STATE OF MICHIGAN
DEPARTMENT OF ATTORNEY GENERAL

P.O. Box 30217
LANSING, MICHIGAN 48909

BILL SCHUETTE
ATTORNEY GENERAL

March 7, 2013

Via E-Mail and First Class Mail

Mellie Nelson
Judith Levy
Susan DeClerq
Disability Rights Section – NYA
950 Pennsylvania Avenue, NW
Washington, DC 20530

Re: DJ 204-37-333; 204-37-334; 204-37-335; 204-37-336
Women's Huron Valley
AG No.: 2010-0034076-A

Dear Ms. Nelson, Ms. Levy, and Ms. DeClerq:

On behalf of the Michigan Department of Corrections and the Women's Huron Valley Correctional Facility (WHV), I am writing to respond to the Department of Justice's two action letters concerning compliance with the American with Disabilities Act (ADA). In September 2010, you asked to tour WHV to investigate possible ADA violations based on complaints you said you received from some disabled WHV prisoners. You thereafter visited WHV on October 21 and 22, 2010, on January 24 and 26, 2011, and again on July 24 and 25, 2012. Your visits consisted of touring the facility and meeting with various staff from WHV, as well as staff of the Michigan Attorney General and Michigan Department of Corrections. As a result of these meetings, you, in consultation with your architectural consultant, medical consultant, and suicide prevention consultant, sent two separate action letters to WHV identifying areas where WHV should implement programs or make architectural changes to WHV to comply with the ADA. While the most recent action letter that the Department of Justice sent to WHV was June 4, 2012, you agreed to allow WHV until now to respond to all of your observations and recommendations in a single document. Accordingly, this letter serves as the WHV's response to the Department of Justice's action letters of June 6, 2011 and June 4, 2012.

Brief History of Women's Huron Valley Correctional Facility

The WHV, as it is currently comprised with an Eastside and Westside campus, came into existence in the fall of 2009 when two previously independent prisons merged. The Eastside

portion of the facility was originally built as a freestanding women's prison in 1977. That facility became part of the Department of Community Health in 1992, which operated it as a mental health facility from 1994 until 2005, at which time the facility returned to the MDOC as a women's prison. All of the housing units in WHV's Eastside were either built or remodeled between 1992 and 1994. Specifically, between 1992 and 1994, the Department of Corrections remodeled the already-existing Emmett, Filmore, Gladwin, and Harrison housing units, and the Calhoun and Dickenson housing units constituted new construction.

WHV's Westside originally opened as a men's prison – Huron Valley Men's Correctional Facility – in 1980. Between 1980 and 2009, the Westside operated as either a men's general population prison or a mental health facility for male prisoners. During this time period, there were few structural modifications of the Westside housing units. There were, however, some modifications to the program building wings, a new food service building constructed, and some modifications to the Fieldhouse. Since the fall of 2009, however, when the Westside and Eastside campuses merged, all female prisoners incarcerated within the Michigan Department of Corrections have been housed at the newly formed WHV, which is the Department's sole prison for female prisoners.

I. June 4, 2012 Letter

In your June 4, 2012 letter, you identify a number of areas related to architectural and general issues for inmates with disabilities that you contend WHV must address to ensure compliance with Title II of the ADA. Below is a discussion of each of the areas you identified, as well as the actions WHV has taken, or will take, to address each of your concerns.

1. Architectural Violations.

Your June 4, 2012 letter included a grid that identified alleged ADA violations related to the physical structures that comprise the WHV campuses. The alleged violations included such things as inadequate van-accessible parking spaces, exposed pipes under wash basins and sinks, improperly placed toilets or mirrors in bathrooms, improper door and shower widths, and improper heights of various fixtures, such as drinking fountains, shower grab bars, and tables.

Even before you issued your June 4, 2012 letter, WHV initiated many structural improvements to address the concerns that your architectural consultant expressed during his visit. Some of those improvements included wrapping exposed pipes underneath wash basins and sinks and removing and repairing outdoor pathways to ensure access for prisoners using a walker, cane, or wheelchair. The WHV maintenance staff also removed some minor wall obstructions and WHV required a contractor to change a shower stall that was incorrectly installed. The shower repair alone cost approximately $85,000.00.

WHV has continued to address architectural improvements in light of your June 4, 2012 letter. Attached as Attachment A is a grid that shows the status of the corrective action taken to address each of the alleged ADA violations that you identified in your June 4, 2012 letter. Attachment A shows that WHV has already corrected a substantial portion of the alleged ADA

violations by implementing the very same corrective action that you suggested. For many of your recommended changes that require substantial financial resources, Michigan Department of Corrections Director Daniel Heyns has made it a priority to locate funds within the Department's already strained budget to make additional structural improvements. For example, as set forth in Attachment B, the Department of Corrections has allocated $1,533,600.00 to replace or repave walking surfaces and parking areas at WHV to comply with your recommendations. Attachment C shows an additional $1,165,230.00 allocated to replace or improve WHV's building entrance systems to bring them into compliance with 2010 ADA standards. Finally, Attachment D shows an allocation of $1,219,800.00 to implement toilet, shower, and housing cell/room upgrades in various WHV housing units to comply with your recommendations.

For the improvements scheduled in Attachments B, C, and D, the MDOC is required by state law to follow a State competitive bidding and contracting process. This statutory competitive bidding and contracting process includes lead times to ensure that the specifications for the projects are appropriately vetted, approved, managed, and completed. WHV anticipates starting these improvement projects sometime in May 2013, with a completion date of December 31, 2014, which is reflected in Attachment A. Included with this letter as Attachment E is a confidential schematic of the WHV Complex indicating, by color code, where the door assist and entrance improvements, walkway improvements, toilet and shower improvements, and the cell renovations, will be made.

Although some of the recommendations in your June 4, 2012 letter exceed what is required by the ADA for some of WHV's buildings, the improvements that WHV has already made, and those scheduled improvements set forth in Attachment A, are consistent with the Department of Corrections' desire to improve the overall operations at WHV and cover nearly all of your architectural recommendations. Accordingly, WHV believes that completion of the planned structural renovations, along with program and operational changes described below, will bring WHV into full compliance with the ADA and the program and service accessibility concerns you expressed in your June 4, 2012 letter.

2. Housing Program.

In your June 4, 2012 letter, you state:

> *To ensure the overall accessibility of the housing program to inmates with disabilities, Huron Valley must implement comprehensive housing policies, including physical modifications to additional cells in accordance with the [ADA] Standards, so as to ensure that each inmate with a disability is housed in a cell or dormitory with the accessible elements necessary to afford such inmate access to safe, appropriate housing, in the most integrated setting appropriate to the individual's needs, and at the appropriate classification level. C.F.R. §35.151(k), §35.152(b); 2010 Standards §§ 807.2 and 404.*

WHV will ensure that all prisoners with disabilities are housed in cells that comply with the ADA. To that end, in addition to the architectural improvements described in Attachments A

and D, WHV intends to modify a cell in the health care unit to accommodate disabled prisoners in segregation status. Thus, disabled prisoners in segregation will not be housed in a housing unit or traditional segregation cell, but rather will be housed in a cell that accommodates their disability.

3. Chapel, Programs, and Activities of Daily Living.

In your June 4, 2012 letter, you state:

> *Some inmates with mobility disabilities are denied access to chapel and other programs because they require assistance in navigating about the facility. In addition, some inmates who require assistance in activities of daily living such as dining hall service, toileting, showers, feeding, and cleaning their cells do not receive such assistance. To provide access to programs, services, and activities for inmates with disabilities, Huron Valley must provide assistance in navigating to chapel and other programs and provide assistance with daily living activities to inmates with disabilities who require it. 28 C.F.R. § 35.130. Huron Valley must also enact policies and rules relating to the qualifications and responsibilities for such aide positions.*

In addition to making architectural improvements to the WHV campuses as described above and in Attachment A to provide prisoners with disabilities with improved access throughout the prison, WHV has also trained a number of "prisoner helpers" to assist these individuals with disabilities. These prisoner helpers are assigned and paid as part of their prison employment. The prisoner helpers assist individuals with mobility, hearing, and sight disabilities with certain access and participation needs. Responsibilities include leading blind prisoners and pushing prisoners who use wheelchairs to locations or activities within the prison.

The prisoner helpers also assist disabled prisoners with their daily living activities, such as assisting with correspondence, cell cleaning, laundry pick up and delivery, dining hall service, and other related duties. A description of the qualifications, responsibilities, and training requirements for prisoner helpers is set forth in Attachment F. The assistance provided by the prisoner helpers ensures that disabled prisoners have access to all prisoner programs offered within WHV.

Additionally, prisoners with disabilities that require assistance beyond what a prisoner helper can provide in a WHV housing unit are transferred to WHV's medical unit, where they receive assistance with their daily living activities from a trained medical aide.

4. Infection Control.

In your June 4, 2012 letter, you state:

Huron Valley does not currently provide separate receptacles for the disposal of waste, diapers, catheters, or other hazardous materials. To maintain an appropriate environment for inmates with disabilities, Huron Valley must provide appropriate receptacles for appropriate disposal of waste, diapers, catheters, and other hazardous materials. 28 C.F.R. §35.130.

Your assertion that "Huron Valley does not currently provide separate receptacles for the disposal of waste, diapers, catheters, and other hazardous materials," is not accurate. The WHV healthcare unit contains "sharps containers," where objects such as needles and syringes are disposed. WHV also uses biohazard containers/red bags to dispose of bandages, 4x4s, and swabs. These biohazard containers are disposed of by Steri-Cycle, a private contractor. Accordingly, WHV complies with applicable ADA Standards for the disposal of medical and related waste.

5. Shower Chairs.

Your June 4, 2012 letter states:

Chairs provided to inmates with disabilities for use in showering pose safety hazards for some inmates with disabilities. Huron Valley must provide a sufficient number of appropriate shower chairs in each of the housing units where individuals with mobility impairments are housed to provide safe and equal access to showering for inmates with disabilities. 28 C.F.R. §35.130.

As set forth in Attachments A and D, WHV has earmarked $1,219,800.00 for architectural improvements, which includes remodeling bathrooms and showers throughout the facility to ensure that there are sufficient numbers of showers that comply with the ADA and are available for disabled prisoners. All of the remodeled showers will have built in benches in the transfer area and in the showers. The built in benches in the remodeled showers will eliminate the need for separate shower chairs.

6. Wheelchairs and Adaptive Equipment.

Your June 4, 2012 letter states:

Many wheelchairs provided for use by inmates are broken, dirty, ill fitting, and lack foot supports. Huron Valley must provide appropriately fitted wheelchairs and other adaptive equipment (canes, walkers, trapeze bars, etc.) to inmates with disabilities as needed. Huron Valley must also ensure that wheelchairs and other adaptive equipment are routinely cleaned, repaired, maintained, and generally

kept in safe, operable condition. In addition, Huron Valley must provide prostheses, orthopedic shoes, braces, air mattresses, and other medically necessary equipment, as required to meet the needs of inmates with disabilities. 28 C.F.R. §35.130.

In March 2011, the MDOC designated a Disabilities Coordinator for WHV. The Disabilities Coordinator worked with WHV healthcare and security staff to implement an adaptive device audit and established a wheelchair repair clinic to ensure that prisoners have appropriate adaptive devices, such as canes, walkers, crutches, and wheelchairs, and that the adaptive devices remain in good working condition. A summary of the work in the wheelchair clinic was provided to you at the July 24-25, 2012 meeting, and is also included here as Attachment G.

