Onsite Investigation Report

Houston Contract Detention Facility, March 2017

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March 7, 2017

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Introduction

This report responds to a request by the Department of Homeland Security (DHS), Office for Civil Rights and Civil Liberties (CRCL), to review and comment on the medical care provided to detainees at the Houston Contract Detention Facility (HCDF) by the U.S. Immigration and Customs Enforcement (ICE), ICE Health Service Corps (IHSC). My opinions are based on the materials provided and reviewed in advance and an onsite investigation of the facility on February 27-March 1, 2017. My opinions are expressed to a reasonable degree of medical certainty. HCDF and IHSC personnel were most pleasant and cooperative during my investigation.

Expert Qualifications

1. (b) (6)
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6. (b) (6) [redacted]

Methods of Review

In advance of the onsite investigation, I reviewed documents provided by CRCL that it received from ICE and HCDF. During the onsite investigation, I toured the facility, including dormitories, pill lines, and the medical clinic, reviewed documents and medical records, and interviewed staff and detainees. I did focused reviews of medical records for those detainees who had chronic medical conditions such as asthma or high blood pressure. Clinical performance was measured by a focused review of medical records using a standardized methodology. (The full methodology for the review is described in the document entitled Assessment of Quality of Medical Care in Detention Facilities and its accompanying Reviewer Pocket Guide.) The measures are based on nationally published accepted clinical guidelines, or consensus guidelines where there are no published clinical guidelines and are similar to those adopted by the IHSC. I reviewed roughly 80 individual detainee medical records in total. I conducted individual interviews with 12 detainees selected at random from chronic care rosters or selected because of complaints received. Where relevant to findings, reference is made to the 2011 Performance Based National Detention Standards (PBNDS 2011).

Overview

HCDF is located in Houston. It houses roughly 1000 adult detainees. Medical care is provided by IHSC with support of contract staff from the staffing contractor InGenesis under the supervision of IHSC.

Overall, I found the medical care at HCDF to be good, but there were four areas where the current program did not meet the PBNDS 2011 as required by contract. This report will focus on deficiencies and areas requiring further attention in order to meet those standards.

Findings of Deficiencies

1. **Insufficient Medical Professional Staffing:** The facility staff has insufficient licensed staff to service the population of over roughly 1000 detainees. This is not just my opinion as a detention medical expert, but it is the opinion of IHSC as documented by vacancies in multiple areas per the facility's own staffing plan. For example, nursing staffing levels are also below the facility staffing plan with a vacancy rate of 40%. Insufficient staffing impacts access to care by delays in follow-up for non-urgent care (such as chronic disease clinics) and reviews of the medical records documented delays in such follow-up.

   At the time of my visit, the clinical medical authority (CMA) was absent on leave and

unavailable. The onsite CMA is a critical position for the medical program. I was assured by IHSC leadership that the CMA is anticipated to return from leave in the near future.

PERFORMANCE does NOT meet the PBNDS 2011, Medical Care, § II.21, V.B.

2. **Insufficient and Inappropriate Space for Medical Care**: The medical housing unit is too small for the detainee population. This insufficiency results in routine use of remote segregation space for overflow of individuals requiring medical observation. It is inappropriate to use segregation space as medical treatment space as it confuses therapeutic space with punitive space and corrodes trust between detainees and clinicians. In addition the segregation space does not meet PBNDS 2011 standards for Medical Housing Units in that it is not staffed by nursing and it is not designed to allow continuous monitoring of patients within line of sight of medical staff.

   PERFORMANCE does NOT meet the PBNDS 2011, Medical Care, § V.F.1.3.a.2 and 3

3. **Pharmacy**: The detainee death case investigation found that there was a delay in continuing a common blood pressure medication on the detainee's arrival to the facility. My own investigation of the procedure for after-hours and weekend access to medications found that the facility after-hours stock medication cabinet contained only a small number of medications and the contents of the cabinet were not based on a reasonable standardized list. The contents of the drawer were limited, reflected whatever the facility pharmacist alone felt should be there, and contents could vary from day to day.

   PERFORMANCE does NOT meet the PBNDS 2011, Medical Care, § V.G.12.

4. **Grievances**: For a facility of this size, there are very few grievances relating to medical care (a total of 19 were recorded during calendar year 2016). Interviews with detainees, including several who had issues to grieve, revealed many detainees were either unaware of the grievance process or feared retaliation by medical staff if they were to file a grievance. One detainee who had files a grievance felt she subsequently was treated poorly by a staff member she had complained about.

   A grievance system is required by PBNDS for good reason. It is a tool to help a facility quickly identify potential problems and address them locally in a timely manner. Staff at HCDF identified the ease of use of the telephone hotline as a potential reason their grievances were so low. The hotline is available at all other detention facilities, and we typically find higher utilization of the in-house grievance process. My own investigation identified lack of awareness and fear of retaliation as two potential barriers to full embrace of the grievance process by detainees, but the facility should explore and address

all barriers.

PERFORMANCE does NOT meet the PBNDS 2011, Grievances, V.D, 6.2.

Complaints

Detainee death

I reviewed the death of a 61 year old detainee who collapsed in custody at HCDF in 2015 (Case #1 in Appendix I). The case had previously been investigated by the ICE Office of Professional Responsibility (OPR), Office of Detention Oversite (ODO), with the assistance of Creative Corrections, a contract subject matter expert. I reviewed those reports as well as the medical record. My findings concur with the OPR/ODO investigation that concluded that there was an unacceptable interruption in providing blood pressure medication to the detainee on arrival to the facility (problem cited above in deficiencies), and that the nurses did not report abnormal vital signs to a provider as required by IHSC policy. In addition, the review found that the nurse practitioner should have, but did not, initiate CPR. My review revealed no additional findings.

Recommendations from August 2014 Onsite Investigation

As part of this onsite investigation, CRCL asked me to review the implementation of recommendations made during CRCL's last onsite investigation at HCDF in August 2014. At that time, the medical expert made nine recommendations to the facility[1]. Based on my review, I found that significant progress had been made in the areas of *performance measurement, scheduling, medical recordkeeping and documentation, acute care, use of language line and care of transgender detainees*. I would characterize those six areas of concern as successfully resolved.

At the same time, the 2014 report cited problems in the areas of *staffing, effective use of the grievance process and pharmacy operations*.

Staffing remains a problem as described in this report, although there have been significant improvements in provider availability. The grievance process continues to be an area of concern as few grievances are filed. However, there was notable improvement in the responsiveness by the Assistant HSA to those grievances that were filed. The pharmacy has implemented some of the recommendations made in 2014, but some issues related to continuity of medications, standardization of practice and accountability remain as described in this report.

These three areas remain a concern, and recommendations or provided below.

Complaints in the retention memo

[1] Two additional policy recommendations were made to IHSC at a headquarters level. I will not address those two recommendations here.

Two cases (Cases #2 and #3 in Appendix I) mentioned in the retention memo alleged inadequate medical care or accommodation. My investigation of the medical records *did not substantiate* either of these complaints.

Other complaints

Late breaking and onsite complaints: Prior to the onsite investigation, CRCL received an additional written eight complaints alleging inadequate medical care. While onsite, CRCL staff received some additional verbal complaints concerning medical care. All complaints were investigated. My investigation of the medical records *did not substantiate* any of these complaints.

Overall Medical Care

While this report focuses on deficiencies in the medical care at HCDF, it is important to comment briefly on the medical program as a whole. Performance of the medical program met the PBNDS 2011 in all other areas, including medical leadership, medical record keeping and acute care and off-site sub-specialty care. Strengths include the quality of the medical leadership in the facility and the electronic health record. Overall I found the medical care to be good.

In one important area, health care internal review and continuing quality assurance, HCDF is demonstrating best practices. A review of their program revealed that they are employing a jointly developed tool kit with 26 modules to review the quality of their medical program and they are completing and documenting reviews on all 26 areas quarterly.

My own use of a similar toolkit did find some discrepancy with their own review, but on further discussion, we jointly concluded that lower compliance with IHSC chronic care guidelines identified by my review (frequency of diabetic labs, pulmonary function tests in asthma, HIV labs, etc.) reflected differences in the versions of the assessment tools we were using. The toolkit CRCL uses is more sensitive in measuring compliance with IHSC guidelines. Even so, the performance of the facility in chronic disease management meets PBNDS standards by both assessments.

Summary of Recommendations

Overall medical care of ICE detainees at the HCDF meets the requirements in PBNDS 2011 with the exception of the following areas where care **does not** currently meet those standards:

1. **Insufficient Medical Professional Staffing:**

   PERFORMANCE does NOT meet the PBNDS 2011, Medical Care, §§ II.21, V.B.

   Recommendation: I found insufficient licensed staff to service the population at the facility, including a 40% vacancy rate among the nursing staff, and the permanent clinical

medical authority on extended leave replaced with offsite personnel filling that role on an acting basis. IHSC should increase staff recruitment efforts in order to secure sufficient staffing in accordance with the current IHSC staffing plan for medical, and IHSC should consider such things as higher compensation for contractors or increased deployment of IHSC professionals.

