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 was asked to tour the Women's Huron Valley Correctional Facility (WHVCF) on two occasions, on August 27-28 and September 17, 2014. I reviewed previous reports issued by Lindsay M. Hayes, which dealt with suicide prevention practices, and was asked to follow up on Mr. Hayes' findings and recommendations. In addition, I was asked to assess the adequacy of the prison's mental health services program.

My findings and recommendations are based upon my review of numerous policies, procedures, post orders, and reports. I reviewed previous reports, inmate case files (including correctional and medical/psychiatric records), correspondence from advocacy groups, and various reports from the print and electronic media. I also reviewed reports submitted by the Michigan Department of Corrections (MDOC) to DOJ.[1]

During my two site visits, 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 Millicent Warren, 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.

Please note that I had previously served as a plaintiff's expert witness and subsequently a Federal Court monitor, supervising the settlement agreement in *MPAS v. Caruso*, a case in which the Michigan Protection and Advocacy System sued the MDOC, alleging system-wide inadequate mental health care, and specifically the presence of inmates with serious mental illness housed in segregated housing. Prior to engaging in this case, I informed the USDOJ of my prior involvement with MDOC, who obtained the approval of the Michigan Attorney General's Office and MDOC for me to participate in this DOJ investigation. All parties were therefore informed of my prior service and in agreement that there was no conflict of interest that would prevent me from performing my duties in a fair and objective manner.

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[1] I was provided with a great deal of information regarding the MDOC and WHVCF responses to Mr. Hayes' earlier reports and recommendations. However, the documentation (in the form of a grid) was dated, and we requested that an updated grid be provided. Unfortunately, it took some months for this updated grid to be provided, which accounts for much of the delay in producing this report.

My first site visit, on August 27-28, 2014, was conducted with DOJ attorneys Mellie Nelson and Susan DeClercq, as well as Robert Greifinger, M.D., who was tasked with reviewing medical issues. The reader is referred to Dr. Greifinger's report regarding issues related to the prescription and administration of medications, medical care, etc. I returned to WHVCF on September 17, 2014, with Ms. DeClercq, primarily to review additional inmate health and mental health records.

Many of the findings and recommendations are areas to which the Department of Corrections has already devoted significant effort. Many of these issues can be described as "works in progress," and I am hopeful that many have been resolved or are in the process of resolution since my visits.

I wish to express my gratitude to Warden Warren and her colleagues for their candor and hospitality during my two visits.

This report is organized into several broad areas, including suicide prevention, mental health service delivery in general, the presence of inmates with serious mental illness or high risk of suicide in segregation housing, and use of restraints. My recommendations are highlighted in bold-faced type.

II. Findings and Recommendations

A. Suicide Risk Prevention

1. Training of Custody and Clinical Staff

The MDOC continues to have an excellent pre-service training curriculum on suicide prevention. However, it is unclear to me whether all inmate-contact staff members at WHVCF have received annually the required 2 hours of live (as opposed to computer-based) in-service refresher training in suicide prevention.

> **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.**

Screening

While WHVCF has very good intake screening and assessment procedures, the Department continues to have 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. However, they have taken steps to communicate the importance of these forms to the State's various law enforcement agencies.

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 Sheriff's offices that repeatedly fail to do so, direct communication from the MDOC Director to the Sheriff is recommended.

2. Suicide Risk Assessment

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.

In general, I found that suicide risk assessments were very deficient, in that they 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 do 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. The failure to document these traumatic experiences significantly impairs the clinicians' ability to provide necessary trauma-informed services.

Although I am aware that the MDOC has previously provided training in suicide risk assessment to many of its mental health clinicians, a review of records suggested the need for additional training of clinicians and regular quality management audits.

During my second visit, I also learned that clinicians typically do not have access to notes from the Prisoner Observation Aides (POAs). This prevents them from reviewing a very important source of information regarding the person whose life they are trying to preserve.

Mental health clinicians must be provided access to and encouraged to review the notes of the Prisoner Observation Aides.

