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

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DISABILITY RIGHTS SECTION

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I. Introduction

At the request of the Disability Rights Section of the U.S. Department of Justice (DOJ), Civil Rights Division, I toured the Women's Huron Valley Correctional Facility (WHVCF) on April 12-13, 2016. 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 records, and discussions with facility leadership, staff, and inmates of WHVCF.

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, nursing, and health care. The reader is referred to Dr. Greifinger's report.

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 informed us of some new developments since our last visit. Sadly, there was a suicide of an inmate, [redacted], that has resulted in the firing of two employees, as well as changes in institutional policy. For example, Prisoner Observation Aids (POAs) are now allowed to report imminent risks to "anyone" (including supervisory staff) if they believe that the correctional officers have not taken appropriate action. In addition, Warden Stewart decided that correctional staff will receive an in-person classroom update (as opposed to on-line training) of their suicide prevention training. Unfortunately, in my opinion, the steps still leave much to be desired. First, based on our conversations with a number of POAs, the vast majority of them report that they would not feel comfortable or safe "going over the head" of correctional officers. Second, the decision to conduct in-person updates of suicide prevention training is only a one-time occurrence. No decision has been made as to whether in-person

updates will be conducted on an annual basis. As noted in previous reports by myself and suicide prevention expert Lindsay Hayes, for over 5 years we have consistently recommended that in-person training should be conducted on an annual basis.

Warden Stewart also reported that a decision has been made to hire an activities therapist and a social worker for the Calhoun Acute Unit. In addition, WHVCF has received authorization to renovate the Calhoun Acute Unit to create 12 "wet cells" that will allow inmates who are confined to their cells to use the toilet or drink water without being escorted by correctional officers out of their cells.

In my last report of August 2015, I discussed what Assistant Attorney General Peter Govorchin 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. As will be discussed below, however, this project was never designed to remove all inmates with serious mental illness from segregated housing. The project was only designed to prevent inmates who are housed or need to be housed in the Calhoun Acute Unit or the Residential Treatment Program (RTP) from being housed in the Segregation Unit.

Dr. Rome reported that the Dialectical Behavioral Therapy (DBT) treatment program has continued to thrive. In my last report, I strongly supported the use and expansion of this treatment model at WHVCF. Dr. Rome reported that plans are underway to extend the reach of the DBT program without sacrificing fidelity to the DBT model.

Other reported changes, including the proposed opening of a medical clinic on the west side of the prison and the hiring of additional nurses, will be discussed in Dr. Greifinger's report.

II. Observations from Facility Tour

I toured the Segregation Unit, where I concentrated on observing the inmates who were on 1:1 or suicide watch, as well as those with any serious mental health diagnosis. None of the inmates appeared to be in any sort of acute distress, and several admitted that their suicidal threats were made solely to obtain a desired change in their housing, for example to get out of segregation or to be housed near a loved one. Nevertheless, because these inmates had uttered a suicide threat, they were placed on suicide watch status and (appropriately, in my opinion) retained in the Segregation Unit.

As previously reported, the Prisoner Observation Aids (POAs) were uniformly diligent and in most cases appeared to engage in pleasant conversation with the inmates that they were watching.

In general, I was impressed with the overall conditions in the Segregation Unit. The unit was reasonably quiet, and there was no evidence of unpleasant odors. Interactions between inmates and staff within the Segregation Unit appeared to be mutually respectful.

As noted in previous reports, the Calhoun Acute Unit continues to suffer from an inadequate amount of therapeutic and other out-of-cell activities. There are several women held on this unit whose mental illness and episodic violence are so severe that in my opinion they should be housed in a psychiatric hospital. That being said, there was evidence of aggressive efforts to treat these very difficult cases, including the appropriate use of forced medication. Sadly, so far, these efforts have not resulted in significant improvement. While there is no guarantee that inpatient psychiatric hospital care would result in significant improvement, in my opinion, it is the appropriate placement for these types of extreme and difficult cases.

I continue to be positively impressed with the Dialectical Behavioral Therapy (DBT) program, which is located in the Emmett Building. As I have repeatedly reported, the extremely high prevalence of severe trauma among female inmates suggests the need for expansion of this effective program. Dr. Rome explained that there are current plans to extend the reach of the DBT program; however, in order to maintain fidelity to the model, the formal program remains small. In my opinion, this program should be treated as a national model for women inmates and its expansion should be supported.

Also located in the Emmett Building is the Residential Treatment Program (RTP), which continues to provide a psychologically safer environment for inmates with serious mental illnesses who might have difficulty functioning in the general population.

