1. Detainee 1[1]

According to the CRCL complaint, "On September 2, 2013, CRCL received notification of the death of Detainee 1 at HCDF. On September 2, 2013, facility personnel found Detainee 1 unresponsive in his cell and transferred him to the Northeast Memorial Hospital in Humble, Texas, where he was pronounced dead. According to the autopsy, the cause of death was respiratory and cardiac arrest. According to the autopsy and a subsequent report by ICE's Office of Detention Oversight (ODO), Detainee 1 died by ingesting a large amount of hoarded psychotropic medication. Detainee 1 has a previous suicide attempt on July 13, 2013."

The ODO Detainee Death Review contained detailed and informative information, and well-reasoned conclusions. Among other details, the report included the following information, as directly quoted below:

> [Detainee 1] died on September 2, 2013, at Memorial Hermann Northeast Hospital, Humble, Texas. The Harris County Institute of Forensic Sciences determined [Detainee 1's] cause of death to be combined toxicity of amitriptyline (brand name Elavil) and risperidone (brand name Risperdal), and his manner of death to be undetermined…
>
> [Detainee 1] was in ICE custody at the Houston Contract Detention Facility (HCDF) at the time of his death…
>
> On May 29, 2012, the HCJ turned [Detainee 1] over to ICE, and he was transported to HCDF. [Detainee 1] immediately continued his pattern of resistance towards authority by refusing to sign his HCDF booking form. At his medical screening the same day, [Detainee 1] said he felt okay. He admitted being treated in the past for "some kind of mental health disorder," which he suspected was depression and schizophrenia. He also acknowledged having had hallucinations and feelings of paranoia…
>
> On May 29, 2012, [Detainee 1] was initially assigned to B-segregation following intake processing, due to his assaultive history...
>
> On May 30, 2012, at 12:19 p.m., the IHSC nurse practitioner performing a physical examination of [Detainee 1] had to discontinue her interview of him regarding his mental health when he became upset and did not want to continue. She immediately referred [Detainee 1] to mental health. Later that same day, contract psychiatrist (b) (6), MD, performed an initial psychiatric evaluation of [Detainee 1]. Dr. (b) confirmed with [Detainee 1], his history of mental illness, but documented he was a poor historian. She noted he denied paranoia, depression, and intent to harm himself or others, that he was somewhat disorganized and could not recall his prior diagnosis and medications. Dr. (b) documented "Depression or Schizophrenia?" as her diagnosis, and noted that although he seemed motivated for treatment, she believed he had poor coping skills with questionable medication compliance. Her notes show she discussed the risks and benefits of two psychiatric medications with [Detainee 1], risperidone and Cogentin, and that [Detainee 1] agreed to take them…

[Detainee 1] refused his risperidone on June 5, June 7, June 8 and June 11…

June 27th, [2012] [Detainee 1] told mental health staff he was tired of being in segregation and that he wanted to die. When asked, [Detainee 1] denied any ideas, plans or intentions he might have to end his life. Staff noted that [Detainee 1] was adjusting adequately to being in segregation, that he appeared to be stable with no intent to harm himself or others, and that he agreed with staff to stay safe and to communicate to them any suicidal ideations or plans…

[Detainee 1] remained in segregation through December 2012, with the segregation committee conducting reviews in August17, October18, November19 and December 20…

On June 29, 2012, Dr. (b) (6) ordered increased dosages of both Trazadone and Paxil for [Detainee 1] and also ordered Geodon…Later in the evening after Dr. (b) (6) ordered these medications, [Detainee 1] used a dinner tray to break a light casing in his cell, because, "demons want the lights turned off."… On July 2, 2012, an Institution Disciplinary Panel found [Detainee 1] guilty of destroying CCA property by breaking the light casing in his cell, ordered him to pay $744.22 in restitution, and sanctioned him with seven days in disciplinary segregation…

On July 1, 2012, officers found [Detainee 1] with a thermal shirt wrapped around his neck "as if in attempt to harm himself." He was taken to the medical clinic where staff noted he denied suicidal ideation or plan to harm himself; they noted their decision not to place him on suicide watch, and they returned him to his cell in segregation. RN Herges noted (Exhibit 10, page 9) the medical record does not contain documentation of evaluation for suicide risk addressing the criteria in the ICE PBNDS 2008 Suicide Prevention and Intervention standard…

[Detainee 1] was held in disciplinary segregation from July 2, 2012, to July 8, 2012. On July 6, 2012, Dr. (b) (6) and CDR (b) (6), a licensed independent social worker (LISW) examined and evaluated [Detainee 1]. Dr. (b) (6) noted [Detainee 1] felt the medications were helpful, but that he continued to be bizarre. [Detainee 1] told them he wanted medical services to help him draw his blood to drink because he believed he was a vampire. [Detainee 1] denied any suicidal or homicidal intentions, but admitted to audible hallucinations. Dr. (b) (6) also documented that [Detainee 1's] cell displayed a number of bizarre drawings mixing common satanic images with his own particular delusions. Dr. (b) (6) increased [Detainee 1's] Geodon medication…

On July 8, 2012, [Detainee 1] was moved from disciplinary segregation, back to administrative segregation. No explanation or supporting documentation to justify his placement back in administrative segregation was provided…

On July 11, 2012, Dr. (b) evaluated [Detainee 1] and documented he was "on a fast from

showering, because his mother died a year ago;" that he was "Not manic or depressed, but delusional, although much improved;" and, that he was compliant with medications and gradually stabilizing…

On July 13, 2012, [Detainee 1] attempted to hang himself by using a torn strip of bed sheet tied to the inside of his cell door. Officers on duty in the unit at the time responded with a suicide knife and cut [Detainee 1] down…admitted to West Oaks Hospital, a comprehensive psychiatric care facility in Houston. On July 14, 2012 …where he was held until July 30, 2012… [Detainee 1] refused all psychotropic medications after returning from West Oaks Hospital, and Dr. (b) discontinued his medications as a result…

On July 30, 2012, at 3:29 p.m., CDR (b) (6) evaluated [Detainee 1] and documented he reported "feeling good," and that he stated he was "just playing" when he wrapped the piece of bed sheet around his neck on July 13, 2012. CDR (b) (6) also documented Dr. (b) (6) directed that [Detainee 1] should be housed in segregation upon his return to HCDF because of his potential for "behavioral issues" and negative interactions with his peers…

Dr. (b) (6) stated he recommended [Detainee 1] be placed in segregation on July 30, 2012, because [Detainee 1] was "manipulative" and "refused to bathe." Dr. (b) (6) stated he ordinarily does not recommend segregation because it is often a "destabilizing environment." Dr. (b) (6) said that when he does recommend segregation, he does so for "behavioral symptoms," not mental health issues…

On July 30, 2012, an Administrative Segregation Order and an Inmate Status Change form were created for [Detainee 1], documenting that he was placed in segregation as a result of his "mental history." The Administrative Segregation Order also documents that [Detainee 1] was "a security risk to self or the security of the facility"…

On September 7, 2012, Dr. (b) (6) documented [Detainee 1] was refusing all medications, and threatened to kill himself if the judge doesn't let him go. Dr. (b) (6) documented [Detainee 1] made numerous suicide threats if he doesn't get released or taken to the hospital, that he remains highly manipulative, and that he wanted to go to the hospital where he has more liberty. Dr (b) (6) noted there was no advantage to taking [Detainee 1] to the hospital, and that he was at risk of acting out at the hospital. Dr. (b) (6) also noted that [Detainee 1] still had chronic delusions…

From September 7-10, 2012, Dr. (b) (6) ordered that [Detainee 1] be placed on constant suicide watch… nursing staff evaluated [Detainee 1] on September 8, and September 9, 2012. The medical records indicate mental health staff did not see [Detainee 1] until September 10, 2012. The medical record also documents that while on suicide watch, [Detainee 1] refused to comply with orders to change his uniform, resulting in the application of chemical force to gain his compliance…

On September 10, 2012, CDR Bryant evaluated [Detainee 1] and removed him from suicide watch. [Detainee 1] was immediately placed in disciplinary segregation for "conduct that disrupts security refuse to obey orders"…

From September 10, 2012, to September 24, 2012, [Detainee 1] was housed in disciplinary segregation. On September 17, 2012, CDR Bryant evaluated [Detainee 1] and documented he refused to take his medication…

On September 24, 2012, [Detainee 1]was transferred from disciplinary segregation to administrative segregation. The Administrative Segregation Order documents [Detainee 1] was placed in administrative segregation for the "Safety & Security of facility."

From September 24, 2012, to January 23, 2013, [Detainee 1] remained in administrative segregation…

[Detainee 1] took his medications sporadically between September 24, and January 23, 2012…

On December 28, 2012, Dr. (b) (6) documented that [Detainee 1] remained very manipulative; that he was essentially off of medications, and he was likely to deteriorate. Dr. (b) (6) also wrote that he does not advise moving [Detainee 1] to a dorm"…

On January 23, 2013, [Detainee 1] was moved to a general population, "Level Three," housing unit. CCA Officer (b) (6), (b) (7)(C), one of the officers who worked in the general population dorm where [Detainee 1] was housed, advised ODO that [Detainee 1] had made a "remarkable change" from his erratic behavior in segregation and was very cooperative when he was moved to general population…

On March 4, 2013, [Detainee 1] was placed in administrative segregation pending a disciplinary hearing after engaging in a fist fight with another detainee. [Detainee 1] was medically cleared for administrative segregation, however… mental health staff did not conduct an evaluation of [Detainee 1] before he was moved to segregation…

On March 6, 2013, the Institution Disciplinary Panel held a hearing for [Detainee 1] for the March 4, 2013 fight, and he was sanctioned to 30 days of disciplinary segregation.

On March 19, 2013, HCDF released [Detainee 1] from segregation to general population. [Detainee 1] was housed in general population unit B3 from March 19, 2013, to June 19, 2013, and was housed in general population unit B1 from June 19, 2013, to August 31, 2013…without any disciplinary incidents…

[Detainee 1 demonstrated] poor compliance in taking his medications as ordered during April, May, and early June 2013…

On August 31, 2013, at approximately 1:00 a.m., [Detainee 1] engaged in a physical fight with detainee (b) (6), and was consequently placed in administrative

> segregation…[two] officer[s] on duty that night went through the property and found an unmarked plastic bottle containing several pills, and that the pills appeared to be damp and partially dissolved…
>
> According to CDR (b) (6), after [Detainee 1's] death, the HCDF's pharmacist analyzed the pills found in [Detainee 1's] property and determined they included 21 units of amitriptyline, and 12 units of risperidone…
>
> [Detainee 1 left a note stating] "For dust you are and to dust you will return! JAHOPE! Life after death!" [Detainee 1] referred to his God as Jahope…
>
> [T]he only preliminary finding from the autopsy was that [Detainee 1's] stomach contained a large amount of whitish granular material, "raising the possibility that there was a large amount of partially digested pills in his stomach."
>
> On February 10, 2014, the Harris County Institute of Forensic Sciences released the autopsy report. The cause of death was determined to be the combined toxicity of amitriptyline and risperidone, and the manner of death was ruled to be undetermined.

The ODO report included the following conclusions in its "INVESTIGATIVE FINDINGS":

> [Detainee 1] …was housed in both administrative and disciplinary segregation for approximately eight of the fifteen months at HCDF, including three days spent on suicide watch. Regular segregation status reviews were conducted throughout the time [Detainee 1] was housed in segregation. However, these reviews did not document specific justification for keeping [Detainee 1] on a segregation status, and did not show participation or input from the mental health professionals who worked with [Detainee 1] regarding his segregation status…
>
> After being transferred to general population on January 23, 2013, [Detainee 1] functioned well. He was involved in one fight on March 4, 2013, which resulted in a sanction of disciplinary segregation. When [Detainee 1] returned to general population on March 19, 2013, he spent over five months there without incident…
>
> [W]hen [Detainee 1's] property was searched on August 31, 2013, discovery of a bottle of partially dissolved pills did not prompt officers to search [Detainee 1] for contraband…
>
> [O]fficers did not enter [Detainee 1's] cell until medical staff arrived on the scene. Their wait to enter the cell delayed the initiation of CPR, and did not comply with CCA Post Order 23, Segregation, which permits officers to open a cell door during a medical emergency…
>
> [Detainee 1's] Administrative Segregation Orders and Inmate Status Change forms from May 29, 2012, July 30, 2012, and September 24, 2012, list "threat to facility security" as one of the reasons for assigning [Detainee 1] to administrative segregation. Those orders

do not contain additional attached records or documentation supporting the decision to assign [Detainee 1] to administrative segregation…

[Detainee 1's] medical documentation indicates Dr. (b) (6) ordered [Detainee 1] be placed in administrative segregation upon his return from West Oaks Hospital on July 30, 2012. [Detainee 1's] July 30, 2012 Administrative Segregation Order notes both "mental history" and "Security risk to self or security of the facility," but is not signed by Dr. (b) (6) and does not include any supporting documentation, leaving ambiguity as to the specific rationale for assigning [Detainee 1] to administrative segregation…

After [Detainee 1] was placed in administrative segregation on August 31, 2012, his property was searched and a bottle of partially dissolved pills was discovered. Those pills constituted hard contraband. CCA Policy 9-6, Contraband Control, section 9-6.5(B), states, "When any CCA employee discovers a Contraband item, that employee will: Confiscate the item; Notify his/her supervisor of the discovery; Document in report form who the Contraband item was taken from, the location and time of the discovery, and the immediate action taken" The officers in B-Segregation on the morning of August 31, 2012, did not notify a supervisor that a bottle of pills was discovered, and did not create a report concerning the pills…

Medical and mental health professionals promptly evaluated [Detainee 1] upon admission to HCDF, and mental health professionals regularly evaluated him throughout the fifteen months he was detained at the facility. Because [Detainee 1] regularly refused his psychotropic medications, providers were largely unsuccessful at treating his mental health issues through medications. However, [Detainee 1] was educated about the benefits of his prescribed medications on multiple occasions and was offered alternative medications and dosages. All medication refusals were dutifully recorded in [Detainee 1's] MARs, and providers were notified of those refusals. ODO learned consent for the specific psychotropic medications ordered for [Detainee 1] was never obtained, and that providers did not document a mental health treatment plan for [Detainee 1]…

[Detainee 1's] medical record does not contain any documentation of a mental health treatment or management plan containing measureable goals and objectives guiding overall mental health care. Additionally, IHSC/ERO Directive, Suicide Prevention and Intervention, section (4)(4-2)(b) requires the development of an overall mental health treatment/management plan following a suicide attempt. [Detainee 1's] medical record does not contain documentation that an overall treatment/management plan was developed after his July 13, 2012 suicide attempt…

[Detainee 1's] medical and detention records do not contain any documentation he was cleared for placement in disciplinary segregation on September 10, 2012, after he was removed from suicide watch. Not medically clearing [Detainee 1] for placement in disciplinary segregation also violates IHSC Policy, Medical, section 8.7, which requires that after a detainee is assigned to segregation, a qualified healthcare professional review the detainee's health record to determine whether existing mental health needs contraindicate placement in segregation…

> After [Detainee 1] was found with a shirt wrapped around his neck on July 1, 2012, he was immediately evaluated by nursing staff. However, Dr. (b) (6) did not evaluate him until July 6, 2012, five days later…
>
> On Friday, September 7, 2012, [Detainee 1] was placed on suicide watch. He remained on suicide watch until Monday, September 10, 2012, when he was transferred to disciplinary segregation. [Detainee 1's] medical record shows nursing staff saw him on September 8, and on September 9, 2012. However, the record does not contain documentation that qualified medical staff reevaluated [Detainee 1] at any time while he was on suicide watch. The absence of reevaluations of [Detainee 1] by qualified medical staff between September 7-10, 2012, also violates IHSC/ERO Directive, Suicide Prevention and Intervention, section (4)(4-2)(a) which requires documentation of daily reevaluation by a mental health provider, physician, or mid-level provider; and, section (4)(4-6) which requires a follow up appointment within a week of discharge from suicide watch. On September 28, 2012, 18 days after he was removed from suicide watch, a mental health provider evaluated [Detainee 1]…
>
> Dr. (b) (6) stated he recommended [Detainee 1] be placed in segregation on July 30, 2012, because [Detainee 1] was "manipulative" and "refused to bathe." Dr. (b) (6) stated he ordinarily does not recommend segregation because it is often a "destabilizing environment." Dr. (b) (6) said that when he does recommend segregation, he does so for "behavioral symptoms," not mental health issues…
>
> CCA Officer Clark said she often accompanies nurses during pill call and conducts a secondary "mouth check" to ensure detainees are not hiding pills in their mouths. She said she remembered [Detainee 1] trying to hide pills on more than one occasion while he was housed in general population prior to August 31, 2013, and specifically remembered [Detainee 1] dropping his pills on the floor and putting them in his pockets.

I watched a videotape of the use of chemical force and a cell extraction done September 7, 2012 after Detainee 1 had been placed in a suicide watch cell in the segregation unit. He had not engaged in active suicidal behavior prior to going on suicide watch or during the videotape. Prior to spraying him with a chemical agent and doing the forced cell extraction, the videotape shows him sitting quietly on his bed but not complying with increasingly loud commands by officers to remove his clothing.

I also reviewed the January 16, 2014 Annual Detention Inspection of the Houston Processing Center from Glynn Maddox, Lead Compliance Inspector, The Nakamoto Group, Inc. Detainee 1's death was included in this annual inspection report, but no meaningful information, details, or analysis appeared in the report. Nevertheless, the annual inspection report concluded that HCDF met all 40 examined standards, including the standard on "suicide prevention and intervention."