3. Prisoner Observation Aides

In general, I was impressed with the training that the Prisoner Observation Aides (POAs) receive, and the diligent and empathic manner in which they appear to be carrying out their duties. I was told, however, that POAs are not allowed to speak to the inmates that they are observing. I do not understand why these aides are prohibited from speaking to inmates on suicide watch, since having someone to talk to could be beneficial to alleviating the severe distress and despair that often leads to suicidal behavior. I assume that this prohibition was based upon fears that the aides would engage in "amateur psychotherapy" that could be inappropriate or even harmful. While this is a reasonable concern, it is an easy one to address in the POA training, along with occasional supervision from mental health clinical staff.

MDOC should train the Prisoner Observation Aides to engage in informal conversation with the inmates they are observing.

4. Administration of Suicide Watch and Precaution Status

At the time of my visits, 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. Hayes, the Segregation cells have many suicide hazards, which make them inappropriate for housing anyone believed to pose a high risk of suicide. In my opinion, due to the nature of the cells' construction, it would be virtually impossible to render these cells safe for housing suicidal inmates.

For this reason, as well as the other reasons listed below, the use of any cells on the Segregation Unit for suicide watch should be discontinued immediately.

At the time of my visits, 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.

Any inmate on suicide watch status should be seen daily in a setting that provides at least audible privacy, unless safety concerns make it literally impossible to do so safely.

I was told that inmates on suicide watch are observed by staff at staggered intervals of 14 minutes or less, and are constantly observed by inmates serving as Prisoner Observation Aids. I was also told that these observations are supplemented by video observation by prison staff. However, when I visited the units, no one was consistently watching the video.

The presence of video recordings can be important data for investigators after the fact, e.g., to determine whether allegations of abuse are valid or to determine whether officers were conducting required watches on a timely basis. However, video monitoring adds very little to the real-time prevention of suicide, since no one is consistently viewing the monitors.

5. <u>Dangerous Suicide Hazards in Cells Used for Suicide Watch</u>

Many of the cells used for suicide watch had numerous, potentially lethal conditions. Mainly, these were of two varieties. First, some of the hazards would have easily allowed inmates to hang themselves, because there were many places from which to suspend a ligature. Second, there were numerous sharp edges and corners that an inmate could easily use to cut herself.

These hazards were especially bad in the Segregation unit; however, they were not limited to this location. I visited the Acute Psychiatric Unit, where a particularly difficult inmate was housed on suicide watch status. I noted several suicide hazards in the rooms used for this purpose, including grates with too-large holes and doorknobs that would allow for suspension of a ligature. I also observed shower rods in the shower area from which a ligature could be suspended which should be replaced by a plastic rod that would not support a human body. Finally, the restraint beds are equipped with handles that are intended to allow leather restraints to be affixed to the bed. However, these handles were at a height that would allow an inmate to hang herself, and should be replaced by a bed that is suicide-resistant (i.e., any handles should be located at floor level). All of these hazards were pointed out to staff during our tour.

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. 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 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.

6. Treatment Plans and Management Plans for Suicidal Inmates

To be fair, some of the treatment plans that I reviewed were excellent. However, as previously noted by Mr. Hayes, most of the treatment plans for inmates on suicide watch that I reviewed were severely deficient. Some were so sparse as to be effectively non-existent. Most did not include a description of signs, symptoms, and the circumstances in which risk for suicide is likely to recur; how recurrence of suicidal thoughts can be avoided; or the actions the patient or staff can take if suicidal thoughts do occur. Far too many of the plans, as previously noted by Mr. Hayes, were "simply a summary of the clinician's recommendations for frequency of observation, applicable restrictions, and frequency of clinical assessment of suicidal inmates."

Treatment plans remain in need of significant improvement at WHVCF. Again, additional training and quality management is indicated. Note that treatment plans for inmates on suicide watch should explicitly refer to interventions that are aimed at reducing the inmate's risk of suicide.

I also reviewed all of the management plans for all prisoners who were on suicide precautions on August 27, 2014. Sadly, the so-called "management plans" are neither helpful nor clinically appropriate. Rather, they appear to be almost "boilerplate," and contain punitive sanctions or restatements of officer duties that ought to be included in post orders.

Management plans should be replaced by positive behavioral improvement plans that are jointly crafted by mental health clinicians and supervisory custody staff. Management plans could be useful if clinicians were trained to write them as consultative advice to correctional officers. [2]

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

[2] As one example, a plan could read, "Yelling at this inmate will likely result in exacerbations of inappropriate behavior. Instead, we recommend the use of verbal praise to reinforce even small pro-social behavioral improvements."

