REPORT ON MENTAL HEALTH CARE AND SUICIDE PREVENTION PRACTICES AT THE WOMEN'S HURON VALEY CORRECTIONAL FACILITY – YPSILANTI, MICHIGAN

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I. Introduction

At the request of the Disability Rights Section of the US Department of Justice (DOJ), Civil Rights Division, I toured the Women's Huron Valley Correctional Facility (WHVCF) on August 11-13, 2015. The purpose of this tour was to review changes made by the facility in response to previous DOJ visits and to update my assessment of the adequacy of the prison's mental health services and suicide prevention program.

My findings and recommendations in this report are based upon my review of updated policies, procedures, and post orders as provided by the Michigan Department of Corrections (MDOC) and the leadership of WHVCF. In addition, I reviewed previous reports, inmate psychiatric records, and correspondence from advocacy groups, and various reports from the print and electronic media.

During my site visit, I toured a variety of housing units and service areas of the prison, paying special attention to the mental health units, segregation units, and psychiatric observation areas. During these tours, I was allowed to speak freely and privately with inmates, medical staff, mental health staff, and custody staff. I met at length with leaders of the facility and the MDOC, including Warden Anthony Stewart, MDOC Director of Psychiatry Dr. Lee (Tony) Rome, and many members of the senior staff of WHVCF. Also present were attorneys from the DOJ, the MDOC, and the Michigan Attorney General's Office.

My site visit was conducted with DOJ attorneys Mellie Nelson and Susan DeClercq, as well as Robert Greifinger, M.D., who was tasked with reviewing medical issues, and nurse consultant James Welch, RN, HNB-BC who reviewed issued relating to nursing and health care. The reader is referred to Dr. Greifinger's and Mr. Welch's reports.

I wish to express my gratitude to Warden Stewart and his staff for their candor and hospitality during my visit. I also wish to thank Dr. Rome, the attorneys from MDOC and the Office of the Attorney General for their assistance during my visit.

During our initial meeting, Warden Stewart expressed his agreement, in general, with the recommendations contained in my last report. (Exceptions will be noted below.) The Warden also told us about a number of changes he had implemented since coming to WHVCF. One impressive new practice is his attendance at weekly "case management" meetings, during which problematic inmates are discussed by a multi-disciplinary team including health care, mental health, and custody. There is also a special management team, which meets daily to discuss inmates in crisis, again by a multi-disciplinary team. In my opinion, the Warden's personal involvement in these meetings will improve the collaboration between these three

disciplines, and improve the facility's ability to respond proactively to improve management of all inmates, especially those with mental health problems.

Assistant Attorney General Peter Govorchin discussed what he called an "Ad-Seg Diversion Project" that was designed to remove all inmates with serious mental illnesses from segregation housing. It was reported that this project was completed successfully several weeks before our August 2015 visit.

Several inmates in need of acute psychiatric care were housed in various locations (i.e., "Acute Overflow") due to an inadequate number of "wet" cells on the Acute Unit. Warden Stewart reported that he has already ordered the creation of four additional "wet" cells in the Calhoun Building's Acute Mental Health Unit for inmates needing acute psychiatric care who temporarily require separation from other inmates because they pose an imminent danger to others. He also reported that he has received approval and funding to renovate two additional cells in the Emmitt housing unit for this purpose as well.

Dr. Rome explained that the WHVCF has continued to refine and enhance its Dialectical Behavioral Therapy (DBT) treatment program, including training by Dr. Michele Galietta, who is a highly respected national expert in DBT. Because DBT is especially well suited to the needs of women who have experienced severe trauma, and in light of the extremely high prevalence of severe trauma among women inmates, I strongly support the use and expansion of this treatment model at WHVCF.

Warden Stewart reported that he is working toward the creation of a special program for women parolees with serious mental illness who have had their parole revoked solely for one or more technical violations. This program currently exists only for men within MDOC.

II. Findings and Recommendations

A. Suicide Risk Prevention

1. Training of Custody and Clinical Staff

I previously recommended that MDOC should mandate that every correctional officer at WHVCF receive at least two hours of live in-service suicide prevention training annually, in addition to the eight hours of pre-service training that is currently provided.