In addition to the wheelchair clinic and adaptive device audit, WHV has policies in place to ensure that prisoners with prescriptions for medically necessary equipment, such as braces, air mattresses, and orthopedic shoes, are provided the equipment in accordance with MDOC policy, as prescribed by a health care professional. See Policy Directive 04.06.160, which is attached as Attachment H.

7. Effective Communication.

Your June 4, 2012 letter identifies five areas where WHV should improve communication with disabled prisoners. A summary of those recommendations are as follows:

a) Huron Valley must provide appropriate auxiliary aids and services where necessary to afford inmates who are deaf or hard of hearing an equal opportunity to participate in, and enjoy the benefits of, each Huron Valley program, service, and activity. In addition, consistent with legitimate security concerns, Huron Valley must ensure that inmates who are deaf or hard of hearing and inmates who are blind or who have low vision are cuffed or restrained in a manner that permits effective communication for inmates who are deaf or hard of hearing (i.e., cuffing inmates in the front so they can sign) and permits safe mobility for inmates who are blind or have low vision, including the use of a cane or sighted guide. 28 C.F.R. §§35.130, 35.160;

b) Huron Valley must ensure that batteries required for hearing aids are replenished and installed in a timely manner to ensure effective communication and program accessibility for inmates with disabilities. 28 C.F.R. §§35.130, 35.160;

c) In all areas housing inmates who are deaf or hard of hearing, Huron Valley must provide, maintain in good operating condition, and consistently utilize, at least one visual appliance with light intensity and

duration sufficient to provide effective communication of times for meals, recreation, education, work assignments, and other events. Huron Valley must establish and implement policies and procedures, and provide training, to correctional officers regarding effective communications with inmates who are deaf or hard of hearing, and the appropriate use of the notification appliance to alert inmates who are deaf or hard of hearing to activities that are ordinarily announced orally, such as times for meals, recreation, education, work assignments, pill call, and other events.

* * *

d) Huron Valley must incorporate training on policies and procedures relating to the effective communication with inmates who are deaf or hard of hearing and use of the alert devices into the training provided to new correctional officers. 28 C.F.R. §§35.130, 35.160;

e) Provide auxiliary aides and services, including cassette or CD players, audio books, radios with headphones, Braille reading materials, large print materials, screen reader software, or other effective methods of making material available to inmates who are blind or have low vision. Huron Valley must establish and implement policies and procedures and provide training to correctional officers to ensure effective communications with inmates who are blind or have low vision. Such procedures and training shall address the steps to be taken to ensure effective communication of both routine and atypical activities. Huron Valley must ensure that training on the policies and procedures is included in the training provided to new correctional officers. 28 C.F.R. §§35.130, 35.160;

f) Huron Valley must provide a call button that is operational, maintained in good operating condition, and located so that it is readily accessible to and usable by persons who are deaf or hard of hearing. Huron Valley must establish and implement policies, procedures, and training to ensure that correctional officers respond in a timely and appropriate manner when call buttons are activated. It must also ensure that training on the policies and procedures relating to the timely and appropriate response to call button activation is included in the training provided to new correctional officers. 28 C.F.R. §§35.130 2010 Standards § 807.3.

For prisoners who have sight or hearing disabilities, WHV has implemented several initiatives. First, WHV has modified its Operating Procedure for emergency evacuations, and now requires a staff person to assist prisoners with hearing, sight, or mobility disabilities when evacuating the housing unit in an emergency. A copy of that Operating Procedure was previously provided to you, and is included here as Attachment I. As part of the Operating

Procedure, all staff present in the housing units are responsible for notifying all prisoners with hearing, sight, or mobility disabilities of the fire/fire drill evacuation upon announcing it for the entire unit.

With respect to hearing-aid batteries, WHV relies on prisoners to request hearing-aid batteries, and maintains adequate supplies of hearing-aid batteries on site to ensure they are replaced upon request. Accordingly, WHV replaces hearing-aid batteries in a timely manner.

WHV has also installed a new signal light system in the housing units that house hearing-impaired prisoners. This system gives hearing-impaired prisoners notification of certain significant events in the housing unit, such as count time and emergency evacuations. WHV also makes sure that a sign-language interpreter is available for deaf prisoners at every scheduled medical appointment and every disciplinary proceeding. For certain other requested activities, such as religious services, WHV allows volunteer interpreters upon request. WHV is also exploring other options to ensure that hearing-impaired prisoners are provided appropriate accommodation for religious services, such as having a written copy of the religious services provided to hearing-impaired prisoners in advance of the service, and identifying community volunteers and/or prisoners with appropriate training to serve as sign language interpreters at religious services.

With respect to providing auxiliary aides and services to disabled prisoners who are blind or have low vision, as previously stated, the Department of Corrections and WHV have policies in place to ensure that prisoners with restricted ability to function in the prison are provided appropriate adaptive devices and equipment. Specifically, Policy Directive 04.06.160, which is attached as Attachment H, provides, in relevant part, as follows:

> E. Whenever a prisoner is identified as having a medical condition which restricts his/her ability to function adequately in the institutional environment, a qualified health professional shall identify reasonable options available in a corrections setting which will meet the prisoner's special medical need. Options may include prosthetics, medical supplies, assistive devices (e.g., wheelchairs, canes), medical treatment, or restrictions on activities, placement, or housing. Options also may include the issuance of non-wool blankets, extra blankets or sheets, special mattresses, or special shoes. The recommended option(s) shall be set forth on a Medical Detail if expected to be temporary (i.e., six months or less) or on a Special Accommodation Notice if expected to be long-term (i.e., more than six months) or permanent.
>
> * * *
>
> P. When a Medical Detail or Special Accommodation Notice requires the purchase of a prosthetic, medical supplies, an assistive device, or other medically necessary item, the item shall be paid for by the Department, except that the prisoner may choose to purchase the item as permitted pursuant to PD 04.07.112 "Prisoner

> Personal Property" or receive the item as a donation from a source approved by the CFA Deputy Director or designee. Questions regarding the appropriateness of an item shall be directed through the chain of command to the Warden or Regional Medical Officer, as appropriate.

Blind prisoners who read Braille are able to order and receive Braille publications from the following vendors: 1) National Library of Congress, 2) Service for the Blind and Physically Handicapped, and 3) American Printing House for the Blind. Prisoners who meet eligibility requirements may also receive free library services through the Service for the Blind and Physically Handicapped, and receive other auxiliary aides without cost to the prisoner, including cassette book machines, digital talking book machines, and books and magazines on cassette and digital cartridge. A description of the Talking Books program available through the Service for the Blind and Physically Handicapped is attached as Attachment J.

Finally, the Department of Corrections has also worked with other agencies of State government to budget more than $85,000.00 to provide personal notification devices to hearing-impaired and vision-impaired prisoners at WHV. The project is designed to also include call buttons in the infirmary. A copy of the work order for this project is included as Attachment K. WHV is awaiting approval from the Michigan Department of Technology, Management and Budget, which must approve the selected vendor before work on the project can begin.

II. Mental Health Care and Suicide Prevention.

In September 2010, when you initially contacted WHV to arrange a tour, you did not identify suicide prevention as an issue of concern. During your October 21-22, 2010 visit, however, you indicated that you wanted Mr. Lindsey Hayes, Project Director for the National Center on Institutions and Alternatives, to tour WHV at a later date as your consultant on suicide prevention. On January 24 – 26, 2011, Mr. Hayes toured WHV, reviewed prisoner records, and interviewed various WHV personnel.

Following Mr. Hayes' visit, you requested the medical, psychiatric/psychological records, relevant policies, and police and critical incident reports for prisoners who had committed suicides. You also asked to review information about two additional prisoners that engaged in self-injurious behavior. You indicated that Mr. Hayes would review the requested materials and, based on his notes and observations, make recommendations relating to the delivery of mental health services and suicide prevention at WHV. Mr. Hayes completed his report on June 9, 2011, but per our previous discussion and agreement, that report was not provided to the Department of Corrections until nearly a year later, on June 4, 2012, when it was included in your letter.

In his report, Mr. Hayes notes that between May 2010 and March 2011, four WHV prisoners committed suicide. Additionally, there were a number of suicide gestures/attempts by other prisoners. From October 2010 through July 2012, WHV reviewed the circumstances of

these four suicides and the suicide gesture/attempts.[1] During our meetings on July 24-25, 2012, you indicated that you did not wish to discuss the results of WHV's investigations or conclusions, which explained the reasons for the suicides or suicide attempts. Accordingly, the details of WHV's review are not included here. However, during the July 24-25, 2012 meetings, your medical consultant acknowledged and accepted a central conclusion that WHV reached as a result of its review. That is, for each of the four suicides, the prisoners' housing conditions, the behavior of staff, and the availability of medical care, had no triggering effect or substantial impact on the prisoners' decision to commit or attempt suicide. Rather, WHV's investigation shows that each of the four prisoners that committed suicide did so in a purposeful and secretive manner after experiencing the end of an important personal relationship – either with a person outside of prisoner or with a fellow prisoner.

Portions of the June 4, 2012 letter and Mr. Hayes' report imply that WHV violated the ADA based on the general availability of mental health treatment services at WHV. The Department of Corrections rejects that proposition. While it is possible that a person with a mental illness could have a disability as defined in the ADA, no WHV prisoner has been denied access to mental health services by reason of their mental or physical disability.

In his report, Mr. Hayes acknowledges, at page 11, that "[v]ery few suicides are actually prevented by mental health, medical or other professional staff. Because suicides are usually attempted in inmate housing units, often during late evening hours and on weekends, they are generally outside the purview of program staff." Mr. Hayes goes on to stress the importance of training staff to look for signs of suicide risk so staff can intervene if they recognize a prisoner is a suicide risk. WHV does not contest this recommendation and, in fact, has taken extensive and costly measures to not only provide additional staff training, but to also strengthen its overall suicide prevention efforts and improve the quality of its mental health care as a general course of business. These actions include:

- *Implementation of Live Suicide Risk Prevention Training*: WHV has instituted eight hours of mandatory live training for suicide risk identification and response for all staff, including clinical, custody, housing, and supervisory staff. This training was provided in December 2010. Additionally, four hours of live update training was again provided to all staff in October 2012, and will be provided annually hereafter.

- *Unification of Mental Health Staff*: In March 2011, in an effort to reduce any possible barriers to mental health services and to better manage and direct available resources, the Department of Corrections consolidated all mental health services, which previously had been divided between the Corrections Mental Health Program, which was managed and staffed by the Department of Community Health, and the parallel Psychological Services staff of the Department of Corrections. This

[1] WHV/MDOC expressly does not waive any privilege associated with attorney work product or attorney-client communications regarding this review.

unification of mental health staff has increased access to mental health services and improved the ability for prisoners to receive a wider range of services. For example, the Department of Corrections has broadened its criteria of mental illness to allow more prisoners to receive mental health treatment.

