Govorchin, Peter (AG)

From: Govorchin, Peter (AG)
Sent: Monday, April 29, 2013 4:41 PM
To: 'Nelson, Mellie (CRT)'; Levy, Judith (USAMIE) (Judith.Levy@usdoj.gov); DeClercq, Susan (USAMIE) (Susan.DeClercq@usdoj.gov)
Subject: FW: Huron report
Attachments: 20130429162211983.pdf; 20130429163304086.pdf; 20130429163331823.pdf; 20130429163355084.pdf

Mellie, Judith and Susan, you requested several documents in anticipation of the May 1, 2013 meeting at WHV:

Pages 1, 5: Suicide training curricula for the 8 hour and 4 hour training and documentation of the staff trained:
Response: These are being collected and will be emailed separately.

Page 3: Behavioral Health Intake Admissions Evaluation form:
Response: First Attachment.

Page 4: Does Attachment O "Department of Corrections, Mental Health Services, Suicide/Self-Injury Risk assessment and Interventions Management Guidelines," revised May 4, 2012, supplement other referenced policy directives, including WHVCF's Operating Procedure on "Suicide Prevention-In-Patient Units," WHVCF's "Suicide Prevention for Women in General Population," and MDOC's Policy Directive on "Suicide Prevention"?
Response: Yes.

If so, please provide the revised policy directives.
Response: Second, third and fourth Attachment.

For Wednesday's meeting, how many on behalf of DOJ will be attending?

From: Nelson, Mellie (CRT) [mailto:Mellie.Nelson@usdoj.gov]
Sent: Tuesday, April 16, 2013 4:47 PM
To: Govorchin, Peter (AG)
Cc: DeClercq, Susan (USAMIE); Levy, Judith (USAMIE)
Subject: Huron report

Attached is Lindsay Hayes' report of his review of your March 7, 2013 letter and attachments. We wanted you to have this before our May 1st meeting. As you will note, Mr. Hayes mentions several items he would like to review. We request that you provide the following documents he references in this report:

Pages 1, 5: Suicide training curricula for the 8 hour and 4 hour training and documentation of the staff trained
Page 3: Behavioral Health Intake Admissions Evaluation form
Page 4: Does Attachment O "Department of Corrections, Mental Health Services, Suicide/Self-Injury Risk assessment and Interventions Management Guidelines," revised May 4, 2012, supplement other referenced policy directives, including WHVCF's Operating Procedure on "Suicide Prevention-In-Patient Units," WHVCF's "Suicide Prevention for Women in General Population," and MDOC's Policy Directive on "Suicide Prevention"? If so, please provide the revised policy directives.

Thank you for your help in this matter. We look forward to our upcoming meeting. Mellie

REVIEW OF ADDITIONAL WHVCF/MDOC SUICIDE PREVENTION DOCUMENTS

I. Correspondence from Assistant Attorney General (for the State of Michigan, Department of Attorney General, dated March 7, 2013)

Relevant discussion of mental health care and suicide prevention begins on page 9 of the Assistant Attorney General (AAG)'s correspondence. This writer was surprised to read that "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." This writer was on-site at the WHVCF in January 2011 and was **never** informed of an 8-hour suicide prevention workshop that had been allegedly conducted a month earlier, nor was provided with a suicide prevention training curriculum reflecting 8 hours of instruction. As reflected in this writer's 2011 report, a curriculum of only 2 hours in length was provided for review and found to be problematic.

Both the 8-hour and 4-hour suicide prevention training curricula identified in the AAG correspondence, as well as verification that "all" WHVCF personnel were trained, should be forwarded for review.

The AAG correspondence indicates that the WHVCF initiated a "Prisoner Observation Aides" program in September 2012. Despite its popularity within the federal Bureau of Prisons, prisoner observation aides programs remain very controversial and only utilized in a small number of state prison systems around the country. The informal use of other inmates to prevent suicides can have various positive attributes, such as having an additional set of eyes watching suicidal inmates, and providing needed companionship to alleviate despair and the loneliness of single cell isolation. However, when use of the program becomes formalized and inmates are given the responsibility to observe other inmates on suicide precautions, and are used as a substitute for (and not a supplement to) the requirements of correctional officers, obvious ethical, legal, and life safety concerns are manifested. Despite promises to the contrary, use of other inmates to manage inmates on suicide precautions can result in relaxation of staff responsibilities for inmate safety and treatment, resulting in death.