2. **Insufficient and Inappropriate Space for Clinic and Medical Housing Unit**:

   PERFORMANCE does NOT meet the PBNDS 2011, Medical Care, § V.F.1. 3.a.2 and 3.

   Recommendation: I found insufficient medical housing unit space to care for the population at the facility. HCDF and IHSC should review current clinic and medical office space in order to determine if the allotted space is sufficient to support the needs of the medical program.

   Recommendation: I found inappropriate use of remote segregation space for overflow of individuals requiring medical observation, which lacks required nursing staff and continuous monitoring of patients within line of sight of medical staff. HCDF and IHSC must discontinue using segregation space as medical housing space. If necessary, a new medical housing unit that meets PBNDS standards and has sufficient bed space to accommodate the population must be created within the facility.

3. **Pharmacy**:

   PERFORMANCE does NOT meet the PBNDS 2011, Medical Care, § V.G.12.

   Recommendation: The detainee death case investigation found that there was a delay in continuing a common blood pressure medication on the detainee's arrival to the facility. I found that current after hours stock medication procedures are inadequate because they are not standardized or planned in collaboration with the prescribing authority. IHSC medical leadership (CMA, has, and their designees) should work with the pharmacist to develop an appropriate stock medication list for the overnight stock medication cabinet. Pharmacy must ensure that the stock medication cabinet is fully stocked with all medications on the agreed upon standard stock medication list.

4. **Grievances**:

   PERFORMANCE does NOT meet the PBNDS 2011, Grievances, V.D, 6.2.

   Recommendation: I found that the facility received a smaller number of grievances than I would expect at the facility of this size, and that treats the number of patients treated in the medical clinic, along with evidence obtained from interviews that suggested a lack of

familiarity with the grievance process, fear of retaliation by medical staff, and other concerns that kept detainees who had issues appropriate for the grievance system from filing grievances. IHSC and HCDF staff should redouble their efforts to orient the detainees to the grievance system, and additional strategies should be explored to reassure the detainees that they will not be subject to retaliation for filing a grievance.

These corrective measures will require monitoring to ensure they adequately address the substantiated deficiencies.

Appendix I

This section includes identifiers to protected health information. Disclosure/distribution of this appendix should be limited accordingly.

Identity of Cases Cited in this Report

My Case No.	Alien No.	Name	CRCL Complaint No.
1.	(b) (6)		15-10-ICE-0736
2.			15-09-ICE-0517
3.			16-07-ICE-0351

CONDITIONS OF DETENTION EXPERT'S REPORT

ON

HOUSTON CONTRACT DETENTION FACILITY

Prepared by:

(b) (6)
MAS
Rocklin, CA

April 18, 2017

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HOUSTON CONTRACT DETENTION FACILITY

I. SUMMARY OF INVESTIGATION

The U.S. Department of Homeland Security (DHS), Office for Civil Rights and Civil Liberties (CRCL), received complaints alleging that U.S. Immigrations and Customs Enforcement (ICE) violated the civil rights and civil liberties of persons being detained at the Houston Contract Detention Facility (HCDF) in Houston, Texas. The complaints were referred by the DHS Office of the Inspector General (OIG) on May 26, 2015,[1] June 9, 2015,[2] and April 27, 2016.[3] In addition, on July 2, 2015, CRCL received notice from ICE of the death of a detainee at HCDF. These new complaints raised allegations related to the provision of medical care, mental health care, use of force, grievance system, retaliation, detention of transgender individuals, and staff-detainee communication. CRCL also conducted a prior onsite investigation at HCDF in August 2014 to look at earlier detainee complaints and a series of detainee deaths.

To examine the allegations in the new complaints, and to review implementation of the recommendations made following the August 2014 onsite investigation, CRCL conducted an onsite investigation on February 27-March 1, 2017, to look at the issues listed above, as well as use of special management units, sexual abuse and assault prevention and intervention, suicide prevention and intervention, access to the law library and legal materials, language access, religious access and services, recreation, visitation, and telephone access. This investigation reviewed HCDF's adherence to the 2011 Performance Based National Detention Standards (PBNDS 2011) in the relevant areas.

Allegations related to medical and mental health care are addressed by CRCL's medical and mental health experts.

Through this review, I found operational deficiencies related to some of the allegations in the new complaints and related to observations I made during this onsite investigation and document review. My review also found that progress had been made on five of the six previous priority recommendations, and on all four of the non-priority recommendations, made following August 2014 investigation.

This report contains recommendations to address any deficiencies identified that are based on ICE's detention standards, correctional experience, and recognized correctional standards including those published by the American Correctional Association (ACA).

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[1] CRCL Complaint No. 15-08-ICE-0440.

[2] CRCL Complaint No. 15-09-ICE-0517.

[3] CRCL Complaint No. 16-07-ICE-0351.

II. EXPERT PROFESSIONAL INFORMATION

(b) (6)

[redacted]

III. RELEVANT STANDARDS

A. ICE Detention Standards

ICE's PBNDS 2011 currently apply to HCDF. This facility was covered by these standards during the entire period relevant to this investigation. Consequently, I relied on the PBNDS 2011 when looking at the specific allegations regarding conditions at the facility. Additionally, I considered ICE Directive 11062.2, Sexual Abuse and Assault Prevention and Intervention, issued May 22, 2014, which was in force and effect during this period.

B. Additional Relevant Standards / Professional Best Practices

On issues not specifically addressed by PBNDS 2011, I made recommendations based on my correctional experience, best correctional practices, and recognized correctional standards including those published by ACA.

IV. FACILITY BACKGROUND AND POPULATION DEMOGRAPHICS

HCDF is located in Houston, Texas, and is operated and managed by CoreCivic (previously known as Corrections Corporation of America), a private corrections company, under a contract between ICE and CoreCivic to house only ICE detainees. HCDF has a rated population count of 1000 detainees and houses both male (580 beds) and female (420 beds) detainees.

On February 27, 2017, the detainee count at HCDF was 874 male and 146 female detainees. The total population count was 1020, which exceeded the rated capacity by 20 detainees, which is addressed in my report below. The detainees are primarily housed in 27 dormitory units. The facility has two special management units (SMUs). The male SMU has a capacity to hold 34 detainees and the female SMU has a capacity to hold four detainees. Detainees held in administrative or disciplinary segregation are housed in the SMU.

V. REVIEW PURPOSE AND METHODOLOGY

The purpose of this review was to examine the specific allegations made in the complaints, as well as to identify other areas of concern regarding the operation of the facility. I was also tasked with reviewing HCDF's implementation of the recommendations made following CRCL's August 2014 onsite investigation. As part of this review, I examined a variety of documents; was onsite at HCDF on February 27-March 1, 2017, along with CRCL staff and experts who examined medical care and mental health care; and interviewed ICE and HCDF staff and detainees. Detainee names and alien numbers are omitted from this report, and instead listed in Appendix A.

The staff at HCDF was helpful and cooperative during our onsite investigation, and I appreciated their assistance. I also appreciated the cooperation and assistance provided by ICE staff before, during, and after our trip.

In preparation for the onsite and completion of this report, I did the following:

- Reviewed OIG referred detainee complaints
- Reviewed the April 2016 ICE National Detainee Handbook
- Reviewed relevant ICE PBNDS 2011
    - Grievance System
    - Detainee Handbook
    - Admission and Release
    - Law Libraries and Legal Material
    - Recreation
    - Religious Practices

    - Staff-Detainee Communication
    - Special Management Units
    - Custody Classification System
    - Population Counts
    - Disciplinary System
    - Sexual Abuses and Assault Prevention and Intervention
    - Facility Security and Control
    - Funds and Personal Property
    - Significant Self-harm and Suicide Prevention and Intervention
    - Telephone Access
    - Detention Files
    - Visitation
- Reviewed relevant ACA correctional standards

While at the HCDF on February 27-March 1, 2017, and post visit, I did the following:

- Toured male and female housing units
- Interviewed housing officers
- Interviewed male and female detainees
- Reviewed detainee housing rosters
- Reviewed detainee files
- Reviewed the HCDF Detainee Handbook
- Inspected telephone pro bono number postings in housing units and SMUs
- Toured visiting room
- Inspected the law library
- Interviewed the law librarian and officer
- Interviewed detainees in the law library
- Reviewed the facility schedule for the law library and the library attendance log
- Inspected the recreation yards for male and female detainees
- Reviewed the recreation schedule for general population and the SMUs
- Reviewed the religious service schedules
- Reviewed the religious service area
- Interviewed the chaplain
- Reviewed detainee grievance logs for 2016 and 2017 (through date of review)
- Reviewed specific detainee grievances and responses
- Interviewed the grievance officer
- Reviewed detainee disciplinary reports
- Inspected the special management units
- Reviewed administrative segregation and disciplinary segregation hearing notices, reports, and detention files
- Reviewed disciplinary segregation orders
- Interviewed selected detainees in the male and female SMUs
- Reviewed detainee requests made to ICE
- Reviewed the daily activity schedule

- Interviewed custody and program personnel regarding PREA/SAAPI, use of force, disciplinary system, law library and legal access, religious access and services, recreation programs, grievance system, staff-detainee communication, investigations, use of segregation, suicide prevention policies, language access, telephone access, and mail
- Met with various ICE staff during the course of the review
- Reviewed the contract between ICE and CoreCivic (previously CCA)
- Reviewed HCDF policies on:
    - Sexual Assault and Abuse Prevention and Intervention
    - Classification
    - Recreation
    - Special Management Unit
    - Use of Force and Restraints
    - Religious Practices
    - Grievance System
    - Code of Conduct
    - Disciplinary
    - Detainee Handbook
    - Staff and Detainee Communication
    - Access to Courts (Law Libraries and Legal Materials)
    - Training
- Reviewed ICE ERO Memorandum, Further Guidance Regarding the Care of Transgender Detainees, June 19, 2015

In the context of this report, a finding of "substantiated" refers to an allegation that was investigated and determined to have occurred; a finding of "not substantiated" refers to an allegation that was investigated and the investigation produced insufficient evidence to make a final determination as to whether or not the event occurred; and a finding of "unfounded" means an allegation that was investigated and determined not to have occurred. Detainee names and alien numbers for detainees described in this report are listed in Appendix A. Staff names referred to in this report were provided to the Warden for appropriate follow-up action.