Finding and Recommendation: Sadly, the Department has declined to implement this recommendation. Officers continue to receive their

annual 2-hour refresher training on-line only. In my opinion, on-line training for suicide prevention is inadequate. In addition to the eight-hour block of pre-service training, I again strongly recommend that every staff member with inmate contact annually receive two hours of live, in-person training for this crucial and life-saving skill set.

2. **Screening**

My previous report noted that WHVCF has very good intake screening and assessment procedures, however, the Department has had difficulty in receiving the "Sheriff's Questionnaire for Delivered Persons." The Department appropriately noted that they do not have the authority to order the completion of these forms. I recommended that MDOC should continue to periodically communicate to all Michigan Sheriffs the importance of completing these forms and providing them to MDOC for every newly admitted inmate. For jails that repeatedly fail to do so, direct communication from the MDOC Director to the Sheriff or Jail Director is recommended.

Finding and Recommendation: MDOC repeated its contention that it lacks any authority to compel Michigan's jails from completing and providing these forms. While this is correct, it does not mean that there is nothing to be done. Dr. Rome has made contact with mental health providers at some of the largest jails, and plans to continue these efforts to improve compliance. Nevertheless, compliance among jails remains inconsistent and unacceptable. I recommend the following steps:

- **The Director of MDOC should send letters to all sheriffs and jail directors regarding the importance of these forms;**
- **MDOC should identify the jails who are the least compliant with this simple request, and contact the appropriate authority; and**
- **MDOC should continue to or initiate meetings (in-person or telephonic) with the chief mental health officers of the most important jails (i.e., those who send the largest number of prisoners to MDOC and those who are especially non-compliant).**

3. **Suicide Risk Assessment**

My prior report noted that the medical charts of inmates placed on suicide precautions did not contain documentation that sufficiently described a suicide risk assessment, a mental status exam, and/or justification for a particular level of observation. I found that suicide risk assessments often did not include specific reference to the reasons for suicide watch (e.g., threats of suicide, parasuicidal

behaviors, etc.); the reasons for the inmate's despair; general or specific risk factors; triggers; and perhaps most importantly, the mental health interventions that are to be provided to the inmate. With the exception of inmates in the Dialectical Behavioral Therapy (DBT) program, I was also struck by the frequent absence of trauma-related diagnoses. While chart reviews did not allow me to assess the accuracy of any particular inmate's diagnosis, numerous studies indicate a very high prevalence of severe trauma, as children and adults, among women inmates, especially those with histories of suicidal ideation and attempts. I recommended that MDOC provide additional training in suicide risk assessment to its mental health clinicians and regular quality management audits and quality improvement efforts.

Findings and Recommendations: Dr. Rome provided training to mental health clinicians, resulting in some improvement in the quality of the suicide risk assessments. I reviewed the curriculum for this training and found it to be excellent. Additional training is planned in the near future. The suicide risk assessment form is helpful, and if used properly should result in at least adequate assessments. Dr. Rome has also begun a process of quality improvement (QI) reviews and audits of suicide risk assessments by clinicians. While some improvement was noted, this remains a work in progress, and further training and QI efforts are recommended.

4. <u>Prisoner Observation Aides</u>

In my last report, I noted that I was impressed with the training that the Prisoner Observation Aides (POA's) receive, and the diligent and empathic manner in which they appear to be carrying out their duties. This continues to be the case. I had been told, however, that POA's were not allowed to speak to the inmates that they are observing. I recommended that WHVCF should train the Prisoner Observation Aides to engage in informal conversation with the inmates they are observing.

Finding: I am happy to report that this recommendation has been fully implemented. I observed many POA's engaging in virtually constant, pleasant communication with the inmates that they were observing. Both the POA's and the inmates on suicide watch appeared appreciative of this change.