Additional pertinent information based on my review of Detainee 1's medical record includes the following:

- 7/16/12 note by (b) (6) LCSW West Oaks: "internally preoccupied…delusional…TV is possessed by Voodoo…"
- 7/18/12 "…paces constantly on the unit and wants to know why he is here…"
- 7/20/12 " continues to respond to internal stimuli; he is malodorous and refuses to take a shower…while fasting… remains psychotic"
- 7/30/12: "returned from hospital…cleared for segregation"
- 7/31/12: returned from West Oak (b) (6), LCSW: "Pt has made a commitment not to engage in any self injurious behavior"
- 8/2-3/12 refusing medications (Geodon 80, Haldol 10, trazodone 100)
- 8/15/12, Dr. (b) note: "…has refused to take psych meds since he returned from West Oaks hospital in July…"
- 9/28/12, note by LCDR (b) (6) "cont. to refuse all meds"
- 10/12/12: continues to refuse meds
- 9/7/12 LCSW note: "(b) cont to refuse all meds…He now states, 'I'm set to kill myself if the judge doesn't let me go.' He makes numerous suicide threats if not released or taken to psych hospital."

In my opinion, Detainee 1's case includes the following significant adverse findings:

Segregation rounds appear to be *pro forma* without any meaningful inquiry into mental health status. For example, the typical chart note for "sick call rounds" in the segregation unit states that the patient had no complaints of pain or illness and made no sick call requests. Most notes are identical.

On 6/27/12 LCDR (b) (6) saw the patient for a mental health encounter. Although he told her that "he is tired of being in segregation and… wanted to die" and his mood was "sad, tearful, depressed," the note also makes the contradictory statement that he had no suicidal thoughts. The assessment concludes that he "appears to have adjusted adequately to detention and placement in SHU…with no intent to harm self…contract for safety…" The plan was to "monitor" him on a "monthly basis."

On 7/1/12 correctional officers brought the patient to the medical clinic because "he had a thermal shirt wrapped around his neck as if in an attempt to harm himself." The RN note states that the "detainee denies suicidal ideation… States he understands that putting objects around his neck can be mistaken for attempts." The note provides no information about the patient's reason for wrapping the shirt around to snack and no additional information obtained from the correctional officers. The RN did notify the on-call mental health professional, but the patient was returned to the segregation unit. On July 2, a mental health clinician spoke with an officer on the segregation unit who reported that the patient had "busted out the light in his cell last night,

was upset about something [but] denied any complaints this morning," but the note makes no mention of the incident with the shirt wrapped around the patient's neck or the breaking of the light in the patient's cell.

Staff appear to have repeatedly minimized or overlooked significant warning signs in this patient's presentation. He appeared depressed, made suicidal statements, and engaged in behavior suggestive of suicide attempts and other disturbances. The chart notes do not indicate an appropriate workup or follow-up for these significant findings. Instead, the assessments appear to have consisted of little more than occasional asking the patient if he intended to kill himself and accepting his negative response without any further exploration, evaluation, or comprehensive assessment of his condition and risk factors.

This case should have resulted in a detailed, internal mortality review. A thoughtful root cause analysis of this sentinel event would have revealed many shortcomings that could better inform staff when dealing with similar situations in the future.

The January 16, 2014 Annual Detention Inspection report also appears to have completely overlooked the many problems with the management of this patient. Although acknowledging the suicide, the inspection report contains no meaningful analysis of the patient's history. Despite the serious management oversights, the inspection report merely, and inaccurately in my opinion, concludes that the facility "meets standards" on "suicide prevention and intervention."

2. Detainee 2[2]

According to the CRCL complaint, "[Detainee 2] alleges that he has not received appropriate medication since arriving at the facility because the medication he was taking previously was not on the IHSC formulary. [Detainee 2] states that he has a history of mental illness and has been diagnosed with schizophrenia, anxiety disorder, depression, and a severe mental disability. [Detainee 2] has requested to receive Saphris, a drug used to treat bipolar disorder, but he claims that he has been placed on a generic version of the drug, which he believes is ineffective."

Detainee 2 had his medical intake assessment on December, 22, 2012. He reported his psychiatric medications as "Abilify, Zyprexa, Safris, Xanax, Buspar" and that he had last taken his medications two weeks ago prior to his admission to HCDF.

Detainee 2's psychiatry appointments at HCDF include diagnoses of either schizophrenia or schizoaffective disorder depending upon the note. He had psychiatry appointment notes for the dates below, which included, in part, the following information:

- 1/2/13 with Dr. (b) : "start Zyprexa 5 mg po qhs, Buspar 7.5 mg po BID…MH follow up tentatively scheduled: 2/20/2013…Agrees to Zyprexa & Buspar as did well on these meds before"

- 1/16/13 with Dr. (b) : "D/C Zyprexa and Buspar 7.5 mg po BID. Start Haldol 2mg po qhs, Buspar 15mg po BID, Cogentin 1mg po qhs"
- 1/30/13 with Dr. (b) (6) "D/C Haldol 2mg po qhs, Buspar 15mg po BID, Cogentin 1mg po qhs…not psychotic and no reason to give meds he is refusing."
- 3/1/13: "Start Risperdal 1mg po bid, Wellbutrin SR 1000mg po qam" "irritability and sudden anger…appears to be more in the Bipolar spectrum, possibly schizoaffective…"
- 3/15/13 with Dr. (b) (6): "Discontinue Risperdal 1mg po bid, Increase Wellbutrin SR 300mg po qam…no symptoms of psychosis"
- 5/31/13: with Dr. (b) (6): "Continue Wellbutrin XL 300mg po qam, start Benadryl 50 mg po qhs…MH follow up tentatively scheduled: 7/12/2013…stable and does not currently exhibit any sign of psychosis"
- 6/6/13 with Dr. (b) (6): "continue current medications…MH follow up tentatively scheduled: 8/9/2013"
- 8/7/13 with Dr. (b) (6) "Renew Wellbutrin XL 450mg po qam"

Detainee 2 had mental health appointments that included the following dates, and selected quotations:

- 12/26/12 with LCDR (b) (6) , LCSW: "(b reported he was initially treated for schizophrenia in 2003 or 2004. (b stated he has tried various medications and his psychosis have been stabilized with Safris, and Xanax. (reported the Buspar helped with his anxiety and anger. (reported his mood is currently stable but he is irritated because he is in ICE custody. (b reported he need his medications as soon as possible in order to keep his mood stable. (denied current depression, psychosis, and si/hi/plans."
- 1/7/13 because he refused Zyprexa "REFUSED ZYPREXA. STATES MAKES HIM DROWSY AND SLEEPS DURING THE DAY EVEN AFTER SLEEPING AT NIGHT"
- 1/15/13 "(b stated he is non-cpmliant [sic] with Zyprexa due to the side effects: drowsiness and feels like having a hang over [sic]."
- 1/24/13 RN note: "Detainee refused some… medications today [Buspirone 15 mg, Haloperidol 2 mg, and Benztropine 1 mg]…States he does not want it them anymore because they cause too many side effects."
- 1/29/13 with LCDR (b) (6) , LCSW: "Detainee refusing Haldol 2 mg, Congentin 1 mg, zyprexa 5 mg, and Buspar 15 mg at 2130"
- 2/25/13 with LCDR (b) (6) , LCSW "(b requested information on whether Wellbutrin is on the formulary. Encouraged the patient that he would have to address the concerns related to the medications with the psychiatrist and reeducated the patient on the policy related to the facilities formulary and the availability [sic] of medications."
- 3/6/13: "S(b) was seen today by mental health in SSU. (was seen due to non-compliance with Risperidal. (stated he does not want to continue to take Risperidal due to the side effects. (denied depression, psychosis, and si/hi/plans but he requested to

continue the Wellbutrin. (b) stated he is currently doing fine but he is in SSU for medical reasons."

- 3/14: LVN note: "Refused Risperidone 1 mg (he never takes Risperidone since re-ordered), and all PM Meds. Meds not given."
- 5/13/13 with LCDR (b) (6), LCSW: "(b) (6) was seen today by mental health. Pt reported he is compliant with the Wellbutrin as it helps with his depression. Pt requested information on how to obtain Saphris and pt expressed that he need the med and does not like the other meds due to side effects. Pt reported that he was previously told that the medication is not available due to the cost to obtain/maintain the medication at this facility….Re-educated the patient that the requested medication Saphris is not on the formulary and not available at this facility."

The mental health and psychiatry notes document frequent follow-up and appropriate medication management given this detainee's presentation. The notes indicate that he almost continuously refused all medications, often including Dilantin, which he took for a seizure disorder.

3. Detainee 3[3]

According to the CRCL complaint, "[Detainee 3] alleged that he received inadequate medical care for schizophrenia, panic and anxiety attacks, and depression" and "that he was placed into segregation for two months at HCDF."

Detainee 3 had his medical Intake Screen on March 19, 2011. He had an initial psychiatry appointment on April 12, 2011 because of psychotic symptoms, which persisted throughout his detention at HCDF. For example, a mental health medical record note from June 25, 2011 describes him as "increased delusional…staff are out to get him, hears voices…" while in segregation; a psychiatry note by (b) (6), MD, on February 22, 2012 describes him as "paranoid…very disheveled…very delusional-paranoid"; and another psychiatry note on March 27, 2012 describes him as "…hearing voices…disheveled… auditory hallucinations present. Tangential…irrational Insight/Judgment: poor. Paranoid."

Detainee 3 had documented psychiatry visits on the following dates:

- 6/14/11
- 7/20/11
- 8/16/11
- 10/25/11
- 11/22/11
- 2/22/12
- 3/2/12
- 3/27/12

- 7/11/12
- 11/7/12

Detainee 3 received a diagnosis at HCDF of "psychotic d/o nos" (i.e., psychotic disorder, not otherwise specified), and at different times his psychotropic medication treatment included at least two antipsychotic medications (risperidone and aripiprazole) and an antidepressant (mirtazapine). Despite being on antipsychotic medication, his medical record had no indication of screening for side effects with AIMS examinations or of routine monitoring for metabolic syndrome. On June 10, 2011 he expressed "concerns about his weight" to a Physician's Assistant he gave him "reassurance" that "he has actually gained 9 lbs in less than 3 months of being here and that his current weight is appropriate for his height and normal" (weight gain can be one indication of a "metabolic syndrome," with often serious health consequences, potentially caused by Detainee 3's antipsychotic medications).

Detainee 3 spent much of his time at HCDF in segregation for reasons that included a "verbal confrontation with an officer" (January 20, 2012) and because he "raised his voice at officier [sic] in dormity [sic]." The February 22, 2012 note by Dr. (b) stated, "...explained he cannot leave seg when is this paranoid." Although I could not determine the exact durations of his time in segregation, his medical record includes notes mentioning his placement there on the following dates and time periods lasting more than three months:

- 4/12/11
- 6/25/11
- 9/5/11
- 10/17/11 ("pre-seg clearance")
- 10/19/11 – 11/12/11
- 1/20/12 ("(b here for seg clearance...verbal confrontation with an officer" (b) (6), (b) (7) RN)
- 2/22/12 - 5/28/12
- 8/12/12 – 11/12/12

On at least one occasion (December 6, 2012), an LVN did Detainee 3's segregation clearance evaluation without any indication of review or supervision by a medical or mental health provider licensed to conduct independent assessments. Medical record notes of "segregation sick call rounds" are all identical, or nearly identical, such as the following:

> S:0525 segregation sick call rounds completed, pt had no c/o of pain or illness.
> O:No sick call requests made by the detainee at this time. CCA Officer on duty also states the detainee has had no complaints during his shift.
> A:Sick Call Rounds
> P:Will continue to offer medical availability daily while in Segregation.

Significant problems with this case include the detainee's repeated stays in segregation, sometimes lasting at least three months, despite his psychotic condition, and for behaviors likely

associated with his mental illness; clinically inadequate segregation clearance evaluations and monitoring; gaps in psychiatry appointments sometimes lasting three months despite his unstable and psychotic condition; and lack of appropriate medication monitoring (e.g., AIMS exams).

4. Detainee 4[4]

This detainee arrived at HCDF on June 6, 2014. The intake evaluation and the Physical Examination on June 8, 2014 each indicate that the detainee is "transgender" (male to female). Neither evaluation provides additional details about the detainee's history in this area, but the physical examination note states "None" under Current Medications and "No" for Surgical History. The physical examination note describes the detainee as stating, "I am depressed because I was placed in seg instead of dorm. I was told that I was going to a dorm, now I am still in the b-seg. This is very depressing for me." She also stated, "I had a bra when I got here, but it was taken." The note indicates that follow-up will be "prn" with no mention of a referral to mental health.

(b) (6), LISW, did the mental health "Initial Assessment" on July 15, 2014, over a month after the detainee's arrival at HCDF. This note includes a diagnosis of insomnia, but makes no mention of transgender issues. A "Seg Rounds" note by Ms. (b) (6) dated July 24, 2014 is the first mental health note identifying a "gender identity disorder," but it provides no history or other information regarding this diagnosis. The detainee had a telepsychiatry appointment on July 29, 2014 with (b) (6), MD, with a chief complaint that "I do not like the SHU. I cannot sleep because of the noise and the lights on." Dr. (b) (6) diagnosed "Insomnia" and prescribed hydroxyzine 50 mg. at bedtime as needed. His assessment does not mention transgender issues.

All of the notes in the detainee's medical record refer to her using masculine pronouns. Lt. (b) (6), (b) (7) told me that she does not know of any policy providing guidance on how to address transgendered inmates, and the correctional officers I spoke with told me that they are unaware of custody policy guidelines.

I interviewed Detainee 4 in the presence of other members of our survey team on Monday, August 18 and Tuesday, August 19, 2014. The first interview lasted only a couple of minutes and used a correctional officer as an interpreter because the detainee does not speak English. During the second and more extensive interview, we used an interpreter retained by CRCL.

Detainee 4 prefers to be addressed as a female, using senorita and with her feminine name. She has asked staff at HCDF to address her as a female, but only some of them do this. She feels distressed and depressed when others refer to her a male. She told me that prior to her current detention she had been treated for her gender dysphoria for eight years at a clinic in Houston, located on "Ella Street." She had been taking hormones, including Premarin, for three years until the week of her detention. She has thought about sex reassignment surgery, but she has never

pursued it "for economic reasons" and because she would first "have to be very well prepared." No one from the medical or mental health departments at HCDF asked her about her transgender treatment history, and she did not tell them because they had not asked. She is willing to sign a consent form for medical and mental health staff at HCDF to obtain her treatment records if asked.

Detainee 4 has not requested feminine attire or hygiene products since her arrival at HCDF. When asked her reason for not making this request, she said that on arrival at the facility an officer had taken away her bra and feminine underwear. The officer allegedly threw these items in the trash right in front of her while telling her that she "was a man" and should not have women's clothing. She became tearful while giving this account stating, "It really hurt me deeply. To me that was discrimination." She has been given one-piece jumpsuits, instead of separate tops and bottoms, to wear in the facility. As a result, she must pull down the top of the jumpsuit when using the toilet, which causes her to feel embarrassed.

Detainee 4 stated that she has "never caused any problems" at HCDF, and she initially did not know the reason for her placement in segregation. She told staff that she did not want to be housed by herself, she felt "fine" about being in a male dormitory, and she never asked for protective housing in the segregation unit. An officer eventually told her that they kept her isolated in segregation "because of my sexuality." She said that "sometimes officers laugh at me while standing at the door of my cell."

On Monday, August 18, Ms. (b) (6), the facility director of recreation, told me that Detainee 4 regularly attended private, one-hour, daily recreation sessions in the main indoor and outdoor recreation area used by general population male inmates. Ms (b) (5) informed me that she typical goes to the segregation unit each day to ask administrative segregation detainees if they want to come to the main recreation unit for solitary exercise. She said that she did not need to go to the segregation unit each day to ask Detainee 4 because this detainee always wanted to come to the recreation area and the officers simply brought her every day without asking.

In contrast to the account of Ms. (b) (6), Detainee 4 told me on Tuesday, August 19 that she had not been allowed access to the general recreation area before Friday, August 15, 2014. She also had only 20 minutes in the general recreation area on Saturday, August16 and Sunday, August 17. When she first arrived at HCDF, she repeatedly asked to go to the general population recreation area, but she stopped asking when an officer told her that she was not allowed to go out of the unit for recreation.

After speaking to Detainee 4, I separately asked two correctional officers from the segregation unit about Detainee 4's access to the general population recreation area. One told me that this "probably" began about two weeks ago, and the other told me that it had begun only four days ago on Friday, August 15, 2014.

On Wednesday, August 20 I asked Ms. (b) (6) again about Detainee 4's access to the general population recreation area. During this discussion, Ms. (b) (6) told me that the access had begun a few weeks earlier. When informed of the detainee's account that this had begun just a few days ago on Friday, Ms. (b) (6) explained that Assistant Warden (b) (6), (b) had given approval to start "recreating her" just one week ago, on Wednesday, August 13, 2014.

Detainee 4 reported that she has never been offered programming or activities, and she has not asked for them. She would like, however, to participate in whatever might be available to her, including handicrafts, transgender programming or counseling, and groups where detainees can discuss their immigration issues.

Detainee 4 said that whenever she "would ask the guard to let me out [of my cell], they said 'no'." About a month ago she gave a written note to one of the officers on the segregation unit "asking them to let me out because I was very depressed in my cell." She never received a response to her note. She spends her time on the unit locked in her cell, even when she is the only detainee on the unit, as was the case during part of our three-day site visit.

Detainee 4 wears handcuffs whenever she leaves the segregation unit (e.g., for medical appointments, attorney visits, and for her recent trips to the recreation area). Being placed in handcuffs for movement within the facility makes her feel "very depressed." I asked (b) (6) Director of Quality Assurance, the reason for cuffing Detainee 4 when she leaves the segregation unit and for keeping her constantly locked in her cell while on the unit. He told me that this was facility "policy" for all detainees in administrative segregation, even those there for protective custody, as overflow from the MHU, or for other reasons unrelated to disruptive or aggressive behaviors. He explained that Detainee 4 might become assaultive or disruptive if out of cell and uncuffed. According to the one segregation unit officer I asked, who has worked with Detainee 4 since her arrival at HCDF, she has never threatened or assaulted an officer or anyone else, and she has never engaged in any disruptive behavior. Mr. (b) did not dispute this account, but he told me that for all they knew, Detainee 4 could be "a serial killer." He had no information or observations to suggest that this was the case. General population detainees do not wears cuffs when moving within the facility despite being no less likely than Detainee 4 to become unexpectedly assaultive or to be serial killers.