VI. CONDITIONS OF DETENTION FINDINGS AND RECOMMENDATIONS

A. Grievance System, Staff Misconduct, Retaliation, Staff Detainee Communication, Use of Force, and staff investigations

The PBNDS 2011 protects detainees' rights and ensures they are treated fairly by providing a procedure to file both informal and formal grievances and receive timely responses relating to any aspect of his or her detention, including medical care. One important aspect of the Grievance System standard is that detainees are protected from harassment, discipline, punishment, or retaliation for filing a complaint or grievance.

On May 26, 2015, CRCL received a referral from the DHS, Office of the Inspector General (OIG), related to Detainee #1's complaint alleging that he and an officer were in a verbal confrontation that led to the officer physically abusing him. Detainee #1 also alleged the grievance officer mishandled his complaint. Detainee #1 could not be interviewed as he was released on May 6,

2016, on an order of supervision. I reviewed Detainee #1's detention file and found no incident report or grievance related his allegations in the OIG referral; therefore, I could not substantiate his allegations. Detainee #1 did file a grievance on February 4, 2016, on an unrelated matter, and this grievance was not sustained. I reviewed the use of force (UOF) incident log and there was no UOF incident logged related to Detainee #1's complaint. I reviewed the UOF incident files and viewed videos of UOF incidents. The UOF policy, after-action review process and findings of these incidents conform to the PBNDS 2011.

I also reviewed the grievance system as part of this investigation. HCDF had 19 formal non-medical grievances logged for the period of January 1 through December 31, 2016. Forty-seven percent (9) of these grievances were staff complaints. There were an additional 73 informal grievances that are tracked in a separate informal grievance log. During the August 2014 CRCL investigation, deficiencies were identified related to lack of adequate investigation of detainee complaints of staff disrespect and staff reprisals. The following recommendation was made:

"HCDF should review the complaints and grievances about officer conduct to determine if officers are simply adhering to the rules, going beyond their authority, or engaging in inappropriate conduct. 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."

I interviewed two groups of randomly selected detainees, one male and one female. The male detainees stated during the interviews that grievances do not make a difference and that officers threaten to move them if they make a complaint. The female detainees stated that "the grievance system is a joke" and some reported that they were forced, coerced, or bullied into signing off on grievances by the Grievance Officer (GO). Male detainees provided the example that they had complained for months that a television was not working properly in Dormitory B5 and that no one had adequately handled concerns they raised that the television's snowy reception interfered with their viewing the television. This was a simple issue to verify. I went into B5 and determined that the detainees' complaint regarding the television was valid. During the female detainee group interview, Detainee #2 reported she had made a complaint regarding favoritism by unit staff of a detainee that was creating problems in the unit and the complaint was not fully investigated. I reviewed this grievance and determined that the GO did not conduct a thorough grievance investigation. When investigating the complaint, the GO asked for reports from the officers involved, but did not interview detainees in the unit to determine if the detainee's complaint was valid. The GO simply relied on the officer's word that no favoritism was occurring. I talked with other detainees who were also housed in the unit and they felt that favoritism was occurring, and that it was causing problems in the unit.

The female detainees also reported being yelled at and subjected to rude and hostile treatment by some of the custody staff and the GO. One detainee reported that the GO refused to accept a grievance. Some of the female detainees also expressed fear of retaliation for making any complaints. The female detainees provided the names of several officers whom they alleged treat them disrespectfully. One officer had been nicknamed by the detainees as "Officer Ferocious." The detainees' allegations of staff misconduct allegations included verbal disrespect

and harassment by custody staff, discrimination of detainees by facility staff based on race, and retaliation by facility staff following submission of detainee grievances. I was concerned about the significant number of detainee staff complaints, so I interviewed the investigator for the facility. There were no formal investigations of staff related to detainee mistreatment complaints. The only investigations of staff complaints were related to allegations of sexual abuse and assault, none of which were substantiated. I interviewed the Associate Warden and the Warden, who confirmed that not all staff complaints are logged. Both the Warden and Associate Warden stated that informal fact-findings into detainee complaints regarding staff can occur and, if an allegation is not substantiated, the complaint may not be logged. This practice completely invalidates any system of staff complaint logging and also results in ICE not consistently being notified when a detainee complaint against staff complaint is made. Additionally, no administrator is reviewing the grievance log or a report of the grievances for trend analysis.

The group detainee reports mirror the staff misconduct formally documented in grievances. The ACA's Adult Local Detention Facility Performance Based Standard 4-ALDF-6A-07 mandates that detainees [Inmates] are not subjected to personal abuse or harassment. The PBNDS 2011, Standard 3.1, Disciplinary System, provides "Detainees shall have the following rights and shall receive notice of them in the handbook: 1. The right to protection from personal abuse, corporal punishment, unnecessary or excessive use of force, personal injury, disease, property damage and harassment; 2. The right of freedom from discrimination based on race, religion, national origin, gender, sexual orientation, physical or mental ability or political beliefs; 3. The right to pursue a grievance in accordance with procedures provided in the detainee handbook, without fear of retaliation…." Several staff names were raised by the detainees in the interviews I conducted and in written grievances I reviewed. These staff names were provided to the Warden during the onsite investigation for follow-up action.

I also toured the dormitory units and inspected the grievances boxes. The grievance boxes were not secure. Plastic mailboxes with locks were provided for detainees to deposit grievances in. Several mailboxes had broken hinges or were secured with plastic zip ties that had broken. The grievance boxes could be easily opened and grievances could be removed and destroyed by unauthorized personnel or detainees.

Findings:

Detainee #1's complaint is not substantiated.

The HCDF grievance system does not conform to the PBNDS 2011, and there was evidence to support detainee claims that they suffer retaliation, verbal harassment, and disrespectful treatment by HCDF staff.

The PBNDS, along with additional applicable guidelines, support the following recommendations:

Recommendations

- HCDF is not logging or reporting all allegations of staff misconduct to ICE. ICE and HCDF should develop a tracking system for all staff misconduct allegations, and ensure that each allegation is reported to ICE. (PBNDS 2011, Grievance System) (Level 1)
- HCDF is not fully investigating all staff misconduct investigations or documenting the findings of the investigations. HCDF should ensure that all staff misconduct allegations are fully investigated and that the findings and results of the investigations are documented. (PBNDS 2011, Grievance System) (Level 1)
- HCDF tracks formal and informal grievances separately, and only reports the number of formal grievances. HCDF should record all formal and informal grievances on the grievance log, along with the information required by the detention standards. (PBNDS 2011, Grievance System) (Level 1)
- Plastic grievance mailboxes in the housing units were not always secure and grievances can be removed and destroyed by unauthorized staff or detainees. HCDF should remove the grievance mail boxes and require detainees to present grievances to staff or replace any grievance boxes that are broken and ensure that they are secure. (PBNDS 2011, Grievance System) (Level 2)

B. Legal Access

Law Library

I reviewed the law library and legal access as part of this investigation. I interviewed male and female detainees, and I interviewed the law librarian and recreational coordinator who share responsibilities for the law library and legal access. The male detainee law library is fully staffed with one to two staff during hours of operation. There is a log of library usage maintained and all computers were fully operational. Copies of legal material were made at the time of request. HCDF also provides a detainee worker position in the male law library to assist with language access to the English language Lexis-Nexis legal software. HCDF is fully compliant with providing male detainees with law library and legal access that conforms to the PBNDS 2011.

Female detainees are not provided with law library and legal access that conforms to the PBNDS 2011. The female detainee law library is not staffed. The law library equipment is in the gymnasium where recreation activities can interfere with law library usage. Because of the colocation of the gymnasium and law library, the posted hours for access to the law library are late in the evening or in the overnight hours, making the library less accessible by female detainees. No language access assistance is provided. Some female detainees reported they would use the law library if assistance was provided. I inspected the law library equipment and asked the law librarian who provides assistance to the female detainees who want to use the law library, Lexis-Nexis software, or need legal copies. The law librarian reported that the recreation officer provides law library assistance for the female detainees, which proved to not be accurate. I interviewed the recreation officer, who said she would help if she could, but it was not her official responsibility and she did not have particular training about the law library resources or software. I reviewed the post order for the recreation officer and found that it does not include any responsibilities related to the law library. The ACA's Adult Local Detention Facility Performance Based Standard 4-ALDF-6B-03 mandates "When both males and females

are housed in the same facility, all available services and programs are comparable. Neither gender is denied services and programs on the basis of its smaller number in the population."