- *Increased Rounding Frequencies*: WHV continues to conduct and adjust rounding frequencies in the housing units to better utilize staff. Rounding, which entails direct contact between a prisoner and a WHV staff member, is more frequent in the acute care, RTP, and segregation areas than in general population, because prisoners in those areas are more likely to engage in impulsive or self-injurious behavior. The increased frequency of WHV staff in those units increases the likelihood of intervention and, in turn, suicide prevention. Suicides that occurred in the general population units, which the prisoners secretly planned and executed, were not, and were not likely to be, interrupted by increased rounding frequency.

- *Prisoner Observation Aides*: For prisoners identified as a suicide risk, WHV has implemented a program to train and use other prisoners as observation aides. This program, modeled after a Bureau of Prisons program, trains prisoners to assist with one-on-one observation of prisoners that are on suicide risk watch. The pilot went into effect in September 2012, and has since been fully implemented via a Director's Office Memorandum. A full description of the Prisoner Observation Aide Program is attached as Attachment L.

- *Dialectic Behavioral Therapy and Counseling Services and Intervention*: In October 2012, WHV initiated two new programs – 1) Dialectic Behavioral Therapy and 2) Counseling Services and Intervention. Each of these programs is designed to increase the availability of contact between prisoners and mental health services staff. The Dialectic Behavioral Therapy assists prisoners in developing a supportive baseline personality so that they will not be susceptible to rash behavior. Attachment M is the admission and discharge criteria for the Dialectical Behavior Therapy program. The Counseling Services and Intervention program, while not intended primarily as crisis intervention, is designed to address a prisoner's mental health conditions that are currently disruptive to the prisoner and that, if left unresolved, could lead to bigger problems. See Attachment N.

Attachment O is a list of Mr. Hayes' recommendations, which are set forth in a grid, and includes notes that describe WHV's actions taken in response to those recommendations. To the extent it is within WHV's ability to implement Mr. Hayes' recommendations, those recommendations have been implemented as described in Attachment O.

The prisoners that committed suicide at WHV between May 2010 and March 2011, and the additional prisoner that committed suicide in May 2012, were not actively treated for mental illness at the time of their suicides because they did not suffer from mental illness. As Mr. Hayes notes in his report, most suicides are not spontaneous, but rather planned out. Accordingly, the

goal of suicide prevention for prisoners that are not suffering from an identified mental illness is two-fold: First, services need to be available so that a prisoner's long-term or sudden stressors are addressed with the assistance of a qualified mental health staff. Second, staff should be trained to identify and respond to the signs or risks associated with suicide. WHV has taken steps to address both of these aspects of suicide prevention. Specifically, WHV has added the Counseling Services and Intervention program as described above, which provides prisoners and qualified mental health professionals an opportunity to discuss stressors and other issues. Additionally, WHV is addressing suicide risk identification by staff training, staff referrals to mental health services, and prisoner kites requesting assistance.

Conclusion Related to the June 4, 2012 Letter.

Although some of the recommendations in your June 4, 2012 letter exceed what is required by the ADA for some of WHV's buildings, the scheduled architectural improvements set forth in Attachment A are consistent with the MDOC's desire to improve the overall operations at WHV. Accordingly, WHV believes that completion of the planned structural renovations, along with program and operational modifications described above and in Attachment A, will bring WHV into full compliance with the ADA and program and service accessibility concerns you expressed in your June 4, 2012 letter.

III. June 6, 2011 Letter

In addition to ADA concerns related to WHV's physical structure, you also expressed concerns about medical care for disabled prisoners. Your medical consultant toured WHV on January 24-26, 2011, during which he interviewed some prisoners and reviewed several prisoners' medical records. Thereafter, your June 6, 2011 letter identified recommendations to remedy alleged ADA violations related to prisoner medical care.

As with the recommendations of your architectural consultant, the Department of Corrections took your medical consultant's recommendations very seriously. In fact, the Department of Corrections' Chief Medical Officer, Dr. Stieve, reviewed the complete medical files of the prisoners that your medical consultant identified in the end notes of his report and, along with WHV Warden Millicent Warren, conducted follow-up interviews with those same prisoners. Based on his medical file review and prisoner interviews, Dr. Stieve identified several factual errors that your medical consultant relied on in reaching his conclusions and recommendations. Notwithstanding these factual errors, however, Dr. Stieve agreed that some of the patients identified would benefit from additional services or medications. As a result, additional medical services and/or medications have been provided, and will continue to be provided hereafter, as deemed medically necessary. The results of Dr. Stieve's medical file review and prisoner interviews are set forth in Attachment P.

Although your medical consultant alleged some lapses in medical treatment, the Department of Corrections does not accept the premise that, even if true, a difference of medical

opinion about a prisoner's care, or whether a prisoner receives adequate medical care, is properly identified as an ADA issue. Nevertheless, a prisoner's legitimate complaint about medical treatment is a concern to WHV, and is something WHV wishes to address.

Your June 6, 2011 letter identifies seven areas of alleged violations of Title II of the ADA, and includes suggested remedies WHV should take to address these alleged violations. A description of the suggested remedies and WHV's responses, are set forth below:

1. Barriers to access to an appropriate level of care for WHV patients with disabilities.

MDOC must reduce barriers to timely access to an appropriate level of care for Huron Valley patients with disabilities.

a) MDOC needs to continue to refine lines of authority and accountability to enhance its ability to provide timely access to an appropriate level of care for Huron Valley prisoners with disabilities.

b) Timelines and appropriateness of care cannot be improved without performance measurement and meaningful quality management activities to respond to self-critical analysis with constructive program change. Develop meaningful performance measures to monitor deficiencies and implement remedies for identified problems. Performance measurement needs to be tracked and trended until there has been sustained compliance with program objectives.

c) File prisoners' requests for care (kites) in the medical record so as to evaluate timely access to an appropriate level of medical care by prisoners with disabilities.

Regional and WHV healthcare management, along with the WHV Warden, recognize the value of a system-wide approach to improving healthcare at WHV, as well as the importance of documenting the results of such efforts. To that end, WHV and Regional and healthcare staff have implemented a system-wide initiative to ensure that WHV timely performs annual health screens for WHV prisoners.

Annual health screens are performed for every prisoner in the month of the prisoner's birth. The annual health screen involves a registered nurse personally meeting with each prisoner and reviewing the prisoner's healthcare status and healthcare records. During the annual health screen, the registered nurse answers the prisoner's healthcare questions, educates the prisoner, collects appropriate medical samples (i.e. blood, urine, etc.) for testing as needed, and determines if the prisoner should be referred to a medical provider for a current medical

problem. Attachment Q shows the success rate of performing the annual health screens in the prisoner's birth month.[2]

After WHV implemented the system-wide effort to ensure timely annual health screens, as a continuation of its self-assessment, WHV and Regional healthcare staff focused their efforts on completing all annual health screens for chronic-care clinic patient/prisoners. Annual health screens for chronic-care clinic patients are also completed in the prisoner's birth month, except screening is completed by a medical provider, such as a physician's assistant or medical doctor, as opposed to a registered nurse. At the end of each month, WHV provides a report to its Regional Health Care Administrator that identifies any patient that did not receive an annual health screen for that particular month. A list of those patients is then returned to WHV with the directive to conduct the health screen within 10 days. The results of those catch-up screens are not included as a separate entry on the attached charts. Attachment R, however, shows catch-up screenings for chronic care patients' annual health screens, which show a timeliness rate of well over 90%.

In early 2013, Regional and WHV healthcare staff intend to add another health care metric to focus on annual health and annual chronic-care screenings to ensure that prisoners enrolled in chronic-care clinics, regardless of whether they have good, fair, or poor control of their chronic-care condition, are seen timely as appropriate for their conditions.

Attachments S, T, U, V and W are additional examples of audits that help ensure the continuing quality of healthcare at WHV. Attachment S is a point-in-time audit of RN documentation related to prisoner/patient visits with the RN. Attachment T is a point-in-time audit for wound care, which reviews fourteen audit points concerning care and relevant documentation. Attachment U is an explanation of the WHV medical kite process and the results of a November 2011 and May 2012 audit of the timeliness and appropriateness of that process. Attachment V is a comparison on a month-to-month basis, from December 2011 through November 2012, of medication grievances filed by prisoners at WHV.

2. Charging prisoners for the medical cost associated with self-injurious behavior.

Immediately abandon this inappropriate and punitive policy of charging prisoners for disability-related medical care, including medications and other medical care for self-injurious behavior. Adopt an ADA-compliant policy that ensures that prisoners with disabilities are not charged for disability-related medical care or medications and that access to disability-related medical care is not restricted for cost-related reasons.

---

[2] The decline in the success rate for August and September 2012 was due to a new scheduler who has since been replaced. Once the replacement scheduler was trained, WHV achieved nearly 100% compliance in October 2012.

The Michigan Department of Corrections does not charge prisoners for required medical or mental health care or for self-inflicted injuries that are caused by a disability. However, not all self-inflicted injuries are caused by a disability and Michigan law requires that the cost of self-inflicted injuries be paid by the prisoner. Michigan law provides that prisoners that receive nonemergency medical care are responsible to pay a minimal copayment for those services, and prisoners that intentionally injure themselves and receive emergency medical care are responsible for their costs. Specifically, MCL 791.267a, provides, in relevant part, as follows:

> (1) A prisoner who receives nonemergency medical, dental, or optometric services at his or her request is responsible for a copayment fee to the department for those services, as determined by the department. If the prisoner is a minor, the prisoner's parent or guardian is also responsible for a copayment fee imposed under this section.
>
> (2) A prisoner who intentionally injuries himself or herself, and receives emergency medical care for that injury, is responsible for the entire cost of the medical care, rather than the copayment described in subsection (1).

Notwithstanding the requirements of MCL 791.267a, the Michigan Department of Corrections has implemented policies to ensure that those prisoners that receive mental health treatment are not charged for their treatment. Additionally, prisoners that engage in self-injurious behavior but lack substantial capacity to know right from wrong, or those that are incapable of conforming their conduct to Department rules, are exempt from paying for emergency medical treatment associated with the self-injurious behavior.

Michigan Department of Corrections' Policy Directive 03.04.101 provides, relevant part, as follows:

> H. A health care visit initiated by a prisoner shall be subject to a copayment except if the visit:
>
> 1. Is for a work-related injury documented by the prisoner's work supervisor;
>
> 2. Is for the prisoner to be tested for Human Immunodeficiency Virus (HIV), sexually transmitted diseases, infestations, or reportable communicable diseases;
>
> 3. Is for an evaluation, consultation, or treatment of a mental health need;
>
> 4. Results in the prisoner receiving, or being referred to receive, emergency medical care within one hour. If the emergency medical care is due to an intentional self-inflicted injury, the prisoner shall be responsible for the full cost of the medical care provided as set forth in Paragraph I.

Self-Inflicted Injuries

I. A prisoner who intentionally injures himself/herself and receives emergency medical care for that injury shall be charged the full cost of the emergency and subsequent medical care provided as a result of the injury except if a qualified mental health professional determines the prisoner was mentally ill at the time of the self-injury, and either lacked substantial capacity to know right from wrong or was incapable of conforming his/her conduct to Department rules. The cost of medical care shall include ancillary services such as transportation and custody costs.

The ADA does not require the Department of Corrections to pay for self-inflicted injuries by prisoners who have no disabilities. The ADA only protects individuals who have a disability. With respect to this class of prisoners, the Department of Corrections' policy of not charging for self-inflicted injuries resulting from mental illness or lack of capacity – as described above – complies with the ADA's requirements.