Within the WHVCF, it would appear from the description of the program that inmates on "high risk" observation status requiring continuous observation by correctional staff (pursuant to policy) are now instead being observed by prisoner observation aides. If such a practice is occurring, it would be contrary to national correctional standards, including those of the National Commission on Correctional Health Care, which require that "other supervision aids (*e.g.*, closed-circuit television, inmate companions, or watchers) can be used as a supplement to, but never as a substitute for, staff monitoring." In other words, an inmate at "high risk" for suicide must receive "direct, face to face, and continuous" observation from staff.

Finally, the most distressing section of the AAG correspondence appears at the bottom of page 11 and reads that "*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 demonstrated in the medical chart of the inmate who committed suicide in May 2012, as well as indicated in the charts of the other inmate suicides, the victim had a history of mental health treatment, psychotropic medication, self-injurious behavior, and complaints about increased anxiety and depression throughout her WHVCF confinement. Despite this information, she never received a comprehensive mental health evaluation to verify/disprove an Axis I diagnosis and/or unsubstantiated Axis II: Borderline Personality Disorder (BPD). In addition, during her 14-month confinement within the WHVCF, there was **no** documentation to warrant a diagnosis of BPD (nor documentation in any available prior records), and contrary to the standard of care, there was never an attempt to rule out and/or rule in an Axis I diagnosis (despite a notation of "diagnosis deferred").

Finally, despite the inmate's request to restart her psychotropic medication in October 2011, the clinician responded with a note that stated "mental health will monitor the degree of Ms. ____'s psychological distress to determine whether a referral to the psychiatrist is warranted." Although Ms. ____'s psychological distress appeared to progressively worsen with increased anxiety and depression—as reflected in her placement on suicide precautions for self-injurious behavior on two occasions, periodic placement in segregation for various rule violations, denial of parole/ineligibility for boot camp program, disturbing family news, relationship problems her peers and girlfriend—and she was **never** referred to a psychiatrist for a psychotropic medication evaluation.

In conclusion, given this writer's inability to review the mortality reviews because they have been withheld by MDOC, it is unclear whether there is a uniform belief within the MDOC that the inmates who committed suicide in the WHVCF were not mentally ill **or** whether this is simply a philosophy held by the AAG.

II. <u>Attachment N</u> (MDOC Policy Directive: Mental Health Services and MDOC Operating Procedure: Mental Health Services - Counseling Services and Intervention (CSI), New Arrivals, Treatment and Discharge)

This writer reviewed "MDOC Policy Directive: Mental Health Services," effective March 18, 2013, and "MDOC Operating Procedure: Mental Health Services - Counseling Services and Intervention (CSI), New Arrivals, Treatment and Discharge," draft of August 15, 2012. It would appear from these policy directives that the MDOC has chosen to differentiate between inmates who are experiencing a "psychological disturbance" from those inmates who have been diagnosed with a "mental illness" or "mental disability" and/or need of mental health services.

As such, two parallel systems are apparently in place: (1) the <u>Counseling Services and Intervention</u> system for inmates "who have been determined by a QMHP to have psychological disturbances that did not meet the threshold for a mental disability but significantly impairs psychosocial functioning," and (2) the <u>Corrections Mental Health Program</u> which "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."

Although not stated in either policy or directive, and for reasons that remain unclear, it would appear that inmates with an Axis I diagnosis of a serious mental illness would receive services in the Corrections Mental Health Program, whereas inmates perceived to have an Axis II behavioral disorder are likely to receive services in the Counseling Services and Intervention program. It also remains unclear from review of the descriptions for both programs as to the specific assessment process for admittance to the programs. It is also unclear as to which program would provide services to an inmate diagnosed with both an Axis I **and** Axis II disorder. Review of the "Behavioral Health Intake Admissions Evaluation form," which was referred to in the CSI operating procedure but was not provided for review, might be helpful in addressing this issue.