The PBNDS 2011, Standard 6.3, Law Libraries and Legal Materials, requires "Detainees shall have meaningful access (no less than five hours per week) to law libraries, legal materials and equipment." In addition, the standard requires "Detainees shall receive assistance where needed (e.g., orientation to written or electronic media and materials; assistance in accessing related programs, forms and materials); in addition, detainees who are illiterate, limited-English proficient or disabled shall receive appropriate special assistance."

Finding:

HCDF fails to provide legal access to female detainees in accordance with the PBNDS 2011.

The PBNDS 2011, along with additional applicable guidelines, support the following recommendations:

Recommendations

- HCDF's law library for female detainees does not have appropriate assistance to users of the law library by staff or detainees, and the late hours affect meaningful access to the library. In comparison, male detainees are provided with more and better access to the law library. HCDF should provide meaningful access to the law library for female detainees by providing appropriate assistance by staff and detainees and hours of operation. (PBNDS 2011, Law Library and Legal Material, 4-ALDF-6B-03) (Level 1)

C. Limited English Proficiency (LEP)-Language Access

I reviewed the language access at this facility as part of this investigation. There were no open language access complaints at the time of investigation; however, during interviews of two groups of detainees, one male and one female, which included detainees who are limited English proficient (LEP) the detainees reported language access issues.[4] LEP detainees reported being required to sign documents in a language they did not understand. A review of detainee files indicated that detainees who were or appeared to be Spanish speakers based on requests they had written in Spanish had signed forms written in English, with no indication of interpretation or translation assistance. Detainees I interviewed alleged that LEP detainees were required to sign documents that were written in English and that no Language Line interpretation assistance was provided. I reviewed the Language Line bills, which confirmed limited usage of this resource. I also reviewed the Language Line log in the Receiving and Discharge (R & D) area of the facility where critical intake interviews occur and all intake forms are signed. The log indicated the Language Line had only being used five times from February 8, 2015, to February 27, 2017. This is very concerning because on February 27, 2017, there were

[4] CRCL staff and I conducted these interviews with the assistance of a qualified Spanish language interpreter.

detainees held at HCDF from 58 different countries, and thousands of detainees are processed through HCDF's R & D each year. Staff also could not produce a report of languages spoken by detainees.

HCDF and ICE do not currently comply with providing language access to LEP detainees. Under federal civil rights law and DHS policy, LEP detainees must be provided meaningful access to information, programs, and services within ICE detention. Title VI of the Civil Rights Act of 1964 (Title VI); Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency, 65 Fed. Reg. 50,121 (Aug. 11, 2000); Department of Homeland Security Language Access Plan, February 28, 2012; and U.S. Immigration and Customs Enforcement Language Access Plan, June 14, 2015 mandate language access for individuals held in detention. This obligation includes providing access to competent interpretation (oral) and translation (written) services for a wide range of interactions and programs covered by the ICE standards, such as Admission and Release, Custody Classification, Sexual Abuse and Assault Prevention and Intervention, Special Management Units, Staff-Detainee Communication; Disciplinary System; Medical and Mental Health Care; Suicide Prevention; Detainee Handbook; Grievance System; and Law Library and Legal Materials. Furthermore, not only is this a legal requirement, but a failure to provide appropriate language services can impact the safety of detainees and staff, and undermine the facility's compliance with detention standards and its own processes and procedures. HCDF and ICE's contractual obligations require them to provide meaningful language access for residents.

ICE and HCDF staff do not consistently provide oral interpretation through Language Line or translate official documents from English to other languages for LEP detainees. LEP detainees are required to sign documents that they do not understand, which invalidates the content of the documents and purpose of having detainees sign documents. Detainees can very easily violate the rules because they do not understand what the rules are due to LEP issues.

Finding:

HCDF fails to provide meaningful access for LEP detainees in compliance with the DHS's and ICE's language access plans and the PBNDS 2011.

The PBNDS, along with additional applicable guidelines, support the following recommendations:

Recommendations

- HCDF records indicate that language access resources are not frequently used to assist LEP detainees. HCDF should provide training to its staff on their obligations to provide meaningful access to LEP detainees and the resources that are available to assist them meet this obligation, and should document provision of this training. (DHS and ICE Language Access Plans) (PBNDS 2011, Multiple Standards) (Level 1)
- HCDF records indicate that language access resources are not frequently used to assist LEP detainees. HCDF should develop a Language Line logging system and require all facility staff to regularly record its use by date, alien number, and language of interpretation. Documenting Language Line usage is essential to validating compliance

with language access obligations. (DHS and ICE Access Plans) (PBNDS 2011, Multiple Standards) (Level 1)

- HCDF records indicate that language access resources are not frequently used to assist LEP detainees, and forms and other materials contained in detainee files are mostly written in English. To ensure that it complies with the arrival screening requirements in the Admission and Release standard, HCDF should ensure the use of qualified interpreters or professionally translated forms to ensure meaningful access for LEP detainees. (PBNDS 2011, Admission and Release) (Level 1)
- HCDF records indicate that language access resources are not frequently used to assist LEP detainees, and forms and other materials contained in detainee files are mostly written in English. HCDF should ensure forms and informational posters for detainees are professionally translated or detainees are provided with qualified interpreters to assist with providing meaningful access to LEP detainees. (DHS and ICE Language Access Plans) (PBNDS, Multiple Standards) (Level 1)
- HCDF should document the language spoken for each detainee to facilitate the process of providing language access. (Best Practice)

D. Treatment of Transgender Detainees

On April 27, 2016, CRCL received a referral from the DHS OIG regarding Detainee #3's complaint that Officer #1 verbally abused and wrote her up on multiple occasions for no reason.[5] I reviewed Detainee #3's detention file and there were no write ups from this officer or grievances contained in the detainee file. I also did not find any evidence to substantiate the detainee's allegations of mistreatment based on her gender identity. This detainee was not available to interview as she had been released to an order of supervision on June 16, 2016. During the August 2014 CRCL investigation, several recommendations were made regarding the care and treatment of transgender detainees at HCDF, including: (1) end the routine use of isolation practices for transgender detainees; (2) house detainees in general population units that allow them full access to privileges and programming available to other [detainees] whose behaviors do not need/require restrictions or, if general population is not provided, at a minimum ensure that these transgender 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; (3) end the routine cuffing, or other restrictive security measures; (4) provide training and monitoring for clinical and custody staff to ensure that transgender detainees are treatment with respect and sensitivity; and (5) issue bras and a two-piece uniform to prevent exposure of their upper body when using the bathroom. HCDF has corrected these previously identified deficiencies.

While Detainee #3 was not available to be interviewed, a transgender detainee (Detainee #4) housed at HCDF was available and I did interview her. Detainee #4 reported that she was being treated with dignity and respect by all staff. She also reported that she was provided with a bra, a two-piece uniform, and had equal access to all programming privileges and had no complaints.

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[5] CRCL Complaint No. 16-07-ICE-0351.

Detainee #4 was being housed in a dormitory unit by herself at her request. She felt more comfortable in this environment. I interviewed the facility staff who reported that the housing of each transgender detainee was based on their individual case factors.

I learned that HCDF has not been designated as a facility to house transgender detainees. If HCDF continues to house transgender detainees on a regular basis, there are additional procedures contained in the ICE ERO Memorandum, Further Guidance Regarding the Care of Transgender Detainees, June 19, 2015, that ICE and HCDF should consider for the facility.

Finding:

The available evidence did not substantiate Detainee #3's April 27, 2016 complaint of verbal abuse and disciplinary mistreatment.

Recommendation

- If HCDF continues to house transgender detainees on a regular basis, there are additional procedures contained in the ICE ERO Memorandum, Further Guidance Regarding the Care of Transgender Detainees, June 19, 2015, that ICE and HCDF should consider for the facility. (Best Practice)

E. Prison Rape Elimination Act, Sexual Abuse and Assault Prevention and Intervention (SAAPI)

As part of this investigation I was asked by CRCL to review HCDF's compliance with the Standard 2.11 of the PBNDS 2011 related to sexual abuse and assault prevention and intervention. I reviewed HCDF's SAAPI policy. The SAAPI policy and protocol at this facility is in partial compliance with PBNDS 2011. Detainees are notified of the zero tolerance policy in the detainee handbook. Required postings are located throughout the facility. Staff are trained on the SAAPI policy. The required SAAPI forms at this facility are in use. SAAPI files are maintained in compliance with the PBNDS Standard 2.11. There were deficiencies identified in HCDF's SAAPI Program. No documented annual review of incidents has been completed as mandated. Detainees are not effectively screened upon intake at HCDF for history of sexual abuse, which can jeopardize the safety of detainees based on inaccurate or incomplete screening. Detainees stand side-by-side, sometimes three at a time, at the R & D intake counter. Detainees' past sexual abuse history screening must be conducted in a confidential setting to ensure accurate reporting occurs and that a detainee's confidential information is not compromised. Additionally, the MOU with Family Time, which is the agency to provide victim support and advocacy services for those victims of reported sexual abuse and assault, is not funded and therefore the agency does not provide the mandated victim services.