3. Allegations that WHV staff minimize patients' requests for care and grievances regarding lags and lapses in care.

Train and supervise staff systematically to assure timely and appropriate responses to requests for care and eliminate cynical attitudes. Performance in this area needs to be monitored, with appropriate corrective actions taken, as part of a quality management program.

WHV continues to address and monitor timeliness and appropriateness of responses to prisoner requests for health care. This performance is monitored as reflected in Attachment U, which explains the health care kite process and includes a WHV kite audit.

4. Audiometric evaluations and access to hearing aids and other auxiliary aids.

Provide patients with hearing disabilities timely access to audiometric evaluation, hearing aids, and other auxiliary aids and services necessary to ensure effective communication in accordance with Title II of the ADA. Please note that the requirements to provide auxiliary aids and services for prisoners with disabilities applies with respect to auxiliary aids for prisoners with all disabilities affecting hearing, vision, and/or speech.

Prisoners have access to hearing aids and other auxiliary aids and services to ensure effective communication as described above. See previous discussion under *Effective Communication* and *Wheelchairs and Adaptive Equipment.* See also Department of Corrections Policy Directive 04.06.160, attached as Attachment H, and Attachment J.

5. Allegations of lapses in medical consultations or medications.

Monitor and ensure conformance with nationally-accepted clinical guidelines for chronic disease, such as those promoted to PHS clinicians.

WHV's medical providers adhere to PHS/Corizon clinical guidelines for chronic disease, and continue to monitor its performance in this area. See Attachment R, audit of catch-up screenings for chronic care patient's annual health screens.

6. Some patients with disabilities must travel to the medication line to get their medications.

Ensure that patients with disabilities have facilitated access to care, including medication prescribed for them, as required by the reasonable modification and program accessibility obligations of Title II of the ADA.

WHV opened a second medication line on the Westside campus in July 2011, near the mental health offices, which has significantly improved medication access for all prisoners. Before this second Westside medication line was operational, prisoners housed on the Westside campus were required to travel to the Eastside campus to pick up their medications. Additionally, the wheelchair repair clinic, which ensures that wheelchairs are in good working condition, and the use of "prisoner helpers" for those prisoners who need assistance with their mobility, ensure that disabled prisoners have access to all areas within the facility, including either the Eastside or Westside campus medication line.

7. Provide appropriate and accessible medical equipment.

As Huron Valley acquires and replaces medical equipment, provide accessible medical examination and treatment tables and chairs, accessible scales, accessible radiological diagnostic equipment, etc., to provide prisoners with disabilities equal access to services. 28 C.F.R. §35.160.

The medical equipment in use at WHV is medically adequate and ensures that all prisoners are provided appropriate medical care. To the extent that specialized medical equipment may be required to ensure adequate treatment for a particular prisoner, WHV ensures appropriate treatment by sending prisoners to outside health care providers when necessary.

As WHV acquires and replaces medical equipment, it will ensure that the medical equipment acquired, or already on hand, complies with any technical standards issued by the Department of Justice in the future. However, there are no such standards at this time. The lack of enforceable standards makes it impossible for the Department of Corrections to commit to purchasing "accessible" equipment.

Conclusion

With a combination of systemic, program, and structural improvements already completed, as well as the additional structural improvements that WHV plans to complete, WHV believes it has fully complied with the goals that you and your consultants have suggested to ensure that prisoners with mobility, hearing, or visual impairments, have adequate and appropriate opportunities to access facility services, housing, and programs.

Moreover, WHV believes that it has fully resolved the ADA concerns alleged about disabled prisoners, regardless of whether the prisoner's disability is due to mobility, hearing, visual, or medical-condition impairment. WHV has taken to heart the recommendation to engage in a systemic review of its prisoner medical care, and continues to make improvements in addition to those described above.

WHV will continue to implement the programs and remediations described in this response. WHV continues to evaluate the advice provided by the Department of Justice and its consultants, including recommendations on issues that do not implicate the ADA. WHV understands, based on discussions with you over the past two years, that you recognize the efforts that WHV has made, and continues to make, to improve its physical structure, its delivery of direct disability accommodations, and its medical and mental health services in order to manage as safe an environment as practical.

WHV trusts that the actions it has taken, and will take as set forth above, appropriately resolve the ADA concerns expressed by the Department of Justice. If you have any questions or wish to discuss WHV's response further, please contact me.

Sincerely,

A. Peter Govorchin

A. Peter Govorchin
Assistant Attorney General
Corrections Division
(517) 335-7021

APG:kjs
Enclosures
cc: Daphne Johnson
Warden Millicent Warden
2010-0034076-A CORR-GA ADA (WHV)\DOJ Letter 030713 FINAL

INDEX OF ATTACHMENTS

Attachment R	Audit of Catch-up Screenings for Chronic Care Patients' Annual Health Screens
Attachment S	Point-in-Time Audit of RN Documentation Related to Prisoner/Patient Visits
Attachment T	Point-in-Time Audit for Wound Care
Attachment U	Explanation of WHV Medical Kite Process and Results of November 2011 and May 2012 Audits of Timeliness and Appropriateness of Process
Attachment V	Comparison on Month-to-Month Basis from December 2011 through November 2012 of Medication Grievances Filed by Prisoners at WHV
Attachment W	Timeliness of Follow-up Chronic Care Visits, May 2012 through November 2012

McKerr, Joseph (AG)

From: Govorchin, Peter (AG)
Sent: Thursday, March 07, 2013 4:42 PM
To: DeClercq, Susan (USAMIE) (Susan.DeClercq@usdoj.gov); Levy, Judith (USAMIE) (Judith.Levy@usdoj.gov); Nelson, Mellie (CRT)
Cc: Johnson, Daphhe (MDOC); Warren, Millicent (MDOC)
Subject: WHV response to DOJ action letters of 6-6-11 and 6-4-12 / First WHV attachment (2nd email)
Attachments: attachment A.pdf

Susan, Judith and Mellie, here is the first attachment referred to in my previous email and in the WHV letter response to the DOJ action letters of 6-6-11 and 6-4-12.

STATE OF MICHIGAN
DEPARTMENT OF CORRECTIONS
LANSING

RICK SNYDER
GOVERNOR

DANIEL H. HEYNS
DIRECTOR

DIRECTOR'S OFFICE MEMORANDUM 2013 - 26 **EFFECTIVE:** January 1, 2013

DATE: December 13, 2012

TO: Executive Policy Team
Administrative Management Team
Wardens

FROM: Daniel H. Heyns, Director

SUBJECT: Prisoner Observation Aide Program

SUPERSEDES DOM 2012 - 32 (effective 9/20/12)

Pursuant to PD 04.06.115 "Suicide Prevention", a prisoner must remain under direct and continuous staff observation while in an observation room due to suicidal or self-injurious behavior until a management plan that reduces the prisoner's suicide risk level is implemented. The Federal Bureau of Prisons implemented a program using specially selected and trained prisoners to observe prisoners on observation status instead of relying solely on staff. In addition to resulting cost savings, studies suggest a suicidal or self-injurious prisoner may be more willing to talk about the motivational factors for his/her behavior with another prisoner who has a greater ability to cope while incarcerated. This potentially may result in the prisoner ceasing or decreasing his/her episodes of suicidal and/or self-injurious behavior.

This Department is piloting a Prisoner Observation Aide Program at the Ionia Correctional Facility, Women's Huron Valley Correctional Facility, and Woodland Correctional Facility. The Program may be expanded to other institutions as identified by the Deputy Director of Correctional Facilities Administration (CFA). Similar to the Federal Bureau of Prisons, the Program uses specially selected and trained prisoners to observe suicidal or self-injurious prisoners as required under PD 04.06.115. In addition, with approval of the Warden, these prisoners may be used to observe prisoners in a mental health setting who are ordered by a psychiatrist to remain under one-on-one direct observation.

Prisoners selected for the Prisoner Observation Aide Program shall be classified as a Prisoner Observation Aide or an alternative work classification that encompasses the same responsibilities as the Prisoner Observation Aide classification. Prisoners shall be selected for this work assignment based on their ability and willingness to provide this service but also for their emotional stability, reliability, and credibility with both prisoners and staff. Other selection criteria may be utilized as determined by the CFA Deputy Director or designee, including misconduct history. The pay for this assignment shall be the highest daily rate of the Advanced Education/Training Pay Scale (i.e., $3.24)

for each 24 hour period during which the prisoner is called-out for the assignment. The prisoner may be classified to another work or school assignment while on this assignment. However, due to OMNI rules that will not allow dual work assignments to be entered, this assignment must be manually tracked if the prisoner has another work assignment.

In conjunction with the Administrator of the Bureau of Health Care Services (BHCS), Operations Support Administration, the CFA Deputy Director shall ensure that appropriate training is provided to prisoners assigned to the Prisoner Observation Aide Program. The training shall include instruction on the prisoner's duties and responsibilities as an observer as well as instruction in record-keeping, handling emergencies, basic communication skills, active listening skills, and maintaining confidentiality. Follow-up training shall be provided at least annually. Only prisoners who have received this training shall be utilized as an observer.

Each institution with a Prisoner Observation Aide Program shall have a Prisoner Observation Aide Program Committee. The Committee shall include the Classification Director and a Resident Unit Manager, Assistant Resident Unit Supervisor, or other appropriate staff designated by the Warden, one of whom shall be designated to chair the committee. The committee also shall include a Qualified Mental Health Professional designated by the Warden after consultation with the Mental Health Services Unit Chief. The Committee shall be responsible for screening and selecting prisoners for assignment to the Program, ensuring adequate observation coverage is available. Prisoners may be removed from this assignment at the discretion of the Prisoner Observation Aide Program Committee. Since this is a voluntary assignment, a prisoner assigned to the Program also may request removal for any reason. The request shall not be considered a refusal and shall not result in any negative work results solely to the request.

The Chairperson of the Prisoner Observation Aide Program Committee shall serve as the Program Coordinator. The Program Coordinator shall be responsible for maintaining a roster of all trained observers at his/her facility, ensuring a current copy is available in the Control Center for reference during non-business hours. The Program Coordinator also shall be responsible for overseeing scheduling of the observers. In addition, the Program Coordinator shall meet at least quarterly with the observers to review procedures, discuss issues, and supplement training.

Prisoner observer aides ordinarily will work a three-hour shift. Except under unusual circumstances, an observer aide shall not work more than six hours in a 24-hour period. Observer aides shall be strip-searched prior to and immediately after reporting to the assignment. Observer aides must maintain unrestricted one-on-one visual observation of the prisoner being observed at all times. Although the observer aide may communicate with the prisoner being observed, at no time shall the observer aide counsel or give advice to the prisoner. Observer aides shall not be provided or allowed to have access to medical, psychiatric, or commitment files of the prisoner being observed and shall not be provided or allowed to access any confidential information on the prisoner.

While on assignment, prisoner observer aides shall be supervised by designated staff in the immediate area of the observation room. The observer aide shall document his/her visual observation of the prisoner every 15 minutes in the Prisoner Observation Aide Documentation Report and document any unusual or significant event as it occurs. Custody staff shall review and initial the report when making required rounds. The observer aide shall immediately alert staff if the prisoner being observed is in

apparent distress or engaging in self-injurious or other behavior that may indicate the need for staff intervention. Whenever an observer aide alerts staff of such behavior, staff must immediately respond and take appropriate action. At the end of each session, the observer aide shall meet with designated unit staff for debriefing. If observation continues with a different observer aide, staff shall ensure that observer aide is provided information regarding any issues/concerns raised during the prior observation session.