This writer previously reviewed a draft of the CSI program (dated November 2011) and raised several questions regarding program criteria and exclusion. Many of these questions remain in the most recent draft of August 2012. For example, the objective of the CSI program is "to ensure prisoners with the need for short-term intervention are identified, evaluated and treated for counseling services and interventions in an appropriate and timely manner." The term "short-term intervention" is not defined and it is unclear as to the time parameters for referred inmates.

As previously offered, it still remains unclear from this revised August 2012 draft CSI policy if it covers any new admitted inmate into the MDOC (*i.e.,* recently sentenced and transported from a county jail system), or is limited to only transferred inmates. There is a procedure for "CSI Transfers Into Facility," but no narrative regarding new MDOC commitments.

Also because "psychological disturbance" is still not defined in the revised draft policy, it remains unclear as to whether a finding of no significant psychological disturbance would result in the denial of mental health services.

Under the August 2012 draft CSI policy, a QMHP is required to re-evaluate a CSI inmate "every 30 days for as long as prisoner remains in segregation, unless there is a clinically indicated need to evaluate more frequently." National correctional standards, including those of the National Commission on Correctional Health Care, require that **each** inmate held in segregation be seen **at least weekly** by medical and/or mental health staff. The CSI policy should be revised to reflect this schedule.

Finally, neither the "MDOC Policy Directive: Mental Health Services," effective March 18, 2013 or "MDOC Operating Procedure: Mental Health Services - Counseling Services and Intervention (CSI), New Arrivals, Treatment and Discharge," draft of August 15, 2012, contain any reference to a psychiatric referral for the purpose of an initial psychiatric evaluation and/or evaluation for the need of psychotropic medication.

In conclusion, in order to provide clarity regarding the full scope of mental health services provided within the WHVCF, whether it is provided through the CSI or CMHP, it would be extremely helpful if mental health officials from either the MDOC and/or WHVCF would opine on the following:

1) Would the inmate who committed suicide May 2012 been the recipient of services within either the Counseling Services and Intervention (CSI) program or the Corrections Mental Health Program (CMHP)? If so, which program?

2) Would this inmate have received a comprehensive mental health evaluation to verify/disprove an Axis I deferred diagnosis and/or unsubstantiated Axis II: Borderline Personality Disorder?

3) Would an inmate with a history of PTSD, anxiety, and depression be referred to a psychiatrist for a psychotropic medication evaluation after her anxiety and depression worsened during confinement (as reflected in placement on suicide precautions for self-injurious behavior, periodic placement in segregation for various rule violations, denial of parole/ineligibility for boot camp program, disturbing family news, relationship problems her peers and girlfriend, and willingness to restart psychotropic medication)?

III. <u>Attachment O</u> (Corrective Action Plan for Lindsay Hayes Recommendations and "Department of Corrections, Mental Health Services, Suicide/Self-Injury Risk Assessment and Interventions Management Guidelines," revised May 4, 2012)

Attachment O contains a document entitled "Department of Corrections, Mental Health Services, Suicide/Self-Injury Risk Assessment and Interventions Management Guidelines," revised May 4, 2012. An initial question is: Does this document supplement and/or replace other MDOC policies and directives previously reviewed in 2011, including WHVCF's Operating Procedure on "Suicide Prevention-In-Patient Units," WHVCF's "Suicide Prevention for Women in General Population," and MDOC's Policy Directive on "Suicide Prevention"?

If this document supplements these three policies/directives identified above, have these documents been revised? If so, they should be forwarded for review.

The May 4, 2012 version of the "Department of Corrections, Mental Health Services, Suicide/Self-Injury Risk Management and Interventions/Management Guidelines" is virtually identical to the document previously reviewed by this writer entitled "Corrections Mental Health Program Guidelines, Suicide/ Self-Injury Risk Management and Interventions," dated January 6, 2009. As such, apparently **none** of this writer's previous recommendations for policy revision were incorporated into the May 2012 version of the MDOC's suicide prevention program.

Attachment O also contains a multiple page Corrective Action Plan (CAP) in a spreadsheet format that addresses this writer's recommendations from the June 9, 2011 report on suicide prevention practices within the WHVCF. The spreadsheet was visually very helpful and outlines the State's varying commitment to implementing this writer's recommendations.