Finding:

HCDF does not fully comply with PBNDS 2011, Standard 2.11, Sexual Abuse and Assault Prevention and Intervention.

Recommendations

- HCDF has not conducted the annual review of sexual abuse investigations and incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. HCDF should complete the annual review of sexual abuse investigations and incident reviews. (PBNDS, SAAPI) (Level 1)
- HCDF does not have appropriate controls on the dissemination of responses to risk assessment questions asked of detainees at intake to screen for risk of sexual abuse victimization or abusiveness. HCDF should modify its intake screening process to provide confidentiality when asking detainees screening questions about their prior sexual abuse and assault history. (PBNDS, SAAPI) (Level 1)
- HCDF does not have the required support services in place for sexual abuse and assault victims. HCDF should fund the Family Time MOU to ensure that victims of sexual abuse and assault can access support and advocacy services. (PBNDS, SAAPI) (Level 1)

F. Admission and Release

As part of this investigation, I was asked by CRCL to review HCDF's compliance with PBNDS 2011 standard on Admission and Release. I toured the HCDF's R &D area and identified several deficiencies. HCDF is not complying with the PBNDS 2011 mandate to complete processing all newly admitted detainees in no longer that 12 hours. The facility is routinely housing detainees in numbers that exceed the facility's rated capacity of 1000 detainees. This is a violation of PBNDS, the ICE contract, and possibly the occupancy permit issued for this facility. Detainees are being housed in the R & D area for up to several days. HCDF has notified ICE, and ICE confirms they are aware of this level of overcrowding and violations of the PBNDS 2011. This is a very serious matter and must be resolved.

Additionally, PBNDS 2011 mandates that all admission and orientation should be communicated to detainees in a language or manner the detainee can understand and oral interpretation or assistance shall be provided to any detainee who speaks another language in which written material has not been translated or who is illiterate. Interviews of detainees, review of detainee files, a review of Language Line billings and Language Line logs in the R & D area indicates that HCDF is not complying with these PBNDS 2011 mandates. As discussed in the Language Access section of this report, HCDF is non-compliant with the Language Access mandates. Recommendations related to Language Access are contained within the Language Access section of this report.

Finding:

HCDF does not comply with the mandates in PBNDS 2011, Standard 2.1, Admission and Release

Recommendations

- Detainees at HCDF are regularly spending over 12 hours in the R&D unit, and the facility has been housing a population beyond its rated capacity. ICE and HDCF should adjust arrivals at the facility to reduce admission processing time to within 12 hours and maintain a population level within the rated occupancy level for this facility. (PBNDS 2011, Admission and Release) (Level 1)

G. Special Management Unit (SMU), Significant Self-Harm and Suicide Prevention and Intervention

As part of this investigation I was asked to review HCDF's SMU. The SMU has made significant progress toward eliminating the deficiencies found in the August 2014 investigation. Prior findings regarding lack of compliance of providing equal recreation and programming access to those detainees on administrative segregation status have been corrected. Escorting in restraints for those not on disciplinary status no longer occurs. The required records are being maintained in both the male and female SMU. Previously there have been some gaps in the mandated reviews; however, the required reviews are being conducted timely as of the date of this investigation. The SMU continues to be used for medical and mental health isolations. Use of the SMU for medical and mental health isolations can result in detainees failing to report medical and mental health needs for fear of being locked up and isolated in the SMU. The medical and mental health experts will address the previous findings related to their respective area of expertise. I will note that one previous recommendation related to restricting the use of the safety smocks only to situations that warrant their use as determined and documented by a qualified mental health professional has been partially addressed. A licensed mental health professional is now the only individual who can authorize the use of the safety smock; however, suicide watches should be conducted in a more therapeutic environment. Additionally, a step-down protocol should also be used in addition to the use of safety smocks.

Finding:

The medical and mental health expert will address findings in this area.

OTHER FINDINGS

During the onsite investigation, I reviewed Religious Practices, Visitation, Recreation, and Telephone Access and did not have any findings in these areas.

VII. ASSESSMENT OF AUGUST 2014 RECOMMENDATIONS

As discussed above, as part of this onsite investigation, CRCL asked me to review the implementation of recommendations made during CRCL's last onsite investigation at HCDF in August 2014. At that time, the conditions of detention expert made six priority and four non-priority recommendations related to suicide prevention and intervention, sexual abuse and assault prevention and intervention, care of transgender detainees, admission and release, complaints against staff and staff investigations, the special management unit, staff-detainee communication, the grievance system, and the detainee handbook.

My review found progress had been made on five of the six previous priority recommendations, and additionally on all four of the non-priority recommendations, made following the August 2014 investigation. Progress on the priority recommendations includes: A licensed mental health professional now authorizes the use of the safety smock for suicide prevention. Policies on the housing and classification of transgender detainees are based on the individual case

factors of each detainee. Transgender detainees are issued two piece uniforms and appropriate undergarments including bras. Shackling of detainees held in protective custody and administrative segregation has been discontinued. Detainees held in Administrative Segregation receive the same privileges as those held in the general population including out of cell and recreation time. HCDF employees' respectful treatment of detainees and ensuring that staff understand and are following conduct expectations is still a work in progress as detailed in my report above. Progress on the non-priority recommendations includes: HCDF menus are based on nutritional standard requirements. Staff have been trained on the grievance system and are in partial compliance with PBNDS 2011 Grievance System requirements. ICE ensures that detainees have frequent opportunities for informal contact with facility and ICE/ERO staff. ICE Deportation Officer schedules are posted in all housing unit. All detainees receive a handbook with local supplements, however, language access issues exists as described earlier in this report.

VIII. SUMMARY OF HCDF RECOMMENDATIONS

Regarding the specific deficiencies I found as part of my inquiry into these complaints, I have recommended the following based on the PBNDS 2011.

1. HCDF is not logging or reporting all allegations of staff misconduct to ICE. ICE and HCDF should develop a tracking system for all staff misconduct allegations, and ensure that each allegation is reported to ICE. (PBNDS 2011, Grievance System) (Level 1)
2. HCDF is not fully investigating all staff misconduct investigations or documenting the findings of the investigations. HCDF should ensure that all staff misconduct allegations are fully investigated and that the findings and results of the investigations are documented. (PBNDS 2011, Grievance System) (Level 1)
3. HCDF tracks formal and informal grievances separately, and only reports the number of formal grievances. HCDF should record all formal and informal grievances on the grievance log, along with the information required by the detention standards. (PBNDS 2011, Grievance System) (Level 1)
4. Plastic grievance mailboxes in the housing units were not always secure and grievances can be removed and destroyed by unauthorized staff or detainees. HCDF should remove the grievance mail boxes and require detainees to present grievances to staff or replace any grievance boxes that are broken and ensure that they are secure. (PBNDS 2011, Grievance System) (Level 2)
5. HCDF's law library for female detainees does not have appropriate assistance to users of the law library by staff or detainees, and the late hours affect meaningful access to the library. In comparison, male detainees are provided with more and better access to the law library. HCDF should provide meaningful access to the law library for female detainees by providing appropriate assistance by staff and detainees and hours of operation. (PBNDS 2011, Law Library and Legal Material, 4-ALDF-6B-03) (Level 1)
6. HCDF records indicate that language access resources are not frequently used to assist LEP detainees. HCDF should provide training to its staff on their obligations to provide meaningful access to LEP detainees and the resources that are available to assist them

meet this obligation, and should document provision of this training. (DHS and ICE Language Access Plans) (PBNDS 2011, Multiple Standards) (Level 1)

7. HCDF records indicate that language access resources are not frequently used to assist LEP detainees. HCDF should develop a Language Line logging system and require all facility staff to regularly record its use by date, alien number, and language of interpretation. Documenting Language Line usage is essential to validating compliance with language access obligations. (DHS and ICE Access Plans) (PBNDS 2011, Multiple Standards) (Level 1)
8. HCDF records indicate that language access resources are not frequently used to assist LEP detainees, and forms and other materials contained in detainee files are mostly written in English. To ensure that it complies with the arrival screening requirements in the Admission and Release standard, HCDF should ensure the use of qualified interpreters or professionally translated forms to ensure meaningful access for LEP detainees. (PBNDS 2011, Admission and Release) (Level 1)
9. HCDF records indicate that language access resources are not frequently used to assist LEP detainees, and forms and other materials contained in detainee files are mostly written in English. HCDF should ensure forms and informational posters for detainees are professionally translated or detainees are provided with qualified interpreters to assist with providing meaningful access to LEP detainees. (DHS and ICE Language Access Plans) (PBNDS, Multiple Standards) (Level 1)
10. Detainees at HCDF are regularly spending over 12 hours in the R&D unit, and the facility has been housing a population beyond its rated capacity. ICE and HDCF should adjust arrivals at the facility to reduce admission processing time to within 12 hours and maintain a population level within the rated occupancy level for this facility. (PBNDS 2011, Admission and Release) (Level 1)