Attachment M

Women's Huron Valley Correctional Facility
Dialectical Behavior Therapy Pilot
Admission and Discharge Criteria
(Rev. 10/22/12)

Dialectical Behavior Therapy (DBT) – is a system of therapy originally developed by Marsha M. Linehan, a psychology researcher at the University of Washington, to treat people with borderline personality disorder (BPD).[1][2] DBT combines standard cognitive-behavioral techniques for emotion regulation and reality-testing with concepts of distress tolerance, acceptance, and mindful awareness largely derived from Buddhist meditative practice. DBT may be the first therapy that has been experimentally demonstrated to be generally effective in treating BPD.[3][4] A meta-analysis found that DBT reached moderate effects.[5] Research indicates that DBT is also effective in treating patients who present varied symptoms and behaviors associated with spectrum mood disorders, including self-injury.[6] Recent work suggests its effectiveness with sexual abuse survivors[7] and chemical dependency.[8]

Common Symptoms associated with Borderline Personality Disorder:

For the purpose of the pilot being launched at WHV, prisoners with the following configuration of symptoms and behaviors will be considered for admission to DBT programming *(this is not to be considered an exhaustive list, but to be viewed as a guideline in determining the most appropriate prisoners for the program)*:

1. **Significant efforts to avoid real or imagined abandonment**
2. **A pattern of unstable and intense interpersonal relationships** characterized by alternating between extremes of idealization and devaluation
3. **Identity diffusion**, such as a significant and persistent unstable self-image or sense of self
4. **Impulsive behaviors** in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)
5. **Recurrent suicidal behavior**, gestures, or threats, or self-mutilating behavior
6. **Emotional dysregulation** due to significant reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7. **Chronic feelings of emptiness**
8. **Intense anger** or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
9. **Transient, stress-related paranoid thoughts** or severe dissociative symptoms.
10. Emotional dysregulation, anger, rage, distress, depression, anxiety; externalized through acting out toward self, others or property
11. Tendencies to split staff – housing, custody, mental health, health care, supervisors, direct line staff, etc.
12. Self-injurious behaviors, para-suicidal gestures, intermittent suicide attempts which are potentially lethal

13. Persistent sabotaging of treatment efforts
14. Severe acting out behaviors including property destruction, yelling, banging, disruptive of the unit
15. Requires, even demands, 1:1 observation – views direct observation as a reward, reinforcement of unhealthy behavior; attempts to exert control and power over staff

Treatment levels

1. Treatment Level I – prisoners placed in acute care or RTP
2. Treatment Level II – prisoners placed in segregation or housing unit 1, level IV security
3. Treatment Level III - a transitional unit (location to be determined)
4. Treatment Level IV – general population on CSI or OPT status in the CMHP

Discharge Criteria:

By the date of discharge from DBT, the prisoner will:

1. Have engaged in no self injurious behaviors for a period of at least 6 months.
2. Have been free of aggressive misconduct for a period of at least 6 months.
3. Meet criteria for possible designation as a peer mentor for the Transition Unit.
4. Achieve parole or complete maximum prison sentence.

Other considerations:

1. The program will be strictly voluntary. Prisoners will be required to sign "consent for voluntary admission" to the DBT program / study.
2. If a prisoner terminates voluntary admission to the DBT program, she will be given a 7 day period of time in which to reconsider; after which she will either remain in the program (by withdrawing termination) or be discharged as a person refusing voluntary admission.
3. Prisoners will be treated at all level of care in the Corrections Mental Health Continuum including CSI, OPT, RTP and Acute Care.
4. For the purposes of the pilot study, the tracking tool will be based on individual prisoners, regardless of the level of care in which they are placed at any given time. The areas which will be studied are in the attached tracking tool.

Attachment N

MICHIGAN DEPARTMENT OF CORRECTIONS **POLICY DIRECTIVE**	EFFECTIVE DATE 03/18/2013	NUMBER 04.06.180
SUBJECT MENTAL HEALTH SERVICES	SUPERSEDES 04.06.180 (10/09/95)	
	AUTHORITY MCL 330.1723, 330.1946, 330.2003, et seq., 768.36, 791.203, 791.265, 791.265b	
	PAGE 1 OF 5	

POLICY STATEMENT:

Mental health services shall be provided to prisoners as set forth in this policy, including appropriate treatment for prisoners who have a mental illness or mental disability.

RELATED POLICY:

04.06.183 Voluntary and Involuntary Treatment of Mentally Ill Prisoners

POLICY:

DEFINITIONS

A. Integrated Health Record - The documentation of all health services provided to the prisoner, both onsite and offsite.

B. Mental Disability - Any of the following mental conditions:

1. Mental illness, which is a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or the ability to cope with the ordinary demands of life.

2. Severe chronic brain disorder, which is characterized by multiple cognitive defects (for example, memory impairment resulting from a medical condition or brain injury due to trauma or toxins).

3. Developmental disorder, which usually manifests before the age of 18 years and is characterized by severe and pervasive impairment in several areas of development (for example, autism; retardation).

C. Qualified Mental Health Professional (QMHP) - A physician, psychiatrist, nurse practitioner, physician's assistant, psychologist, social worker, or registered nurse who meets the requirements set forth in MCL 330.1100b and is trained and experienced in the areas of mental illness or mental disabilities.

GENERAL INFORMATION

D. For purposes of this policy, "prisoner" includes parolees housed in Department correctional facilities. Probationers in the Special Alternative Program shall be provided mental health services only as set forth in PD 05.01.142 "Special Alternative Incarceration Program".

E. The Mental Health Services Section of the Bureau of Health Care Services (BHCS), Operations Support Administration (OSA), is responsible for coordinating and monitoring the integrative continuum of mental health services for prisoners. This includes providing counseling, psychotherapy, and psychiatric services.

F. Qualified Mental Health Professionals (QMHP's) shall be available to provide mental health services. Prisoners in need of mental health services shall be identified in a timely manner, have reasonable access to care, and be afforded continuity of care, including aftercare planning and follow-up as indicated. A prisoner who is diagnosed as having a mental disability shall be periodically reassessed for mental health status throughout his/her period of incarceration. Prisoners in need of other mental health services shall have services provided as deemed necessary and appropriate.

G. Prisoners received by the Department who have been found Guilty But Mentally Ill (GBMI) shall be provided an intake psychiatric evaluation as defined in OP 04.06.180A "Psychiatric Evaluation of Prisoners Committed as Guilty But Mentally Ill (GBMI)".

INSTITUTIONAL SERVICES

H. The following institutional services are provided by QMHP's to prisoners as clinically indicated:

1. Mental health intake evaluations;
2. Crisis intervention;
3. Monitoring psychological status of prisoners confined in segregation units;
4. Suicide prevention services including screening, assessment, and treatment;
5. Specialized group therapies;
6. Parole Board psychological evaluations, as requested;
7. Integrated treatment for co-occurring disorders;
8. Aftercare planning including relapse prevention and transition/discharge planning;
9. Behaviorally based treatment for prisoners under 17 years of age.

COUNSELING SERVICES AND INTERVENTION

I. Individual and group psychotherapy services are available to prisoners who have been determined by a QMHP to have psychological disturbances that do not meet the threshold for a mental disability but significantly impair psychosocial functioning. Recommended psychotherapy services shall be provided by QMHP's, who also shall determine admission into and discharge from these services. The types of therapies that may be provided include, but are not limited to, solution focused therapy, cognitive behavioral therapy, and dialectical behavior therapy.

CORRECTIONS MENTAL HEALTH PROGRAM

J. Pursuant to MCL 330.2003 *et seq.*, the corrections mental health program (CMHP) provides a continuum of mental health services to prisoners who have been diagnosed with a mental disability and are in need of mental health services. The Administrator of Mental Health Services in BHCS shall serve as the CMHP Director.

K. Services available through the CMHP include but are not limited to the following:

1. Outpatient mental health services for general population prisoners. This includes services through a Secure Status Outpatient Treatment Program (SSOTP) for prisoners with a mental disability who are clinically stable but, due to behavioral issues which present a risk to the custody and security of the facility, cannot receive outpatient mental health services in a traditional general population setting. A prisoner's out-of-cell activities and property may be restricted while in the program unless otherwise provided for in a current mental health management plan.

2. Residential Treatment Programs (RTP's) in specially designated housing units within Department facilities for general population prisoners who cannot function adequately in general population without significant supports and modified behavioral expectations. This includes an Adaptive Skills Residential Program (ASRP) for prisoners who have significant limitations in adaptive functioning due to a developmental disability or chronic brain disorder and a Secure Status RTP (SSRTP) for Level IV and V prisoners. A prisoner's out-of-cell activities and property may be restricted while in an RTP unless otherwise provided for in a current mental health management plan.

3. Inpatient treatment at the Woodland Correctional Facility, Women's Huron Valley Correctional Facility, and at other facilities as identified in the attachments to PD 05.01.140 "Prisoner Placement and Transfer" for prisoners who are at high risk of harming themselves or others, are in need of intensive assessment and treatment, or are chronically unable to cope with ordinary demands of life. Mental health services are

provided through a crisis stabilization program, acute services treatment, or rehabilitation treatment services. Therapeutic seclusion and/or therapeutic restraints may be used in these inpatient units as ordered by a psychiatrist and in accordance with institutional procedures.

L. The BHCS Administrator shall ensure that a program statement is developed for each type of mental health service available to prisoners. The program statement shall identify the program components and standards of service for each of these levels of care. The program statements also shall identify eligibility, admission, and discharge criteria for each of type of service offered through counseling services and intervention and the CMHP. An initial decision to admit and subsequent decision to discharge a prisoner shall be based on these criteria and the findings of a comprehensive psychiatric evaluation.

M. Mental health programs shall be conducted pursuant to the approved program statement. Transfers within the CMHP shall be based on these criteria and the concurrence of the attending treatment team, and in accordance with PD 05.01.140 "Prisoner Placement and Transfer".

REFERRAL FOR TREATMENT

N. Staff who suspect that a prisoner may be in need of mental health services shall refer the prisoner for a QMHP mental health evaluation. A prisoner also may request mental health services through BHCS.

O. All QMHP mental health evaluations shall be based on a review of the prisoner's mental health records and a face-to-face evaluation, which may be conducted through teleconferencing. Evaluations shall be completed in accordance with clinical standards developed by the Administrator of Mental Health Services. If the prisoner is referred for psychotherapy, an individualized treatment plan shall be developed and entered in the integrated health record. The QMHP shall refer the prisoner for a comprehensive psychiatric evaluation if clinically indicated.

P. If a prisoner is referred for a comprehensive psychiatric evaluation, the evaluation shall be performed by a QMHP who is a psychiatrist or nurse practitioner. All comprehensive psychiatric evaluations shall be based on a review of the prisoner's mental health records and a face-to-face evaluation, which may be conducted through teleconferencing. Evaluations shall be completed in accordance with clinical standards developed by the Administrator of Mental Health Services. A prisoner who is determined to be in need of psychiatric services through the CMHP shall be referred for such services as set forth in PD 04.06.183 "Voluntary and Involuntary Treatment of Mentally Ill Prisoners". For parolees, the Parole Board shall be immediately notified.

