DISABILITY RIGHTS MAINE

September 2, 2021

SENT BY EMAIL ONLY
Randall.Liberty@maine.gov

Commissioner Randall A. Liberty
Maine Department of Corrections
State House Station 111
Augusta, Maine 04333-0111

Re: Urgent Safety Concerns at Long Creek Youth Development Center

Dear Commissioner Liberty:

As you know, Disability Rights Maine conducts monthly visits to Long Creek Youth Development Center pursuant to our authority as Maine's protection and advocacy agency for people with disabilities. During our most recent visit, youth shared concerns about restraints that occurred during an incident on the Cedar unit on August 2, 2021. In addition, we subsequently learned there was another significant incident, also involving multiple restraints, that took place on August 30, 2021.

While we may decide to conduct a complete investigation of these incidents, and we request that you ensure that all records and information related to these incidents are preserved, we are writing today because, based on conversations with youth about the August 2 incident, and the additional information we have obtained, we have urgent concerns about the health and safety of youth at Long Creek. As outlined below, we are calling on the Department of Corrections (DOC) to take immediate action to ensure the safety of youth at the facility.

As you know, in September 2017, the Center for Children's Law and Policy (CCLP) conducted a conditions assessment of Long Creek Youth Development Center. To provide some context for our concerns, we highlight the following findings and recommendations from the Conditions Assessment Narrative Report, which is included with this letter.

1) The Conditions Assessment found that there was a lack of clarity in the restraint training and noted that staff were using prone restraint even though the training director told the assessment team that prone restraints were contrary to training due to the risk of serious injury or death.[1] And the Conditions Assessment recommended that the training be clarified to explicitly prohibit prone restraint.[2]

2) The Conditions Assessment found that there was not enough training on crisis prevention and verbal de-escalation techniques, noting that this was particularly important given the significant trauma histories and mental health needs of the youth at Long Creek.[3] Additional pre-service and in-service training was recommended.[4] The Conditions Assessment also found that training was needed regarding working with youth with mental health needs and disabilities.[5]

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[1] "There is a lack of clarity in the restraint training. Crisis Consultant Group (CCG) provides de-escalation and restraint training for staff. After the closeout meeting at the end of the on-site visit, ***the training director for CCG told the assessment team that staff are not trained to restrain 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***. Yet multiple videos showed staff restraining youth in that position."(p.57)(emphasis added).

[2] **"Recommendation**: For facility administrators and 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." (p. 57)(emphasis added)

[3] "Long Creek's training curriculum does not offer enough training on crisis intervention and verbal de-escalation techniques. The facility's current curriculum includes content on these topics, but staff would benefit from additional and more specific training on the particular challenges that adolescents may present for staff in a secure facility. Given the significant trauma and mental health histories of youth at Long Creek, staff need more skills training on verbal de-escalation and crisis intervention, including practice and role playing using actual scenarios." (p. 43).

[4] "**Recommendation**: Provide additional pre-service and in-service training on the use of conflict management and verbal de-escalation strategies with youth. Adopt additional training with a focus on non-physical interventions for adolescents, such as Safe Crisis Management". (p. 43)

[5] "There is inadequate staff training on handling youth with mental health problems and disabilities. For many youth at the facility, their disruptive behavior is a manifestation of their mental health problems and disabilities. (p. 56); "**Recommendation**: For administrators and training coordinator, provide staff with training on handling youth with mental health problems and disabilities, including how disruptive behavior may be a manifestation of mental disorders." (p. 57); "De-escalation training should include more material about adolescent development and how that relates to de-escalation efforts. It should include more role-playing with scenarios involving youth who may be attention-seeking, needy, hostile,

3) The Conditions Assessment found that the facility was failing to use clinical staff to support youth in crisis or to de-escalate a crisis.[6] And it was recommended that mental health clinicians be "involved in standoffs between youth and staff and confrontations while the incidents are going on and that they spend more time on units, like Cedar, which houses youth with the most significant mental health needs."[7]

4) The Conditions Assessment noted that the heavy protective gear should be removed from the facility.[8]