In my opinion, this case presents many problematic findings that have caused ongoing psychological harm to this detainee. I review these issues in the Recommendations section below.

5. Detainee 5[5]

On August 30, 2013, this detainee had an intake assessment that noted Estrogens under current medications and a Physicians' Assistant physical examination that noted a history of depression,

indicated that "he does not do well in isolation," and included "Gender Identity disorder" among the diagnoses. On the same date, the detainee had an initial psychiatric assessment by Dr (b) (6) that included diagnoses of PTSD and "Major Depression, recurrent, moderate," but did not mention gender identity disorder.

A nursing note on September 7, 2013, states that the detainee was "moved to Seg due to MHU overflow." A social worker mental health crisis intervention note on September 18, 2013 states, (b) reports difficulty ignoring being in segregation without anyone to talk to" and the patient's complaint that "CCA originally stated they will not handcuff her; but has since been handcuffing her all the time." This note and a psychiatry follow-up note on September 20, 2013 do not include transgender issues among the assessment. The first explicit mention of this occurs in a social worker note on October 28, 2013 that states, "anxious and tired of being alone…anticipates transferring to a facility with transgender [sic]."

On March 3, 2014, the detainee reported took 50 pills that she had hoarded while in segregation because "he was tired of the way he was treated by the officers."

In my opinion, this case presents many of the same issues and harm to mental health as that of Detainee 4.

6. Detainee 6[6]

I reviewed this case extensively with (b) (6), M.D. We agree on the findings, which his report will address in greater detail.

The detainee arrived at HCDF on May 22, 2012. According to a psychiatry note by Dr. (b) (6) dated May 25, 2012, she appeared "profoundly depressed" with a likely diagnosis of major depression with psychotic features. She remained in the MHU until her deportation on June 18, 2012. She had frequent, often daily, contact with mental health social workers or psychiatrists during that time. She had intermittent, selective mutism. She was also followed by medical staff for hypertension, low blood oxygen saturation, and heartburn.

A social worker note on June 5, 2012 reported that the detainee had not eaten for the past 24 hours. During the next two weeks notes intermittently continue to mention not eating or not drinking. The patient's selective mutism, which had briefly improved, appeared to worsen during at least her last week at HCDF. According to a social worker note on June 12, 2012 the patient vomited and had dry lips and mucous membranes. A social worker note on June 15, 2012 states that the patient "last ate" on June 13, and a Physician Assistant note from June 17 stated that she was still not eating, had not been drinking for the past two days, and had been refusing to have her vital signs and daily weight monitored by nursing staff. Despite these observations, the PA "deferred" doing a physical examination on that date. On the following day, June 18, the patient

was deported by plane to Honduras. Upon arrival in Honduras, the staff accompanying her noticed that she had died on the plane en route.

Despite leaving HCDF on June 18, 2012 and dying the same day on her flight to Honduras, the medical record contains five notes by CDR (b) (6), CD, with "Event" dates of July 14 and 15, 2012 describing contacts with the patient and physical examination findings that the medical record indicates as occurring one month after the detainee's death.

The chart notes do not describe communications or coordination of care between medical and mental health staff. I found no indication of discussions about the reason she stopped eating and drinking, the role of her depression and psychosis in this prolonged and life-threatening significant decrease in food and fluid intake, or the potential consequences of her fasting and dehydration.

7. Detainee 7[7]

On the morning of Wednesday August 20, 2014, the final day of this site visit, I found out that this female detainee had been placed on a suicide watch the previous night. I briefly saw this detainee while she was still in the suicide watch cell in the A-Segregation unit, but I did not get the opportunity to speak privately with her. She was wearing only a suicide gown when I observed her because her clothes had been removed.

According to a RN note electronically signed at 12:36 a.m. on August 20, 2014, the precipitating event for moving this detainee to the segregation unit was "sitting in her bed crying." The extent of the clinical intervention as far as I could determine was being asked by the first nurse on the scene if she wanted to hurt herself a question that she refused to answer because "she did not feel like she needed to talk to the nurse about her feelings." A second nurse, the RN who wrote this note, was then "called to MHU [by a CCA Captain] at 2215 [on the evening of August 19]." The RN reported in her note "that [the patient] was very upset and was concerned about her medical care, her current medical problems and being unable to adequately provide and care for her children…[but] did not have intentions on hurting herself, she was only upset about her situation." The RN explained that a "medical provider" had already ordered suicide observation and "due to existing order, she has to be placed on suicide observation with 1 to 1 watch with guard." The patient reportedly refused to go to the segregation unit and said, "that the nurses and providers at this facility are all stupid and don't know anything about medical care." Because of her refusal, a "SORT team [was] notified and entered room to assist detainee with transfer to A-Segregation for Suicide Observation." The patient resisted the transfer and became "very hostile and verbally disrespectful" while "officers attempted to place cuffs to both arms and legs."

A Physician's Assistant note electronically signed at 07:20 on Wednesday morning 8/20/14 states, in part:

"Detainee was placed in Aseg for suicide purposes last night. Today detainee states she never stated that she wanted to hurt herself and states she currently does not want to hurt herself...she states she feels humiliated by being placed in segregation and placed in a security gown. I have explained that we have to take precautions if there is any indication that someone voices or acts in a way that displays feelings of helplessness or hopelessness, crying, thoughts or voicing thoughts of suicide, harm or death."

RECOMMENDATIONS AND RATIONALES:

Applicable Standards: As an overarching matter, PBNDS 2011, Medical Care, states "This detention standard ensures that detainees have access to appropriate and necessary medical, dental and mental health care." The following recommendations result from deficiencies in meeting this overarching standard. I also include for reference purposes relevant portions of ICE's 2000 National Detention Standards (NDS) and the Standards for Health Services in Jails, National Commission of Correctional Health Care (NCCHC).

Each recommendation below is designated either as Level 1 (highest priority and essential), Level 2 (important), or a best practice recommendation.

1. (b) (5)

Rationale: PBNDS 2011, Medical Care, states "This detention standard ensures that detainees have access to appropriate and necessary medical, dental and mental health care, including emergency services," and PBNDS 2011 Standard 2.12, Special Management Units (SMU), states in II, 8: "Detainees with serious mental illness may not be automatically placed in an SMU on the basis of such mental illness. Every effort shall be made to place detainees with serious mental illness in a setting in or outside of the facility in which appropriate treatment can be provided rather than an SMU, if separation from the general population is necessary" and Standard 2.12.III.c.9 states "Use of administrative segregation to protect vulnerable populations shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing options exist, and as a last resort. Detainees who have been placed in administrative segregation for protective custody shall have access to programs, services, visitation, counsel and other services available to the general population to the maximum extent possible." NCCHC Standards for Mental Health Services (MH-G-02, an "essential" standard) requires that "mental health programs or residential units meet the serious mental health needs of patients." Part of this NCCHC standard requires "housing in a safe and therapeutic environment, conducive to symptom stabilization."

(b) (5)

HCDF should either find an alternative location for protective custody and medical or mental health housing of detainees or end its current practice of imposing the same high security or punitive segregation practices for those detainees placed on the segregation unit solely for protection or medical or mental health reasons.

2. **HCDF needs to make the following changes in its clinical and custody management of detainees with gender dysphoria (i.e., transgendered detainees): (a) provide comprehensive medical and mental health assessments and interventions by knowledgeable clinicians and consistent with prevailing clinical standards of care; (b) end the routine use of isolation practices for these detainees; (c) house detainees in general population units that allow them full access to privileges and programming available to other inmates whose behaviors do not need require restrictions or, if general population housing is not provided, at a minimum ensure that these transgendered detainees can directly and fully participate in programming and other services and can spend time outside of their cells to the same extent available to general population detainees; (d) end the routine use of cuffing, or other restrictive security measures; and (e) provide training and monitoring for clinical and custody staff to ensure that transgendered detainees are treated with respect and sensitivity. (Level 1)**

Rationale: ICE Health Service Corps Directive 03-25 states:

"This policy applies to all IHSC personnel (including, but not limited to, Public Health Service officers, employees, and federal contractors) assigned to IHSC-staffed facilities supporting healthcare operations in ICE owned or contracted detention facilities…If, at any time during the Intake Screening Process, a detainee self-identifies as being transgender…or medical transfer records indicate a diagnosis of GID, a physical and mental health evaluation will be scheduled within 72 hours. All transgender detainees will have access to transgender-related health care and medication, based on medical need. Treatment shall follow excepted guidelines regarding medically necessary care…Specialty consultation with off-site providers may be necessary to provide appropriate assessment and treatment…When making classification and housing recommendations for a transgender detainee, medical staff shall consider the detainee's gender self-identification and assessment of the effects of placement on the detainee's mental health and well-being. A medical or mental health professional will provide a housing recommendation…"

PBNDS 2011 Standard 2.12.II.11 states, "Detainees in SMU shall be afforded basic living conditions that approximate those provided to the general population, consistent with the safety and security considerations that are inherent in more controlled housing, and in consideration of the purpose for which each detainee is segregated," Standard 2.12.II.14 states, "Each detainee in an SMU shall be offered individual recreation or appropriate group recreation time, unless documented security, safety, or medical considerations dictate otherwise," and Standard 2.12.II.19 states, "Detainees in SMU shall have access to programs and services such as commissary, library, religious guidance and recreation, in accordance with provisions in the PBNDS."

PBNDS 2011 Standard 4.3.J.15 states that the medical and mental health screening of all detainees shall "inquire into a transgender detainee's gender self-identification and history of transition-related care, when a detainee self-identifies as transgender" and Standard 4.3.U states, "Transgender detainees who were already receiving hormone therapy when taken into ICE custody shall have continued access. All transgender detainees shall have access to mental health care, and other transgender-related health care and medication based on medical need. Treatment shall follow accepted guidelines regarding medically necessary transition-related care."

Practices at HCDF have not complied with the IHSC Directive or with PBNDS 2011. The two detainees whose cases I reviewed did not have comprehensive evaluations or treatment for their gender dysphoria at HCDF, and Detainee 4 did receive continuation of the hormone therapy that she reports receiving in the community for three years prior to her detention. Medical and mental health staff did not participate in the classification and housing placements of these detainees. Placement in the segregation unit with significant restriction to their cells, lack of congregate time with others, absence of programming, and restrictions on normal movement all contributed to substantial psychological distress that precipitated or exacerbate depression.

The Standards of Care published by the World Professional Association for Transgender Health provide the most widely accepted guidelines for medically necessary care, which HCDF has not been providing. HCDF will likely need to retain an outside consultant to train custody, medical, and mental health staff in how to interact with transgendered detainees in a way that does not cause psychological harm (including use of gender preferred pronouns) and to provide training or consultation to clinical staff on appropriate medical and mental health evaluation and care for these detainees. If requested, I can provide some information about local resources and experts.

3. **HCDF should provide the same access that general population detainees have to recreational areas and programming for detainees placed on the segregation unit for protective custody or medical or mental health overflow reasons. (Level 1)**

Rationale: PBNDS 2011 Standard 2.12.III.c.9 states "Use of administrative segregation to protect vulnerable populations shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time

practicable, and when no other viable housing options exist, and as a last resort. Detainees who have been placed in administrative segregation for protective custody shall have access to programs, services, visitation, counsel and other services available to the general population to the maximum extent possible." NCCHC Standards for Mental Health Services (MH-G-02, an "essential" standard) requires that "mental health programs or residential units meet the serious mental health needs of patients." Part of this NCCHC standard requires "housing in a safe and therapeutic environment, conducive to symptom stabilization."

Despite inaccurate or misleading statements by some staff, detainees in administrative segregation for reasons unrelated to disruptive behaviors (e.g., for medical or mental health overflow from the MHU) have not been receiving the same access to recreational areas and programming as general population detainees. Contrary to the statements of some custody officials, my observations and discussions with other staff and with detainees do not support the contention that meaningful, if any, programming has been brought to the segregation unit. Wheeling a television to a detainee's cell front and showing a video of a meditation program or similar programming, even if this had been occurring, does not substitute for full participation in group activities.

4. **HCDF should conduct meaningful assessments as part of medical clearances for segregation and ensure that detainees in segregation receive regular mental health monitoring on rounds and through periodic mental status updates. (Level 1)**

Rationale:

PBNDS 2011 Standard 2.12.II.7 states "Health care personnel shall be immediately informed when a detainee is admitted to an SMU and shall conduct an assessment and review of the detainees medical and mental health status and care needs. Health care personnel shall at a minimum conduct a daily assessment of detainees in an SMU. Where reason for concern exists, a qualified medical, or mental health professional shall conduct a complete evaluation" and Standard 2.12.V.N states "Health care personnel shall conduct face-to face medical assessments at least once daily for detainees in an SMU. Where reason for concern exists, assessments shall be followed up with a complete evaluation by a qualified medical or mental health professional, and indicated treatment."

NCCHC Jail Standards (J-E-09) and Standards for Mental Health Services (MH-E-07, an "essential" standard) address the need for screening and regular monitoring of inmates in segregation. For example, as a compliance indicator, the mental health standards state, "On notification that an inmate is placed in segregation, mental health staff reviews the inmate's mental health record to determine whether existing mental health needs contraindicate the placement or require accommodation. Such review is documented in the clinical record." The standards also require monitoring of segregated inmates with frequencies based on the degree

of isolation. Individuals "under *extreme isolation* with little or no contact with other individuals are monitored daily by medical staff and at least once a week by qualified mental health professionals," (emphasis in original) and "inmates who are segregated and have limited contact with staff or other inmates are monitored 3 days a week by medical or qualified mental health professionals." The Jail Standards specify that the medical staff must be a "qualified healthcare professional," defined as someone "who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for patients."

HCDF does not meet these standards for screening detainees when first placed in segregation or monitoring during their stays in segregation. LVNs do not fall within the definitions of qualified mental health professionals or qualified healthcare professionals. The screenings that occur at the time of placement appear to be *pro forma* without meaningful clinical information and without taking into account detainees' significant history and current symptoms of mental illness. This creates two potentially serious consequences. First, detainees may receive punitive sanctions for behaviors rooted in their symptoms. Second, detainees with serious underlying mental disorders spend time in segregation – an environment likely to exacerbate their conditions.

The absence of adequate mental health screening may result in the placement in segregation of detainees with serious mental health problems. Isolation, as a result of the disciplinary infraction, can precipitate or exacerbate symptoms of psychological distress. A failure to detect significant symptoms can result in further decompensation for detainees with underlying mental disorders. In addition, detainees who do not have underlying mental disorders can develop anxiety, depression, and other mental health problems as a consequence of social isolation and confinement in segregation settings.

HCDF also does not adequately monitor detainees while they remain in segregation. As with segregation clearances, segregation rounds, as documented in medical records, also appear to be *pro forma* and without meaningful mental health assessment. For example, some of the detainees described in this report experienced psychological harm from their segregation placements that was not adequately detected or addressed in their segregation round notes.

5. **HCDF should modify the following practices and circumstances surrounding suicide watches and risk assessments: (a) conduct watches in a more therapeutic environment than the segregation unit and provide patients on suicide watch with at least daily therapeutic contact in a private setting with a licensed mental health professional; (b)** [redacted (b) (5)] **; (c) CCCF should conduct adequate suicide risk assessments that consist of more than just a patient's denial of suicidal ideation. (Level 1)**

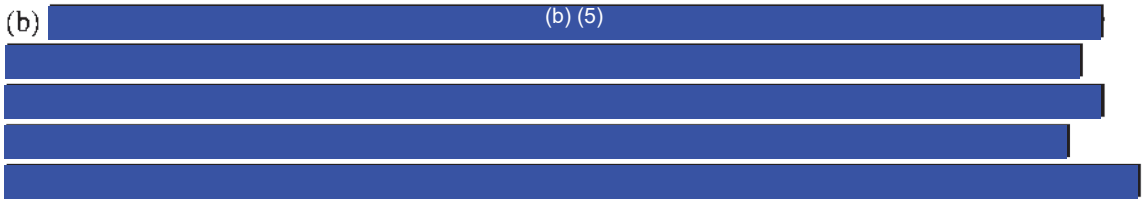
Rationale: PBNDS 2011 Standard 4.6, Section V.F.1. No Excessive Deprivations, states "Deprivations and restrictions placed on suicidal detainees need to be kept at a minimum. Suicidal detainees may be discouraged from expressing their intentions if the consequences of reporting those intentions are unpleasant or understood to result in punitive treatment or punishment. Placing suicidal detainees in conditions of confinement that are worse than those experienced by the general population detainees can result in the detainees not discussing his or her suicidal intentions and falsely showing an appearance of getting well fast." PBNDS 2011 Standard #4.6, Section V.F.2. Clothing states: "Detainees should be provided suicide smocks to wear when medically indicated."

The 2000 NDS state, "Staff will act to prevent suicides with appropriate sensitivity, supervision, and referrals. Any clinically suicidal detainees will receive preventive supervision and treatment." They go on to state "The detainees may be placed in a special isolation room designed for evaluation and treatment. The isolation room will be free of objects or structural elements that could facilitate a suicide attempt."

A suicide prevention program that "identifies suicidal inmates and intervenes appropriately" constitutes an essential NCCHC standard, J-G-05. Appendix C of the NCCHC Standards for Health Services in Jails addresses "Suicide Prevention Protocols." They state, "mental health staff should assess and interact with the suicidal inmate on a daily basis."

(a) Appendix C of the NCCHC Standards for Health Services in Jails addresses "Suicide Prevention Protocols." It states, "mental health staff should assess and interact with the suicidal inmate on a daily basis." As noted above, the PBNDS 2011 state, "Minimum requirements for medical housing units will be met"; and the 2000 NDS also specify "treatment" along with evaluation for suicidal detainees in special isolation. These standards provide recognition that monitoring and ongoing assessment are necessary but not sufficient components of a suicide watch. Unless clinically contraindicated (e.g., extreme agitation), a suicide watch should occur in a therapeutic settings and contain a therapeutic component. The segregation units at HCDF are punitive, not therapeutic, settings. Whenever possible, the suicide watch should take place in a clinical unit that contains clinical staff. In addition, a qualified mental health professional must meet with the patient in a private setting, or in the watch cell if necessary, to provide daily therapeutic treatment and intervention that address the cause of the crisis and can hasten its resolution. The absence of such therapeutic contact renders a suicide watch little more than an unpleasant experience that the individual seeks to end as soon as possible by falsely denying ongoing distress or suicidal thoughts.