CRCL HOUSTON CONTRACT DETENTION FACILITY INVESTIGATION

APPENDIX A

Detainee Name and A Number

	(b) (6)
Detainee #1:	
Detainee #2:	
Detainee #3:	
Detainee #4	

CRCL HOUSTON CONTRACT DETENTION FACILITY INVESTIGATION

BEST PRACTICE RECOMMENDATIONS

APPENDIX B

1. HCDF should document the language spoken for each detainee to facilitate the process of providing language access. (Best Practice)
2. If HCDF continues to house transgender detainees on a regular basis, there are additional procedures contained in the ICE ERO Memorandum, Further Guidance Regarding the Care of Transgender Detainees, June 19, 2015, that ICE and HCDF should consider for the facility. (Best Practice)

REPORT FOR THE
U.S. DEPARTMENT OF HOMELAND SECURITY
OFFICE FOR CIVIL RIGHTS AND CIVIL LIBERTIES
Onsite February 27 – March 1, 2017

Investigation regarding Houston Contract Detention Facility, Houston, Texas

Complaints reviewed in this report included the following:

Complaint No. 15-08-ICE-0440
Complaint No. 15-09-ICE-0517
Complaint No. 15-10-ICE-0736
Complaint No. 16-07-ICE-0351

Prepared by (b) (6) PhD, MPA, CCHP
(b) (6)
Madison, WI 53707

Report date April 7, 2017

Introduction and Referral Issues

The U.S. Department of Homeland Security (DHS), Office for Civil Rights and Civil Liberties (CRCL), enlisted me to participate in an onsite investigation regarding complaints it received alleging civil rights and civil liberties abuses of individuals in U.S. Immigration and Customs Enforcement (ICE) custody at the Houston Contract Detention Facility (HCDF) in Houston, Texas. The complaints raised allegations regarding the conditions of detention, including medical care at HCDF. Specifically, three complaints detailed in the retention memo identify concerns about timely access to quality health care (15-10-ICE-0736, 15-090-ICE-0517, and 16-07-ICE-0351).

Additionally, a previous review conducted by the CRCL in August 2014 detailed significant issues related to mental health care in a variety of areas. The 2014 review identified the following mental health-related concerns: HCDF utilizes the special management unit to house detainees with mental health concerns; HCDF does not provide adequate care for detainees identified with gender dysphoria (i.e., transgender detainees); HCDF does not provide the same access to programming and recreational areas for detainees placed on the special management unit for mental health overflow reasons; HCDF does not provide regular mental health monitoring for detainees housed on the special management unit; HCDF is overly punitive when detainees present with suicide or self-harm ideation; and psychiatrist contact with detainees does not include sufficient medical education or follow-up.

While none of the four primary complaints prompting the current investigation details concerns related to any specific element of the mental health care program at HCDF, they and the results of the earlier review prompt the need to evaluate HCDF's compliance with PBNDS 2011 related to mental health care during this onsite investigation.

Method of Review

I was onsite at HCDF over the course of three days, February 27 through March 1, 2017, totaling approximately 25 hours. While there, I toured the facility including detainee general housing units for both male and female detainees, the intake unit, indoor and outside recreation space, and health care unit. I also toured the special management units for both male and female detainees consisting of 20 beds and 4 beds respectively, and the unit utilized for transgender detainees.

Prior to the onsite, I reviewed the applicable ICE Performance Based Detention Standards (PBNDS 2011), mental health forms and policies provided by the facility, material on quality improvement activities, staffing patterns, detainee handbook, and suicide prevention activities.

During the site visit, I reviewed the following documents:

1. Policy and procedures
2. QA/QI reports and minutes pertinent to the mental health system
3. A list of HCDF grievances related to medical and mental health care

4. Various written complaints submitted by ICE detainees
5. Minutes from the HCDF multidisciplinary meetings
6. The HCDF chronic care roster for detainees receiving mental health services
7. A roster of suicide and self-harm attempts in the previous six months
8. Twenty-six healthcare records (see Appendix 1) of detainees – 19 male, 3 female, and 4 transgender – chosen from the following sources:
    a. roster of detainees housed in restricted housing in the previous two weeks,
    b. list of detainees identified with mental health concerns on the chronic care list,
    c. list of detainees placed into suicide watch in the previous 12 months,
    d. list of detainees whose complaints prompted the current review,
    e. list of detainees identified as transgender in previous three months, and
    f. list of detainees provided by other experts present on the current site visit arising from their individual reviews.

Additionally, I conducted individual interviews with 12 detainees who were chosen from a list of patients on the chronic care list for medical or mental health treatment. These interviews were in collaboration with (b) (6) the medical expert assigned to this review team, along with the aid of a qualified Spanish-language interpreter. Five of the 12 interviewees were also part of the group for whom I completed a file review. A list of the interviewees is provided in Appendix 2.

I also had the opportunity to interview the following staff: CAPT (b) (6) PsyD; (b) (6) LCSW; and Psychiatrist (b) (6) MD.

Analysis, Conclusions, and Recommendations

Review of overall mental health care activities

The following section provides an assessment of compliance with PBNDS 2011 relevant to mental health care activities at HCDF.

Mental Health Program

(Standards: PBNDS 2011, Std. 4.3, Medical Care, §§ V.A, V.B, V.E, V.F.1, V.I, V.O.1, and V.O.2.)

Administration

(Standard: PBNDS 2011, Std. 4.3, Medical Care, §§ V.B. and V.DD.2.)

The medical department, including mental health care, is administered by ICE Health Service Corp (IHSC). Medical staffing consists of a health service administrator (HSA), a deputy HSA, and a Clinical Medical Authority who is currently out on extended medical leave. Staff were uncertain when the CMA was expected to return. There is no acting CMA. Nursing vacancies total 40%. There is a licensed psychologist in an acting leadership role. The department

conducts rounds at shift change that are meaningful. Language line is regularly utilized. The department holds monthly interdisciplinary meetings, and maintains minutes from all meetings. The facility houses both male and female detainees who remain separated at all times. The medical and mental health units attempt to schedule appointments to maintain the separation, however providers indicated the current system of separation for centralized medical services is inefficient at times. The HSA oversees quality improvement activities for the medical department that address PBNDS 2011 standards. Mental health care is not regularly specifically targeted for quality monitoring or review, a concern noted in the 2014 report.

Staffing, Space, and Access to Care

The mental health program staffing pattern includes: 1.0 FTE Licensed Psychologist (Acting Mental Health Director); 1.0 FTE Licensed Clinical Social Worker; and 1.0 FTE Psychiatrist. Another 1.0 FTE Licensed Clinical Social Worker position is currently vacant but a qualified staff person has been hired and is expected to start within the next two months. All positions are full time 40-hours per week and there is onsite mental health coverage from 6:30 am until 4:30 pm five days per week. The mental health providers rotate on-call. The mental health director is an IHSC officer. The other mental health professionals are civilian staff.

The facility's mental health providers are co-located with other health providers in space that includes several small offices, medical treatment rooms, administrative space, a pharmacy, 16-bed medical housing unit that includes four negative pressure rooms and a large space holding four beds that was identified as space for detainees with mental health concerns, and other general medical staff space. The psychiatrist has her own office. The psychologist and social worker share a single office with interview spaces separated by a partition that does not allow for adequate patient privacy. The providers noted that they attempt to schedule clients such that the shared space is private for clinical visits, or plan other activities outside of the office while detainees are being seen by their clinician. Over the course of the three days in which I was located in the shared office, one provider offered counseling while I was seated at the other desk, but I never observed two detainees participating in clinical activity in the office at the same time.

Medical and mental health care providers utilize the language line for interpretation needs if the provider is not fluent in the detainee's language. The psychologist provides treatment services in Spanish. Security staff and other detainees are not used to interpret mental health care concerns. All forms are translated into Spanish. Intake evaluations are conducted using interpretation either in person or via the language line. A review of the log of language line usage in the intake area suggests that the line is either not regularly used or not well tracked. Orientation activities and the ICE Detainee Handbook are available in Spanish.

The mental health staff report that the staffing pattern is sufficient to provide the services required by IHSC and PBNDS 2011. With the addition of another full time LCSW, the unit hopes to add psychoeducational and other short term treatment opportunities.

Health Care Record

(Standard: PBNDS 2011, Std. 4.3, Medical Care, §§ V.F.2 and V.BB.)

HCDF utilizes a comprehensive electronic health care record called E-Clinical Works. A health care summary report accompanies the detainee to hospital visits and is provide to the detainee at release to another facility. The electronic record is relatively easy to use and documentation completed by both mental health providers and psychiatry was thorough and timely.

Suicide Prevention Program

(Standard: PBNDS 2011, Std. 4.6, Significant Self-harm and Suicide Prevention and Intervention, §§ V.A. – V.F.)

There have been no suicide attempts or successes at HCDF in the last year.