5) Finally, the Conditions Assessment found that policies around room confinement were not being consistently implemented and recommended that the facility ensure that any unit or facility lockdowns last no longer than the time actually necessary for staff to gain control of a situation.[9] In addition, the Conditions Assessment recommended that any

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and aggressive. The training should also have additional competency testing specifically focusing on deescalating confrontations." (p. 56-57)

[6] "By policy, staff do not contact mental health clinicians at the facility to intervene directly in confrontation situations, even though the clinicians are trained to work with youth in crisis. The clinicians generally only get involved during reviews of the incidents. The rationale for this is that engaging the clinicians directly would positively reinforce youth who are acting out to obtain one-on-one meetings with the clinicians. It is true that many youth told the assessment team that they wanted more one-on-one time with clinicians, and that they have manipulatively told staff that they want to harm themselves in order to get to see clinicians. But the rationale seems to mix up priorities in the facility. The purpose of having clinicians at the facility is to provide mental health services to youth who need them. In many situations the assessment team reviewed, clinicians could have intervened effectively as third parties in standoffs between youth and staff." (p. 56)

[7] "**Recommendation**: 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 of the clinicians would not be threatened." (p. 57); "Recommendation: Have mental health clinicians spend more time in units like Cedar, which house youth with the most serious mental health disorders and youth who are most likely to cause disruptions." (p. 57)

[8] "Heavy protective gear is inappropriate in a juvenile facility. It makes staff look like a riot squad." (p. 59); "**Recommendation:** Remove leather cuffs, zip ties, and heavy protective gear from the facility." (p. 60).

[9] The policy is fully consistent with the JDAI standards. However, it is not being consistently implemented. Some youth are clearly being locked in rooms long past the time it takes for them to regain control. For youth who do regain control, such extended room confinement is punitive. The small number of youth who continue to act out over a long period of time should be transferred to a psychiatric facility or other mental health program that is equipped to handle them. (p. 66); "**Recommendation:** Ensure that

room confinement be limited to four hours and recommended the closure of the Special Management Unit.[10]

Based on the information we have gathered about the incident on August 2, as well as the preliminary information we have obtained about the August 30 incident, we have concerns that, four years after the Conditions Assessment, insufficient progress has been made to address these areas of concern.

In reviewing information obtained about the August 2 incident, it is clear that Long Creek staff continue to engage in dangerous restraint practices, including the apparently routine use of prone restraint. In the span of an hour, six youth on the Cedar unit were subjected to prone restraints, as outlined below.

- *Youth #1*: When a youth damaged a phone, then tried to evade staff, a restraint was initiated by grabbing him from behind before he was placed in the prone position for over 8 minutes.

- *Youth #2*: Restraint was initiated on a youth using an arm around the neck from behind and the youth was placed in a prone restraint with two staff applying pressure to his back. After the youth was handcuffed, three staff appeared to apply pressure to the back, head and legs. The prone position and pressure to the back appeared to continue for several minutes after ankle restraints were applied. In all, the youth was restrained in the prone position for over 28 minutes, and for at least 8 of these minutes, it appeared pressure was applied to the youth's back.

- *Youth #3*: Restraint was initiated by two staff, one using a forearm chokehold and another grabbed the youth from behind. Again, the youth was placed in the prone position. Even after the youth was handcuffed, staff were applying pressure to his back and legs. Staff then repositioned to continue applying pressure with their arms instead of a knee. In all,

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unit lockdowns and facility lockdowns last no longer than actually necessary for staff to gain control of the situation." (p. 66)

[10] **"Recommendation:** Limit the use of room confinement to four hours. At the end of four hours, release the youth to a living unit, transfer the youth to a psychiatric hospital or other mental health program that is equipped to handle the youth, or provide continuous 1-on-1 supervision by staff with hourly visits by mental health clinicians." (p. 66); "**Recommendation:** Reduce the use of the Special Management Unit and close it completely within six months." (p. 66).

this youth was restrained in the prone position for over 20 minutes. And during at least 3 of these minutes, it appears pressure was being applied to the youth's back.