I also noted in my last report that clinicians did not have access to notes from the POA's, which prevented clinicians from reviewing a very important source of information regarding the person whose life they are trying to preserve. I recommended that mental health clinicians must be provided access to and encouraged to review the notes of the Prisoner Observation Aides.

Finding: I am happy to report that WHVCF has implemented this recommendation. While the POA notes are not entered into the medical record, they are now available to the mental health clinical staff for review.

5. **Administration of Suicide Watch and Precaution Status**

At the time of my last visit, suicide watch occurred in the intake area, the infirmary, the mental health Residential Treatment Program (RTP), the mental health Acute Care Unit, and in "select" Segregation Unit cells. As noted previously by Mr. Lindsay Hayes, the Segregation Unit cells have many suicide hazards, which make them inappropriate for housing anyone believed to pose a high risk of suicide. I recommended that use of any cells on the Segregation Unit for suicide watch should be discontinued immediately.

Finding and Recommendation: I am pleased to report that WHVCF has made strong and largely successful efforts to remove all prisoners with serious mental illness from the Segregation Unit. They have also implemented my recommendation to remove anyone who is believed to pose a high risk of suicide from the Segregation Unit.

This being said, during my tour of the Segregation Unit, several inmates were on suicide watch there. I had a frank discussion with Warden Stewart, who explained that these inmates had been evaluated by clinicians, who opined that the inmates did not pose a serious risk of suicide, despite their claims of suicidality. Warden Stewart explained that some of the women admitted that they simply wanted to be transferred to mental health units to be closer to particular inmates with whom they had relationships. He noted that every inmate who claims to be suicidal is evaluated by mental health clinicians and placed on a suicide watch in order to err on the side of safety.

Finding: I agree with Warden Stewart that it may be appropriate to conduct a suicide watch on the Segregation Unit, but only for inmates who have been evaluated by qualified mental health professionals (QMHPs) and deemed to pose no serious risk of suicide. However, in order to further remove unnecessary risk, I made a number of specific suggestions to Warden Stewart to remove obvious suicide hazards from any cell that is to be used for this purpose. Warden Stewart declared his intention to implement these improvements for selected cells immediately, and for all of the cells on the Segregation Unit as soon as practical.

As noted in my last report, inmates on suicide precautions were being seen by mental health clinicians on a daily basis; however, these visits were almost exclusively conducted at cell front, which provided no privacy and no ability to create a therapeutic alliance, especially for inmates housed in the Segregation Unit. I recommended that any inmate on suicide watch status should be seen daily in a setting that provides at least audible privacy, unless documented safety concerns make it literally impossible to do so safely.

> **Finding and Recommendation: I received conflicting reports regarding this recommendation. It appears that mental health clinicians are more frequently meeting with inmates privately, but not as often as recommended. There appears to have been a sincere effort on the part of custody and mental health staff to implement this recommendation; however, it appears that this, too, is a work in progress. I continue to recommend that any inmate who is on suicide watch should be seen daily in a setting that provides at least audible privacy, unless documented safety concerns make it literally impossible to do so safely.**

In my last report, I noted that video camera, while useful for post-hoc review of incidents and allegations, was not a reliable method of conducting suicide watches, and staff should be informed (e.g., through training, post orders, etc.) that video should only be considered as an adjunct to mandatory in-person observations.

> **Finding: This recommendation has been implemented.**

6. **Dangerous Suicide Hazards in Cells Used for Suicide Watch**

In my last report, I noted that many of the cells used for suicide watch had numerous, potentially lethal conditions, and recommended that they be altered to further reduce the risk of suicide. While the most dangerous cells were located in the Segregation Unit, there were also issues with the suicide prevention cells in the Acute Unit. I also recommended that WHVCF should embark upon an inspection and renovation program to ensure that suicidal inmates are housed only in "suicide-resistant" cells, (i.e., without any obvious protrusions that would easily enable an inmate to hang herself or sharp edges that would allow an inmate to cut herself). I recommended that any room that is used to house, toilet, or shower an inmate on suicide precautions should be inspected regularly, using a "punch list" of inspection points. Included in this list should be the presence of any sharp edges, gaps around fixtures, grates with too large holes, and any other method by which an inmate would be likely to engage in suicide attempt or deliberate self-harm. Any exceptions should be abated immediately, prior to the room being used for suicide watch.