HCDF has a comprehensive suicide prevention program. Staff participates in required suicide prevention training. The initial intake screening process uses a mental health questionnaire that asks questions specific to self-harm risk. Every medical and mental health note includes a statement on risk to self or others. Policy requires that detainees who express self-harm ideation or engage in self harm behavior be placed into an observation/isolation status. HCDF utilizes the segregated Special Management Unit as their default suicide watch placement location. Detainees who engage in self harm necessitating a hospital consultation return to the facility and are placed into the segregated suicide watch setting. Use of the Special Management Unit as the designated placement location for suicide watch violates PBNDS 2011, Std. 4.6, § V.F. This is detailed more fully in the recommendations section. When placed into suicide watch status, detainees are seen every eight hours by health care staff, and reviewed by mental health staff daily. Notes from mental health professionals typically provide a rudimentary plan that includes follow-up timeline. There is no additional plan-driven mental health treatment provided to detainees while in suicide watch. Detainees placed in suicide watch in the special management unit are overseen using 24-hour 1:1 monitoring by security staff.

Detainees who express self-harm ideation are regularly placed into a suicide smock with no other property, which is the standard for suicide watch as directed by IHSC operations memorandum (OM) 16-002. Mental health staff indicated that they have the ability to "step down" the restrictions but file reviews showed that the "suicide watch" status is the norm and step-downs do not generally occur. Other statuses such as "constant watch" allow for additional property including clothing, reading material, etc. "Suicide watch" is the most restrictive status. Consistent and automatic use of the most restrictive status violates PBNDS 2011, Std. 4.6, §§ V.K.1 and V.K.2 directing use of the least restrictive/least punitive status based on the individual clinical needs of the detainee. This is detailed more fully in the recommendations section.

Detainees in suicide watch are not allowed to participate in recreation or other out-of-cell activities. Contact with mental health providers occurs at the cell door rather than in a private setting. The clinicians reported that the location of contacts is determined by security and not

based on clinical judgment, and that cell-side contact is the norm for all detainees in the special management unit. Consistent normative use of cell-side contacts to provide mental health services violates PBNDS 2011, Std. 4.3, Medical Care, § II.25 directing that medical and mental health care be conducted in settings that respect detainee privacy and encourage frank discussion.

The mental health staff indicated that they have recently re-initiated the required multidisciplinary patient consultation when detainees are placed into the special management unit as required by the PBNDS 2011, Std. 2.12. Special Management Units, § V.B.3.c.

The suicide prevention plan relies upon the mental health provider developing a treatment plan to address the factors that contribute to the detainee's suicidal ideation. The treatment plans provided in the notes often detail goals or treatment options for addressing the concerns that resulted in the isolated stay. Rounds by a mental health provider occur at the required intervals and notes from those rounds are detailed and generally meaningful. Following release from suicide watch, the detainee receives a follow up contact at 1-, 3- and 30-day intervals.

Screening, Assessment and Referral

(Standards: PBNDS 2011, Std. 4.3, Medical Care, §§ V.J, V.O.1, V.O.3, V.O.4, V.P, and V.BB.4.)

The screening, assessment, and referral processes related to mental health care generally meet PBNDS 2011 standards, and policies clearly delineate the process of detainee referral to mental health services. Mental health screening is conducted by nurses or mental health providers within the required timeframes after the intake screening is conducted by security staff upon arrival. The officer-conducted interview asks questions related to mental health and physical health history, trauma, and other topics. That screen is conducted at a desk in full view and hearing of other detainees and staff and allows for little privacy.

The screening tool and interview conducted by health care staff adequately addresses the required points including suicide risk evaluation and evaluation of factors associated with PREA, and asks questions related to current and historical psychiatric symptoms or treatment, experience of criminal victimization, recent loss, traumatic experiences, and other information. Detainee records indicate regular completion of consent forms.

Detainees who enter the facility on current psychiatric medications receive a continuing prescription by a physician or nurse practitioner pending review by the psychiatrist at the next available opportunity. Transfer summaries do not regularly accompany the detainee to the facility, even when the detainee has transferred from other facilities from which a transfer summary should be accessible.

Detainees receiving medication are regularly seen on a monthly basis by mental health providers as required by PBNDS 2011 standards. Psychiatric consultation regularly occurs at the required interval. Notes are meaningful and reflect clinical thinking and treatment plan. Use of language line is noted and notes regularly reflect that patient education is occurring.

Sick Call

(Standard: PBNDS 2011, Std. 4.3, Medical Care, §§ V.D and V.S.)

Sick call occurs in person on every unit and includes requests for mental health care. There is no written sick-call request process. Detainees housed in a segregated unit may request medical visits during one of the several cell-side visits by medical staff throughout the day. The ICE Detainee Handbook details the process for making sick call requests for health care or to report suicidal ideation, however approximately 20% of the interview subjects were unable to identify how they can request mental health care or what services were available to them.

Medical Isolation, Involuntary Medication, and Use of Restraints

(Standard: PBNDS 2011, Std. 4.3 Medical Care, §§ V.O.5, V.O.6,V.W and V.Y.)

Isolation for medical purposes generally occurs in the medical housing unit. The special management unit is used as overflow space but no medical staff are located on that segregated unit 24 hours per day during those periods. Suicide watch invariably occurs in the special management unit and includes 1:1 monitoring by officer staff, use of a suicide resistant smock, finger food, and no other property at least initially. Mental health providers report that they can "step down" the watch to allow additional property but review of records does not show this occurring. Detainees placed in suicide watch typically are released back to their housing unit directly from that status. Detainees on suicide watch are seen daily by mental health providers and every eight hours by medical staff. Detainees placed in the medical housing unit space within the medical unit are not required to be seen daily by mental health staff unless they are there for purposes of suicide risk management. Detainees with identified mental health conditions but who do not express self-harm ideation who are placed in the special management unit setting are seen weekly by mental health staff and monitored daily by medical staff.

Rounds for detainees in the special management unit occur cell-side with minimal privacy. Out of cell mental health treatment is not provided while in the special management unit. Detainees with significant mental health concerns housed in the special management unit received the same recreational, property, and out-of-cell opportunities as other detainees housed in the unit. Detainees housed in the special management unit for protective placement receive similar privileges as general population detainees. Interviews with several protective placement detainees clearly reflect that they have access to library, recreation, and out-of-cell activities and are moved from location to location without use of restraints.

Detainees in need of treatment intervention beyond the scope of HCDF are routinely transferred to a regional hospital for acute care. This has been generally successfully accomplished. However there is one case detailed in the file review section in which medical and mental health staff clearly identify that inpatient stay is needed for a detainee who was exhibiting active signs of psychotic illness over the course of two months and the detainee was removed from the United States without that care being provided. The facility does not initiate involuntary

psychiatric medication. If needed, the patient goes off site to the inpatient facility. HCDF does not restrain detainees for mental health purposes.

Medication refusals are noted in the EMR and followed up in contact with mental health counselor or medical professional visits promptly.

Continuity of Care

(Standard: PBNDS 2011, Std. 4.3, Medical Care, §§ V.J, V.Z, and V.BB.4.)

Detainees arriving at the facility with prescribed medications are regularly evaluated within required timeframes. Detainees indicated that there were not typically gaps between arrival at the facility and provision of medications when the detainee brings an active prescription. When there is no prescription and the detainee indicates they have been taking specific medications, there are occasional delays pending evaluation by mental health staff or receipt of outside records. Transfer summaries do not regularly accompany the detainees at intake to HCDF even when arriving from other facilities who should be providing them. Detainees releasing from the facility are provided with at least a 30 day supply of medication and a detailed medical care summary to aid in transition to the next living situation.

Review of Health Care Records

Twenty-six healthcare records of ICE detainees were reviewed. As noted above, there were no complaints directly relevant to mental health care. Thus general findings are offered below. Where significant concerns are identified, I have listed more details of the case to reflect areas that prompt recommendations later in this report. A list of files reviewed is provided in Appendix 1.

1. General mental health program requirements identified in PBNDS 2011, Medical Care, § V.O were regularly provided in a timely manner. Intake interviews were typically conducted within required timeframes. Interview documentation reflects history of previous diagnoses and psychotropic interventions, suicidal ideation, and traumatic history for all files reviewed. Referrals were made to mental health providers and psychiatric staff as appropriate. Prescribed medications were typically received without unusual delay.

2. Twenty-one of the 26 detainees arrived with no transfer summary. Five of those detainees (2, 17, 18, 22, and 26) endorsed being diagnosed with a serious mental illness during the initial screen with the intake officer. Two detainees (9 and 21) reported no mental health concerns during the initial officer-led interview but endorsed significant mental health concerns during the first visit with a mental health professional. Two detainees who arrived with no transfer summary and reported no mental health history to the intake officer were placed into suicide watch within the first week of arrival (16 and 19); a third (20) was placed into suicide watch within 12 days of arrival. Additionally, one detainee who arrived with no transfer summary denied being transgender to the intake officer but acknowledge being transgender at the first contact with a mental health

or health care provider in screening (5). The lack of transfer summaries and unreliable information gathering between intake screen by the officer and contact with the medical or mental health staff points to concern about the effectiveness of the intake interview process related to identifying mental health needs during the initial intake screen. These concerns and associated PBNDS 2011 standards are detailed further in the recommendation section of this report.