In the Kent Building, I observed approximately 10-12 inmates who were in observation status. I was pleased to see that almost all of the women appeared to be in conversations with their respective POAs. However, because these conversations were taking place through a solid steel door, it was difficult for the inmates to hear each other. Frankly, I do not understand why an inmate who is deemed to be a danger only to herself needs to be contained in this manner. Ideally, it would be more clinically and cost-effective to create a suicide prevention dormitory of 6-12 beds, where one officer could provide constant observation of a number of inmates on suicide watch. In the current physical plant, however, this suggestion appears to be impractical. That being said, I can think of no reason why, at the very least, food

slots could not be open for individuals who are deemed to present no danger to others. This change would improve the environment for inmates deemed to be at high risk of suicide. Further, as noted in previous reports, when the conditions of suicide watch are experienced as punitive, it reduces the likelihood the truly suicidal inmates will ask for help. Opening the food slots on an individualized basis would reduce the degree to which suicide watch is experienced as unnecessarily punitive.

I also participated with DOJ attorneys Nelson and DeClercq in interviews of a number of POAs. With few exceptions, these POAs reported that they felt very well trained, and that they were encouraged to engage in pleasant conversation with the inmates they were watching. They also reported that mental health therapists have been responsive to crises, and that therapists now routinely interview inmates privately, instead of talking to them through the steel doors of their cells. As reported by facility leadership, the POAs confirmed that inmates on suicide watch are given access relatively quickly to books and other non-dangerous possessions. Finally, the POAs also reported that their notes are frequently reviewed by mental health staff, as well as nurses and correctional supervisors.

One important problem that emerged from these interviews had to do with delays in giving inmates access to the toilet. This problem was especially likely to occur in the Calhoun Acute Unit, where many inmates are housed in cells without water or toilets. They noted that some inmates are not allowed to be removed from their cells without the physical presence of the supervisor, which sometimes results in unacceptable delays of up to an hour in providing access to the toilet.

In addition, the POAs described experiencing trauma when observing inmates engaging in self-harm or (in one case) suicide, cell extractions, or other dramatic events. In years past, they reported being "de-briefed" following such experiences. I recommend that mental health staff be instructed to routinely check with POAs who have been present for these types of incidents and provide them with appropriate support.

The most common complaint shared by the POAs had to do with access to medical care. For example, all inmates, without exception, reported that they had to see a nurse three times before they would be allowed to see a doctor, and in many cases they had to pay for each visit with the nurse. These inmates reported that this was a strong disincentive to obtaining needed medical care.

Finally, I reviewed approximately 30 clinical records, paying attention mainly to the Suicide Risk Assessments, Treatment Plans, and Management Plans for inmates who had been on various forms of suicide prevention status. As noted below, I was extremely positively impressed with the consistent excellence of the Treatment Plans.

Unfortunately, in contrast, there has been no improvement in the quality of Suicide Risk Assessments and Management Plans, which remain in need of dramatic improvement. (See below.)

III. Findings and Recommendations

A. Suicide Risk Prevention

1. Training of Custody and Clinical Staff

Since 2011, it has been recommended that MDOC should mandate that every correctional officer at WHVCF receive at least two hours of live, in-person suicide prevention training annually, in addition to the eight hours of pre-service training that is currently provided. In August 2015, I wrote: "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."

Findings and Recommendation: In the aftermath of a recent tragic suicide, Warden Stewart decided to conduct in-person classroom suicide prevention training for all staff. However, there has not yet been a decision to make this an annual event. I continue to recommend that all staff receive live, in-person updates of the suicide prevention training annually.

2. Screening

My previous reports noted that WHVCF has very good intake screening and assessment procedures. This continues to be the case. Unfortunately, the Department has continued to have difficulty in receiving the "Sheriff's Questionnaire for Delivered Persons."

Findings: MDOC again repeated its contention that it lacks any authority to compel Michigan's jails from completing and providing these forms. That being said, the Department has taken several meaningful steps in an effort to increase the willingness of the jails to provide this information, including presentations by the Office of the Attorney

General to the State Sheriffs' Association. This recommendation has been fully implemented.

3. **Suicide Risk Assessment**

My prior reports noted that the medical charts of inmates placed on suicide precautions did not contain documentation that sufficiently described a suicide risk assessment, and 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. 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: I reviewed more than 20 Suicide Risk Assessments (SRAs), virtually all of which were extremely deficient, for exactly the same reasons noted in my earlier reports. While some training was provided to clinical staff, it did not result in the needed improvements. Dr. Rome reported that the planned revision of the electronic medical record (NextGen) will contain a protocol for suicide risk assessment that guides the clinicians to address each important variable. While the change in NextGen will undoubtedly help, this situation is serious and requires a comprehensive quality improvement effort, including regular audits and diligent management. As noted below, this process has been successfully used to dramatically and consistently improve the quality of mental health Treatment Plans. A similar effort in regard to SRAs is imperative.