Findings and Recommendations: As noted above, WHVCF has removed the vast majority of women on suicide watch from the Segregation Unit. Warden Stewart has agreed to remove suicides hazards from cells used to house inmates on suicide watch on the Segregation Unit, who have been evaluated and deemed to pose no serious risk of suicide. Regarding a punch list of cell inspection points, no officers appeared to be aware of any such list. If the list has not been created, it should be created immediately. If such a list exists, custody staff assigned to any area that is used for suicide watch must be trained in its use and to conduct suicide-preventive cell inspections, which must be regularly documented and audited for compliance.

7. <u>Treatment Plans and Management Plans for Suicidal Inmates</u>

In my last report, I recommended significant improvement in the quality of treatment plans for inmates with serious mental illness and those who have been deemed to pose a serious risk of suicide. To assess progress in this area, I reviewed mental health treatment plans and progress notes for more than 20 inmates.

Finding: I am very happy to report a vast improvement in the quality of mental health assessments and treatment plans, as well as progress notes, for inmates on the mental health caseload. The vast majority of the plans I reviewed were simple, easily understandable, and obviously individualized. Progress notes were meaningful, and frequently referred directly to goals articulated in the treatment plans. Many of the plans also included measurable short-, intermediate-, and long-term goals. Perhaps most importantly to me, the assessments indicated that each clinician had taken the time to get to know the inmate, and included a sensible discussion of the inmate's problems and needs. The mental health leadership at WHVCF -- specifically Outpatient Director Denise Armstrong and Chris Wilson-DeMedina who runs the RTP, RTS, and Acute units -- have been particularly diligent in conducting audits, corrective instruction, and training, which appear to have been the cause of this significant improvement.

My previous report also noted that treatment plans for inmates on suicide watch should explicitly refer to interventions that are aimed at reducing the inmate's risk of suicide.

Finding: While there was significant improvement in this area, it remains in need of continued training and monitoring, especially for inmates who were not previously on the mental health caseload.

My last report stressed the importance of positive behavioral management plans for inmates on suicide watch and those whose mental health symptoms resulted in being housed alone. I noted that the management plans reviewed appeared to be "boilerplate," and mainly consisted of punitive sanctions or restatements of officer duties that ought to be included in post orders. I recommended that management plans should be replaced by positive behavioral improvement plans that are jointly crafted by mental health clinicians and custody staff.

Finding: I found no improvement in this area, although there was discussion by the mental health leadership regarding a recent in-service training, and of their intentions to provide training and monitoring of these plans in the near future. Frankly, I am not sure that the mental health clinicians understand exactly what is being recommended. I now recommend that WHVCF invite an outside consultant psychologist with expertise in positive behavioral management, and provide clinician trainees with examples of appropriate plans.

8. Mortality Reviews and Reviews of Fatal or Near Fatal Suicide Attempts

As was the case during my last visits, the attorneys representing the State of Michigan regard mortality reviews as protected from disclosure by the peer review privilege. I was therefore prevented from assessing the adequacy of any investigations, peer reviews, psychological autopsies, or mortality reviews that may or may not have been conducted following suicides or near-fatal attempts. Therefore, despite their profound importance, I can offer no opinion of the quality or comprehensiveness of these reviews.

9. Punitive Administration of Suicide Watch Status

In my last report, I noted that the conditions of suicide watch must never be unnecessarily punitive. I wrote, "Preventing inmate suicides relies in large part on honest admission by inmates that they are actively suicidal. However, in order for this to happen, the consequences of admitting suicidal ideation or intent cannot be reasonably experienced as punitive. During my visits, some staff members seemed to suggest that punitive conditions are necessary to prevent inmates from malingering or feigning suicidality in order to be moved. Even if this were generally true, it is equally true that punitive conditions of suicide watch will discourage inmates who are truly suicidal from asking for help." During my previous visits, I found numerous examples of unnecessarily punitive conditions for inmates on suicide watch, including denial of telephone calls, prohibition against reading materials, and denial of other privileges for no good reason. I noted that no

privileges should be suspended or denied to an inmate on suicide watch unless there is a specific, individualized, and documented reason.