ADMISSION TO THE CMHP

Q. Prisoners shall be admitted into, and discharged, from the CMHP in accordance with CMHP program statement and as set forth in PD 04.06.183 "Voluntary and Involuntary Treatment of Mentally Ill Prisoners".

R. An individualized treatment plan shall be developed and entered in the integrated health record for each prisoner. The treatment plan shall identify the problems, goals, and objectives of treatment, interventions and treatment modalities; and amount of time, frequency, and responsible person for each aspect of care. The recommended treatment modalities shall be indicated in the prisoner's treatment plan and may include, but are not limited to, the following:

1. Pharmacotherapy;

2. Individual and/or group psychotherapy;

3. Adjunctive therapies (e.g., recreational, occupational, educational, planning for discharge and aftercare).

S. During the course of treatment, a physician, psychiatrist, nurse practitioner, or physician assistant may prescribe psychotropic medication. These medications shall be ordered, administered, and monitored in accordance with PD 04.06.183 "Voluntary and Involuntary Treatment of Mentally Ill Prisoners" and appropriate CMHP guidelines.

PROTECTION FOR PRISONERS RECEIVING SERVICES

T. A prisoner admitted to counseling services and intervention or to the CMHP shall be provided with the Mental Health Services Guidebook containing rights information, including contact information for rights representatives.

The Admission/Rights/Consent for Mental Health Services form (CHJ-321) shall be used to document the offender's receipt of the Guidebook.

U. A QMHP shall report suspected criminal abuse of prisoners receiving mental health services to the BHCS Mental Health Services Regional Manager, CMHP Rights Specialist, and Warden immediately upon knowledge, suspicion, or accusations reasonably believed to be true. Criminal abuse includes, but is not limited to, an assault, a homicide, and criminal sexual conduct. In addition, local law enforcement or the Michigan State Police (MSP) shall be notified immediately and a written report submitted to local law enforcement or the MSP, as appropriate, within 72 hours. The written report shall include the name of the prisoner, a description of the alleged criminal abuse, and other information available that might establish the cause of the alleged abuse and the manner in which it occurred. The report shall be included in the prisoner's medical record; however the name of the reporting QMHP and the individual accused of the abuse shall be deleted. This reporting requirement is in addition to any requirements contained in PD 01.05.120 "Critical Incident Reporting", PD 01.01.140 "Internal Affairs", and PD 03.03.140 "Prohibited Sexual Conduct Involving Prisoners".

DUTY TO WARN

V. Information obtained from a prisoner during treatment is generally privileged. However, pursuant to MCL 330.1946, the QMHP shall immediately advise the Warden both verbally and in writing if a prisoner threatens physical violence against a reasonably identifiable individual if the prisoner has the apparent intent and ability to carry out that threat in the foreseeable future. The QMHP shall provide the prisoner's name and number, the name and any other available identifying information regarding the person who has been threatened, and the precise nature of the threat.

W. The Warden shall ensure that the following actions are taken as soon as possible after receipt of notice from the QMHP:

1. A Special Problem Offender Notice (SPON) is issued pursuant to PD 03.03.110 "Special Problem Offender Notice" to ensure notification of the following upon parole, release, escape, or discharge:

   a. The threatened individual or, if the individual is known to be a non-emancipated minor or incompetent, to the Department of Human Services in the county where the individual resides and to the parent or legal guardian, if known.

   b. Local law enforcement or MSP in the area in which the threatened individual resides;

   c. Local law enforcement or MSP in the area in which the prisoner will be paroled, released, or discharged.

2. Written notification of the threat is sent to those identified on the SPON. If the threatened individual is another prisoner or an employee, notification also shall be provided verbally.

DOCUMENTATION OF MENTAL HEALTH SERVICES

X. All health care providers shall comply with the health record documentation requirements outlined in the Health Record Management Standards Manual. All mental health services shall be documented promptly in the prisoner's electronic medical record (EMR) within the integrated health record.

Y. Clinical documentation within the prisoner's integrated health record shall be used to drive the Department's managed electronic data system. The system shall enable mental health care personnel to identify and track prisoners with mental disabilities who have been referred for and received mental health treatment through all levels of the mental health services delivery system. The EMR shall provide summary output reports containing both individual case and aggregate information regarding patient characteristics and diagnostic groups and service utilization. EMR output reports shall be used to assist in individual cases and unit management, as well as administrative planning and decision making with regard to program capacity, program efficacy, and staff allocations. Appropriate automated EMR output reports shall be made available to mental health treatment teams, health record offices, and BHCS Central Office.

Z. Only personnel trained in data entry shall enter information into the managed electronic data system. Mental

health staff shall make available to data entry staff the clinical or mental health care information required to be entered into the system. The unit chief shall ensure that information entered in the system is entered accurately and in a timely manner.

AA. There shall be documentation of EMR audit report review and completion of any required error corrections. Signed and dated EMR audit reports shall be retained in a secure fashion for at least one year for auditing purposes.

PROCEDURE

BB. The BHCS Administrator shall ensure that procedures are developed as necessary to implement requirements set forth in this policy directive. This shall be completed within 60 calendar days after the effective date of the policy directive. This requirement includes ensuring that existing procedures are revised or rescinded, as appropriate, if inconsistent with policy requirements or no longer needed.

AUDIT ELEMENTS

CC. A Primary Audit Elements List has been developed and is available on the Department's Document Access System to assist with self audit of this policy pursuant to PD 01.05.100 "Self Audit of Policies and Procedures".

APPROVED: DHH 02/25/13

MICHIGAN DEPARTMENT OF CORRECTIONS **OPERATING PROCEDURE**	EFFECTIVE DATE DRAFT 8/15/2012	NUMBER DRAFT
SUBJECT Mental Health Services – Counseling Services and Intervention (CSI) New Arrivals, Treatment and Discharge	SUPERSEDES NEW	
	AUTHORITY PD 04.06.180	
	PAGE 1 of 4	

OBJECTIVE:

To establish a procedure to ensure prisoners with a need for short term intervention are indentified, evaluated and treated for Counseling Services and Interventions in an appropriate and timely manner.

FORMS USED:

CHJ-194 Mental Health Record - Data Entry
CHJ-246 Mental Health Referral/Evaluation - Data Entry
CHJ-321 Admission/Rights/Consent for Mental Health Treatment
Behavioral Health Treatment Plan
Behavioral Health Treatment Plan Review
Behavioral Health Progress Note
Behavioral Health Intake/Admission Assessment
Brief Symptom Inventory Test (BSI)
CSI Satisfaction Survey
Management Plan
Mental Health Evaluation/Admission Referral
Monthly Group Therapy Progress Notes
Prisoner Orientation Welcome Letter
QMHP Evaluation Report
Segregation Progress Note

REFERENCE DOCUMENTS:

Mental Health Record Documentation Standards
Health Record Management Standards
Health Information Systems Manual

DEFINITIONS:

A. Business Day - Monday through Friday, excluding holidays.

B. Corrections Mental Health Program (CMHP) – The program provided to treat prisoners with serious mental illness/severe mental disorder. The program includes outpatient level of care, residential treatment program units, adaptive skills residential programs, rehabilitation treatment services, inpatient services and crisis stabilization programs.

C. Counseling Services and Intervention (CSI) – Programming which involves brief counseling/psychotherapy. It includes but is not limited to, supportive counseling, brief therapy, solution focused therapy, cognitive-behavioral therapy, and dialectical behavior therapy. Prisoners are admitted and discharged from the counseling program by a qualified mental health professional (QMHP). The QMHP is not required to be a psychiatrist.

D. Integrated Health Record - The documentation of all health services provided to the prisoner, both onsite and offsite.

E. Management Plan - A plan developed and given to the custody staff to help in the

management of the mentally disabled/ill prisoner. The management plan is used for prisoners on interventions for suicide/self-injury risk, segregation prisoners and management in RTPs and ASRPs. The management plan will include the problem or rationale, restrictions, frequency of observations, behaviors to observe and report, staff interventions and frequency of QMHP evaluation.

F. Mental Disability: Any of the following mental conditions:

- Mental illness, which is a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or the ability to cope with the ordinary demands of life.
- Severe chronic brain disorder which is characterized by multiple cognitive defects (for example, memory impairment resulting from a medical condition or brain injury due to trauma or toxins).
- Developmental disorder, which usually manifests before the age of 18 years and is characterized by severe and pervasive impairment in several areas of development (for example, autism; retardation).

G. Mental Illness – A substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality or ability to cope with the ordinary demands of life.

H. Qualified Mental Health Professional (QMHP) – A physician, psychiatrist, nurse practitioner, physician's assistant, psychologist, social worker or registered nurse who meet the requirements set forth in MCL 330.1100b and is trained and experienced in the areas of mental illness or mental disabilities.

I. Treatment Plan - The treatment plan shall identify the problems, goals and objectives of treatment (with timelines and measures); intervention and treatment modalities; and amount of time, frequency and responsible person for each aspect of care.

CSI TRANSFERS INTO FACILITY

WHO		DOES WHAT
MH Secretary	1.	Print Corrections Management Information System (CMIS) HC-281 report daily; enter admission/transfer data to the MHR screen the same day prisoner arrives or appears on the HC-281 report. Notify Unit Chief of prisoner arrival, suicide level and lock.
Unit Chief/Designee	2.	Assign QMHP to case.
QMHP	3.	Schedule evaluation interview to be held within five (5) business days of receiving notice of inmates' arrival. Place prisoner on call out for appointment. **NOTE: CSI PRISONERS ARRIVING ON A MANAGEMENT PLAN SHOULD BE ADDRESSED IN ACCORDANCE WITH THE MANAGEMENT PLAN GUIDELINES.**
	4.	Meet with prisoner within five (5) business days. Provide inmate with Prisoner Orientation Welcome Letter and document in the integrated health record.
	5.	Review health record, and complete a new Behavioral Health Intake/Admissions Evaluation.

WHO	DOES WHAT	
QMHP	6.	Have prisoner sign Admission/Rights/Consent for Mental Health Treatment Form (CHJ-321) if no signed consent is currently in integrated health record.
	7.	Complete Treatment Plan within ten (10) business days of transfer into team. Complete Mental Health Record Data Entry (CHJ-194) reflecting the treatment plan completion with the current diagnoses; forward to the MH Secretary.
MH Secretary	8.	Enter data from the Mental Health Record Data Entry (CHJ-194) into CMIS; update the Health Update HCC status code on the back of the prisoner integrated health record; update the HCC status code in CMIS.
	TREATMENT IN CSI	
QMHP	9.	Evaluate prisoner at a minimum of every 30 days.
	10.	Document prisoner's progress on an Individual Therapy Progress Note or Monthly Group Progress Note according to the inmate's Treatment Plan and Documentation Guidelines in the Health Record Management Standards manual.
	11.	Re-evaluate prisoner every six (6) months. Document progress on a QMHP Evaluation, including conclusions and recommendations for discharge from CSI, continued treatment in CSI or referral to CMHP programs.
		IF DISCHARGE IS RECOMMENDED
	12.	Complete a BSI in accordance with OP 04.06.180G "BSI/BPRS Data Collection" and forward to MH Secretary. Provide inmate with a Satisfaction Survey. Complete a Mental Health Record Data Entry (CHJ-194) within one business day and forward to the MH Secretary. Go to Step 17.
		OR
		IF CONTINUED CSI SERVICES IS RECOMMENDED
	13.	Revise the Treatment Plan. Complete the Mental Health Record Data Entry (CHJ-194) within one business day and forward to the MH Secretary. Continue following OP for Treatment in CSI.
		OR
		IF REFERRAL TO CMHP PROGRAM IS RECOMMENDED
	14.	Complete a Mental Health Evaluation/Admission Referral then follow OP 04.06.180A Draft "Initial Referrals and Intakes to Mental Health Services". Complete a Mental Health Record Data Entry (CHJ-194) and the top and middle portion of a Mental Health Referral/Evaluation Data Entry (CHJ-246) within one business day and forward to the MH Secretary.
MH Secretary	15.	Enter within one business day of receipt the data from the Mental Health Record Data Entry (CHJ-194) and/or Mental Health Referral/Evaluation Data Entry (CHJ-246) into CMIS. Update the Health Update HCC status codes on the back of the prisoner health record and in CMIS.