4. **Prisoner Observation Aides**

In my last report, I noted that 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. This continues to be the case. I also noted that the facility had successfully implemented our recommendation that the POAs be allowed and encouraged to engage in conversation with the inmates they are observed. Happily, this change has remained in place.

Finding: As noted in my last report, this recommendation has been fully implemented. I repeatedly observed POAs engaging in virtually

constant, pleasant communication with the inmates that they were observing.

I also noted in my last report that POA notes are available to the mental health clinical staff for review.

Finding: POAs report that their notes are routinely reviewed by mental health clinicians and other health care workers. This recommendation has been fully implemented.

5. <u>Administration of Suicide Watch and Precaution Status</u>

In my last report, I mistakenly stated, "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." As noted in the introduction, we subsequently learned that these efforts were limited only to people who were housed, or needed to be housed, in the Calhoun Acute Unit or the RTP. It is important to note that approximately half of the women at WHVCF are on the mental health caseload, and that the vast majority of them reside in general population and receive treatment on an outpatient basis. In some cases, this includes people with serious mental illnesses who are reasonably stable.

When one of these outpatient mental health clients commits a serious institutional infraction, it is not unlikely that they will be housed in the Segregation Unit as a disciplinary sanction, or because they are believed to pose a risk to institutional safety. I noted that in virtually all such cases, the inmate's tenure in the Segregation Unit was relatively brief, and the inmates were seen frequently by mental health professionals.

Findings and Recommendations: WHVCF has taken a number of steps to ensure that inmates, especially those on the mental health caseload, be removed from segregation if they are experiencing a mental health crisis. I observed some inmates with serious mental illnesses still housed in the Segregation Unit, although none of them appeared to be in acute psychiatric crisis. When inmates with SMI who are clinically stable commit acts of intuitional violence or serious misconduct, it is reasonable to house them in the Segregation Unit, with two important caveats: The inmates must be frequently assessed by mental health clinicians, and their lengths of stay in segregation should generally be of short duration. Further, whenever any inmate in the Segregation Unit experiences an acute psychiatric crisis, she must be removed to a therapeutically appropriate setting.

During previous visits, I recommended removing anyone believed to pose a high risk of suicide from the Segregation Unit. I agreed with Warden Stewart that it may be appropriate to conduct suicide watch on the Segregation Unit, so long as the inmate is evaluated by clinicians and deemed to pose no serious risk of suicide. For example, several women readily admitted to me that their claims of suicidal intent were aimed solely at getting them moved to a particular cell location. When an inmate has been assessed and is not believed to pose a risk of suicide, it remains appropriate for the facility to err on the side of caution and implement a suicide watch on the Segregation Unit, even if they reasonably believe it to be clinically unnecessary. However, this analysis relies heavily on the credibility of SRAs, which are currently very poor. This practice mandates a vigorous and immediate effort to improve the quality of these assessments.

Finding and Recommendation: The practice of conducting suicide watch on the Segregation Unit is appropriate when a segregation inmate makes a suicide threat so long as they have been evaluated and are believed to pose no serious risk. However, I reiterate my recommendation that the quality of SRAs be immediately and dramatically improved.

In previous reports, I noted that inmates on suicide precautions were being seen by mental health clinicians almost exclusively at cell front, which provided no privacy and no ability to create a therapeutic alliance. 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: I am happy to report that this recommendation appears to have been fully implemented. Reports from clinicians, custody staff, and POAs all agreed that the vast majority of clinical contacts with inmates on suicide watch status are now being conducted privately.

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

In previous reports, I noted that some of the cells used for suicide watch contained hazards, and recommended that they be altered to further reduce the risk of suicide. 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. Warden Steward 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.

Findings and Recommendations: This recommendation has not yet been implemented. While the presence of POAs certainly mitigates the risk, it does not remove the need to make these cells as safe as possible. 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. When 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. This recommendation stands.

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

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

Findings: As noted in my last report, the vast improvement in the quality of mental health assessments and Treatment Plans has been maintained. The vast majority of the plans I reviewed were simple, easily understandable, and obviously individualized. 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 causes of this significant improvement in Treatment Plans.

Sadly, the same cannot be said for SRAs and Management Plans, where I noted no improvement.