In my last report, I wrote, "As previously recommended by Mr. Hayes, WHVCF should revise its practices regarding the management of suicidal inmates to provide that any limitations of non-dangerous property and privileges (e.g., reading material, eyeglasses, access to showers, telephone calls, etc.), are only justifiable on a case-by-case basis, commensurate with the assessed suicide risk, and only when based on an individualized and documented clinical assessment of the person's risk of suicide."

Findings and Recommendations: MDOC continues to presumptively deny inmates reading materials while on suicide watch, but this prohibition exists only until a clinician decides to allow reading materials and other privileges, which reportedly occurs within 24 hours. The consequences of this prohibition (i.e., forced boredom) have been alleviated by the fact the WHVCF now allows POA's to converse with inmates on suicide watch. WHVCF has implemented a policy that requires QMHPs to make an individualized assessment of any inmate on suicide watch, and to document recommendations regarding the conditions, including clothing, reading materials, telephone calls, visits, and other privileges. These assessments often occur within minutes, and are almost always conducted within 24 hours. Warden Stewart has issued a directive mandating that inmates on suicide watch receive all of the privileges to which they would have otherwise been entitled unless a clinician recommends otherwise.

B. Use of Restraints

In my last report, I described a method of restraint that is euphemistically referred to by MDOC as "alternative restraint." It was demonstrated to me, and consists of wrist cuffs, a waist belt, and leg irons; with the leg irons connected to the back of the belt. As they explained, this is intended to make it difficult for the inmate to stand up, while allegedly allowing the person to sit down or lie down "comfortably."

As I wrote in my last report, "During their demonstration, the master trainers made a special point of claiming that this form of restraint is not fairly described as 'hog-tying.' The fact that they need to say this, in my opinion, is reason enough for the MDOC to stop using it. Whether or not the description of this form of restraint as hog-tying is accurate, it is almost universally described that way by inmates who have watched or experienced it." I also noted that I have not seen this form of

restraint used in any other prison system, which belies any claim that it is "necessary."

I noted that this form of restraint is especially inappropriate when used on an inmate who is experiencing suicidal intent or a mental illness, for a host of reasons. I therefore recommended that this form of restraint must be immediately stopped.

> **Findings and Recommendations: I am pleased to report that WHVCF has banned the use of this form of restraint for inmates in any of the mental health units and for those who are deemed to be seriously mentally ill. For reasons that I frankly do not understand, however, MDOC continues to insist on the appropriateness and necessity of allowing this form of restraint to be used on other inmates. However, Warden Stewart told me that this form of restraint had not been used in the six months that he had been at WHVCF. I continue to recommend prohibition of this form of restraint for all inmates.**

C. Mental Health Service Delivery

During my last visits, I found significant room for improvement in both mental health assessments and treatment planning.

> **Finding: As noted about, treatment plans and progress notes have dramatically improved since my last visits.**

As noted above, the worst cases of inadequate and inappropriate treatment and management were those inmates with mental illness or suicidal behaviors who were housed in segregation housing. I wrote, "Inmates who were most in need of treatment at any given time were denied it, as they were placed in a setting that provided no meaningful psychiatric treatment, except for medications that were frequently refused.... Danger to self and others is never an acceptable reason to deny, rather than to provide, needed acute psychiatric treatment.... Inmates in acute and severe psychiatric distress should not be denied access to the Acute Inpatient Unit except in extraordinary and rare circumstances, which should be immediately reviewed by the Warden and the MDOC Director of Psychiatry."

> **Finding: This situation has dramatically improved. To its credit, WHVCF has removed all of the women with serious mental illness from the Segregation Unit. Except when there is an inadequate number of cells available, inmates in need of acute psychiatric care are treated on the Calhoun Acute Unit, with "overflow" provided in units other than the Segregation Unit. Further, Warden Stewart has already ordered 4**

additional cells in the Acute Unit to be renovated with toilet and sinks to expand this capacity.