WHO	DOES WHAT
QMHP	16. Record BSI data on the data collection score sheets. Forward BSI data collection score sheets to the designated collection point at end of month.

DISCHARGE FROM CSI

QMHP	17. Complete a QMHP Report titled as a Discharge Evaluation which is to include conclusions and recommendations. Complete a BSI in accordance with OP 04.06.180G "BSI/BPRS Data Collection". Provide inmate with a CSI Satisfaction Survey. Complete within one business day a Mental Health Record Data Entry (CHJ-194). Forward completed BSI, CSI Satisfaction Survey and Mental Health Record Data Entry (CHJ-194) to the MH Secretary.
MH Secretary	18. Enter data within one business day from the Mental Health Record Data Entry (CHJ-194) into CMIS. Update the Health Update HCC status codes on the back of the prisoner health record and in CMIS.
	19. Record BSI data on the data collection score sheets. Forward BSI data collection score sheets and CSI Satisfaction Survey to the designated collection point at end of month.

CSI PRISONERS IN SEGREGATION

MH Secretary	20. Print daily the HC-141 "At Risk in Segregation Report" and HC-161 "Mental Health Referral Report". Notify QMHP when CSI prisoners' names appear on the HC-141 or referral to CSI appears on the HC-161, and/or kites and ROBERTA-R(s) are received.
QMHP	21. Evaluates CSI prisoners in Segregation within one (1) business day of notification. Document evaluation on Segregation Progress Note.
	22. Complete Mental Health Referral/Evaluation Data Entry (CHJ-246) within one business day if prisoner is referred via the CMIS reports. Forward completed form to MH Secretary.
	23. Re-evaluate prisoner every 30 days for as long as prisoner remains in Segregation, unless there is a clinically indicated need to evaluate more frequently. Document follow up evaluations on Segregation Progress Note.
MH Secretary	24. Enter data within one business day of receipt the data from the Mental Health Referral/Evaluation Data Entry (CHJ-246) into CMIS.
	Note: All referrals from the HC-141, "At Risk in Segregation Report" are considered emergent..

Approved by: _____ **Date:** _____

Prepared By: Bureau of Health Care Services, Mental Health Services

McKerr, Joseph (AG)

From:	Govorchin, Peter (AG)
Sent:	Thursday, March 07, 2013 4:58 PM
To:	DeClercq, Susan (USAMIE) (Susan.DeClercq@usdoj.gov); Levy, Judith (USAMIE) (Judith.Levy@usdoj.gov); Nelson, Pam R. (MDOC)
Cc:	Johnson, Daphne (MDOC); Warren, Millicent (MDOC)
Subject:	Bonus attachments to the WHV response to the DOJ action letters of 6-6-11 aand 6-4-12
Attachments:	attachment O.pdf; attachment P.pdf

Susan, Judith and Mellie, here are the final (or so I thought) attachments to WHV's response letter to the action letters of 6-6-11 and 6-4-12.

Maybe the next email will be the last in the series.

Attachment O

LINDSAY HAYES REPORT3/7/2013

	A	B	C	D	E	J
2	AREA	#	VIOLATION NOTED	COMPLETE	ANTICIPATED COMPLETION DATE	NOTES
3	Staff Training	1.a.	Discontinue use of any computer-based training program for suicide prevention.	December 2010 and October 2012; initially and again on 12-5-12		1) 8 hour live training for all staff in December 2010 - clinical, custody, housing, and supervisors. Periodic updates as needed. 2) 4 hour live training on October 24, 2012 to approximately 160 WHV staff members and 60 prisoner-candidates for the new Prisoner Observation Aide classification. Follow-up Prisoner Observation Aide training on December 5, 2012. Prisoner Observation Aide Training on February 7, 2013. 3) November 7, 2012 and November 8, 2012 - DBT Training to approximately 200 WHV custody, housing and mental health staff.
4	Staff Training	1.b.	Ensure that all correctional, medical, and mental health personnel working at huron valley receive eight hours of initial suicide prevention training. At a minimum, the program should include avoiding negative attitudes to suicide prevention, prison suicide research, why correctional environments are conducive to suicidal behavior, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, identifying suicidal inmates despite the denial of risk, components of the suicide prevention policy, and liability issues associated with inmate suicide.	December 2010	December 2010	
5	Identification/ Screening/ Assessment	2.a..	Require that state counties submit a completed "sheriff's questionnaire for delivered persons" form whenever an inmate is transferred from county to state custody.	No	N/A	Require the questionnaire; however, not within MDOC's authority to make regular requests.

	A	B	C	D	E	J
2	AREA	#	VIOLATION NOTED	COMPLETE	ANTICIPATED COMPLETION DATE	NOTES
6	Identification/ Screening/ Assessment	2.b.	Revise the criteria for an inmate/patient's entry into the out-patient mental health services program to allow less restrictive criteria, as well as eliminate the provision that a psychiatrist is the sole determiner of services.	Yes	Approx. March 2011	
7	Communication	3.a.	Maintain a daily roster of all inmates on suicide precautions and distribute the list to appropriate correctional, medical, and mental health personnel.	Yes	February 2011	On blotter report
8	Housing	4.a	Ensure that suicidal inmates are housed in "suicide resistant" cells, i.e., without any obvious protrusions that would easily enable an inmate to hang herself.	Yes	June 2011 through December 2014	Suicide resistant cells are in segregation, acute care (Calhoun Unit A), RTP (Emmett Unit A), and infirmary (under construction)
9	Housing	4.b.	Revise policies and procedures for the management of suicidal inmates in general population to be housed in the least restrictive setting possible. Restrictions must be reasonable and commensurate with the inmate's level of suicide risk. The new procedures should include, but not be limited to, the following:			
10	Housing	4.b.1	All decisions regarding the removal of an inmates's clothing, bedding, possessions (books, shoes or slippers, eyeglasses, etc.) And privileges shall be commensurate with the level of suicide risk as determined on a case-by-case basis by mental health staff. There must be written justification as to why an inmate under constant observation needs to be issued a safety smock.			See Suicide Prevention Guidelines
11	Housing	4.b.2	All inmates on suicide precautions shall be allowed all routine privileges (e.g., family visits, showers, telephone calls, recreation, etc.), unless the inmate has lost those priviliges as a result of a disciplinary sanction;	Partial		1) Visits allowed. 2) Showers allowed. 3) Personal property and telephone calls restricted.
12	Housing	4.b.3	Safety smocks shall never be utilized to deter/punish perceived manipulative behavior.	Yes	March 2011	

	A	B	C	D	E	J
2	AREA	#	VIOLATION NOTED	COMPLETE	ANTICIPATED COMPLETION DATE	NOTES
13	Housing	4.c.	Revise and implement policies so that an inmate is not subect to disciplinary sanction and/or charged for medical services as a result of engaging in self-inurious behavior.	No		Prohibited by state law. Law interpreted to require ability to control conduct. No control - no charge.
14	Levels of Supervision/ Management	5.a.	tilie two suicide risk levels and require that suicidal inmates be observed in a range between constant observation and intervals of 10 to 15 minutes.	No/ Partial		Safety precuations apply to high and moderate risk 2 levels). Intermediate and low relate only to frequency of M HP contacts, not to observation.
15	Levels of Supervision/ Management	5.b.	Mental health staff must "assess," not simply "see," suicidal inmates on a daily basis, and must enter quality progress notes into the mental health section of the inmate's medical record.	Yes	April/May 2011	
16	Levels of Supervision/ Management	5.c.	Suicide risk evaluations must provide a sufficient description of the current behavior and ustification for a particular level of observation and/or discharge from suicide precautions. "cell-side" assessments should be avoided whenever possible, and ustified in writing if utilied.	Yes / when safely possible	April/May 2011 / July 27, 2011	Out of cell assessments done when safely possible
17	Levels of Supervision/ Management	5.d.	Discontinue the practice of contracting for safety.	Yes	Mid-2011	Not used at WHV since mid-2011
18	Levels of Supervision/ Management	5.e	mental health staff must provide regularly scheduled follow-up assessments of all inmates discharged from suicide precautions until their release from custody unless an inmate's individual circumstances direct otherwise e.g., an inmate inappropriately placed on suicide precautions by non-mental health staff and released less than 24 hours later following an assessment). A reassesment schedule following discharge from suicide precautions should be within the first 24 hours, then within the next 72 hours, then within the next week, and then periodically until release from custody.	Partial	March 2011	The step down level of suicide precautions (intermediate level and low) are the procedures used for follow-up. See Suicide Prevention uidelines

	A	B	C	D	E	J
2	AREA	#	VIOLATION NOTED	COMPLETE	ANTICIPATED COMPLETION DATE	NOTES
1	Levels of Supervision/ Management	5.f.	Develop treatment plans for all inmates on suicide precautions greater than 24 hours, regardless of whether they are on the mental health caseload. The treatment plans must describe signs, symptoms, and the circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient or staff can take if suicidal thoughts do occur.	Partial	March 2011	For duration of the suicide risk, a management plan is developed and followed.
20	Intervention	6.a.	To ensure efficient emergency response to suicide attempts, incorporate "mock drills" into both initial and refresher training for all staff.	Yes	Since WHV	Is sometimes a part of a mobiliation drill.
21	Reporting	7.a.	The critical incident report regarding an inmate's death, must include the time that the inmate was last observed alive.	Not required by PD 01.05.120 "Critical Incident Reporting"	Has been the practice for many years	This information is often included in the full critical incident report in the involved person's statements.
22	Reporting	7.b.	Discipline any employee who violates a policy, falsifies a document, or impedes an investigation.	Yes	Since WHV inception	Standard Operating Procedure

	A	B	C	D	E	J
2	AREA	#	VIOLATION NOTED	COMPLETE	ANTICIPATED COMPLETION DATE	NOTES
23	Follow-up/morbidity-mortality review conclusion/ remedy	8.a.	The area of follow-up morbidity/ mortality review is deferred because we were not allowed to review the mortality reviews conducted on the four 4) recent inmate suicides, and it was unclear if the process also included a morbidity reviewfor serious suicide attempts i.e., incidents requiring outside medical treatment). The department renews its request for its suicide prevention consultant to review these records so that he can provide any constructive feedback that may be needed for ada compliance.	Deferred	Deferred	Mortality Review is protected by peer review privilege.
24	Follow-up/morbidity-mortality review conclusion/ remedy	8.b.	Include the topic of suicide prevention in quality assurance and performance improvement plans.	Yes	Current	As part of training I/A

DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
SUICIDE/SELF-INJURY RISK ASSESSMENT AND INTERVENTIONS MANAGEMENT GUIDELINES

INTRODUCTION:

There is no single instrument, protocol, or combination of factors which can reliably predict the likelihood of suicide attempts or self-injury in the prison population. Evaluating risk is a complex clinical process in which generally understood risk factors, gleaned from retrospective analysis and normative data must be weighed in terms of their impact and meaning for the individual. Qualified mental health professionals (QMHP) must assess the level of suicide risk (on a continuum which includes the categories high, moderate, intermediate, and low) employing their clinical judgment. The following guidelines identify critical factors or variables which the QMHP is expected to consider. In general, the greater the number of factors involved and the greater the intensity or severity, the higher the risk.

