information that DDOC should want to know. Dr. Venters observed: "The grievance system at DDOC appears designed to limit and silence very credible reports of problems with care and treatment among a vulnerable cohort."

> **"IF YOU AREN'T IN THE RTU, YOUR MENTAL HEALTH CARE IS FINISHED."**
>
> **-INCARCERATED PERSON DURING MONITORING**

The step-down unit observed at JTVCC, T2, appeared to offer limited on-site support and activities. Dr. Venters also noted that such a step-down unit did not appear to exist in other settings. Mr. Pacholke noted that the SHU buildings at JTVCC appeared to provide very little programming or groups, specific to mental health or otherwise, and very limited opportunity to socialize at all. Several incarcerated people reported that available programming had long waiting lists and younger individuals were prioritized for participation. Many people housed in the SHU reported participation in correspondence programming. The CRU at SCI did not appear to offer many programs or groups.

What is required is a continuum of care. Because there is no intermediate level of care, such as an intensive outpatient model, individuals who leave the RTU can quickly deteriorate, and either end up back at RTU or in the SHU because of behaviors. Dr. Venters suggested the following:

Location	General Population	General Population	Transitional	RTU	Hospital
Care Level	None or outpatient	Intensive outpatient	Intensive outpatient plus housing area supports	Therapeutic setting required	Inpatient

More attention also needs to be paid to de-escalating individuals by providing crisis intervention in order to avoid the need to seclude or restrict them. DDOC appears to lack mental health crisis response outside of the RTU, other than placement on PCO. Dr. Venters noted that many systems in other states offer other interventions such as face-to-face encounters during off-hours or a video or phone call with a mental health provider. He observed: "While some patients may benefit from a suicide watch, there are many patients who simply experience a crisis that would benefit from speaking with a mental health clinician and engaging around their acute issues."

The lack of crisis response throughout the system leads to unnecessary confinement in PCO status, arguably putting individuals at greater risk of transfer to the SHU and exacerbating rather than de-escalating their crises. In review of individual medical records, Dr. Venters noted cycles of self-harm and PCO placement that could be avoided by providing more options for acute crisis intervention.

- **Recommendations:**
  - Each facility should have at least one RTU area, with exploration of clinical specialization as multiple units are opened.
  - The stepdown units like T2 should have on-site programs including group therapy and the ability to serve as true step-down units rather than long-term housing areas. It may be that both are needed: some stable long-term housing that is sub-acute, as well as step-down for patients leaving the RTU.

- An intensive outpatient model of care should be developed so that patients who can live in general population settings but who require additional support and more frequent care are identified and reviewed via case conferencing.[10] Part of this approach would involve creating a care designation in the electronic medical records for intensive outpatient treatment, and estimation of additional mental health staffing and escort staff (and potentially space for encounters) would be required.

- Patients in all DDOC settings should have the capacity to speak with a mental health professional during a mental health crisis, at any time. This process should be dedicated and should be included in the handbook and basic orientation for all newly arrived people, whether they are on the mental health service or not. A range of crisis response options can be considered, from dedicated crisis response teams to mental health crisis lines.[11]

D. Substance Abuse Treatment Practices

Expert monitor Dr. Venters reported that, based on records and interviews, individuals on medications for opiate use disorder (MOUD) are not consistently getting treatment when they go through intake. He noted that updated DDOC policies on MOUD from 2023 do not reflect basic clinical standards of care, by time-limiting access to buprenorphine to the first six months of incarceration.

Dr. Venters observed: "This preferential offering of one form of MOUD throughout the period of incarceration while another is time-limited ignores basic clinical standards of care that a patient who meets criteria for treatment should have access to treatment whenever they come to the attention of health staff. This approach is likely to have a disproportionately negative impact on people with serious mental illness, who may enter DDOC and require months of intensive psychiatric and mental health support and services before the diagnosis or treatment readiness for MOUD is apparent. In addition, it is my experience that limiting or denying access to MOUD is an important contributor to illicit drug use and overdose because patients seek relief of symptoms and treatment on their own."

> **"THIS PREFERENTIAL OFFERING OF ONE FORM OF MOUD...IGNORES BASIC CLINICAL STANDARDS OF CARE...[AND] IS LIKELY TO HAVE A DISPROPORTIONATELY NEGATIVE IMPACT ON PEOPLE WITH SERIOUS MENTAL ILLNESS."**
>
> **-DR. HOMER VENTERS**

[10] https://www.ncbi.nlm.nih.gov/books/NBK64083/; https://store.samhsa.gov/sites/default/files/pep20-02-01-021.pdf; https://www.maine.gov/corrections/behavioralhealth; and https://www.ncbi.nlm.nih.gov/books/NBK64102/.

[11] https://nicic.gov/resources/nic-library/all-library-items/crisis-intervention-teams-frontline-response-mental-illness; https://journals.sagepub.com/doi/full/10.1177/0093854820942274; and https://www.maine.gov/corrections/behavioralhealth.

Dr. Venters also suggested that naloxone be distributed in housing areas and discharge planning units and not stored away from where incarcerated people are likely to be. Correctional officers mistakenly believe that naloxone is dangerous to handle; better education of staff regarding the safety of naloxone and its life-saving benefits should be undertaken.