(b) (b) (5)



(c) Suicide risk evaluations at HCDF consist of little more than a statement that the individual "denies" active suicidal intent. An individual's self-report of the presence or absence of suicidal thoughts or intent does not constitute an adequate risk assessment. Studies have found that a majority of patients who commit suicide deny suicidal ideation immediately before they do so. Several reasons can account for this. The individual may have acted impulsively or may have deliberately misled the clinician. Even when a patient is honest, a denial of suicidal ideation does not necessarily mean an absence of suicide risk.

A meaningful suicide risk assessment should identify suicide risk factors, including acute risk factors, unique to the individual; identify protective factors; and evaluate the therapeutic alliance that the patient has with treating clinicians. Other clinical and custody staff can also provide useful information and observations. Appropriate assessments include a review of current symptoms such as depression, anxiety, insomnia, change in appetite, diminished concentration, loss of interest, and feelings of hopelessness. In addition to subjectively reported symptoms, observed objective signs include behavior (e.g., agitation or withdrawal) and affect. A diagnostic assessment also provides useful data as some diagnostic groups such as major affective disorders, schizophrenia, and borderline personality disorder have an increased risk for suicide. Depression complicated by anxiety or panic attacks can significantly increase potential lethality. The clinician can attempt to identify interpersonal, environmental, and situational risk factors. Remediable risk factors, including treatable disorders, warrant special attention and intervention. The assessment also includes a detailed exploration of suicidal thinking, intent, and plan. When a recently suicidal individual no longer reports suicidal thoughts, the clinician should explore and attempt to understand the reason for the change. Self-reported resolution of the patient's suicidal feelings by itself provides little reassurance in the absence of identifiable reasons for the improvement. So-called "no-harm contracts" never substitute for an adequate risk assessment.

6. **Psychiatrists' contacts with patients must include medication education, monitoring for side effects, and appropriate laboratory and other testing. (Level 1)**

Rationale: The required "duties and responsibilities" for psychiatrists in the ICE Health Services Corps (formerly the USPHS, Division of Immigration Health Services) include the following: "Prescribes and monitors psychiatric medication treatment services including monitoring the side effects of medication and/or adverse reactions. Offers comprehensive psycho-educational information with each medication… Assessment of Involuntary Movement Scale (AIMS) is used if identified treatment carries the risk of inducing a movement disorder."

PBNDS 2011 Standard 4.3.II.12 states "Detainees with chronic conditions shall receive care and treatment, as needed, that includes monitoring of medications, diagnostic testing and chronic care clinics," Standard 4.3.V.N states "Any detainee prescribed psychiatric medications must be regularly evaluated by a duly-licensed and appropriate medical professional, at least once a month, to ensure proper treatment and dosage," and Standard 4.3.V.T states "Qualified health care personnel shall provide detainees health education and wellness information."

Some patients on psychotropic medications require monitoring that currently does not take place. For example, patients on antipsychotic medications need baseline and periodic monitoring for metabolic syndrome and for abnormal involuntary movements, such as tardive dyskinesia. Prescribers also need to provide basic information, such as common side effects, to patients about the medications that they take. The records at HCDF show no indication that this has been occurring.

7. **HCDF needs to improve communication and coordination of care among custody, medical, and mental health staff. (Level 2)**

Rationale: Adequate care requires communication and coordination. This review revealed several shortcomings in this area, especially the cases of Detainee 1 and Detainee 6 which had potentially avoidable fatalities.

8. **HCDF needs to implement meaningful mental health quality improvement (QI) activities. (Level 2)**

Rationale:

PBNDS 2011 Standard 4.3.V.BB.2 states "The HSA shall implement a system of internal review and quality assurance."

QI provides an important mechanism for improving services and preventing avoidable adverse events. I found no documentation of mental health-related QI activities going back to at least the fall of 2013.

9. **HCDF needs to take detainee reports of disrespectful treatment, dismissive**

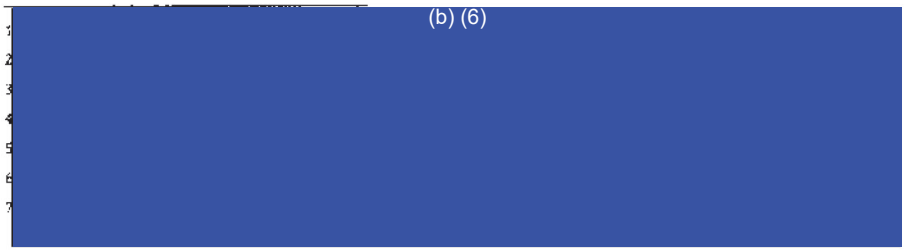
responses to legitimate medical needs, and staff reprisals against detainees who complain as serious allegations that warrant ongoing monitoring and review. This may need involvement by a credible and independent third party monitor, at least until the findings no longer raise concerns. (Level 1)

Rationale:

PBNDS 2011 Standard 6.2.V.A.8 requires "guarantees against reprisal" for detainee grievances.

Detainee allegations of problems in these areas and the unusually low percentage of detainees who chose to speak privately (but with the awareness of facility staff) with me and other reviewers raises concerns beyond those typically encountered during on-site reviews.

(b) (6)



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Report of Corrections Expert

Houston Contract Detention Facility

Houston, Texas

Prepared by:

(b) (6)

November 9, 2014

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Houston Contract Detention Facility
Houston, Texas
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CRLI-00002-000650

I. Executive Summary

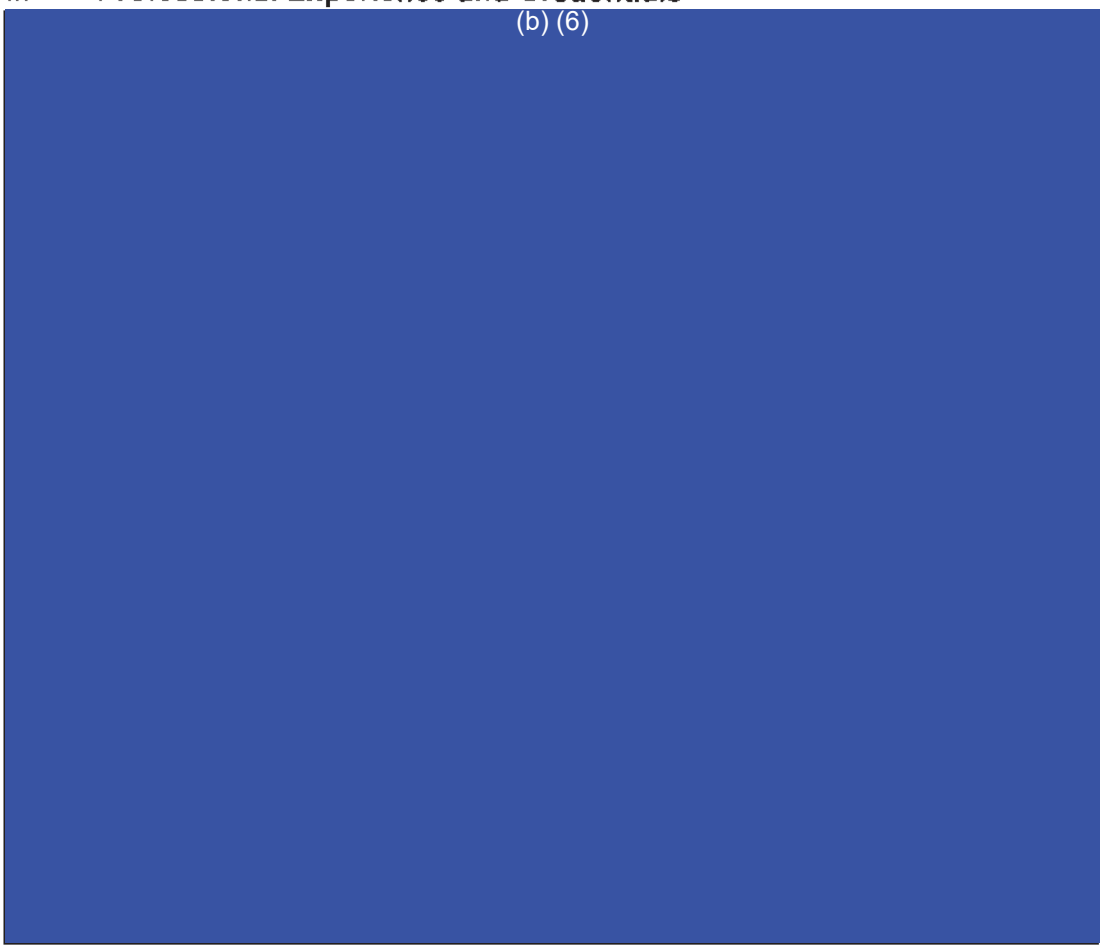
The Office for Civil Rights and Civil Liberties (CRCL) evaluated several issues while on site at the Houston Contract Detention Facility (HCDF for two and a half days. The HCDF is operated under contract to the Corrections Corporation of America (CCA). The HCDF staff were very helpful and responded in a timely fashion to our questions. The team had an opportunity to tour several areas of the facility and found it to be in substantial compliance with the 2011 Performance Based National Detention Standards (PBNDS).

This report addresses several issues. Of significant concern is the facility's use of the Segregation Units to hold detainees on suicide watches. The PBNDS specifies that facilities should not use Segregation to house those with serious mental illnesses and requires facilities to make "every effort....to place detainees with serious mental illness in a setting in or outside the facility in which appropriate treatment can be provided, rather than a [Special Management Unit] if separation from the general population is necessary." During a tour of the facility, the Health Services Administrator said detainees on suicide watch were housed in the Medical Unit. This contradicted the team's observation of a detainee on suicide watch in Segregation and the security staff's confirmation that Segregation is used for suicide watch which raises two significant concerns: whether or not the Medical Unit approved Segregation as appropriate for suicide watches per the PBNDS, and the effectiveness of communication between the security and the medical staff.

The other significant matter of concern was the housing of a transgender detainee who had been engaged in gender reassignment to become a female and was participating in hormone therapy prior to her detention. This individual has been housed in the Male Segregation Unit since her arrival on June 6, 2014 as the facility was concerned that she could potentially be a victim of sexual abuse and claimed that she requested protective custody when she arrived. Although there were no other detainees housed in the unit at the time of our visit, she was subjected to all of the high-security procedures used for detainees in disciplinary segregation—such as handcuffing every time she is removed from her cell—with limited recreational opportunities in violation of the facility's policies regarding programming, privileges, education and work opportunities.

Many detainees expressed their concerns to the team about retaliation from the staff for talking with the team members. This should be of great concern to the leadership of this facility. If this is in fact happening, it speaks to larger problems regarding the culture of the facility and potential violations of the PBNDS.

II. Professional Experience and Credentials



III. Nature of the Review

The purpose of this site visit was to review the in-custody deaths of two detainees as well as the facility's use of the Segregation Units, the grievance process, religious services, the law library, and uses of force.

The site visit occurred on August 18 through August 20, 2014 and was coordinated by CRCL's (b) (6) (Senior Policy Advisor) and (b) (6) (Policy Advisor). The other members of the team were (b) (6) M.D., a psychiatrist, and (b) (6), M.D., a medical doctor. Ms. (b) (6) of ICE joined the team for several of the interviews.

The medical experts examined the deaths and other medical and mental health issues which were brought forth by CRCL. I reviewed several digital recordings of uses of force, examined how mail is processed, and assessed the grievance process, recreation, and the law library. All team members reviewed the use of segregation and suicide watches, as well as the transgender detainee in segregation. I reviewed a substantial number of documents provided by

HCDF before, during, and after the onsite visit. I talked with CCA employees, and about 35 ICE detainees in "A" and "B" Buildings.

IV. Relevant Standards

A. ICE's 2011 Performance Based National Detention Standards (2011 PBNDS)
B. PREA – U.S. Department of Homeland Security's standards implementing the Prison Rape Elimination Act of 2003.
C. ACA – I relied on both the American Correctional Association's (ACA) Standards for Adult Correctional Institutions, 4th Edition, and the Core Jail Standards, First Edition.
D. Additional benchmarks – During the tour, and in this report I also relied on my professional correctional experience to assess conditions and provide relevant best practices to improve operations.

V. Facility Overview

HCDF is located in Houston, Texas. HCDF is comprised of three buildings which are all joined together. Buildings A and B house detainees while Building C is used by ICE for processing and other administrative tasks, as well as office space. Building A was built in 1983 and the other two (B and C) were added in 2005. CCA employs 315 staff members to operate Buildings A and B. Each building has a unit manager overseeing the operations. Females are housed in Building A and about six months ago, the female population significantly increased from about 100 detainees to the current number of 400.

The population of the Buildings A and B during the site visit was 900 with 404 females and 496 males. The rated bed capacity of the facility is 1000. This facility processes all individuals detained by ICE from the Houston region and in July, 2014, processed about 4000 detainees. The daily population may fluctuate by 100 depending upon how many detainees arrive at or/depart from the facility. There are three classification levels at HCDF (high, medium, and low) and the color of the detainees' clothing denotes the classification—red, orange, and blue, respectively. The facility is a Direct Supervision facility. The detainees are generally housed by nationality when it is feasible to do so. This housing plan is intended to limit the possibilities for conflicts due to culture and allows for better communication among the detainees.

The average length of stay according to CCA as of July 1, 2014 is 71 days. Detainee visits occur seven days per week between 0700 and 1900 hours and detainees may have one visit per week. The detainees may spend up to $100 per week on commissary items.

There are 24 dormitories in the facility with two units with cells for male and female segregation. Three of these units house 60 detainees and the

remaining 23 units house 40 detainees. The population is classified as mostly high and medium custody detainees as these two groups account for 70% of the population. The segregation units are single person cells. There are 32 cells in the male segregation unit and four cells in the female unit. The medical unit has 16 beds—eight are medical beds, four have negative air flow cells and four are for detainees with mental health issues.

VI. Findings, Analysis and Recommendations

Grievances

Officer (b) (6), (b) (7)(C) is the Grievance Coordinator. We spoke with her during our tour, and she described how a grievance from a detainee is filed. Once the grievance is written, it is placed in a locked box in the housing unit. She collects the grievances every weekday from each unit and gives those grievances pertaining to medical issues to the Medical Unit. She contacts the staff member who would have relevant information about the grievance and obtains a response from him/her. Acosta then sends the detainee a copy of the response and logs the information both in writing and electronically. A copy of the grievance also goes in the detainee's file. Grievances involving staff often go to Wayne Davis, the manager of the Quality Assurance Unit, for his response. The same process for securing the response to the detainee's grievance is followed by Davis.

Acosta said that about 90% of the grievances are based on issues with the televisions in the units, and most are resolved informally by the officers in the units. The informal resolutions are also tracked by Acosta. She said there had been about 54 formal grievances for the first six months of 2014. Of those, she said less than 15 percent were appealed.

Near the end of our tour, a detainee told us of an incident wherein they requested grievance forms from an officer. They received the forms and were going to complete them when another officer removed the forms from their hands, telling the detainees they did not need to grieve anything.

PBNDS Standard 6.2, Grievance System, states in Section II.3.:

> "Detainees shall be able to file formal grievances, including medical grievances, and shall receive written responses, including the basis for the decision, in a timely manner."
>
> *Recommendation*: HCDF should ensure that all staff are trained on and are following the provisions of the PBNDS and the CCA policy on grievances. This is a Level 2 recommendation.

Segregation and Suicide Watches

The Male Segregation Unit has 32 cells on two tiers. Two officers are posted in the unit at all times. There is an indoor recreational area in the middle of the unit. It is a fenced space containing an exercise machine, a computer-based law library, and a television. There are also four outdoor recreation areas attached to the unit, about 10 feet by 20 feet and separated by cyclone fencing. The Female Segregation Unit has four cells. The female recreation area has none of the items provided to the male detainees except the television. During our visit, there was one female detainee housed in segregation on a suicide watch and only one person in the male unit who was housed there for protective custody reasons.

The facility uses the Segregation Units to house detainees on suicide watches. When a detainee is placed on suicide watch, he/she will be taken to the appropriate Segregation Unit where all clothing is removed and replaced with a "strong suit" to prevent self-harm. The cells have no mattresses but are equipped with an elevated platform for sleeping and sitting, a toilet and a sink. There are no exterior windows in the cells. The detainee is not permitted any books or reading materials and is provided meals that do not require utensils. He/she can watch a television outside of the cell by looking through the window in the cell door.

According to CCA, during a suicide watch, an officer is posted outside of the cell and is to maintain a constant watch on the individual. A representative from the facility's Mental Health staff is to check on all detainees on suicide watch daily. This is accomplished by communicating through the handcuff port in the door—the mental health specialist does not go into the cell and the detainee does not come out. Staff reported the last suicide watch in the Male Segregation Unit was about four months ago, however, we did not verify this.

Not all staff we asked were aware of the procedures to safely house detainees. For example, the Assistant Warden had to correct the Health Services Administrator's statements as the Administrator apparently did not know detainees on suicide watch were held in Segregation. This raises the question of which medical staff approved Segregation as an appropriate location for suicide watches. PBNDS 4.6, V.F. states a segregation unit can be used for suicide watches "provided the space has been approved for this purpose by the medical staff....." It is concerning that the facility asserts that Segregation placements are approved by the medical staff as appropriate for a suicide watch, while, when questioned, the Health Services Administrator did not know Segregation was used for suicide watches.

It is well known among the HCDF detainees with whom we spoke that suicide watch is conducted in the Segregation Units and that there is constant observation by an officer. Therefore, when the other detainees housed in

Segregation see the officer's observation outside a single cell, the detainees know this is a suicide watch.

Conducting suicide watches in Segregation is a clear advertisement of a detainee's mental health status, an unnecessary risk not only to the safety of the facility but to the individual detainee. While the male segregation unit housed only one detainee during our tour, when additional detainees are placed in Segregation at the same time a suicide watch is happening, it will be clear to the other detainees that a watch is occurring.