However, verification of compliance with the stated corrective actions cannot be confirmed without an on-site assessment. With that said, the following comments are offered:

A. **Staff Training**: The CAP indicates that an 8-hour live training for all staff was held in December 2010, with a 4-hour live training held on October 24, 2012, to approximately 160 WHV staff members. The CAP indicates "periodic updates as needed," whereas the AAG correspondence dated March 7, 2013 indicated that training would be provided "annually." Therefore, it remains unclear as to the frequency of the training (*e.g.*, national correctional standards highly recommend annual training), as well as the total percentage of correctional, medical, and mental health personnel receiving both the 8-hour training in 2010 and the 4-hour training in October 2012 (*i.e.*, the number of total correctional, medical, and mental health personnel employees trained versus the total number of personnel).

   As stated earlier, this writer was on-site at WHVCF in January 2011 and was never informed of, nor provided with documents relating to a suicide prevention training workshop and curriculum of 8 hours in length. As reflected in this writer's June 2011 report, only documents relating to a curriculum of only 2 hours in length were reviewed and found to be problematic..

   Both the 8-hour and 4-hour suicide prevention training curricula identified in the CAP should be forwarded for review.

B. **Identification/screening/assessment**: This writer previously found that the "Sheriff's Questionnaire for Delivered Persons" provided an excellent mechanism in which county jails could communicate health care needs of newly arrived inmates into the WHVCF, but that only approximately 20% of county jurisdictions throughout the State were cooperating in completing the form. The CAP indicates that it was "not within MDOC's authority to make regular requests" of the counties to complete the forms. Such a response is disappointing and unhelpful. The purpose of a CAP should be the development of a strategy to encourage all county jurisdictions to cooperate in completion of the form (*e.g.*, determining the reasons why 20% of the jurisdictions are cooperative and attempting to transfer such reasoning to the uncooperative jurisdictions).

C. **Housing**: The CAP indicates that "suicide-resistant cells are in segregation, acute-care, RTP, and infirmary." However, there was no information provided as to whether any renovation and/or remodeling of these areas had been made since this writer's survey of the cells to ensure that the designated cells were suicide-resistant, or whether the State simply disagreed with this writer's finding and believe these designated cells are already suicide-resistant.

   In addition, as stated in the CAP, this writer recommended that the MDOC "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." These recommendations

were offered because of the overly restrictive, punitive, and anti-therapeutic management of inmates on suicide precautions, particularly when housed in segregation. As reflected in this writer's June 2011 report, the conditions for inmates placed on suicide precautions in segregation were more restrictive than placement in segregation for a disciplinary sanction. As such, the following procedures were offered:

- All decisions regarding the removal of an inmate's clothing, bedding, possessions (books, shoes or slippers, eyeglasses, etc.) and privileges should 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 observations needs to be issued a safety smock;

- 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 privileges as a result of a disciplinary sanction;

- Safety smocks shall never be utilized to deter punish perceived manipulative behavior.

On these issues, the CAP simply refers readers to "See Suicide Prevention Guidelines," in an apparent indication that procedures regarding the above recommendations would be found in the "Department of Corrections, Mental Health Services, Suicide/ Self-Injury Risk Assessment and Interventions Management Guidelines" (or perhaps another document). Unfortunately, review of this document reveals that, other than a slight name change, it has remained virtually **unchanged** from the January 2009 version and, more importantly, does **not** contain any narrative regarding possessions and privileges afforded to inmates on suicide precautions. In addition, the CAP indicates that: "1) Visits allowed, 2) Showers allowed, and 3) Personal property and telephone calls restricted," but these assertions cannot be verified without an on-site assessment nor are they contained in any supplied policy directive. The CAP also indicates that, as of March 2011, safety smocks would not be utilized to deter /punish perceived manipulative behavior," but, again, this assertion cannot be verified without an on-site assessment nor are they contained in any supplied policy directive.

Finally, this writer had previously recommended that the State should "revise and implement policies so that an inmate is not subject to disciplinary sanction and/or charged for medical services as a result of engaging in self-injurious behavior." The CAP indicates that such a revision of policy would violate state law and the AAG indicated in his March 6, 2003 correspondence that state law requires inmates to be charged for medical services received as a result of self-injurious behavior. This writer will allow the counsel for the parties to argue the legal interpretation of state law, but the CAP does not address the issue as to whether the MDOC will continue to subject inmates to a disciplinary sanction as result of self-injurious behavior. The

AAG did not cite any state law in his March 6, 2013 correspondence that would condone such an antiquated response to self-injurious behavior.