- **Recommendations:**
  - Ensure every person currently in DDOC custody and newly arrived has been screened for substance use disorder, ensure evidence-based care is offered to anyone who meets clinical criteria, including medications for opiate use disorder. Track and report the numbers and percentage of people identified with substance use disorder and those offered and receiving evidence-based treatment.[12]
  - Consider placement of intranasal naloxone in all housing areas with direct access by incarcerated people.[13] Also consider placement of intranasal naloxone in all discharge planning kits.[14]

E. Use of Punitive Point and Classification Systems and Privilege Sanctions to Restrict and Isolate Incarcerated People

There is always a concern that corrections systems responding to the end of traditional solitary confinement practices will develop informal ways of restricting incarcerated people. As Mr. Pacholke observed: "Systems seem to compensate, for lack of a better word, by increasing and extending loss of what are called privileges but should be considered critically important human needs: things to occupy your mind and connection to family and loved ones."

Our monitors uncovered a number of concerns related to punitive disciplinary practices.[15] DDOC policies still reflect the limits on the imposition of discipline agreed to as part of the *CLASI v. Coupe* settlement, namely that placement in disciplinary detention cannot exceed 15 days at one time, that stays in disciplinary detention must be separated by a minimum of 15 days, and that before sanctions can be imposed on individuals classified as Seriously Mentally Ill (SMI) their mental illness must be taken into account. However, DDOC appears to be using a point system, lengthy privilege restrictions, and administrative segregation to subject individuals to more restriction outside of the confines of disciplinary detention for longer periods of time.

[12] https://cchcs.ca.gov/wp-content/uploads/sites/60/MAT-in-United-States-Jails-and-Prisons-Final.pdf.

[13] https://www.courier-journal.com/restricted/?return=https%3A%2F%2Fwww.courier-journal.com%2Fstory%2Fnews%2Flocal%2F2023%2F09%2F19%2Fjailed-people-saved-24-lives-in-louisville-facility-using-narcan%2F70900358007%2F and https://lasd.org/sheriffs-naloxone-custody-pilot-project-saves-inmates-from-overdose/.

[14] https://www.multco.us/multnomah-county/news/overdose-reversal-drug-be-offered-upon-jail-release-beginning-june-1 and https://www.whas11.com/article/news/local/louisville-metro-corrections-drug-overdose-free-narcan-vending-machine-jail/417-b2f9a767-4b3f-4ca7-9d04-21975ab195cf.

[15] As noted in the introduction, DDOC was not cooperative in sharing documents and data that might shed more light on these restrictions. We strongly encourage DDOC to be more transparent regarding data about restrictive settings, including the nature and length of restrictions.

First, DDOC appears to be using a points-based system to keep individuals at more restrictive levels for longer periods. Many individuals who were interviewed in restrictive housing specifically identified "points" as their barrier to leaving restrictive housing. Mr. Pacholke expressed concern that the point system could be used to override other policy directives related to placement in restrictive housing. Although policy requires a multidisciplinary team to review the status of any individual in non-disciplinary restrictive housing every 90 days, it did not appear the individuals we spoke with were aware of such reviews taking place. Several of them reported not being reviewed for less restrictive settings for over a year.

Many individuals our monitors spoke to expressed that they didn't feel there was anything they could do to get bumped down. However, as Mr. Pacholke observed, "[t]he goal should be to continually push towards getting prisoners into lower security levels where they have more opportunities and will be better prepared for release."

> **"SYSTEMS SEEM TO COMPENSATE...BY INCREASING AND EXTENDING LOSS OF WHAT ARE CALLED PRIVILEGES BUT SHOULD BE CONSIDERED CRITICALLY IMPORTANT HUMAN NEEDS: THINGS TO OCCUPY YOUR MIND AND CONNECTION TO FAMILY AND LOVED ONES."**
>
> **-DAN PACHOLKE**

Mr. Pacholke also expressed concern that DDOC may be using privilege restrictions as disciplinary sanctions for long periods of time, even in restrictive housing units such as SHU buildings where individuals already have fewer privileges and very limited options for programming or activities. He spoke with individuals who reported losing all privileges for periods as long as 90 days at a time.

These "privileges" are often basic human needs, such as communicating with family. DDOC should only impose a restriction on communication with family if the infraction relates to that privilege. Mr. Pacholke also observed that many units did not offer access to reading materials or that access to reading materials or materials for correspondence were being denied for disciplinary reasons, which is contrary to policy.

Finally, Mr. Pacholke expressed concern about use of administrative segregation, which is imposed using a vague standard and which is not reviewed with any due process to the incarcerated person.

Per DDOC policy, "administrative status" (AS) is a non-programmatic transfer to higher security level and may be ordered immediately by a watch commander or higher authority upon determination that "the offender's presence in the general population poses a threat to life, property, self, staff, other offenders, or to the safety/security or orderly operation of the facility." Specific evidence or justification does not appear to be required; a qualifying reason simply needs to be selected on a form.