Standard 2.12, Special Management Units (SMU), states in Section II, 8:

> "Detainees with serious mental illness may not be automatically placed in an SMU on the basis of such mental illness. Every effort shall be made to place detainees with serious mental illness in a setting in or outside of the facility in which appropriate treatment can be provided rather than an SMU, if separation from the general population is necessary."

Standard 4.6, Significant Self-harm and Suicide Prevention and Intervention, states (in part) in V.F. Housing and Monitoring:

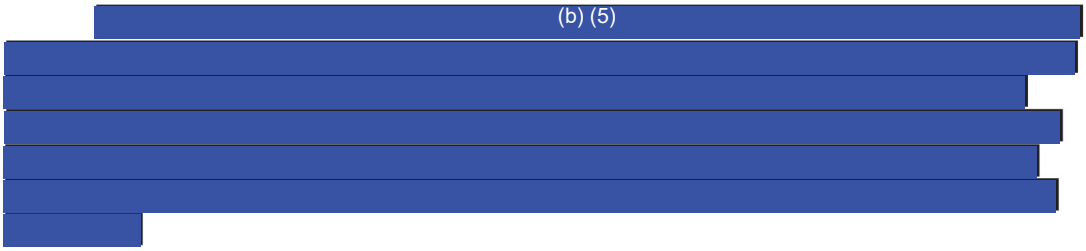
> "If necessary the detainee may be placed in the Special Management Unit, provided space has been approved for this purpose by the medical staff and such space allows for unobstructed observation."

Standard 4.6, Section V.F.1., No Excessive Deprivations, states:

> "Deprivations and restrictions placed on suicidal detainees need to be kept at a minimum. Suicidal detainees may be discouraged from expressing their intentions if the consequences of reporting those intentions are unpleasant or understood to result in punitive treatment or punishment. Placing suicidal detainees in conditions of confinement that are worse than those experienced by the general population detainees can result in the detainees not discussing his or her suicidal intentions and falsely showing an appearance of getting well fast."

Standard 4.6, Section V.F.2., Clothing states:

> "Detainees should be provided suicide smocks to wear when medically indicated. Under no circumstances shall they be held without clothing."



Recommendation: (b) (5) [redacted]

PREA, Prison Rape Elimination Act

Based on my review, the facility is complying with the requirements of PBNDS 2.11, Sexual Abuse and Assault Prevention and Intervention to post information about PREA, the Prison Rape Elimination Act. The postings were present in all of the units I entered and on hallway bulletin boards in both English and Spanish. Additionally, the contact information for the Office of the Inspector General was posted and presented in eight different languages.

I reviewed the facility's policy, which is comprehensive and requires reporting allegations of sexual misconduct via the facility chain of command, prompt attention to making reports, data collection, and medical and mental health contact with the victim. Allegations of sexual misconduct appear to be investigated promptly and thoroughly. The local law enforcement agency is always contacted but it rarely conducts any criminal investigation based on a review of the reports provided by the facility.

When a staff member or an official visitor of the opposite gender is going to enter a housing unit, at least two announcements are made advising the detainees of their presence (PBNDS 2.11.II.15). Upon entry into all of the units, the staff escorting us made two announcements prior to us entering the unit to advise the detainees that members of the opposite gender were present. The detainees are clothed in two piece uniforms instead of one-piece jumpsuits. This provides appropriate modesty and privacy for females. The only area where a one-piece jumpsuit was seen was in the Male Segregation Unit.

Recommendation: If jumpsuits are used in the Female Segregation Unit, HCDF should consider placing female detainees in Segregation in two-piece uniforms. This is a Best Practice recommendation.

Recreation

Recreation Specialist (b) (6) manages recreation for the facility and is currently filling in for the chaplain who is ill but who is responsible for detainee religious services. She escorted us to the outdoor and indoor recreation areas for both male and female detainees. The large outdoor area is used by the male detainees and features an area large enough to play soccer. (During extremely warm weather, the detainees stop their activities periodically

for a 20 minute break to prevent medical problems from overheating.) The facility reports it surpasses the 2011 PBNDS (5.4, Recreation) by giving the detainees in Administrative Segregation two hours of recreational time every day. Female detainees receive one hour of recreation per day and have eight exercise machines available in the inside recreation room. When we toured the indoor recreational area for the men, I noted the area has about a dozen machines for exercising.

There are 71 religious volunteers providing religious services to the detainees. I reviewed the religious services schedule provided by CCA and found that services are scheduled for every day of the week and include Baptist, Catholic, Hindu, Muslim and Buddhist services. There are also non-denominational services and one-on-one religious counseling.

There was one detainee housed in Administrative Segregation status in the Male Segregation Unit while the team was on-site. (This person was housed in Administrative Segregation under the provision of protective custody.) There was some confusion among the CCA staff when we asked about where the individual was provided recreation time. The staff working in the Recreation area stated that this detainee's recreation was taking place in the large indoor recreation room where multiple exercise machines were available, and this had been happening for two weeks or more. The officers in the Segregation Unit reported that recreation was occurring only in the Segregation Unit, either indoors or outdoors until three days before our arrival. We confirmed the officers' statements via the log in the Male Segregation Unit.

> *Recommendation:* HCDF should ensure that detainees placed in Administrative Segregation receive the same privileges available to detainees in the general population including recreation and other out-of-cell time required by the PBNDS and CCA policies. This is a Level 1 recommendation.

Immigration and Customs Enforcement (ICE)

The ICE representatives are expected to check the units once per week and be available to talk with detainees about their cases. All of the detainees I spoke with said the ICE staff come to the units very early in the morning while the detainees are still asleep. Other detainees said many of the ICE staff only speak English. One detainee stated he had been at the facility for seven months and during that time had not spoken to a representative from ICE regarding his case however; there was no confirmation of this assertion.

> *Recommendation:* ICE should ensure that detainees have frequent opportunities for informal contact with facility and ICE/ERO staff. This is a Level 2 recommendation.

Programming

The female detainees expressed a strong desire to have programming besides reading books, doing crafts, and religious services. They were anxious to receive classes on anger management, English as a Second Language, and Thinking for Change.

The CCA staff told us the detainees can participate in some programming in the housing units, such as meditation, anger management, and crafts. The anger management programming is presented by the unit counselors. When I spoke with one of the counselors about her training to present this program, she said she facilitates the program and the participants usually do some reading and watch videos and she oversees discussions about the videos. I reviewed the schedule for found the modules posted in the units

Mail

Each building has a mail room where incoming and outgoing mail is processed. We spoke with detainees who reported several concerns about the mail being delivered untimely. One detainee said the mail was not sent out in a timely manner which compromised his court requirements for filling.

Detainee 1[1] submitted several grievances regarding his mail. Ms. (b) (6), Ms. (b) (6) and I interviewed Detainee 1 about his concerns. He said that he was not allowed to mail a package before the mailroom closed. This was unverified by looking at the facility's surveillance cameras that showed Detainee 1 did not attempt to mail the package within the appropriate hours. Detainee 1 also reported that DO (b) (6), (b) was interfering with his outgoing mail by not allowing him to place mail in the mailroom's outgoing .area.

DO (b) (6), (b) was not available for an interview during our time at the facility so I spoke with the Security Manager, (b) (6), (b) (7), about (b) (6), (b). He remembered the incident with Detainee 1 and said it was clear on the video that Detainee 1 wanted to mail an item after the mailroom was closed. Therefore, (b) (6), (b) denied Detainee I's request. He said (b) (6), (b) held his ground and Detainee 1 filed a grievance though he did eventually mail his item. The exact date of this incident is unknown but it was significant enough for Security Manager (b) (6), to remember it.

I spoke with Officer (b) (6), (b) (7)(C) who processes the mail. She said Detainee 1 often slides his outgoing mail under the mailroom door when the mailroom is closed and he is enroute to the legal library. (b) (6), said if Detainee 1 requests an item be mailed out as Priority Mail, she does so despite him dropping the mail off while the mailroom is closed. She said she does not keep a separate log for priority mail but priority mail is logged in each detainee's file in

the Offender Management System. I reviewed the log in Detainee 1's file and his priority mail is clearly noted.

Law Library

The library for the male detainees in Building B has eight computers for detainee use. The computers are updated every six months and contain case law and the Bice Law Library. Some detainees reported that the law library in the Male Segregation Unit needs to be updated. (This information was provided just prior to the team's departure and was not verified. However, this information was provided to ICE and facility leadership during the exit briefing.) The computers for both the female and male detainees were functioning and there were no complaints from the detainees we spoke with and no grievances about the inadequacy of or access to the law library.

Transgender Detainee

Dr. (b) (6), Ms (b) (6), Ms. (b) (6) and I spoke with Detainee 2[ii]. Detainee 2 was housed in the Male Segregation Unit in Administrative Segregation under protective custody. The Assistant Warden explained to us that Detainee2 requested protective custody upon arrival at the facility on June 6th, 2014 and had been housed in the Male Segregation Unit since then.

Prior to coming into custody, Detainee 2 was going through gender reassignment, transitioning from male to female, and prefers to be referred to as a female. She told the team that she was taking hormone treatments prior to her detention but has had no surgeries related to her transition. During our initial conversation with Detainee 2 on August 18, Officer (b) (6), interpreted for us as Detainee 2 said she did not speak English well enough to converse with us. Detainee 2 said she has been in the Male Segregation Unit since she arrived at the facility. She said she doesn't know why this is as she has never created a problem for the facility. When she first arrived, she was told she would be going to a dorm. Detainee 2 said she never requested to be in Segregation despite signing the document requesting protective custody. Detainee 2 said she did not have a mental health interview after her arrival until July 15. When she was placed in Segregation, she said she experienced insomnia and eventually saw a psychiatrist on July 29th. This was verified by Dr. (b) (6) review of her medical and mental health files.

We resumed our interview with Detainee 2 again on August 19 from 1035 to 1120 hours. Present were Dr. (b) (6), Ms (b) (6), Ms. (b) (6) and me. Assisting was an interpreter provided by DHS, Ms (b) (6).

Detainee 2 told us she has had no recreational time since she arrived. She said she was told she could not get out of her cell. Last week (August 10-16) she was allowed to go to the recreation area across from the Male

Segregation Unit where she has access to a large outside recreational area as well as an indoor area which contains multiple exercise machines. We confirmed via the log in Segregation that Detainee 2 was not leaving the unit for recreational time until August 15th, 2014.

Detainee 2 said she felt depressed when first detained and was told she was in Segregation because of her sexuality. She said she was initially told she would be housed in a dormitory and she accepted that as she did not want to be housed in Segregation. She was then placed in the Male Segregation Unit after she signed the Administrative Segregation Order requesting protective custody. However, she still asserts she did not request protective custody.

I reviewed the Administrative Segregation Order which was completed on June 6, 2014. The reason marked on the order for Administrative Segregation is, "(F) Detainee has requested admission for Protective Custody." This document is in English and was signed by Detainee 2 on June 6. A CCA form—CCA Request Form—was attached to the Administrative Segregation Order. The CCA form is in English and Spanish and is used for detainees to make requests to the facility staff. The form reflects a brief sentence written in Spanish with Reyes' name below the sentence. Below Detainee 2's sentence is a translation: "(I agree to be placed under protection.)" The name of the translator is illegible.

I also reviewed the Confinement Review documents which are completed weekly. Each week the detainee is assessed to determine if housing in Administrative Segregation should continue. This form is reviewed and signed by the Warden or his/her designee. I reviewed the Confinement Review forms for Detainee 2 from June 9 through August 18. The forms were properly completed and signed. Starting on July 28, Detainee 2's signature appears on the document as well as a staff member's signature.

Detainee 2 said she had been receiving treatment for her gender reassignment process in the community. She stated that she had started hormone treatments via pills and shots. She said she has been receiving treatment at a clinic for eight years and hormone treatment for three years. She had to discontinue treatment prior to coming into custody due to her financial situation. At the time of this interview, Detainee 2 said she wants to continue hormone treatments.

Detainee 2 stated that she told the staff that she wanted to be referred to as a female detainee. Staff appeared to be confused about this as there are no policies that specifically address how to interact with transgender detainees.

When asked if she was offered any programming while housed in Segregation, Detainee 2 said she had not—no group counseling, no crafts, no other programming. She said she was interesting in crafts and interacting with others who are facing an assortment of immigration issues, and being able to talk

with those who are going through gender reassignment. Detainee 2 reported that she was offered a transfer by an ICE representative to a facility in California where she has been told there were other transgender detainees. She turned this option down after a discussion with her attorney.

PBNDS 2.11, Sexual Abuse and Assault Prevention and Intervention, states in Section V.G.4. regarding classification of detainees:

> "Detainees at risk for sexual victimization shall be identified, monitored, and counseled. Detainees identified as "high risk" for sexual victimization shall be assessed by a mental health or other health care profession. Detainees who are considered at risk shall be placed in the least restrictive housing that is available and appropriate."

HCDF provided mental health care for Detainee 2 six weeks after her arrival. The facility was aware of Detainee 2's status as they moved her to Administrative Segregation. The placement of Detainee 2 in Segregation goes against the PBNDS as this is the most restrictive house available, not the least restrictive as required by the standard—2.11, Section V.G.4.

Detainee 2 said that when she is moved from her cell to anywhere, she is handcuffed behind her back. This includes going to the inside recreational area in her unit where she is the only resident, to the outside recreational area in the unit where she is the only resident, and across the hall to the recreational area. She also goes to the Medical Unit and even to the shower in the unit handcuffed behind her back.

Detainee 2 told the team that prior to August 15 she had been permitted to participate in the inside recreation area two to three times per week. After August 15, she has been able to engage in recreation in the recreational area across the hall from Segregation which includes inside and outside opportunities. She wasn't sure why this happened but said she had sent a request to staff about a month and a half ago requesting recreation outside of Segregation. Although there was never a written or oral response to her request, Detainee 2 was allowed to partake of recreation outside of Segregation.

Despite being classified as Administrative Segregation for protective custody reasons, Detainee 2 is handcuffed any time she is removed from her cell. This includes walking the 20 feet across the unit to the inside recreation area in Segregation despite the fact that no other detainees are in the unit.

The CCA Policy on Segregation Management, #10-100 states in Section A.6.b.vi:

> "Inmates/residents placed in segregated housing for this purpose [potential sexual victimization] shall have access to programs, privileges, education, and work opportunities to the extent possible. If access to programs, privileges, education, or work opportunities is restricted, the facility shall document the following:

- The opportunities that have been limited;
- The duration of the limitation; and
- The reasons for such limitations."

HCDF is not complying with its own policy (#10-100, Section A.6.b.vi) as Detainee 2 is not able to participate in any programming, education or work opportunities. Nor has the facility documented any of the reasons for why this is not occurring.

Recommendation: HCDF should immediately review its current practices regarding transgender detainees and align them with the PBNDS and its own policies. Additionally, CCA should develop policies, procedures, and training to address transgender detainees. The policies should include guidance on appropriate housing and classification assignments as well as the use of security measures such as shackling for protective custody and others in administrative segregation. This is a Level 1 recommendation.

Detainee 2 told us that when she was processed into the facility, she was told to put on the clothing provided by the facility. Once she had undressed, the officer took her bra and threw it in the waste basket. The officer told Detainee 2 that she was a man and could not have women's clothing. This hurt Detainee 2 deeply and she viewed it as an act of discrimination. An inventory of her property was not reviewed prior to leaving the facility. There has been no effort to provide Detainee 2 a bra although she has stated she has been going through gender reassignment. Detainee 2 said staff have laughed at her but she did not identify to CRCL the staff member who have harassed her. While in Segregation, she is dressed in a jumpsuit as this is standard attire for Segregation detainees.

PBNDS 2.1, Admission and Release states in Section II.2.:

"Each detainee's personal property and valuables shall be checked for contraband, inventoried, receipted and stored."

Recommendation: HCDF should ensure staff are familiar with the policy regarding personal property and not dispose of any detainee property. Additionally, the facility should consider issuing appropriate undergarments, such as bras, to transgender detainees. Lastly, transgender detainees should have the opportunity to wear a two-piece uniform to prevent exposure of their upper body when they use the bathroom. This is a Level 1 recommendation.

Food Services

The Food Services Division provides approximately 2700 meals per day. About 45 "special" meals are prepared for each meal, or 135 per day. These meals are low sodium, diabetic, renal, and soft diets as well as pregnancy, allergy, and religious needs. Meals are prepared by detainees under the

supervision of the contract staff from Trinity Services Group. There are 15-20 detainees on a crew--females are on the evening crew and the males are on the day shifts.

Detainees reported that the food was "poor." The examples they provided included that hot food is generally cold, the vegetables are overcooked, there is no fruit available, and they often receive the same foods twice in one day. They said potatoes are frequently served and they have received eggs and oatmeal for breakfast and for dinner in the same day. Several of the detainees said their breakfasts were missing nutritional value and said the lack of fruit was distressing to them as many said they would like to have fruit added to their meals.

My review of five weeks' of menus for the facility indicated that "Fruit Juice 20%" is served every morning for breakfast. During this period, canned fruit is served a total of 11 times (about 10% of the meals) with no mention of fresh fruit. Potatoes were served 41 times which is 39% of the 105 meals served during this five week period. The request for fresh fruit was presented to the leadership of the facility at the exit briefing. Avoiding fresh fruit in a correctional facility is not unusual given the possibility for the fermenting the fruit to make a facsimile of an alcoholic beverage.

Some of these issues were reviewed with (b) (6), the Food Services Manager of Trinity Services Group, who provides the food services for the facility. She confirmed this, and said the breakfast meal included scrambled eggs and oatmeal and the evening meal included hard boiled eggs.

A Trinity Services Group dietician reviews the menu quarterly to ensure adequate nutritional content which is required by PBNDS 4.1, II.1.

> *Recommendation:* HCDF should review its menus to ensure they comply with the standards regarding nutritional requirements. It may be useful have the food services provider explore some foods and/or means of preparing fresh fruit to prevent making alcoholic beverages. This is a Level 2 recommendation.