Because the attorneys representing the State of Michigan regard mortality reviews as protected from disclosure by the peer review privilege, I was 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.

8. Punitive Administration of Suicide Watch Status

As noted above, it is imperative that the Department immediately cease the practice of holding inmates on suicide watch in the Segregation Unit. However, this change in policy and practice, though essential, is not alone sufficient.

The conditions of suicide watch must never be unnecessarily punitive. 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.

I found numerous examples at WHVCF where conditions of suicide watch appeared unnecessarily punitive, either by policy or practice. For example, Warden Warren and her senior staff told me that stripping an inmate naked and issuing her a safety smock is only done after an inmate has attempted to misuse clothing to attempt suicide. However, several correctional officers told me, "Everyone [on suicide watch] gets a bam-bam suit [i.e., a safety smock,]" in direct violation of Department policy. (Emphasis added.) Indeed, every inmate I observed who was on suicide precautions was clothed in a safety smock.

Another example is that I was told that telephone calls are presumptively forbidden for inmates on suicide watch, allegedly because "talking to their family might make them worse." This is a ridiculous presumption as family contact can, often does, reinforce protective factors that will help an inmate to overcome the despair that leads to suicidal intent. Meaningful therapeutic contacts with a mental health professional should inform the clinician as to the appropriateness or inappropriateness of contact with specific family members. Indeed, as recommended by Mr. Hayes, visits with friends and family members should be

permitted for inmates on suicide precautions unless there is a specific, individualized, and documented reason not to allow a visit.

I also observed that inmates on suicide precautions appeared to be routinely denied all possessions, including books, magazines, or reading materials. During my visits, I observed that inmates on suicide watch were always housed alone in a cell. They were denied mental health treatment such as group therapies, and in many cases they were denied showers while on suicide watch. Indeed, the conditions for inmates placed on suicide precautions in the Segregation Unit were more restrictive than the conditions for inmates placed in segregation as a disciplinary sanction. Intended or not, the conditions of suicide watch in the Segregation Unit were virtually guaranteed to be experienced as extremely punitive.

This method of addressing suicide risk is flawed for a number of reasons. First, there is no evidence to support or reason to believe that extreme boredom and isolation is an effective treatment for suicidal depression and despair. Second, there is every reason to believe that such conditions are likely to exacerbate a suicidal depression. There is simply no justification for these practices, which can actually exacerbate the inmate's clinical condition.

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. Some specific examples include but are not limited to the following:

- **All inmates on suicide watch must be offered reading materials, so long as the materials do not contain staples or other instruments that could be used to cause self-harm.**

- **There must be written justification as to why an inmate under constant observation needs to be clothed only in a safety smock and it should never be utilized to deter/punish perceived manipulative behavior.**

- **Inmates on suicide watch should be allowed the same access to telephone calls and visits that they would have received had they not been placed on suicide watch, unless**

clinically contraindicated and documented based on an individualized clinical assessment.

B. Use of Restraints

I met with Steve Halliwill and Rob Klamarus, who are considered "master trainers" regarding the use of force continuum within MDOC. According to them, the use of force policy appropriately requires a progression, implying that officers are required to use the least amount of force necessary in each case. They noted that the shift commander can approve anything in the use of force continuum for two hours.

I was told that the facility has restraint chairs, which are kept in the armory. They reported that these chairs are only used for transportation, and that no inmate is placed in a chair for an extended period of time. This is an acceptable use of restraint chairs, and I found no exceptions or violation of this policy during my tour.

Master trainers Halliwill and Klamarus demonstrated for me the use of a particular type of restraint that includes 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. According to them, the maximum amount of time that an inmate can be placed in these restraints without approval by the MDOC central office is 24 hours. They also reported that this form of restraint is only used in segregation settings, which could include inmates on suicide watch or those with serious and acute mental illnesses.

Before commenting on this particular form of restraint, it is important to note that master trainers Halliwill and Klamarus provided me with an impressive explanation and demonstration. I have little doubt that they are well-intentioned and skillful trainers, and I very much appreciated their demonstration and explanation.