In my last report, I noted that WHVCF continues to provide Dialectical Behavioral Therapy (DBT), which is an evidence-based treatment for people who engage in deliberate, non-suicidal self-harm.

Finding and Recommendation: The DBT unit continues to be an excellent resource. However, considering the overwhelming prevalence of severe trauma among women inmates, I recommend expansion of this program.

Complaints forwarded to DOJ from local advocacy groups included an allegation that inmates housed on the Acute Unit are not provided with adequate hours of therapeutic programming. My assessment supports this claim, predominantly due to an inadequate number of QMHPs at WHVCF and especially in the Acute Unit.

Finding and Recommendation: Staff and inmates alike reported that on average, inmates in the Acute Unit receive "one or two" groups per week, which is grossly inadequate for inmates in need of intensive psychiatric care. There remains a need for more QMHPs at WHVCF, especially, but not limited to, the Acute Unit. It is particularly urgent that at least one activities therapist (e.g., recreation therapist, rehabilitation therapist) be recruited and hired to provide more active programming for these inmates.

There were other significant shortcomings regarding treatment on the Acute Unit. For example, when inmates are on 1:1 status, they are seen "most of the time" at cell front, where the clinician speaks to them through the inmate's food slot. This method of providing services is simply unacceptable. Among other things, it virtually precludes the creation of a therapeutic alliance, which is crucial to meaningful psychiatric treatment.

Finding and Recommendation: Any time an inmate is on 1:1 status for mental health reasons, especially when the inmate has been transferred to Calhoun for acute psychiatric care, the inmate must be seen daily, in-person, by a QMHP. Any exception to this rule should be justified by a written explanation regarding why it was deemed to be impossible or unsafe, and how the treatment plan has been amended to alleviate this danger and allow treatment to occur. Simply put, it is unacceptable to deny meaningful treatment to the people who need it most.

Male inmates within MDOC who are in need of inpatient or acute psychiatric care are now transferred to the Woodland Center, which includes acute psychiatric care among its treatment units. However, there is no equivalent treatment facility for women who are in need of inpatient or acute psychiatric care.

> **Finding and Recommendation: MDOC must assure that female inmates in need of intensive and acute psychiatric care receive services that approximate those services found in psychiatric hospitals. This typically includes psychiatric nursing services, several hours per day of meaningful individual and/or group therapy, and the existence of a reasonably therapeutic environment. None of these conditions currently exists on the Calhoun Acute Unit. MDOC should seek to increase the clinical resources on this unit as soon as possible, or make other arrangements to provide acute inpatient care for women inmates.**

Similarly, when male MDOC inmates with intellectual disabilities are unable to cope with the stresses and demands of general population, they can be transferred to the ASRP Unit at St. Louis Correctional Facility. However, no such resource exists for women with intellectual disabilities at WHVCF.

> **Finding and Recommendation: WHVCF should create a safe and therapeutic environment for inmates with intellectual disabilities who are unable to negotiate the demands and stresses of general population.**

Unfortunately, the Calhoun Acute Unit is treated as level 4 housing, regardless of the actual custody classification of each inmate housed there. Once again, this makes the treatment of serious mental illness a punitive experience. For example, inmates in the Acute Care Unit are not allowed contact visits, even when they pose a danger only to themselves. To deny inmates visits when they are experiencing their most extreme despair is inexplicable and counter-therapeutic.

> **Finding and Recommendation: Any restriction on the privileges to which an inmate would otherwise be entitled must be made on an individualized basis and documented.**

D. Inmates with Mental Illness in Segregation Housing

During my last visits, I was told that mental health rounds are conducted for every inmate in the Segregation Unit three (3) times per week. These visits, however, were being conducted solely at cell front, where there is no privacy. I applaud the practice of segregation rounds for all inmates – to allow for early identification of those whose mental health is deteriorating in segregation. While cell front visits serve an important screening function, either the inmate or the clinician should be

able to request that an audibly private conversation occur within a reasonable period of time.