Retaliation

Many of the detainees in the units we toured believe they would be retaliated by the CCA staff for talking with the team. They said this has happened before when the detainees "stood up for their rights." They said the retaliation would not be overt but very subtle. They said their requests for things to which they are entitled—medical attention, access to the law library, visits, etc.—would be delayed, not denied, just delayed so the detainee would know they were being punished for talking with the team. One said he/she would be moved to another dormitory, there will be multiple "shakedowns," and they would be "harassed' very indirectly. There were no grievances to support the claims of

the detainees but this would not be unusual if they are truly being retaliated against by the staff.

> *Recommendation:* HCDF should ensure proper policies for conduct and ethics are in place, and ensure that staff understand and are complying with the policies. Supervisors should be held responsible for enforcing the policies and taking corrective actions as necessary. This is a Level 1 recommendation.

Staff Conduct

Several of the detainees said they were treated unprofessionally by the staff. They said they have not been convicted of any crime yet the staff treat them as if they are criminals. Some say they deny their knowledge of English so they can listen to the staff talk about them as the staff believe they don't understand English. As a result, the detainees say they have heard the staff engage in disrespectful conversations about detainees. They said the staff do not respond to their questions. One detainee reported an unidentified staff member referred to her mouth using the Spanish word for an animal's mouth instead of a human's mouth. According to the interpreter, this is extremely disrespectful.

There were ten grievances filed against staff during the first six months of 2014 with one of them being found in favour of the detainee.

> *Recommendation:* (b) (5) [redacted]
> Leadership should remind staff of the need to be respectful of the detainees and their status and to respond in a timely manner to inquiries from the detainees. Allegations of misconduct by staff should be addressed thoroughly and swiftly. This is a Level 1 recommendation.

Detainee Handbook

During the visit, I asked about 20 detainees if they had a detainee handbook and all but one of the detainees said they did not have one. The individual who had a handbook requested it; the handbook was not issued to him upon intake.

PBNDS 6.1, Detainee Handbook, states in part in section II.1:

> "Upon admission to a facility, each detainee shall be provided the comprehensive written orientation materials, which shall consist of the *ICE National Detainee Handbook* (ICE Handbook) and a local detainee handbook supplement."

Recommendation: HCDF should ensure all detainees receive the Detainee Handbook with the local supplements. Facility leadership needs to make sure facility policies are being followed and hold the supervisors responsible for enforcing them. This is a Level 2 recommendation.

Laundry

The female detainees told the team that they wash their own underwear as it does not get clean in the facility laundry. They are issued three pairs of underwear. Once the underwear is washed in the sinks in the unit, they hang it on their bunk beds in accordance with the facility rules—only between 6PM and 6AM. Due to the humidity, they do not fully dry and are still damp when the detainees put them away. However, a female officer assigned to the housing unit often removes the underwear while it is hanging during the permitted times. The officer puts the items in a drawer and does not give them back to the detainees and the detainees will not be issued any additional underwear.

It is unsanitary for detainees to wash any of their clothing or bedding in sinks in the housing units.

Section V.B. of PBNDS 4.5, Personal Hygiene, states detainees will be issued two pairs of underwear in addition to other clothing. Section V. H. of the same policy states the detainees "shall be provided with clean clothing, linen and towels on the following basis: #1 a daily change of socks and undergarments" with a provision for and additional exchange of underwear for health or sanitation reasons.

Recommendation: HCDF should review its laundering procedures and ensure the laundry is getting clean and dry before returning it to detainees. This is a Best Practices recommendation.

Use of Force, Detainee 3

I reviewed the use of force written reports and digital recording involving Detainee 3[iii]. Detainee 3, according to the CCA staff, failed to remove his clothing, a jumpsuit, which under the current policy, must happen so the detainee can be placed in a "strong suit," a cape-like garment that is draped over the individual's shoulders to provide coverage of the body. The suit is made of material that cannot be torn or used to facilitate self-harm. A cell extraction team entered the cell, removed his jumpsuit, and placed the "strong suit" on Detainee 3.

On the digital recording, which was made of the use of force, the extraction team leader presented a thorough description of why they had to enter the cell. On the recording, Detainee 3 is shown moving about his cell, often singing and chanting. He did not comply with staff directives and Detainee 3 was

not demonstrating any actions of self-harm. The extraction team explained on the digital recording that to comply with the suicide watch policy the detainee's jumpsuit had to be removed. They consulted the Medical Unit to determine if the detainee had any allergies. They were advised he had no known allergies or asthma which would prohibit the extraction team from using chemical sprays to obtain compliance.

Detainee 3 was in Cell 114 in the Male Segregation Unit. The video shows him in the cell wearing a jumpsuit. After several directives to comply with the orders of the extraction team to present himself for handcuffing, Detainee 3 failed to do so. He was then sprayed with OC spray and began disrobing. He appeared to be ready to submit to handcuffing and moved to the cell door and then moved to the back of the cell. Eventually, he did submit to the handcuffs while lying on the floor of the cell. Staff carried him to the shower for decontamination.

While in the shower, Detainee 3's cell was also decontaminated. He was then returned to the same cell. A member of the Medical Unit was present during the entire event and did a visual examination of Detainee 3 after the event.

Detainee 3 committed suicide on September 2, 2013 by hoarding psychotropic medications and taking them all at once. Drs. (b) (6) and (b) (6) reviewed the mental health and medical files regarding Detainee The facility should ensure that any deprivations and restrictions placed on suicidal detainees are kept at a minimum, in accordance with the PBNDS. The decision to place a detainee in a suicide smock should involve the concurrence of appropriately trained and qualified medical staff, in accordance with the PBNDS. 3's death and will comment on his care in their respective reports.

Uses of Force

I reviewed the reports and digital recordings of two uses of force involving Detainee 4[iv] that occurred on April 24, 2014 and July 7, 2014. Both incidents involved Detainee 4's refusal to comply with directives to submit to restraints to be moved to the Male Segregation Unit. The use of force in April was the result of Detainee 4's refusal to comply with directives to submit to restraints while in the Building C with the ICE staff. The precipitating event for the use of force in July was Detainee 4 urinating in his cell and smearing feces on the walls. Both incidents were resolved by an extraction team putting Detainee 4 on the floor where the doctors were able to inject Detainee 4 with a drug which was to subdue him. Dr. (b) (6) injected Detainee 4 in April and Dr. (b) (6) injected him in July.

In both incidents, the staff adhered to all of the policies regarding use of force. They digitally recorded their attempts to get compliance from the detainee; they explained the reasons for the use of force; the Medical Division was

consulted to determine if there were any medical conditions that would prevent use of chemical agents; Mental Health was consulted prior to the force; a medical doctor was present during the use of force; the force used appeared appropriate; and, the post event statement on the recording was thorough.

Beds

Many of the detainees, both male and female, said it is difficult to get into the top bunk of the bunk beds. They requested ladders, steps or step stools to assist them.

APPENDIX A: DOCUMENTS REVIEWED

The following documents were reviewed before, during or after the site visit on August 18 through the 20, 2014.

- 2011 Performance Based National Detention Standards
- Dept. of Homeland Security's Prison Rape Elimination Act standards
- ACA –Both the American Correctional Association's (ACA) Standards for Adult Correctional Institutions, 4th Edition, and the Core Jail Standards, First Edition.
- CCA Policy on Use of Force and Restraints, Revised 12.04.13 (#9.1)
- CCA Policy on Chaplaincy and Religious Services, Revised 12.04.13 (#20-4)
- CCA Policy on Legal Rights of Inmate/Residents, Revised 12.04.13 (#14-4)
- CCA Policy on Correspondence Procedures, Revised 12.04.13 (#16.1)
- CCA Policy on Classification, Housing, Work and Program Plan, Revised 12.004.13 (#18.100)
- CCA Policy on Internal Investigations, Created 03.15.11, (#3-22)
- CCA Policy on Sexual Abuse Prevention and Response, Revised 12.04.13, (#14.-2)
- CCA Policy on Segregation Management, Revised 12.04.13 (#10-100)
- CCA Procedure on Access to Legal Material; Revised 01.06.14
- Menu for Five Weeks from Trinity Food Services, Dated 04.13.14
- Grievances from assorted inmates
- Mail room General Requests for Detainee 1
- Administrative Segregation Orders Detainee 2
- CCA Houston Processing Center Detainee Handbook, undated

APPENDIX B: PEOPLE CONTACTED/INTERVIEWED

Mr. (b) (6), (b) (7)(C), Facility Warden, CCA

Mr. (b) (6), (b) (7), Facility Assistant Warden, CCA

Mr. (b) (6), Quality Assurance, CCA

Ms. (b) (6), Quality Assurance, CCA

Ms. (b) (6), Detention Supervisor, ICE

Ms. (b) (6), Commander, US Public Health Service, Acting Health Services Administrator

Mr. (b) (6), Lt. Commander, US Public Health Service, Assistant Health Services Manager

Mr. (b) (6), Assistant Field Office Director, ICE

Mr. (b) (6), Chief of Security, CCA

Ms. (b) (6), Recreational Specialist, CCA

Ms. (b) (6), Classification Supervisor, CCA

Ms. (b) (6) Grievance Coordinator, CCA

Mr. (b) (6), Unit Manager, CCA

Ms. (b) (6), DHS Interpreter

Ms. (b) (6) Mailroom, CCA

Ms. (b) (6), Food Services Manager, Trinity Services Group

Detainee 1

Detainees in the Female Units

Detainees in the Male Units

i
ii
iii
iv

(b) (6)

University of Massachusetts
UMASS Medical School

Commonwealth Medicine
University of Massachusetts Medical School
Center for Health Policy and Research
333 South Street, 13E779
Shrewsbury, MA 01545-2732
(b) (6)
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(b) (6) M.D.
Clinical Professor of Psychiatry

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REPORT FOR THE

U.S. DEPARTMENT OF HOMELAND SECURITY

OFFICE FOR CIVIL RIGHTS AND CIVIL LIBERTIES

March 18, 2013

Investigation regarding Stewart Detention Center

Complaints reviewed in this report include:

- 12-08-ICE-0173 regarding Detainee #1
- 12-08-ICE-0136 regarding Detainee #2

STEWART DETENTION CENTER (SDC)
Site visit February 5 and 6, 2013

INTRODUCTION/REFERRAL ISSUE:

The U.S. Department of Homeland Security's (DHS) Office for Civil Rights and Civil Liberties (CRCL) asked me to participate in an investigation of complaints it received on May 15, 2012, from the ACLU of Georgia alleging civil right and civil liberties abuses of individuals in U.S. Immigration and Customs Enforcement (ICE) custody at the Stewart Detention Center (SDC) in Lumpkin, Georgia. The complaints raised allegations regarding the conditions of detention for detainees being held by ICE at SDC, including inadequate medical and mental health care. Specific mental health complaints made by the ACLU of Georgia include the following allegations:

- 12-08-ICE-0173 regarding Detainee #1[1]: the detainee was placed in segregation because he had a panic attack;
- "Intake examinations are insufficient":
  - Delays greater than 14 days in conducting medical examinations;
  - Many detainees are not asked mental health questions during intake;
- SDC does not employ a psychiatrist;
- Inadequate mental health staffing:
  - Lack of adequately licensed healthcare professionals;
  - One clinical nurse and one psychologist serve the population of over 1700 detainees;
- "Inadequate mental health care regime that cannot effectively treat detainees with mental disabilities";
  - "psychological and psychiatric treatment is only available for people who are 'dangerous or suicidal'";
- Delays of days to weeks in receiving treatment after submission of "Sick Call Request" forms;
- Delays of at least one hour in response to emergencies;
- Delays in receiving prescription medications;
- Use of other detainees as interpreters;
- Segregation of detainees with mental disabilities is "an established practice";
- Lack of response to grievances;
  - Placement in segregation for detainees who make complaints;
- Verbal and physical abuse by guards.

Mental health complaints regarding specific detainees include the following:

- Detainee #1 has bipolar disorder, depression, addiction issues, and a history of panic attacks. Detainee #1 told the ACLU that he had a panic attack while detained at SDC, and facility personnel responded to his panic attack by placing him in segregation for six months.
- Detainee #2 alleges that he has not received treatment for his insomnia and depression. He states that mental health personnel are available only if a detainee is suicidal or very

[1] Detainee names and alien numbers are included in an appendix to this report.

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upset. Additionally, he states that he has back pain and requested a mattress from facility personnel but has not received one.

PROFESSIONAL QUALIFICATIONS:

(b) (6)

METHOD OF REVIEW:

1. Site visit:
   I spent full days at SDC on February 5 and 6, 2013. In addition to the Units noted below where I interviewed detainees, I toured and met staff on the SSU (health services unit), Unit 7 (the segregation unit), and the Intake unit.

2. Interviews included the following:
   a. I participated in group and individual meetings with SDC clinical and custody administrators;
   b. I met and spoke privately with groups of male ICE detainees on Units 1D, 2D, and 5C;
   c. LCDR (b) (6), LCSW, mental health provider at SDC;
   d. CAPT (b) (6), (b) (7)(C), M.D., psychiatrist (tele-interview);
   e. CDR (b) (6), Pharm D., SDC pharmacy director and performance improvement director.

3. Document reviews: I reviewed documents provided by CRCL and additional documents provided at SDC, including a list of all detainees on psychotropic medications, a list of detainees on the caseload of LCDR (b) (6), and records of detainees described below in this report.

EXECUTIVE SUMMARY:

I received full cooperation from all staff at SDC during this site visit, although I was not allowed to make on-site copies of portions of detainee medical or custody charts that I identified as pertinent to my review. Otherwise, I had unrestricted access to detainees and documents.

The social worker at SDC and the psychiatrist who covers the facility appear dedicated and extremely hard working. Detainees generally have access to medical and mental health services, but the amount of mental health and psychiatry time at the facility is insufficient to meet the needs.

The geographical location of SDC makes it difficult to recruit qualified professionals. The facility has been seeking up to full-time psychiatry coverage, and they have a full-time mental-health vacancy. Even if successful with recruitment, SDC would have only two full-time mental health professionals in addition to a full-time psychiatrist. This level of staffing would still not adequately meet the needs of the size of the detainee population and the number of new receptions each year.

The relatively low mental health caseload (approximately 3.5% of the population as open cases and approximately 2% of population on psychotropic medications) at SDC reflects the inadequate amount of coverage time. Based on similar types of facilities, one would expect to find caseloads several times larger than the numbers at SDC. Some individuals with mental health needs may be being screened out and sent to other facilities instead of SDC, but the extent to which this happens is unclear. Nevertheless, even my limited review found instances of unaddressed significant psychopathology among the detainee population at the facility.

In addition to inadequate staffing, SDC has significant problems in communication and sharing of information among healthcare professionals. The current medical record system has major flaws that render it unnecessarily time-consuming and unwieldy. Some information is nearly impossible to track or find. As a result, significant findings go unrecognized and unaddressed.

The lack of efficient utility of the electronic medical record likely adds to deficiencies in monitoring and supervision of mental health staff. Some instances of poor management and judgment by staff appear to go completely unrecognized placing detainees at risk.

SDC uses segregation inappropriately for some detainees with mental illnesses. Individuals with serious psychiatric disorders, including active psychoses, are placed in punitive segregation for behaviors associated with their mental illnesses. Medical clearances for placement in segregation seem completely pro forma at least with respect to mental health factors that go unacknowledged or considered.

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SDC also has problems with use of its segregation unit for medical or mental health reasons, and with procedures related to suicide watches both on and off of the segregation unit. The segregation unit is used in an inappropriate manner as an overflow for the health services unit and as a location for some suicide watches. Detainees who are on the unit for medical or mental health reasons are unnecessarily subjected to procedures (e.g., cuffing and shackling when out of cell) specifically geared toward detainees who are there for disciplinary segregation. Other suicide watch practices, such as the routine removal of all clothing from all patients on a suicide watch, discourage detainees from coming forward to seek help. If a detainee acknowledges feeling depressed and having thoughts of self-harm, the standard response at SDC involves placing the detainee naked in a cell in the segregation unit with only a safety smock for coverage. Detainees understandably view this response as humiliating, even punitive, and as a result, they do not seek help when needed. Removal of all clothing and use of a safety smock should occur only for compelling clinical reasons that include active efforts to cause self-injury.

OVERVIEW AND MENTAL HEALTH CARE AT SDC:

Unless noted otherwise, the information in this section is based on what I was told by SDC staff.

Most of the detainees at SDC come from the Georgia Department of Correction or the Federal Bureau of Prisons. Detainees who are actively psychotic or noncompliant with medications reportedly are excluded from referral and admission to SDC and sent to other facilities. How this process occurs, however, remains unclear to me. LCDR (b) (6) told me that only one or two detainees a year are screened out from admission after arrival to SDC. Given the many thousands of admissions to the facility each year, exclusion of only one or two after arrival suggests either that ICE conducts highly effective pre-screening before sending a detainee to SDC or that SDC may not be identifying significant mental health issues when detainees arrive at the facility. Even the very limited review of records that I conducted, however, indicates that substantial oversights occur in identifying detainees who meet the stated exclusionary criteria.

New arrivals receive an intake screening either from an LPN or RN within 12 hours of admission and before leaving the intake area. If an LPN does the screening, an RN must review the documentation within 24 hours. The screen includes eight questions related to mental health, including suicide and violence history or current ideation, past mental health treatment, and history of sexual abuse. I was unable to determine the percentage of positive screens, but the day prior to this site visit, there reportedly were no positive screens among 25 newly received detainees. Facility staff report that positive screens are referred immediately to mental health and detainees on documented psychiatric medications have their medications ordered immediately during the intake process. For psychotropic medications, the order may come either from Dr. (b) (6) the internist, or staff can page Dr. (b) (6), the psychiatrist, for a telephone order at the time of detainee admission.

Within 14 days of admission, detainees receive a physical exam and further screening history and mental status taken either by a physician or mid-level provider. SDC is in the process of changing the timeline for this from 14 days to 72 hours. As with the intake screen, a

standardized paper or electronic form is used for this assessment. Positive mental health findings at this time also result in a referral to mental health.

A licensed mental health professional conducts a comprehensive mental health evaluation of detainees who screen positive at intake or as part of the physical exam process. SDC, however, has no standardized paper or electronic form used for the comprehensive mental health evaluation.