- *Youth #4*: Restraint was initiated by two staff by grabbing the arms of the youth and the youth was then placed in a prone position. At one point, staff used a knee to the upper back/neck of the youth, forcing the youth's head to the ground with the shin. The youth was in a prone restraint for approximately 18 minutes, and for over a minute, while prone and handcuffed, pressure was apparently applied to the youth's back.

- *Youth #5*: Restraint was initiated by two staff and the youth was moved quickly into the prone position. Handcuffs were applied followed by ankle restraints several minutes later. The youth was restrained in the prone position for almost 10 minutes and, for almost this entire time, a staff member was apparently applying pressure by kneeling on his lower back.

- *Youth #6*: A youth had blocked his door with a mattress, potentially in an effort to keep water from the broken sprinkler system out of his cell, and when the door was opened by staff he stumbled out and staff initiated a restraint by grabbing his arm. Two staff rushed in to assist, including one who wrapped his arms around the youth, lifted him off the floor, and took him to the ground with such force that both the staff and the youth appeared to bounce from the impact. The youth was then put in a prone position for several minutes until he was handcuffed and escorted out of the room.

Prone restraints are inherently dangerous and potentially deadly.[11] Long Creek has been on notice since at least 2017 that these practices should be eliminated at the facility. And at that

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[11] See: Haeberle, A. B. (2020, November 19), "*Since 2010, at least 107 have died from prone restraint despite police departments being warned 25 years ago"*, available at: https://www.10tv.com/article/news/investigations/10-investigates/at-least-107-people-have-died-since-2010-due-to-prone-restraints/530-3363bf95-d125-4960-b714-c6f5d328266e (Following the death a 28-year-old man held in a county jail who was subject to a 22 minute prone restraint, an investigation into the nationwide fatality rate for prone restraints revealed that between 2010-2020, at least 100 people died from prone restraint in the custody of law enforcement.); Equip for Equality, "NATIONAL REVIEW OF RESTRAINT RELATED DEATHS OF CHILDREN AND ADULTS WITH DISABILITIES: The Lethal Consequences of Restraint" (2011) available at: https://www.equipforequality.org/wp-content/uploads/2014/04/National-Review-of-Restraint-Related-Deaths-of-Adults-and-Children-with-Disabilities-The-Lethal-Consequences-of-Restraint.pdf ("Of the 69 dangerous practices identified, 54% involved a person lying facedown in a prone position, which is associated with increased risk of asphyxia and aspiration; 51% involved a person lying face-up in the supine position without the person's head being elevated, which is associated with increased risk of asphyxia, fatal cardiac arrhythmia or respiratory arrest and 44% involved staff exerting pressure to the person's neck or torso, creating a high risk of fatality.") See also: *SECLUSIONS AND RESTRAINTS, Selected Cases of Death and Abuse at Public and Private Schools and Treatment Centers* (2009), United States Government Accountability Office, p. 8,

time, the training coordinator made clear that prone restraints were contrary to training due to the dangers associated with these restraints. Despite this, not only do staff continue to use prone restraints, but they appear to be the go to option. This is unacceptable.

In addition to the dangerous restraint techniques used, the information we have obtained about the August 2 incident raises significant concerns regarding staff training. With regard to restraints detailed in #2-5, which occurred at essentially the same time, there was no indication that clinicians were involved before or during the incident, as recommended by the Conditions Assessment, to try and help deescalate the situation. In addition, the manner in which staff prepared to engage the youth and then proceeded to engage the youth appears to have been informed by the same training deficiencies identified in the Conditions Assessment. There were minimal observable attempts to deescalate the situation. In fact, on information and belief, staff decided, while waiting outside the door before entering the room, which of the four youth they would be responsible for restraining. And while it seems clear the youth were not complying with staff instructions, they were not physically aggressing toward staff. Instead, staff appeared to move, all at once, to manage the youth physically, which escalated the situation and increased the danger to both youth and staff.