That being said, there are a host of reasons that this form of restraint must immediately be discontinued:

- Even if perfectly administered, this form of restraint is extremely likely to be experienced as punitive. Further, because restraints are often administered in crisis circumstances or resisted by inmates, it is very likely that this form of restraint will be administered in a manner that does not conform exactly to the method recommended by trainers. If that occurs, this method of restraint, in my opinion, is far too likely to cause physical pain to the restrained inmate.

- During their demonstration, the master trainers made a special point 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.

- This form of restraint is especially inappropriate when used on an inmate who is experiencing suicidal intent or a mental illness. As noted elsewhere in this report, when the consequences of admitting one's suicidality are experienced as punitive, it dramatically reduces the likelihood that a truly suicidal inmate will ask for the help she needs to stay alive. Indeed, psychiatric hospitals that only treat patients with serious mental illness or acute risk of suicide would never use this form of restraint, even for patients who are deemed to pose a serious risk of harm to themselves or others.

- The fact that this form of restraint is widely perceived as "hog-tying" greatly contributes to the stigma already experienced by inmates with serious mental illness. It reinforces the stigmatizing and inaccurate perceptions that people with serious mental illness can only be managed with harsh, intrusive, and restrictive methods.

- It is a well-known principle of corrections that intrusive and restrictive interventions are justified only by their necessity. It is important to note that in investigations, consultations, and surveys of literally hundreds of correctional facilities, this is the first and only system in which I have seen this method of restraint utilized. Thus, if it is rarely, if ever, utilized in other prisons, it is literally impossible to argue that it is necessary to use this extreme and potentially punitive form of restraint.

- I was told by the master trainers that this form of restraint is only used in segregation settings. This again demonstrates that it is not necessary, if inmates in psychiatric or suicidal crises can be safely managed in other settings (e.g., acute inpatient) without using this method of restraint.

- Finally, I was told by the master trainers that this form of restraint may be used for up to 24 consecutive hours without approval of the MDOC Central Office. The prospect of restraining someone in this manner for 24 consecutive hours is frankly horrific. While the master trainers reported that a person could "lie down comfortably" in these restraints, I do not agree, and neither do the inmates who reported that they had observed their use.

For all of the reasons noted above, this form of restraint must be immediately stopped.

C. Mental Health Service Delivery

I reviewed a number of patient charts to review the documentation of mental health assessments and treatment. Despite excellent and well-intentioned assistance from MDOC staff, reviewing charts at WHVCF was exceptionally time-consuming and difficult, due to the nature of the electronic medical record and the condition of the computers used to access the record. As a result, it is apparently difficult for supervisors at WHVCF and the MDOC to conduct chart reviews and audits in an efficient manner. Nevertheless, the deficiencies in documentation and treatment planning listed below necessitate routine audits of mental health records.

To its credit, WHVCF has created a unit to provide Dialectical Behavioral Therapy (DBT), which is an evidence-based treatment for people who engage in deliberate, non-suicidal self-harm. I applaud the creation of this program, which teaches people to better manage their emotions. I believe that it should be expanded, and would be of value to many more inmates than are currently able to be enrolled

In general, however, I found significant room for improvement in both mental health assessments and treatment planning. For example, charts often contained contradictory information, with no resolution of the apparent conflict. Further, as previously noted, many so-called "management plans" for disruptive or suicidal inmates with mental illness made no mention of treatment. Many of the so-called "treatment plans" contained no explanation of the inmate's psychological problems or what clinicians were going to do to help the person. For example, one discharge plan noted that an inmate "needed to learn" how to better handle her distress, with no plan for staff intervention to help her do so.

To be sure, some very good treatment plans were observed in the records. For example, some inmates with self-harming behaviors were appropriately referred to the DBT program. The Department and WHVCF should take justifiable pride in starting this cutting-edge, trauma-informed type of treatment. Some of the inmates in the other mental health programs also appeared to be receiving meaningful mental health care from the clinical staff. Unfortunately, however, the prevalence of emotional and psychiatric problems among the inmate population at WHVCF exceeds the capacity of these discreet programs.