After placement in population, detainees can request mental health services by placing a written sick call request in a box by the chow hall. They also can request an urgent mental health visit by asking a member of the custody staff to contact mental health. Detainees report that it can take from approximately two to ten days to be seen after submitting a sick call slip. Custody staff usually contact mental health immediately if an inmate requests an urgent appointment, but according to detainees, officers sometimes use their own judgment in deciding whether to contact medical or mental health as requested by a detainee or to send the request through the written sick slip process.

There are no psychiatric hospitals in the area willing or able to take detainees from SDC. When a detainee needs hospitalization, SDC transfers him to available facilities, usually in Houston or Miami.

Dr. (b) (6) has served as chief of behavioral health for the past five years. For the past 3 ½ years she has also provided telepsychiatry services for four hours every Wednesday morning to SDC. When a new detainee enters the facility on documented medications, the nursing staff immediately contact either Dr. (b) (6) or Dr. (b) (6) for a telephone order to continue the medications. Within 30 days, or sooner if needed, either of them will see the patient. After that initial encounter, Dr. (b) (6) sees every patient on psychotropic medications at least every 90 days. She can see unstable patients every week, and she sees patients at least monthly if they are undergoing medication changes. Because of difficulties accessing the electronic medical record, Dr (b) (6) sends her notes to SDC by email for scanning into the chart. Most of the patients who receive medications were taking them prior to arrival at SDC, but "very rarely" a new patient will be started on psychotropic medications. She sees new referrals within two to three weeks, or sooner, as needed. A nurse does a baseline AIMS (abnormal involuntary movement scale) examination and re-examination's every three to six months with the results provided to Dr. (b) (6) She is immediately notified of any positive findings. Mid-level providers monitor lab results and send them to Dr. (b) (6). When Dr. (b) (6) and Dr. (b) (6) are not available, psychiatric coverage is provided by a community psychiatrist, Dr (b). SDC is also actively recruiting for up to a full-time psychiatrist who would take over primary coverage from Dr (b) (6)

Detainees reports no impediments to accessing their medications. Medication passes happen at 9 a.m., 1 p.m., dinner time, and 9 p.m. The medication lines can have up to a one hour wait, but they are usually shorter.

On the segregation unit, a nurse passes medications each shift and conducts daily rounds. The rounds do not include asking detainees about mental health issues. Either a licensed mental

health professional or a mid-level provider conducts a mental status exam every 30 days on detainees in segregation.

SDC uses an electronic medical record (EMR), but the system has serious limitations and inefficiencies. Navigation between encounter notes and other entries is cumbersome, time-consuming, and confusing. This difficulty using the system does not reflect my own inexperience with it. At all times that I reviewed patient records, I had members of the health services staff who use the system assisting me and handling the navigation. They too had difficulty ascertaining the content of individual entries in a record without opening the entry because the "description" field for items lacks specificity. Searching for specific items in the EMR often involves opening and closing multiple entries in an attempt to find a particular item. Some encounter notes are almost impossible to identify without opening multiple entries in the EMR. SDC is aware of these issues and ICE is working to replace the current EMR with a new one. However, the system presents serious problems that need to be addressed in the interim.

The most significant example of these difficulties using the EMR involves psychiatry notes. Dr. (b) (6) emails her notes to the facility and one of the on-site nurses or other staff scans the emailed note into the system. Because Dr. (b) (6) does not personally initiate the entry of the note into the system, one cannot search for entries under her name. A member of the health services staff knowledgeable with the system spent over 15 minutes unsuccessfully trying to locate Dr. (b) (6) notes for me in the chart of one of her patients. During the second day of our site visit, part of the EMR system went down, rendering it impossible to access or open entries that had been scanned into the system (e.g., as PDF documents), including any notes by Dr. (b) (6)

Due to the inherent inefficiency of the EMR, I made relatively little progress in conducting comprehensive chart reviews. More importantly, the difficulties that I experienced, despite constant assistance by staff, reflect the difficulties and challenges that staff face in using the system. As a result, important documentation appears to often go unread by medical and mental health staff. The case descriptions below illustrate some of these breakdowns in communication of information and the serious consequences, including breaks in administration of critical medications and failure to appropriately follow-up on and treat major pathological findings.

Although the unwieldy nature of the EMR primarily accounted for my limited progress in reviewing records on-site, I had further delays due to a restriction on my ability to request and obtain copies of selected notes that I identified. As a result, I had to hand copy information such as date and author of notes, quotations regarding critical observations and findings, diagnoses, medication lists, and all other information central to my review and report. This process added additional time and inefficiency to my progress through the EMRs.

Several problems exist with management of detainees who report having suicidal thoughts. Routine practice at SDC involves automatic placement of those detainees in a suicide watch cell with a safety smock and no clothing, instead of limiting removal of clothing to only those inmates who are actively attempting to harm themselves. A correctional staff person constantly observes detainees on suicide watch and a nurse does rounds every two hours. When detainees

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come off watch, they spend 72 hours on observation status, during which a nurse sees them every shift. SDC has no watch levels other than these two.

The medical unit at SDC has only five cells – four negative pressure cells and one watch cell. Because the single watch cell in the health services unit may be already occupied, either for mental health or medical reasons, the detainee may end up in a watch cell in Unit 7, the segregation unit. Several detainees told me that they would never tell staff about suicidal thoughts for fear of being "put in the hole." Not surprisingly, being placed naked in a segregation cell with only a safety smock or blanket for coverage and modesty discourages detainees from revealing and seeking help with suicidal thinking. Under these circumstances, the suicide watch can feel punitive, rather than therapeutic, in nature.

In at least one other respect, however, SDC does take a therapeutic approach to suicide watch management. On days when she is at the facility, LCDR (b) (6) meets privately in her office with any detainee on a suicide watch. This constitutes a recommended practice that can help address the root causes of the crisis.

SDC has a performance improvement program overseen by its pharmacist, CDR (b) (6), who is the spouse of the facility Social Worker. They conduct quarterly reports on several measures as selected and required by leadership from above the facility level. They also conduct one analysis per year of an issue identified by facility staff. None of these internally initiated annual performance improvement projects have involved mental health issues.

According to the facility grievance log, SDC had no mental health grievances in calendar year 2012. SDC reportedly has never had a suicide and never used non-emergency, involuntary medications. They do use chemical restraints once or twice every 4-6 months, but have used physical restraints only once in January 2011.

REVIEW OF SPECIFIC COMPLAINTS LEADING TO THIS INVESTIGATION:

12-08-ICE-0173 regarding detainee Detainee #1 [allegation: the detainee was placed in segregation because he had a panic attack]

Disciplinary incidents:

- 2-17-11: aggressive when asked to go to pod and put his shoes on: "Insolence" 3 days in seg
  - 2-22 to 2-23: put on "Suicide Watch: 1 to 1 in Seg."
- 4-6-11: "Disruptive conduct" over issuance of phone card: 59 days seg time
- 5-27-11: speaker wires inserted into wall receptacle, sentenced to time served (6-6-11)
- 6-8-11: yelling and threatening staff with bodily harm when asked for his ID card: 59 days seg time
- 6-19-11: "used a small staple to cut an incision in his private area" "stated that he made the cut in order to get the domino out of his private part;" charged with "Any act that could endanger" prohibited under Code 223; 15 days seg time
- 8-15-11: "flooding and yelling" "conduct that disrupts" no seg time

- 9-13-11: upset while in medical, officers put him on floor to prevent self-harm; detainee says it was anxiety attack; "concluded that detainee…refused to be housed in segregation to be monitored for one on one suicide observation…"
- 9-28-11: "throwing items around his room" when medical advised him that he would not be getting more meds; "conduct that disrupts" code 399, 3 days seg time

Based on this record review, I found no information consistent with the allegation that the detainee was placed in segregation due to having a panic attack. I cannot determine within reasonable medical certainty, however, whether the detainee received segregation time on at least one other occasion due to mental health issues. The incident on 6-19-11 may have involved intentional self-injury, in which case segregation time would not be an appropriate response, but it also could have been associated with an unusual sexual practice that involves insertion of foreign bodies into the penis to heighten sexual arousal.

12-08-ICE-0136 regarding Detainee #2: I reviewed a 39 page copy of this detainee's medical record. He booked into SDC on 6-7-11, had an intake evaluation the following day, and booked out on 9-30-11. The record does not describe mental health issues and contains no mental health related sick call requests. Thus, I found no information to substantiate the complaint of lack of treatment for insomnia and depression.

Other specific mental health complaints made by the ACLU of Georgia are addressed at various places within this report.

REVIEW OF ADDITIONAL CASES:

Detainee #3: This detainee first came to SDC on 9-7-12. No mental health problems were noted at intake or at the time of the physical exam on 9-13-12. During this detention, however, he was noted to have behaviors and symptoms suggestive of a psychotic disorder. He spent a couple of weeks on medical watch in segregation, and on 11-23-12, he was psychiatrically admitted to West Oaks Hospital. On 12-14-12, they discharged him with a diagnosis of paranoid schizophrenia and on several medications, including haloperidol, olanzapine, valproate, and benztropine. The detainee was initially processed through other ICE facilities and came back to SDC on transfer from Jena in Louisianna on 12-27-12. The transfer summary from (b) indicates that the detainee was on all of the above medications at time of transfer. An SDC Intake screen dated 16:40 on the 12-27 indicates that the detainee was sent to segregation pending mental health clearance. Dr. (b) (6) completed the physical exam on 12-28-12, but for medications he noted "none." On 12-29-12, (b) (6), PA, however, ordered the four medications. Thus, for the first 48 hours in segregation, the detainee was not offered medications. When medications were offered on 12-29-12, he refused to take them and continued to refuse them on subsequent days. LT (b) (6), RN, saw the detainee on 1-1-13 and stated that he "will notify primary [of the ongoing refusal] when assigned." Although I could find no documentation that this notification occurred, LCDR (b) (6) saw the detainee on 1-2-13, cleared him from restrictive housing, and noted that the patient was not taking his medication. He was "seen by IHSC psychiatrist" on 1-3-13, medications were changed, and

follow-up scheduled for one month later. Other than his two medical watches, the detainee did not have any stays in segregation.

Impressions regarding this case: This detainee had a psychotic disorder that went undetected on admission. He spent a couple of weeks on a medical watch in segregation, an environment not conducive to therapeutic improvement. He then required a three week psychiatric hospitalization for a major and chronic disorder, paranoid schizophrenia, followed by another two weeks for stabilization at another facility. On return to SDC, for 48 hours he was offered none of his medications, which included two antipsychotic medications, a mood stabilizer, and a medication for side effects. Despite the transfer summary from Jena, which mentioned his medications, it appears that none of the staff at SDC noted that he was on these medications, including Dr. (b) (6), who completed the physical exam the day after the detainee's return. In addition to not receiving his medications, the detainee was placed back into segregation. After 48 hours in segregation and without medications, the detainee's condition likely regressed to the point that he was refusing medications when offered. Given the seriousness of his disorder, the recent lengthy hospitalization, his refusal of several powerful medications, and his housing in the segregation unit, a referral to a physician was indicated immediately and not merely "when assigned."

Thus, this case involves a missed significant diagnosis, inappropriate use of segregation, failure to note or communicate significant information upon return from hospitalization, and lapse in needed treatment. The circumstances also warranted follow-up sooner than one month later, a delay likely due to the insufficient psychiatry time at SDC.

Detainee #4: During my site visit to SDC, several detainees mentioned this individual as an example of someone who in their view had severe mental health problems but did not receive adequate mental health services. I reviewed all 226 pages of a PDF file reportedly containing this detainee's complete medical record, and I reviewed records of seven disciplinary infractions. He was booked into SDC on 4-3-12 and appears to have left sometime after 2-18-13, which is the date of the last entry that I could find in his medical record. Based on the medical record, I could not determine a complete timeline of events during this period of detention. What I could determine, however, was that the detainee had multiple medical clearances for placement in disciplinary segregation due to behaviors unspecified in the medical record. I could not determine the dates of discharge from segregation, but overall, he appears to have spent more time there than in general population. He had frequent episodes, often lasting for several days or longer, during which he would not acknowledge the presence of medical or custody staff or communicate with them. He typically refused meals and medications during these episodes.

The following timeline summarizes some of the highlights from his medical records:

- Placed in segregation for unspecified reasons just after midnight on 4-4-12, soon after his arrival at SDC.
- Medically cleared for another stay in disciplinary segregation on 5-20-12. Stopped taking medications, eating meals, or acknowledging nurses or CCA officers by 5-22.
- Seen by LCDR (b) (6) on 5-23, but refused to acknowledge her presence. He had thrown food on the floor and his room was "untidy and in disarray." LCDR (b) (6) concluded, "it is unclear as to whether he has psychological problems or whether he is

upset due to his placement in segregation." She saw the detainee again the following day. At that time, he had been eating but continued to refuse to interact, and no mental health follow-up was scheduled. Notes by nursing staff later that day indicate that he again was not eating, continued to not respond to or acknowledge the presence of staff, kept his cell in disarray, and spent his time lying on his bed.

- 6-15: again refusing meds (ranitidine 150 mg) or acknowledging nurses or CCA officers.
- 7-5: seen by a social worker because "it was reported that (b) was upset and throwing his feces at the CCA officers." Told the social worker, "I'm doing great!" and was scheduled for a "Mental Status Exam" for the next day.
- 7-9: seen in follow-up by the social worker, who noted, "(b) reports that he hear [sic] voices in 2005 for years until he went into a Psych hospital and in 2008 the voices slowed down. Last heard voices two weeks ago but he could not tell me what the voices said…(has the delusions that (b) has given him special knowledge and a special task which he calls the peace bomb that when it goes off it will bring about the end and make the world peaceful. (report that he is paranoia [sic] he think that "His family (Arab people) are out to kill him. Insight and judgment: poor. Impulse control: poor.""
  The social worker note concluded that the detainee had "Schizophrenia, Paranoid Type" and the "Recommendations" were for "Supportive therapy every two weeks…Patient will see the doctor for medication. 10-3-2012"
  The social worker saw him for scheduled follow-ups on 7-26, 8-9, and 8-23, indicating on each occasion that the patient "denied" or "reported no" hallucinations or delusions. The management plan remained the same.
- 7-16: in SHU, not taking meds or responding to staff, missed 3 meals
- 8-28: RN note "detainee currently in segregation"
- 8-31: "housed in Unit 7"
- 9-6: Detainee was seen by a different social worker "to assess for reported feelings of depression." He reported "difficulty sleeping" and that he wanted to remain in segregation because he "likes the solitude." He also reported that he "acted out so he could be placed in segregation." The note also states, "he had heard voices back in 2006 but he knew that this was because someone had put voodoo on him, but being that it only lasted seven years, he was now fine." The assessment concluded that the detainee "did not present with any acute mental health issues at the time of this encounter." The plan was for him to "be reevaluated periodically to assess for any signs of decompensation."
- 9-10: medically cleared for segregation
- 9-10: RN note "detainee nonverbal…Detainee will not wake up to get medication"
- 9-15: RN note "brought by CCA staff for medical clearance to unit 7 segregation…Detainee quite agitated and will not calm down when asked. [blood pressure] 186-94….A: Ineffective coping skills…P:…Detainee cleared for unit seven segregation admission."
- 9-16: RN note "Detainee housed in Seg… not responding in any way…began to rant about not getting special meal…refused supper and meds…P: Will monitor food intake per C.O.'s and behavior."
- 10-2: detainee was seen again by the second social worker "to assess for any current psychiatric issues." The note states that the detainee "began to talk about various religious aspects of the world and the way in which different groups interpreted the Bible. He reported that he was doing fine with no real problems and he often try to get others to

understand that they only have one life and everyone is suppose to unit [sic] as brothers for the best. He stated that sometimes they listened and sometimes they didn't but he would make it known that he would not be around forever to guide them. The writer informed [the detainee] that it was a pleasure talking to him and encouraged him to complete a sick call request if he needed to be seen." These social workers notes concluded that the detainee "did not present with any acute mental health problems at the time of this encounter" but he would "continue to be provided supportive therapy."

- 11-22: RN note "Detainee presented to medical escorted by CCA officers for a Unit 7 clearance…detainee was acting out, jerking, singing, cursing, wiggling, talking loudly….made it impossible to get vital signs…A: Anger management…P: Detainee taken to Unit 7."
- 11-23, 11-28, 12-3: nonverbal and refusing medications.
- At least until 12-6 NP note, still in seg
- 1-2-13: LPN note "medically cleared for segregation."
- 1-9: RN note "A: ineffective coping…medically cleared for segregation."

The following summarizes this detainee's disciplinary records according to date of infraction, description of the index event, and sanctions received:

1. 5-20-12: "Slammed" a cup of juice on the floor when an officer did not allow him to get a refill of juice in the chow hall; 15 days segregation time for a "prohibited act."
2. 6-29-12: during a "Muslim service…detainee…approached [an officer] stating he was ready to go back to his unit…because he was at 95% anger and when he reach [sic] the other 5% he was going to punch another detainee…in the face because he came to give him the word but he wouldn't listen"; 29 days in segregation for a "prohibited act."
3. 7-4-12: He "was upset about receiving 29 days at his disciplinary hearing. Detainee started throwing unknown substances under his door and stated there was more to come"; 30 days in segregation for a "prohibited act."
4. 7-5-12: "Detainee was upset and threw an unknown substance under the cell door." During the investigative interview, he was "very talkative, said he would not cause trouble if he was given a Arabic Bible. Otherwise he would shit on the floor and continue causing trouble in seg." 29 days in segregation for a "prohibited act."
5. 9-15-12: when an officer confronted him about arriving late at the chow hall, "he began to curse and talk loudly at me…stating…that I was a snake like the rest of them and few [sic] other slanderous phrases." 10 days in segregation for a "prohibited act."
6. 11-22-12: He "repeatedly kick [sic] his door, he then urinated on the floor by the door and splashed it under the door with water from his toilet." During the investigative interview, the detainee "claims that he advised the ofc that there was too much criminals in the cell and he would like to move to another cell and the ofc wouldn't let him move." 20 days in segregation for a "prohibited act."
7. 1-9-13: He "had been beating on the door [of his cell]" because he wanted to see a Counselor. When told that he could not see the counselor, he "said very loudly to me that he did not want to hear that shit and that he did not give a fuck. I told [the detainee] that he was not going to talk to me like that." The record does not indicate the disposition of this case.