While we have much less information about the August 30 incident, the information we have obtained is equally troubling (many restraints; riot gear; inability to deescalate the situation without force; facility wide lock downs; etc.). And it calls to mind the reports coming out of the facility in 2017 that gave rise to the Conditions Assessment. To the extent progress was made to improve the conditions for youth at Long Creek, it appears to have been lost.

We are asking DOC to take immediate action to address these safety concerns, including but not limited to the following steps:

1. DOC should clearly communicate to all staff and contractors at Long Creek that prone restraints are prohibited. Appropriate and sufficient training should be provided to ensure that this practice is eliminated. And, as recommended by the Conditions Assessment, supervisory staff should review all incidents to ensure that staff have actually ended the

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available at: https://www.gao.gov/products/gao-09-719t ("**Death from Face Down Restraints or Restraints that Block the Airway**: Of the hundreds of allegations we identified, at least 20 involved restraints that resulted in death. Of the 10 closed cases we examined, 4 involved children who died as a result of being restrained. In all 4 cases, staff members used restraint techniques that restricted the flow of air to the child's lungs. In one of these cases, an aide sat on top of a child to prevent him from being disruptive and ultimately smothered him. The other cases related to the use of different types of prone restraints, a technique that typically involves one or more staff members holding a child face down on the floor").

use of this dangerous practice. As outlined above, the types of restraints that occurred on August 2 are the types of restraints most likely to lead to serious injury or death. Urgent action is needed.

2. DOC should engage Mark Soler and the Center for Children's Law and Policy (CCLP) to support Long Creek administration in addressing the concerns outlined in this letter, all of which are tied to the recommendations made in the 2017 Conditions Assessment. It appears there is an immediate need for staff training that is aligned with the recommendations from September 2017.[12]

3. In addition to the above, we request that DOC ask CCLP to conduct an updated conditions assessment, to include an independent review of the incidents that took place on August 2 and August 30. Following this assessment, CCLP should be engaged to provide technical support to DOC in developing a plan to address any concerns identified, including those that remain from the 2017 Conditions Assessment.

We understand that DOC is engaged in system reform efforts at this time. We are hopeful those efforts will lead to the eventual closure of Long Creek and the provision of more individualized and appropriate services to support youth in their homes and communities. But while that work proceeds, DOC cannot ignore its responsibilities to keep youth at Long Creek safe, which includes ensuring they have access to appropriate clinical supports and are not subjected to dangerous restraints or other inappropriate interventions due to inadequate training and support for staff. Please ensure that the staff at Long Creek receives the expert consultation and support they need to meet the needs of youth without engaging in these dangerous and harmful practices.

Due to the nature of these concerns, and the need to ensure they are addressed quickly, we are providing a copy of this letter to the other two co-chairs of the Maine Juvenile Justice System Assessment Task Force. We will also forward this letter to the attorneys assigned to do post-disposition work at Long Creek, and to Chris Northrop at the Cumberland Legal Aid Clinic.

I am willing to speak with you or Associate Commissioner O'Neill or Superintendent Raymond about this letter at any time. Please feel free to email areilly@drme.org or call 207.626.2774 x220. Thank you for your attention to these concerns.

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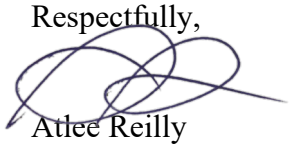
[12] We understand that Mark Soler remains involved in some ongoing work in Maine related to the Juvenile Justice Systems Assessment, so we are hopeful that he and his team at CCLP can provide some support within the facility on an emergent basis. But if he and his team cannot provide this training and support, they will certainly know people who can.

Respectfully,



Atlee Reilly
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Encl. - Long Creek Conditions Assessment (September 2017)

CC: Colin O'Neill, Associate Commissioner, Department of Corrections
Caroline Raymond, Superintendent, Long Creek Youth Development Center
Representative Michael Brennan, Co-Chair, Juvenile Justice System Assessment Task Force
Jill Ward, Co-Chair, Maine Juvenile Justice System Assessment Task Force
Mark Soler, Center for Children's Law and Policy