Recommendations: As noted above, training, auditing, and supervision must be applied immediately toward SRAs with the same diligence that

resulted in improvement of the Treatment Plans. When the evaluator is a psychiatrist, this quality improvement effort must include the leadership of the relevant contractor agency.

My last report stressed the importance of positive behavioral improvement plans for inmates on suicide watch and for 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.

Findings and Recommendations: I found improvement in one aspect of the Management Plans, whereby clinicians approve the safe possession of items (e.g., books) by inmates on suicide watch. However, positive behavioral recommendations were virtually non-existent. I remain convinced that the mental health clinicians do not understand exactly what is being recommended. I again recommend that WHVCF invite an outside consultant psychologist with expertise in positive behavioral management, and provide clinician trainees with examples of appropriate positive behavioral plans. This could be conducted as part of the SRA training discussed above.

8. <u>Mortality Reviews and Reviews of Fatal or Near Fatal Suicide Attempts</u>

As was the case during previous 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. The only exception was in regard to the recent suicide at WHVCF, where some investigative findings were shared with us.

Findings: Although I was not privy to the mortality review of the most recent suicide, it appears the facility identified the staff failures that may have contributed to the death. The review of the recent suicide resulted in clear findings, and apparently accurately identified the staff failures that may have contributed to the death. While I was not able to review the actual mortality review, this provides some evidence that a meaningful review took place in this case. Other than this example, I was again unable to review any mortality reviews, investigations, peer

reviews, or psychological autopsies, and offer no opinion as to their existence or adequacy.

9. **Punitive Administration of Suicide Watch Status**

In previous reports, 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 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.

Findings and Recommendations: I am happy to report significant improvement in this area. Inmates on suicide watch are now routinely able to possess books and other safe items in their cells. This part of the recommendation has been fully implemented. I was also pleased to learn and observe that POAs are allowed and encouraged to engage in pleasant conversation with the inmates they are watching. This type of normal social interaction reduces some of the most negative aspects of suicide prevention statuses. Unfortunately, the ability to engage in pleasant conversation is hampered by the fact that it is very difficult for people to hear each other though solid steel doors. Especially in Kent Observation, this resulted in a rather chaotic and noisy environment. Therefore, when inmates are deemed to pose a risk only to themselves, I recommend an individualized assessment regarding allowing the food slot to remain open.

B. Use of Restraints

In previous reports, I criticized a method of restraint that is euphemistically referred to by MDOC as "alternative restraint." I remain opposed to this form of restraint, but I am happy to report that it has not been used at WHVCF for more than a year, and has been prohibited by Warden Stewart from being used on any inmate on the mental health caseload.

Findings: I am pleased that WHVCF has banned the use of "alternative restraints" for inmates in any of the mental health units and for those who are deemed to be seriously mentally ill. Despite the fact that this

form of restraint is still authorized by the Michigan Department of Corrections, because it has not been used for over a year and has been prohibited for use with any inmates on the mental health caseload, which by definition includes all inmates with serious mental illnesses, I regard this recommendation as having been fully implemented.

C. Mental Health Service Delivery

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. This form of treatment is also recommended for people who have experienced severe forms of trauma in their lives, which includes a very high percentage of all women prisoners.

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

In previous reports, I noted that inmates on the Calhoun Acute Unit are not provided with adequate hours of therapeutic programming, predominantly due to an inadequate number of qualified mental health professionals at WHVCF and especially in the Calhoun Acute Unit.

Finding and Recommendation: This situation has not improved significantly, although two additional clinical staff positions have been approved for the Calhoun Acute Unit. I continue to recommend auditing the number of hours of therapy and other out-of-cell activity that is afforded to each inmate on the Calhoun Acute Unit.

I previously recommended that inmates in the Calhoun Acute Unit presumptively be seen privately and face-to-face, as opposed to cell front visits.

Finding and Recommendation: I am happy to report that face-to-face meetings have become the rule, rather than the exception on the Calhoun Acute Unit.

I previously recommended that inmates at WHVFC who are 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 exist 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.

Finding and Recommendation: Even with the addition of two clinicians and the creation of 12 "wet" cells, the Calhoun Acute Unit will not come close to an inpatient level of care as described above. I recommend that the Department consider transferring a small number of WHVCF inmates to a psychiatric hospital when their clinical needs exceed the capacity of the Calhoun Acute Unit.

I also previously recommended that WHVCF create a safe and therapeutic environment for inmates with intellectual disabilities (ID) who are unable to negotiate the demands and stresses of general population.