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Impressions regarding this case: This detainee had significant mental health problems throughout his detention at SDC. The records substantiate the impressions of other detainees with whom I spoke. These problems, however, went mostly unrecognized and inadequately addressed by staff at SDC. During his detention, he had paranoid and grandiose delusions, along with some auditory hallucinations. Staff too readily accepted his usual denials of these symptoms, and concluded that he did not have acute mental health problems despite his ongoing behavioral difficulties, including episodes, lasting up to several days, during which he refused food, medications, and would not communicate with or even acknowledge the presence of staff. His disciplinary problems also involve incidents that occurred in the context of his ongoing symptoms. His medical clearances for placement in segregation appear to have completely overlooked his significant mental health problems.

When a clinical social worker did become aware of the detainees symptoms and correctly diagnosed a psychotic disorder on 7-9-12, the social worker did not put in place an adequate assessment and treatment plan. Instead of an immediate referral to psychiatry for further assessment and likely medications, the detainee was given an appointment for three months later. "Supportive psychotherapy" alone, every two weeks or at any frequency, is not appropriate treatment in a case such as this. The encounter notes for those sessions also do not address or even make note of the ongoing behavioral problems, as described above, that the detainee continued to have. Thus, these sessions do not in fact appear to have had a "supportive" focus on helping him to deal with his symptoms or cope more effectively. These notes for the most part only document the detainee's reports that he is doing well, denies symptoms, and presents no danger. This disconnect between his presentation as described in these mental health encounter notes, and the documentation elsewhere in the records of continuing significant behavioral problems, provides another example of an apparent breakdown in sharing and awareness of important information among staff at SDC.

Inadequate staffing levels and the absence of on-site consultation and supervision by at least a doctoral level clinical psychologist, if not a psychiatrist, likely contributed to poor identification and management of this detainee's psychiatric issues. The inefficiencies and impediments to use of the current EMR system also likely contributed to the failure of mental health, segregation clearance, and other encounters to document a full awareness of this detainee's symptoms and behaviors.

Detainee #5: I reviewed the 188 page medical record and seven page disciplinary record for this detainee. He arrived at SDC on 10-30-12 and left on 2-11-13. Prior to arrival, he had been taking Prolixin decanoate (a long-acting intramuscular antipsychotic medication), 37.5 mg every two weeks and Cogentin (a medication to treat antipsychotic medication side effects) 2 mg every day. He had a history of auditory hallucinations and diagnoses of schizophrenia and mild mental retardation. During his stay at SDC, he occasionally refused his antipsychotic medication and frequently refused to take the Cogentin. He repeatedly complained of being unable to sleep for several days at a time, and the medical record often describes him as having tangential speech and hypomanic symptoms. On at least one occasion, he presented with significant side effects to his medication, and he received appropriate treatment with intramuscular Cogentin.

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On 12-3-12, the detainee "broke the water sprinkler head in his cell." He claimed that he had been drying his underwear on the sprinkler head, which broke when he tried to pull his underwear off. The progress note from an unrelated medical appointment earlier that morning stated, in part, (b) cannot remain focused during interview. (touching exam table and pulling stirrups from exam table. (does not respond to verbal redirection initially. (verbally redirected x3 before effective." An encounter note from that evening, however, stated little more than "No acute distress noted" and "medically cleared" him for placement in segregation. According to the disciplinary record, he received 29 days in segregation for the incident with the sprinkler head. A psychologist note from 12-11-12 describes him as "hypomanic" while in segregation. He was placed on a suicide watch from 12-16 to 12-17 because of statements about harming himself "with razors." He made similar threats on 12-26-12.

The detainee had at least five encounters with a psychologist and at least another five encounters with a clinical social worker during his stay at SDC. He had telepsychiatry appointments with Dr. (b) (6) on 11-26-12, 12-21-12, and 1-30-13. During the final appointment, Dr. (b) (6) discontinued the Prolixin and Cogentin because the detainee did not want to continue to take them, and started trazodone to aid with sleep. The next psychiatry follow-up was scheduled for three months later. AIMS exams were reportedly completed on 12-6-12 and 1-24-13.

Impressions regarding this case: With only two exceptions, this case demonstrates remarkably good engagement with mental health professionals, considering the staffing shortages at the facility, during the 3 ½ months stay at SDC. Between psychology, social work, and psychiatry, the detainee had at least 13 contacts with mental health.

Nevertheless, scheduling a follow-up psychiatry appointment for a patient with a diagnosis of schizophrenia for three months after discontinuing medications is too long to wait for scheduled monitoring. Given the otherwise close attention to follow up, this long gap is almost certainly due to the severe shortage of psychiatry time at SDC. Simply stated, there is no way that Dr. (b) (6) or any other psychiatrist could adequately keep up with patient needs at the facility with only four hours a week of dedicated time.

The second area of concern with this case involves the clearance for placement in segregation. The detainee had a documented disturbance in mental status on the morning prior to that clearance. This disturbance persisted while in segregation, and it may have worsened as evidenced by the suicidal statements and watches that occurred not long after placement and segregation. As with almost all other medical clearances for segregation that I viewed in detainee medical records, the clearance for this detainee contained no meaningful clinical information and did not take into account the detainee's significant history and symptoms of mental illness. This medical clearance for segregation note, as with other notes that I viewed in other records, appears to be little more than a pro forma documentation. It is also likely that the detainee's mental status abnormalities contributed to the behavior for which he was sanctioned.

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RECOMMENDATIONS AND RATIONALES:

Overarching Rationale: As an overarching matter, the "purpose and scope" of PBNDS 2008 Standard on Medical Care "ensures that detainees have access to emergent, urgent, or non-emergent medical, dental, and mental health care that are within the scope of services provided by the DIHS, so that their health care needs are met in a timely and efficient manner." The Inter-Governmental Service Agreement with SDC requires the provider "to perform in accordance with the most current editions of...Standards for Health Services in Jails, latest edition, National Commission of Correctional Health Care (NCCHC)." The recommendations that follow result from deficiencies in meeting these overarching standards, along with additional standards, as noted. Although the indicated PBNDS 2008 and NCCHC standards support each recommendation, I also include for reference purposes relevant portions of ICE's 2000 National Detention Standards (NDS), and Performance-Based National Detention Standards 2011 (PBNDS 2011).

These standards have relevance to all of the recommendations below. They provide broad, additional support to the other more focused rationales for the numbered recommendations that follow.

1. **ICE should recruit additional "qualified mental health professionals." This includes a need for additional psychiatry time, and on-site, experienced, doctoral level mental professionals who can provide regular oversight and supervision for other staff. (Level 1 Recommendation) (PBNDS 2008, Medical Care)**

Rationale: PBNDS 2008, Medical Care, states "Detainees with suspected or known mental health concerns will be referred as needed for evaluation, diagnosis, treatment, and stabilization" and "Every facility shall directly or contractually provide its detainee population...Initial medical, mental health, and dental screening...[and] Mental health care." The NDS on Medical Care states "[a]ll facilities will employ, at a minimum, a medical staff large enough to perform basic exams and treatments for all detainees" and "[t]he health care staff will have a valid professional licensure and or certification." In addition, the standard states, "Health appraisals will be performed according to NCCHC and JCAHO standards."

NCCHC essential standard J-G-04 states, "mental health services are available for all inmates who require them." It defines mental health services as "a variety of psychosocial and pharmacological therapies, either individual or group, including biological, psychological, and social, to alleviate symptoms, attain appropriate functioning, and prevent relapse." It requires "treatment documentation and follow-up" of mental health services and that "[o]utpatients receiving basic mental health services are seen as clinically indicated, but not less than every 90 days." Standard J-E-05 requires that the "health record contains results of" mental health screenings and evaluations. PBNDS 2011, Medical Care, requires treatment plans that include "regular follow-up appointments based on level of acuity."

PBNDS 2011, Medical Care, defines a "Mental Health Provider" as a "Psychiatrist, clinical or counseling psychologist, physician, psychiatric nurse, clinical social worker or any other mental health professional who by virtue of their education, credentials, and experience are permitted by

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law to evaluate and care for the mental health needs of patients." It further states that "The facility shall have a mental health staffing component on call to respond to the needs of the detainee population 24 hours a day, seven days a week" and "Health care services will be provided by a sufficient number of appropriately trained and qualified personnel."

NCCHC standards define a "qualified mental health professional" as "a psychiatrist, psychologist, psychiatric social worker, licensed professional counselor, psychiatric nurse, or others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients." The NCCHC standards require a qualified mental health professional to perform the following "essential" services:

- Full mental-health evaluations for individuals with positive mental health screens
- Mental health appointments that provide "timely assessments in a *clinical setting*" (emphasis in original) and "treatment"
- Individualized treatment planning
- Suicide risk evaluations

And the following "important" services:

- Evaluations for crisis intervention counseling and long-term follow-up of victims of sexual assault
- Psychological autopsies

The NDS, PBNDS 2008, PBNDS 2011, NCCHC standards, and this recommendation all recognize the fundamental need for adequate numbers of qualified individuals to provide medical and mental health services.

As documented elsewhere in this report, SDC does not have sufficient staffing to be in compliance with these standards of care. Some detainees with significant psychopathology are either not identified or not adequately followed. Others may have regular contact with mental health ended despite presentations that warrant further monitoring and involvement by mental health. For example, the behavior of Detainee #4 indicated a need for ongoing mental health involvement despite his failure at times to respond to or acknowledge the presence of mental health staff. This behavior, which occurred for reasons unknown to mental health staff at the time, along with his intermittent refusals of food and medications and his other problematic behaviors, were indications for continued mental health follow-up through liaison with custody and medical staff and attempts to engage the detainee. Inadequate mental health staffing levels at SDC, however, make this level of service difficult, if not impossible, for current mental health staff to provide.

Services are best delivered by multidisciplinary mental health teams that include at least a psychiatric social worker, psychologist, and psychiatrist, as each discipline adds its own valuable expertise. Ongoing, on-site supervision by a psychiatrist, or at least a doctoral level psychologist, will help prevent the type of inadequate assessment and management described in this report (e.g., overlooking significant positive findings and failing to adequately refer and regularly follow Detainee #4).

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With respect to psychiatry coverage, PBNDS 2011, Medical Care, states that "[a]ny detainee prescribed psychiatric medications must be regularly evaluated by a duly-licensed and appropriate medical professional, at least once a month, to ensure proper treatment and dosage."

NCCHC Jail Standards require a "sufficient number of health staff of varying types provide inmates with adequate and timely evaluation and treatment consistent with contemporary standards of care." NCCHC Standards for Mental Health Services require a "sufficient number of mental health staff of varying types (e.g., psychiatrists, psychologists, social workers, nurses) is available to provide adequate and timely evaluation, treatment, and follow-up consistent with contemporary standards of care."

The above standards underscore the need for every correctional and detention system to have sufficient psychiatry time to provide vital services to individuals receiving psychotropic medications. Information conveyed to a psychiatrist by a non-prescribing, qualified mental health professional can supplement but not replace direct contact between the prescribing psychiatrist and the patient. The standard of care requires direct contact with patients on ongoing psychotropic medication regimens. These contacts must include, at a minimum, personal evaluation and diagnostic assessment, patient education, and monitoring for treatment efficacy and side effects. Although Dr. (b) (6) appears to provide excellent telepsychiatry care, her available hours are not sufficient for SDC to meet this standard of care for all detainees who need it.

2. **ICE should implement a user-friendly and accessible electronic medical record. Until this can be accomplished, SDC should take steps to address the problems presented by the current system. (Level 1 Recommendation) (PBNDS 2008, Medical Care)**

Rationale: PBNDS 2008, Medical Care, states, "Health record files on each detainee will be well organized [and] available to all practitioners...." The current SDC medical record system is associated with significant problems with organization, availability, and communication. As a result, staff often fail to identify or follow-up on significant mental health problems. The system must allow staff to readily identify detainees who are open mental health cases. Currently, there is no easy way to do this. SDC is aware of these issues and ICE is working to replace the current EMR with a new one. However, the system presents serious problems that need to be addressed in the interim.

3. **SDC should conduct meaningful assessments as part of medical clearances for segregation and ensure that detainees in segregation receive meaningful and regular mental health monitoring on rounds and through periodic mental status updates. (Level 1 Recommendation) (PBNDS 2008, Medical Care)**

Rationale: PBNDS 2008, Medical Care, states, "A detainee may be removed from segregation if a health care professional concludes that continued segregation is detrimental to the detainee's medical or mental health." NCCHC Jail Standards (J-E-09) and Standards for Mental Health Services (MH-E-07, an "essential" standard) address the need for screening and regular

monitoring of inmates in segregation. For example, as a compliance indicator, the mental health standards state, "On notification that an inmate is placed in segregation, mental health staff reviews the inmate's mental health record to determine whether existing mental health needs contraindicate the placement or require accommodation. Such review is documented in the clinical record." The standards also require monitoring of segregated inmates with frequencies based on the degree of isolation. Individuals "under *extreme isolation* with little or no contact with other individuals are monitored daily by medical staff and at least once a week by qualified mental health professionals," (emphasis in original) and "inmates who are segregated and have limited contact with staff or other inmates are monitored 3 days a week by medical or qualified mental health professionals." The Jail Standards specify that the medical staff must be a "qualified healthcare professional," defined as someone "who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for patients."

SDC does not meet these standards for screening detainees when first placed in segregation. A pro forma screening occurs at the time of placement. The chart notes documenting these screenings in the records of Detainee #4 and Detainee #5 contained no meaningful clinical information and did not take into account the detainees' significant history and current symptoms of mental illness. This creates two potentially serious consequences. First, detainees may receive punitive sanctions for behaviors rooted in their symptoms. Second, detainees with serious underlying mental disorders spend time in segregation – an environment likely to exacerbate their conditions.

SDC also does not meet standards for monitoring detainees while they remain in segregation. The nurses who conduct clinical rounds as part of medication administration on the segregation unit do not question detainees about mental health issues. A licensed mental health professional or a mid-level provider does conduct a mental status exam every 30 days on detainees in segregation. Regular mental health rounds, however, must accompany these periodic mental status examinations as part of ongoing screening of detainees in segregation settings. In addition, staff must conduct these rounds and periodic examinations in a meaningful way or the encounters can become a merely pro forma exercise, similar to the current segregation clearance screenings conducted at SDC.

The absence of adequate mental health screening and monitoring of detainees in segregation results in the placement in segregation of detainees with readily apparent mental health problems that remain unidentified by staff. Isolation can precipitate or exacerbate symptoms of psychological distress. Failure to detect significant symptoms can result in further decompensation for detainees with underlying mental disorders or development of anxiety, depression, and other mental health consequences of segregation for other detainees.

4. **SDC should end its current practice of imposing segregation conditions on detainees placed on the segregation unit for medical or mental health overflow reasons. (Level 1 Recommendation) (PBNDS 2008, Medical Care)**

Rationale: PBNDS 2008, Medical Care, states "Minimum requirements for medical housing units will be met." NCCHC Standards for Mental Health Services (MH-G-02, an "essential"

standard) requires that "*mental health programs* or *residential units* meet the serious mental health needs of *patients*" (emphasis in original). Part of this NCCHC standard requires "housing in a *safe and therapeutic* environment, conducive to symptom stabilization" (emphasis in original).

SDC uses the segregation unit as overflow housing for detainees with medical or mental health needs, including suicide watches. These detainees are unnecessarily subjected to procedures (e.g., cuffing and shackling when out of cell) specifically geared toward detainees who are there for disciplinary segregation. This practice compromises care and does not comply with standards.

SDC should either find an alternative location for medical or mental health housing of detainees when beds are not available on the health services unit, or end its current practice of imposing the same high security or punitive segregation practices for those detainees placed on the segregation unit solely for medical or mental health reasons.

5. **SDC should modify the following practices and circumstances surrounding suicide watches and risk assessments:** (b) (5) **(b) restrict use of safety smocks only to situations that warrant their use as determined and documented by a qualified mental health professional. (Level 1 Recommendation) (PBNDS 2008, Suicide Prevention and Intervention)**

Rationale: The PBNDS 2008, Suicide Prevention and Intervention, states, "Staff will act to prevent suicides with appropriate sensitivity, supervision, and referrals. Any clinically suicidal detainees will receive preventive supervision and treatment." The standard goes on to state "The detainees may be placed in a special isolation room designed for evaluation and treatment. The isolation room will be free of objects or structural elements that could facilitate a suicide attempt."

A suicide prevention program that "identifies suicidal inmates and intervenes appropriately" constitutes an essential NCCHC standard, J-G-05.

(b) (5)

(b) Routine use of safety smocks discourages individuals from voluntarily seeking help for suicidal thoughts and feelings. Most individuals experience removal of their clothing and placement in a smock as embarrassing and humiliating. The NCCHC Suicide Prevention Protocols state "removal of an inmate's clothing (excluding belts and shoelaces) and the use of physical restraints (e.g., restraint chairs or boards, leather straps, handcuffs, or straitjackets) should be avoided whenever possible, and used only as a last resort when the inmate is physically engaging in self-destructive behavior." I recommend that the detainee's medical record contain required documentation by a qualified mental health professional of the reason for removal of clothing and placement in a smock to help ensure that this is done only in appropriate instances.

6. SDC should conduct performance improvement reviews of some of the issues identified in this report. (Level 1 Recommendation) (PBNDS 2008, Medical Care)

Rationale: Performance improvement provides an important mechanism for improving services and preventing avoidable adverse events. Among other things, this report describes breakdowns in communication of information, inadequate assessment and treatment plans, lack of sufficient supervision, and an apparently pro forma nature of medical clearances for segregation placement. These and similar issues should be the focus of performance improvement reviews to identify and address needs of the system.

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APPENDIX A:

Detainee Name and Alien Numbers

Detainee #1: (b) (6)

Detainee #2:

Detainee #3:

Detainee #4:

Detainee #5:

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