A summary of my review of records reveals that the worst cases (i.e., inadequate treatment, inappropriate management) were those inmates with mental illness or suicidal behaviors who were housed in segregation housing. Often, these appeared

to be the inmates who were most in need of treatment. Inexplicably, in many cases, the records implied that inmates were denied acute psychiatric care and retained in the Segregation Unit until their psychiatric condition was no longer deemed to be acute. In other words, the 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.

In one case, an inmate with a long history of involuntary mental health treatment and guardianship, including a psychotic diagnosis, was diagnosed as having an adjustment disorder with anxiety. Several months later she was diagnosed with schizoaffective disorder, and shortly thereafter was documented to be acutely psychotic. Inexplicably, instead of being moved to the acute mental health unit, this inmate was housed in the Segregation Unit where she was observed as not sleeping or eating, experiencing auditory hallucinations, psychotic symptoms, manic symptoms, slurred speech, anxiety, depression, clouded consciousness, poor reasoning and impulse control, blocked thought process, incoherence, and refusing medications. Alarmingly, on the same day that these observations were documented, a nurse wrote that the inmate had "no unmet medical or mental health needs." Finally, a psychiatric note indicated that this inmate would be "considered for transfer to a mental health treatment placement after she stabilizes." (Emphasis added.)

Although I did not have the opportunity to examine this inmate, there is ample evidence that this inmate's mental health needs were not effectively assessed and treated, and that it was inappropriate to house this psychotic inmate in segregation, or to deny her the acute psychiatric treatment that she so obviously needed.

> **Danger to self and others is never an acceptable reason to deny, rather than to provide, needed acute psychiatric treatment.**

In general, these record reviews reinforced many of the observations and recommendations listed above. However, it is important to note that several clinicians wrote exceptionally good treatment plans, which should be emulated by other clinical staff. These were specifically pointed out to Dr. Rome, so that he might use them as positive examples.

> **Mental health records should be routinely and randomly reviewed regarding the adequacy of documentation, psychiatric and psychological assessments, suicide risk evaluations, progress notes, and especially treatment plans on a frequent basis until audit results indicate sustained improvement.**

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.

D. Inmates with Mental Illness in Segregation Housing

In the Segregation Unit, I was told that mental health rounds are conducted for every inmate, three (3) times per week. These visits, however, were being conducted 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 – however, either the inmate or the clinician should be able to request that an audibly private conversation occur within a reasonable period of time. Based on my observations of staffing, space limitation, and current practices, it is extremely unlikely that this would occur in the Segregation Unit.

Inmates with serious mental illness should receive a meaningful and private clinical contact on a daily basis. With rare exceptions, these contacts should not occur at cell front, where there is no privacy and it is difficult to hear.

On a similar note, I was told that all mail (including grievances, complaints, and requests) must be handed to correctional officers (CO's), which ruins any sense of confidentiality and can cause inmates to fear making allegations of abuse.

I was also told that nurses conduct rounds on the Segregation Units "several times a day," mainly to deliver medications. Some nurses told me that these rounds also served as a form of sick call, but others suggested otherwise, so it was not clear to me whether inmates had confidential access to medical services.

Nurses should be explicitly allowed to receive and pass along grievance forms, medical requests, or allegations of abuse, so that inmates will not be required to hand such documents to the same CO's about whom they wish to complain.

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

During my tour, several inmates were identified as possibly having intellectual disabilities. I was informed by Warden Warren that psychiatric observation cells were no longer located in the Segregation Unit, and that the Warden the Warden's designee can waive segregation if the inmate was deemed not responsible for a disciplinary infraction.

> **When inmates with intellectual disabilities are accused of disciplinary infractions, they should be evaluated to determine whether: (a) their intellectual disability was the cause of the disciplinary infraction, in which case they should be found not guilty; or (b) their intellectual disability will make it difficult for them to psychologically tolerate segregation, in which case their sanction should be mitigated.**

One inmate whose record I reviewed was sent to the Segregation Unit for the explicit purpose of one-to-one observation due to her self-injurious behavior (cutting). A review of her record suggested that this inmate should have been considered for referral to the DBT program. Notably, custody staff (with no mental health credentials) reported that the inmate was trying to "manipulate" a move to be with her girlfriend. A review of this record clearly indicates that this person was sent to segregated housing in order to punish her for her "manipulative" behavior.