Finding and Recommendation: Considering the size of the female population within MDOC, creation of a discreet unit for inmates with ID may be unrealistic. I recommend that WHVCF clinicians receive training from an expert in this area, such as Dr. Russ Scabo, who runs the ID unit at St. Louis Correctional Facility.

Finally, I previously noted that 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. I recommended that any restriction on the privileges to which an inmate would otherwise be entitled must be made on an individualized basis and documented. I should add that these same observations apply to the Kent Observation Unit.

Findings and Recommendations: There has been some improvement in this area. Inmates in the Calhoun Acute Unit are being allowed some privileges on a case-by-case basis. However, it remains true that some restrictions are imposed simply because of the building in which a program is housed, rather than the programmatic or clinical need for them. I recommend reconsideration of such restrictions in both the Calhoun Acute and Kent Observation Units, especially when the staffing and capital improvements are accomplished in the Calhoun Acute Unit.

D. Inmates with Mental Illness in Segregation Housing

Mental health rounds continue to be conducted for every inmate in the Segregation Unit at least three (3) times per week. Most of these visits are being conducted at cell front, where there is no privacy. However, clinicians are now able and likely to request private interviews when there appears to be an emerging mental health problem.

Finding and Recommendation: Cell front visits serve an important screening function, and clinicians are now more likely to interview inmates privately. However, either the clinician or the inmate should be able to request that an audibly private conversation occur within a reasonable period of time.

In my last report, I erroneously noted that inmates with serious mental illness have been removed from the Segregation Unit. As noted above, this only applies to those who are housed in the Calhoun Acute Unit or RTP Unit. Thus, should any mental health caseload inmate be housed in the Segregation Unit, they should receive at least the same treatment that they were receiving in population.

Finding: Mental health clinicians have been consistently maintaining the level of care that they provided to Segregation inmates when they were in population. They have also been empowered and willing to request that inmates be moved out of the Segregation Unit when clinically necessary. I was also pleased to hear from POAs that mental health response to crises have continued to be timely.

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

Previously, I noted that Warden Stewart has mitigated the sentence or dismissed charges for inmates with known mental disabilities. It appears that this is one mechanism that has resulted in eliminating such people from Segregation Unit housing. I also recommended providing appropriate training to the hearing examiners, similar to the training that was provided some years ago.

Finding: Warden Stewart noted that the hearing investigators (as opposed to hearing examiners) typically inquire as to an inmate's mental illness long before the case gets to a hearing examiner. This person has been trained for this task. Thus, I regard this recommendation as having been implemented.

F. Additional Recommendations

Previously, 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. Indeed, this idea has been considered and rejected. The Warden's logic is that WHVCF has been successful in lowering the average length of stay in segregation by other means.

Finding: This recommendation has been implemented.

While medical and nursing services are generally outside of my purview, I do want to repeat an important recommendation regarding the side effects of psychotropic medications. Every inmate who is prescribed psychotropic medications should receive all of the information necessary for them to provide informed consent. Further, nurses should be well-informed about the side effects of psychotropic medications and routinely inquire about the side effects in their interactions with inmates.

Finding and Recommendation: Physicians should be trained and instructed to provide information regarding side effects when they prescribe psychotropic medications. Interviews with inmates suggest that this is currently not the case. Equally important, every nurse should be well-informed of the side effects of psychotropic medications, and trained and supervised to inquire about side effects on a periodic basis.

Dr. Greifinger has repeatedly criticized WHVCF for inadequate quality improvement (QI) processes.

Finding and Recommendations: The skillful use of QI methods has resulted in drastic improvement in the quality of mental health Treatment Plans. However, this QI effort remains an exception rather than the rule. I agree with Dr. Greifinger regarding the need for more robust QI programs at WHVCF, and add that this recommendation applies to mental health care in general, and should not be limited to medical services.

To his credit, Warden Stewart has built upon the successful use of POAs and created an impressive program of peer support.

Finding and Recommendation: The peer support program is off to an outstanding start and deserves support and expansion.

IV. 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 Calhoun Acute Unit.

It is impossible to exaggerate the importance of immediately and effectively improving the quality of Suicide Risk Assessments by WHVCF clinicians.

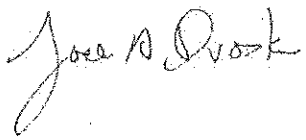
I remain impressed with the Dialectical Behavioral Therapy program, although it should be expanded so that more inmates can participate in it.

Treatment Plans and progress notes have improved significantly. However, there remains room for improvement in the provision of 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 Calhoun Acute Unit, who appeared to me to be grossly over-medicated.

Overall, the facility has obviously worked very hard to remedy most of 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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