Because inmates with serious mental illness have been removed from the Segregation Unit, there is no longer a need to provide mental health services of this nature on the Segregation Unit. However, mental health staff still must provide screening and crisis response services to all of the inmates on the Segregation Unit. Segregation custody staff reported that mental health response to crises during work hours is typically "almost immediate." In addition, mental health clinicians are reportedly available for telephonic consult 24 hours per day. In the event that emergency psychiatric response is indicated, nurses can reach a statewide on-call psychiatrist 24 hours per day in order to get an emergency order for psychotropic medication.

Findings and Recommendations: Mental health clinicians continue to conduct cell-front rounds on the unit 3 times per week, but there were conflicting reports about how frequently clinicians meet with individual inmates privately. I recommend reminding clinicians that either the inmate or the clinician should be able to request that an audibly private conversation occur within a reasonable period of time.

E. Discipline of Inmates with Intellectual Disabilities and/or Mental Illness

As noted in my previous report, the Warden or the Warden's designee can waive disciplinary or administrative segregation if the inmate was deemed not responsible for a disciplinary infraction. However, this generally only applies to inmates who were already identified as having mental health or intellectual disabilities.

When inmates with apparent mental illness (MI) or intellectual disabilities (ID) are accused of disciplinary infractions, even if they had not been previously identified, they should be evaluated to determine whether: (a) their MI or ID was the cause of the disciplinary infraction, in which case they should be found not guilty; or (b) their MI or ID will make it difficult for them to psychologically tolerate segregation, in which case their sanction should be mitigated.

As noted in my last report, "Under no circumstances should an inmate be punished for behaviors that are symptomatic of serious mental illness, psychiatric or emotional crisis, (intellectual disabilities), or suicidal despair. Decisions about housing, management, and treatment should be driven by clinical need. Although

custody staff can appropriately participate in such collaborative discussions, the primary driver of such decisions should be clinical."

Findings and Recommendations: The Warden appears to support this policy, and, reportedly, has already mitigated the sentence or dismissed charged for inmates with known mental disabilities. It appears that this is one mechanism that has resulted in eliminating such people from Segregation Unit housing. My only additional recommendation is to provide appropriate training to the hearing examiners, similar to the training that was provided some years ago.

F. Additional Recommendation

In my last report, I recommended that WHVCF should consider emulating the segregation incentive program originated at Alger C.F. and currently used at other MDOC men's facilities.

Finding: While a segregation incentive program has not been introduced at WHVCF, Warden Stewart expressed an intention to consider doing so in the coming months.

III. Conclusions

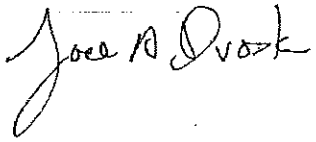
The most important problems noted in my last report stemmed from housing inmates with serious mental illness, as well as those in psychiatric or suicidal crisis in the Segregation Unit. I am pleased to report that this problem has largely been resolved, thanks to collaboration between Warden Stewart, his mental health and custody staff, and MDOC Central Office. However, a major problem continues to be the lack of active programming in the Acute Unit.

I also remain impressed with the Dialectical Behavioral Therapy program, although it should be expanded so that more inmates can participate in it. Treatment plans and progress notes have improved significantly. However, there remains room for improvement in the provision of suicide risk assessments and positive behavioral plans for the most difficult inmates. Further, while I am not a psychiatrist, I am pleased to report that I did not observe any inmates, including those in the Acute Unit, who appeared to me to be grossly over-medicated.

Overall, the facility has obviously worked very hard to remedy the problems noted in my previous reports.

Again, thanks to Warden Stewart and his staff, Dr. Rome, and all of the attorneys and experts involved in this investigation, which has been marked by cooperation between all parties and in my opinion has greatly improved the lives of the inmates at WHVCF. While there is need for additional improvements as noted above, I am confident that each of these items will be successfully addressed.

Respectfully submitted,



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