D. **Levels of supervision/management**: The CAP indicates that inmates on "high risk" or "moderate levels" of suicide precautions are seen by mental health staff on a *daily* basis. However, the recently revised (May 2012) "Department of Corrections, Mental Health Services, Suicide/Self-Injury Risk Assessment and Interventions Management Guidelines" indicates otherwise—with "high risk" inmates being seen *daily* and "moderate risk" inmates seen *every other business day*. This is the same schedule that this writer previously found to be below the standard of care in 2011. All inmates on suicide precautions should be assessed by a QMHP on a daily basis.

In response to this writer's previous recommendation that "suicide risk evaluations must provide a sufficient description of the current behavior and justification for a particular level of observation and/or discharge from suicide precautions," the CAP indicates that "out of cell assessments done when safely possible." Such a response does not address the thoroughness of suicide risk evaluations and this issue, as well as discontinuation of the "contracting for safety" practice, cannot be verified without an on-site assessment. Issues of comprehensive suicide risk evaluations, avoidance of cell-side assessments, and contracting for safety were **not** addressed within the May 2012 "Department of Corrections, Mental Health Services, Suicide/ Self-Injury Risk Assessment and Interventions Management Guidelines."

In response to this writer's previous recommendations to provide follow-up assessments following discharge from suicide precautions at intervals of 24 hours, 72 hours, one week, and then periodically until release from custody, the CAP indicates that "step down levels of suicide precautions (intermediate level and low) are the procedures used for follow-up. See suicide prevention guidelines." As previously indicated, the MDOC suicide prevention guidelines have remained unchanged since 1999, therefore, the State apparently does not agree with this writer's recommendations in this area. Although an "intermediate risk" and "low level" management protocol might be appropriate for step down, it is currently problematic because it is **not** applied as a step down process in **all** cases (*e.g.,* an inmate can be released from suicide precautions without being placed on either intermediate or low risk status and, therefore, never receive any follow-up services). And, as shown in the May 2012 inmate suicide, the inmate was not even consistently seen on the "intermediate risk" level of management even when it was ordered.

In response to this writer's previous recommendations that treatment plans should be developed for all inmates on suicide precautions greater than 24 hours, the CAP indicates that "for the duration of the suicide risk, a management plan is developed and followed." It is unclear from this response whether or not the State acknowledges that treatment planning was not occurring during this writer's 2011 assessment. More importantly, indicating that a management plan will "last the duration of the suicide risk" apparently means that the plan will expire when the inmate is released from suicide precautions. However, the purpose of a treatment

plan is to describe signs, symptoms, and the circumstances in which risk for suicide is likely to recur; how recurrence of suicidal thoughts can be avoided; and the actions the inmate and staff can take if suicidal thoughts do occur. Treatment planning includes follow-up assessments and, therefore, often exceeds the duration of time that an inmate is on suicide precautions. This CAP response remains problematic.

E. **Reporting**: This writer previously recommended that, when writing a critical incident report regarding an inmate suicide, it is imperative that staff include the time that the inmate was last observed alive. In response, the CAP lists several responses, including that documenting when the inmate was last seen alive is "not required" by the critical incident reporting policy, "has been in practice for many years," and "this information is often included in the full critical incident report in the involved person statements." These responses are unclear and unhelpful. If there are no current policy requirements for correctional staff to document when the inmate was last seen alive prior to the discovery of their suicide, then a reasonable CAP would be to revise/develop a policy that mandates such a requirement.

F. **Follow-up/Morbidity-Mortality Review**: The MDOC has refused to allow this writer to review any completed mortality reviews of WHVCF suicides, and will not even acknowledge whether or not morbidity reviews are conducted as a result of serious suicide attempts (*i.e.,* incidents requiring outside medical treatment). Simply acknowledging whether or not the agency has a morbidity review process is certainly not violating any "peer review privilege" and thus such information should be shared.

Respectfully Submitted by:

s/s Lindsay M. Hayes
Lindsay M. Hayes

April 16, 2013