Any individual on AS for longer than 7 days is reviewed through Prioritized Classification by the Institutional Release Classification Board (IRCB). The decisions of the IRCB can be vetoed by the warden, BOP chief or Commissioner. Their decisions are not appealable. Other reclassification meetings by the Initial Classification Board and Multidisciplinary Team require that an individual be interviewed, that records be reviewed, and that staff are available to assist the person in the process. The IRCB process that reviews placements in AS does not provide these protections.

Cell in Security Housing Unit (SHU) at James T. Vaughn Correctional Center

The vague standards for when this status can be imposed and the lack of due process create potential for abuse. Instead, Mr. Pacholke recommended that "DDOC should create additional due process safeguards to ensure that people being held on administrative status have a meaningful opportunity for review and the ability to appeal this placement. Wardens should be required to articulate a legitimate, clear, and imminent threat to safety or security instead of simply checking a box."

- **Recommendations:**
  - Evaluate the overall time people are spending in any type of maximum or restricted custody level, including disciplinary detention and administrative segregation.
  - Analyze sanction data over time to assess whether the frequency and duration of privilege restrictions has increased since changes in policy to limit the use of disciplinary detention.
  - Create additional due process safeguards for the placement of individuals on administrative segregation.

Segregation cell at Howard R. Young Correctional Institution

F. Lack of Activity in Restrictive Housing

As noted above, programming and group activities appeared to be very limited on the SHU units at JTVCC as well as in the CRU at SCI.

Additionally, we observed that the newly renovated program space in the maximum security area at JTVCC did not appear to be in full use while we were on-site. We saw several new classrooms that appeared to be well-equipped and well-maintained, however only one class was taking place while we were present in the building. The program building is a resource at JTVCC that could be more effectively utilized.

Mr. Pacholke indicated that, in his experience, congregate activities benefit individuals by reducing isolation, and also aid correctional professionals in assessing the individual's behavior and their ability and limitations in interacting with other people. He also pointed out that programming can help address underlying criminogenic needs that may relate to an individual's likelihood of re-offending.

- **Recommendations:**
  - Develop a plan to bring more programming and opportunities to the SHU and other restricted housing units that lack activity.
  - Create paths for people to work their way out of restricted housing units sooner.

G. Other Concerns

Monitors noted that DDOC persists in utilizing interventions that are no longer generally used in correctional settings across the country. This includes the use of large dogs for security, which is archaic and inhumane. Using a large and aggressive animal, particularly around shackled individuals who would have no ability to defend themselves, is cruel. It is suggested that DDOC develop a service animal training program for incarcerated people instead.

DDOC policy also authorizes use of "loaf" meals, or ground up food put into a loaf shape (known as "Alternative Meal Plan" or AMP) for disruptive behavior. The policy does not allow use of AMP for disciplinary reasons; however, providing it for "disruptions" is intuitively punitive in nature. This practice is not favored or used in many states, including Pennsylvania. There are other alternatives to feed individuals who are misusing food or related items.

As Mr. Pacholke observed: "Taking food and grinding it into something that doesn't resemble food serves no purpose other than to communicate that a person is less than human. DDOC should either end this practice all together or change the language in their AMP policy to significantly narrow when it can be used."

While most individuals who were directly asked reported being offered hours of out-of-cell time that met or exceeded the terms of the previous settlement agreement, we were not provided with the data required to assess the provision of out-of-cell time and unstructured recreation more globally.

Dr. Venters also noted concerns that DDOC's grievance process may not be fully accessible to people with disabilities, including intellectual disabilities or serious mental illness, and that language in existing policy may be insufficient to ensure that people with disabilities will be provided assistance to submit a grievance when necessary.

Finally, the experts observed extremely unclean shower facilities at HRYCI. On one day of our visit to JTVCC, they observed a lot of food-related trash and waste in the RTU. Monitors observed, and incarcerated individuals confirmed, that many individuals with physical disabilities appeared to be housed on the same unit at HRYCI, reportedly due to that unit having accessible shower facilities, and that access to programming on this unit was minimal.

IV. CONCLUSION

In conclusion, while CLASI's monitoring in 2023 found areas where DDOC appeared to remain in compliance with the policy changes previously agreed to as part of the *CLASI v. Coupe* settlement, and where additional progress had been made since the settlement, it also identified areas where further reforms are needed.

With respect to mental health treatment, CLASI urges DDOC to modify its suicide prevention practices to be less punitive and isolating to individuals in crisis and to bolster the continuum of mental health care available outside of the RTUs at JTVCC and BWCI.

With respect to security and discipline, CLASI encourages further transparency on the part of DDOC regarding their practices surrounding points-based classification, privilege restrictions, and the use of administrative segregation. CLASI also encourages DDOC to create pathways for individuals to work their way out of restrictive housing settings sooner.

CLASI encourages the DDOC to review the findings and specific recommendations in this report, to ensure that incarcerated Delawareans with mental illness are treated fairly and humanely, and calls on DDOC to increase transparency by collecting and making available data regarding the length of restrictions, use of point-based classification, privilege restrictions, and administrative segregation in its facilities.