> **Under no circumstances should an inmate be punished for behaviors that are symptomatic of serious mental illness, psychiatric or emotional crisis, 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.**
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> **Virtually all of the serious deficiencies in the treatment and management of inmates with serious mental illnesses or in suicidal despair require the same solution; WHVCF should immediately prohibit the placement of inmates who are currently psychotic or deemed to be at serious risk of suicide from placement in segregated housing.**
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> **For the foreseeable future, I recommend that any time an inmate at WHVCF with serious mental illness or a recent history of suicidal behavior is housed in segregation, the case should be immediately referred to both the Warden and the MDOC Director of Psychiatry for review and approval.**

Subsequent to my facility visits, I was provided with a new policy, dated January 9, 2015, that will "establish uniform standards of practice to manage prisoners with

urgent or emergent Mental Health or Medical Problems requiring placement on observation status by Custody or Health Care/Mental Health and/or who have serious healthcare issues requiring medical services unavailable in the segregation unit." The policy includes the following language:

> "At Women's Huron Valley Correctional Facility (WHV) identified prisoners will be divergent from Segregation placement if they present urgent or emergent Mental Health or Medical Problems and/or who have serious health care issues requiring medical services unavailable in the segregation unit."

As written, this policy represents a significant improvement over the *status quo.* Unfortunately, the policy allows for an unacceptable loophole. As written, the policy would allow WHVCF to place a seriously mentally ill inmate or one who is acutely suicidal in segregated housing if the decision-maker were to allege that the services needed by the inmate were available in the Segregation Unit. Considering the facility's history of purporting to provide mental health treatment and suicide prevention in the Segregation Unit, this loophole is extremely troubling.

> **The policy must be rewritten to explicitly preclude the placement of any inmate who is currently psychotic or suicidal in the Segregation Unit. Any exception must be the rare and extreme case of an inmate who poses such an extreme danger that there is no other safe or reasonable way to manage the situation, such exceptions to be documented and immediately reviewed by the Warden and the MDOC Director of Psychiatry. If such an exception occurs, the Director of Psychiatry must approve a specific and individualized treatment plan that ensures the inmate's safety and provides the inmate with an appropriate array of mental health services wherever she is housed.**

Moreover, this policy does not address the underlying issue of WHVCF's imposition of overly restrictive or punitive conditions on inmates who are mentally ill or on suicide precautions. Simply removing them from the Segregation Unit but continuing to treat them the same way wherever they are housed does not solve the problem.

> **As noted above, WHVCF must 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, visits, 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.

F. Additional Recommendation

The MDOC has significantly changed its manner of administering segregation housing in a number of its male facilities. I am particularly aware of these changes at the Alger C.F., which piloted this program. The program provides inmates with incentives for better behavior. I asked Warden Warren if WHVCF uses a similar incentives system, and was told, "Yes, but tailored for this (female) population." While it is beyond the scope of this consultation, frankly, I do not understand why there is not a similar behavioral contingency system in place at WHVCF, and recommend that staff from Alger CF consult with the current Warden on creating one.

WHVCF should consider emulating the segregation incentive program originated at Alger C.F. and currently used at other MDOC men's facilities.

III. Conclusions

The most important problems noted in this report are the direct and predictable result of housing inmates with serious mental illness, as well as those on suicide watch, in segregation housing units. The remedy for each of these is the same; except in the most extreme and rare situations, inmates on suicide watch and inmates known to have serious mental illness must not be housed in segregation housing at WHVCF. In addition, the Department must take steps to ensure that suicide watch, no matter where the location, is not administered in a manner that is likely to be experienced as unnecessarily punitive, and that suicide watches are conducted in cells that are free of suicide hazards such as sharps and protrusions from which it would be easy to hang a ligature.

There were a number of positive observations about the mental health care at WHVCF. I was especially impressed with the Dialectical Behavioral Therapy program, which has been a big help to the women who were fortunate enough to be admitted to it. Many of the clinicians appeared to be deeply concerned about the well-being of their clients, and some of the treatment plans and progress notes were excellent. That being said, there is a great need for systematic improvement in the treatment plans and suicide risk assessments conducted by clinicians at WHVCF.

This will require routine monitoring, training, and other quality improvement activities at all levels of the staff.