Research indicates the more severe the anxiety, panic attack, agitation, severe insomnia, rage, and anger, the greater the risk of suicide attempts in the immediate future.

Research also indicates that, in the prison system, there are certain time periods in which a higher risk for suicide exists. Some of these periods include: Prisoner's entry to prison system, parole decisions (favorable and unfavorable,) discharge from prison, and other stressors such as divorce, death of family member, etc.

Similarly, there is no single prevention plan which meets the needs of a prisoner judged to be at risk for self-injury or suicide attempt. When a risk of intermediate level or greater has been determined, the QMHP is required to make recommendations in the form of a Mental Health Management Plan. These guidelines include categories which must be considered, and actions which may be included in developing a management plan for prisoners at each risk level.

The QMHP should engage in interventions to address reduction of anxiety, anger, insomnia, and psychotic symptoms. Interventions to be considered include: de-escalating techniques, cognitive behavioral techniques or interventions, relaxation activities, and possible referral to a psychiatric provider for medication to address acute symptoms.

When completing a management plan for the behaviors to observe, the plan should be written in basic, general language, not clinical terminology. For example, "behaviors to look for include agitation, fidgeting, wringing of hands, excessive body movement, rocking, pacing, moaning, pounding doors, threats of assaultive behaviors." In addition, some of the de-escalation techniques should be listed such as engaging in active listening, problem solving, asking open ended questions, and making positive and encouraging responses.

Note: All prisoner suicide evaluations and follow up treatment are to occur out of the observation cell per the Chief Psychiatric Officer Memorandum 2011-3 unless contraindicated due to security or safety concerns.

QMHP ASSESSMENT OF SUICIDE RISK LEVEL:

I. HIGH RISK

Determination of High Risk assessment requires referral to the Crisis Stabilization Program (Operating Procedure 04.06.180B), direct, continuous observation and a management plan.

A. Self-injurious acts, especially if violent, near-lethal, or premeditated, which require emergency medical care.

B. Confirmed current symptoms of a severe depression with a constant suicidal preoccupation with a specific plan (described verbally or in writing) for imminent end to one's life:

- Lethality
- Opportunity
- Immediacy (plan to "smoke" oneself to death is not high risk.)

C. Recent, sudden changes in mental status

D. Severe mood or perceptual disturbance including:

- Severe agitation
- Manic behavior/panic attacks
- Severe anger/hostility/rage
- Severe psychotic symptoms, especially delusions or hallucinations
- Severe anxiety
- Severe insomnia

E. Confirmed historical factors including:

- Repeated suicide attempts or self-injurious acts
- Seriousness or potential lethality of these acts
- Mental illness (especially a Major Mental Illness diagnosis)

II. MODERATE RISK

Determination of Moderate Risk requires observation at least every 15 minutes and a management plan. A combination of some or all of the following factors requires moderate risk determination.

A. Threats of suicide or serious self injury.

B. Moderate mood or perceptual disturbance including:

- Major depressive episode
- Agitation/anxiety
- Manic behavior
- Anger/hostility
- Expressed desire for revenge
- Some psychotic symptoms, especially delusions or hallucinations
- Severe hopelessness and/or helplessness.

C. Confirmed historical factors including:

- Repeated suicide attempts or self-injurious acts
- Seriousness or potential lethality of these acts

- Mental illness (especially a Major Mental Illness diagnosis)

D. Minor self-injurious acts or suicidal gestures designed to elicit attention.

E. Strong statements made to manipulate environment for secondary gain (e.g., If this happens, I might feel like committing suicide, cutting myself, etc.)

III. INTERMEDIATE RISK

Movement downward from higher levels of risk and interventions requires a transitional period of intermediate risk and heightened awareness. Major life stressors outside the norm for prison can also necessitate a transitional period of intermediate risk. The following factors may be used in determining the need for intermediate risk management:

A. Return from inpatient treatment.

B. Upon prisoner's release from safety precautions after evaluation and determination that individual is no longer at high or moderate risk for suicide or self-injury.

C. Threats of self-harm by prisoners who are being transferred from a RTP or hospital to an Outpatient setting. The threats appear manipulative in nature and designed to stop planned placement.

D. Report of occasional self-destructive thoughts, although no evidence of current threat.

E. Major life stressors outside the norm for prison, such as: divorce, death of family member or significant other, threats of harm by other prisoners, lawsuits, new charges, etc.

F. Entry to prison, parole violation/return to prison, parole decisions (favorable and unfavorable,) discharge from prison are statistically higher risk periods.

IV. LOW RISK

Determination of Low Risk does not require special precautions or a management plan.

A. History of suicide attempt or superficial self-injuries for secondary gain but no evidence of suicidal ideation or self-injurious behavior in past month.

B. No history of suicide attempts or self-injurious acts.

C. Normal stressors of incarceration.

MANAGEMENT PLAN GUIDELINES:

NOTE: When suicidal or self-injurious behavior is observed by custody staff and urgent medical treatment for injury is not required, the prisoner must be placed immediately in an observation room on safety precautions with continuous observation. A Mental Health Services Referral (CHX-212) for a QMHP evaluation must be initiated. After face-to-face, out of cell evaluation of the prisoner, the QMHP will determine appropriate actions in accordance with the guidelines found

below and complete a Mental Health Management Plan. The QMHP will complete a new mental health management plan to address changes in the prisoner's condition or whenever the prisoner's risk level increases or decreases (with the exception of Low Risk.)

I. HIGH RISK

A. When the QMHP concludes that the prisoner is at a HIGH RISK FOR SUICIDE, refer for admission to the Crisis Stabilization Program.

B. While referral is pending, the management plan must address:

1. RESTRICTIONS - All safety precautions listed in policy remain in force. Additional restrictions, such as restraints, may be implemented if prisoner continues to engage in serious suicidal behaviors and should only be used after all other attempts, including medication if deemed appropriate by a Psychiatric Provider or Medical Services Provider, have been implemented to stop the prisoner's suicidal behavior. The use of restraints should only be considered as a last resort and are to be used on a short-term basis until the prisoner regains composure or is transferred to a higher level of care, whichever occurs first. Use of restraints should begin with soft restraints.

2. FREQUENCY OF OBSERVATION – Must be direct, face to face, and continuous.

3. BEHAVIORS TO OBSERVE AND REPORT - These will be specific to the prisoner. Identify any usual behaviors known to have preceded escalation or past attempts at suicide.

4. STAFF INTERVENTIONS - Linked to behaviors observed in #3 above. Identify specific actions recommended to officers, RUMs, counselors, and health care workers.

5. FREQUENCY OF QMHP CONTACT - Clearly identify the frequency of planned prisoner contact by QMHP. Include any behaviors which, when observed, require immediate notification of QMHP. Until transfer to CSP, prisoner must be seen at a minimum of once per day.

II. MODERATE RISK

A. When the initial QMHP evaluation is inconclusive, or the prisoner is engaged in non-suicidal self-injurious behavior, continue safety precautions and placement in observation room and develop a Management Plan as described in B. (NOTE: Generally, the length of stay in observation room may not exceed seven days unless reasons for stay are documented by a QMHP and an intervention plan is formulated.)

B. When the QMHP concludes that the prisoner is at a MODERATE RISK for suicide or is engaging in self-injurious behavior, a Mental Health Management Plan must be developed. The plan shall be reviewed and revised as needed at least every seven days. The plan shall address the following:

1. RESTRICTIONS - Continued safety precautions, including observation cell placement, for a minimum of one day. All safety precautions listed in policy remain in force. Additional restrictions, such as restraints, may be implemented if prisoner continues to engage in serious self-injurious behaviors and should only be used after all other attempts, including medication if deemed appropriate by a Psychiatric Provider or Medical Services Provider, have been implemented to stop the prisoner's self-injurious behavior. The use of restraints should only be considered as a last resort and are to be used on a short-term basis until the prisoner regains composure or is transferred to a higher level of care, whichever occurs first. Use of restraints should begin with soft restraints.

2. FREQUENCY OF OBSERVATION - Minimum every 15 minutes

3. BEHAVIORS TO OBSERVE AND REPORT - These will be specific to the prisoner. They must include specific behaviors known to have preceded previous suicide attempts or episodes of self-injury. Additionally, they must include particular symptoms of mental illness, mood or mood changes, or statements and behaviors requiring action.

4. STAFF INTERVENTIONS - May be routine or can be linked specifically to behaviors observed in #3. Identify specific actions recommended to officers, resident unit managers, counselors, health care workers.

5. FREQUENCY OF QMHP CONTACT - Clearly identify the frequency of planned contact by QMHP. Include any behaviors which, when observed, require immediate notification of QMHP. At a minimum, face-to-face out of cell contact by a QMHP is required every other business day until the prisoner is removed from safety precautions.

III. INTERMEDIATE RISK

A. When the QMHP concludes that the prisoner is at INTERMEDIATE RISK, a Mental Health Management Plan must be developed that addresses:

1. RESTRICTIONS - NONE for intermediate risk. Intermediate risk prisoners are not placed in observation cells or on suicide precautions.

2. FREQUENCY OF CONTACT - Recommendations for various correctional staff interactions with prisoner may include: contact by designated officer each shift or at certain time of day (e.g., within one hour of bedtime, talk with resident unit manager daily, etc.)

3. BEHAVIORS TO OBSERVE AND REPORT - These will be specific to the prisoner. The QMHP will include information about specific behaviors, responses to inquiries, or actions which have proceeded past deterioration in condition. The plan will identify all behaviors which, when observed, require immediate notification of the QMHP.

4. STAFF INTERVENTIONS - May be routine related to #1 above or specifically linked to behaviors observed in #3 above. Identify specific actions recommended to officers, resident unit managers, counselors or health care workers.

5. FREQUENCY OF QMHP CONTACTS – All Mental Health Management Plans will identify the frequency of planned contact by the QMHP. At a minimum, a face-to-face out of cell interview will occur every other business day for one week, then weekly for two additional weeks.

IV. LOW RISK

A management plan is not required. Safety precautions and observation cell placement are not used with low risk prisoners. QMHP may, however, share information with resident unit manager concerning prisoner's treatment status, recent and past risk evaluations, history of suicide attempts or self-injuries, and other information pertinent to management of the prisoner on the unit. As necessary for managing the prisoner on the unit, the resident unit manager may notify custody staff of pertinent information.