3. Eighteen of the 26 detainees for whom I did a file review were detained in the special management unit during the course of their detention for either disciplinary separation or suicide watch. Five of those placed into the special management unit for disciplinary purposes were identified at intake or during the initial mental health screen as experiencing a serious mental illness or having a history of self-harm (1, 2, 9, 17, and 26). Another detainee (3) was placed into the special management unit before an intake could be completed, however he had recently been transferred to another facility and had a noted history of self-harm and mental health concerns from his prior placement at HCDF. Two were exhibiting signs of significant impairment at the time of the infraction resulting in placement:

    a. Detainee 1 arrived endorsing symptoms of significant mental illness and treated through hospital placements and on-site care for the first six months. He acknowledged in October 2016 that he was no longer taking medications for diagnosed schizophrenia. Within six days he was placed into the special management unit for disciplinary purposes. He was released but requested continued placement in the special management unit for protective custody.
    b. Detainee 2 arrived with no transfer summary but noted long-term history of psychotic illness with inconsistent use of medication. Shortly after admission, she was placed into the special management unit for disciplinary purposes after threatening an officer. She acknowledged experiencing significant symptoms of active psychosis. She remained in segregated housing during the length of her stay exhibiting clear psychotic symptoms while health care staff made efforts to initiate court order for psychiatric medications or placement in a higher level of care. That placement in inpatient care was not accomplished as the detainee was removed from the United States while still symptomatic.

   Placement of detainees in a segregated setting based on their mental illness is a violation of PBNDS 2011, Std. 2.12, Special Management Units, and professional standards. This is discussed more fully in the recommendations section.

4. Nine of the 26 detainees for whom I did a file review were placed into suicide watch on at least one occasion during their detention (3, 16, 17, 18, 19, 20, 21, 22, and 23). Two of those had been previously identified as having a serious mental illness (17 and 18). Suicide watch occurs invariably in the special management unit and is the most restrictive status, which under IHSC policy requires removal of all clothing and property except for a suicide smock, a suicide resistant blanket, a mattress on the floor or fixed bed, and food that can be eaten without utensils (IHSC OM-16-002). Use of segregated housing for suicide watch violates PBNDS 2011 standards of care as well as NCCHC

Standards of Mental Health Care and Standards of Care for Jails. These concerns are described fully in the recommendation section of this report.

Assessment of August 2014 recommendations

As mentioned above, as part of this onsite investigation, CRCL asked me to review the implementation of recommendations made during CRCL's last onsite investigation at HCDF in August 2014. At that time, the mental health expert made nine recommendations. My findings related to those recommendations are noted below:

1. *2014 Recommendation: HCDF should end its practice of imposing segregation conditions on detainees placed on the segregation unit for protective custody or medical or mental health overflow reasons.*

Based on my review, I find that HCDF has changed its practices related to protective custody detainees, regularly allowing a general population level of privileges. However, the special management unit continues to be the primary placement location for detainees expressing suicidal or self-harm ideation or engaging in difficult behaviors linked to symptoms of significant mental illness. This remains a Level 1 concern and is noted in the recommendation section.

2. *2014 Recommendation: HCDF should changes its management practices for detainees identified with gender dysphoria (i.e., transgender detainees).*

Based on my review, I find that HCDF has addressed those concerns. Detainees are assessed at intake and offered medical and mental health services, housing placements are made with input from the detainee, detainees have access to the full range of programming and services offered to other detainees, and staff receive training related to unique needs of transgender detainees.

3. *2014 Recommendation: HCDF should provide the same access that general population detainees have to recreational areas and programming for detainees placed on the special management unit for protective custody or medical or mental health reasons.*

I found that HCDF has changed its practices regarding out of cell activities for detainees housed in the special management unit for protective custody purposes. However detainees engaging in rule infractions that are related to symptoms of significant mental illness continue to receive disciplinary sanctions and receive the same level of programming offered to detainees serving disciplinary sanctions unrelated to mental illness. While all special management unit detainees receive weekly mental health rounds, they occur cell-side, and little other programming is offered. This remains a concern and is noted in the recommendations section.

4. *2014 Recommendation: HCDF should conduct meaningful assessments and ensure that detainees placed into special management unit receive regular mental health monitoring.*

I found that this concern has been partially addressed. There are meaningful assessments conducted, however review of files for detainees housed in the special management unit during this onsite showed that there are cases in which detainees receive disciplinary sanctions for behavior notably related to symptoms of mental illness (see Review of Healthcare Records). Thus, the assessment did not result in a differential placement or additional services. There are documented regular mental health rounds with meaningful mental status updates for detainees housed in the special management unit.

5. *2014 Report: Noted concerns related to management of suicide watches including placement in the special management unit, use of the highest level of restrictions, and inadequate suicide watch assessments.*

I find that these concerns continue to be present. Suicide watch is continually conducted in the segregated setting, detainees are routinely placed in suicide smocks with little other property, and assessment results continue to focus on detainee report of suicidal ideation. These concerns are addressed fully in the recommendations section and are a key finding in this report.

6. *2014 Recommendation: Psychiatrist contacts with detainees should include medication education, monitoring for side effects and appropriate laboratory and other testing.*

My review finds that the 2014 concerns have been addressed. Psychiatry notes clearly show that education and monitoring is occurring and review of detainee files confirm the presence of timely laboratory testing.

7. *2014 Recommendation: HCDF needs to improve communication and coordination of care among care and custody staff.*

This review suggests that there are no new concerns specific to communication and coordination among affected staff. Interdisciplinary meetings include both care and custody staff and are occurring on a timely basis. Meetings in on the special management unit between care and custody staff have been reinitiated. While there are no notable issues identified during this onsite, it remains important that care and custody staff continue their efforts to improve communication and coordination of care.

8. *2014 Report: There was a lack of quality improvement activities related to mental health care.*

My review found a continuing paucity of robust quality improvement activities specific to mental health care. The HSA oversees quality improvement activities for health services. The mental health staff are involved in quality improvement meetings or planning activities. Mental health leadership reported an interest in monitoring of specific information such as diagnoses, but there were no quality improvement studies related to mental health programming reported and no systematic plan for implementing meaningful continuous

quality improvement activities specific to mental health care. This is detailed in the recommendations section.

9. *2014 Recommendation: HCDF needs to take detainee reports of disrespectful treatment seriously and address concerns related to staff reprisal against detainees who complain.*

There were no complaints lodged related to mental health care for this 2017 onsite. During detainee interviews two detainees expressed hesitance in filing complaints against both care and custody staff out of concern for reprisal. Neither identified specific recent incidents for immediate investigation. As recommended by the mental health expert in the 2014 report, additional review and monitoring of this concern – potentially using a credible external monitor – is warranted.

Summary of Recommendations

PBNDS 2011, Std. 4.3, 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. When relevant, I also include other relevant portions of the PBNDS 2011, as well as references to the Standards for Health Services in Jails and Standards of Mental Health Care, National Commission on 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.

Priority Recommendations and Rationale

1. **HCDF regularly uses the special management unit for suicide observation and for overflow mental health observation. HCDF should develop additional space in the medical unit to house medical and mental health patients who need closer supervision. (Level 1)**
2. **The special management unit does not have physical space or staffing that is required for medical or mental health observation. If HCDF continues to use special management unit space for medical and mental health monitoring, 24 hour nursing coverage that allows for constant sight and sound observation is required, and additional treatment opportunities must be offered. (Level 1)**

Rationale: PBNDS 2011, Std. 4.6, Suicide Prevention and Intervention states in section V.F. that "if the qualified mental health professional determines that the detainee requires a special isolation room but there is either no space in the medical housing unit or a medical housing unit does not exist, the detainee may, *as a last resort*, be temporarily placed in an administrative segregation cell in a Special Management Unit, provided space has been approved for this purpose by the medical staff and such space allows for constant and unobstructed observation."

PBNDS 2011, Std. 4.3, Medical Care notes in sections V.F.3 and V.O.5 relative to medical isolation that "the CMA may authorize medical isolation for a detainee who is at high risk for violent behavior because of a mental health condition." Further, it notes "if there is a specific area, separate from other housing areas, where detainees are admitted for health observation and care under the supervision and direction of health care personnel… the following minimum standards shall be met… 'Staff members within sight and sound of all patients.'" NCCHC standard MH-G-02 supports that requirement indicating that acute mental health residential units shall have "continuous coverage by mental health staff assigned to the unit…"

PBNDS 2011, Std. 2.12, Special Management Units indicates in section II.8 that "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." Further, the standard states in section V.A.1.C.9 that "Use of administrative segregation to protect detainees with special vulnerabilities… 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."

The American Psychiatric Association noted that "inmates who are in severe psychiatric crisis, including but not limited to acute psychosis and suicidal depression, should be removed from segregation until such time as they are psychologically able to tolerate that setting (APA, Psychiatric Services in Jails and Prisons. Washington, DC (2000)).

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." It further requires that acute mental health residential units have, "at a minimum… programming or appropriate therapies, if indicated; individualized treatment plans, and housing in a safe and therapeutic environment conducive to symptom stabilization…" Best practice dictates that every detainee with a serious mental illness housed in a segregated setting should receive ten hours of documented out-of-cell, treatment plan driven therapeutic activity and ten hours of out-of-cell recreation each week (NCCHC, Standards for Mental Health Services in Correctional Facilities, MH-E-07, Segregated Inmates).

Finally, NCCHC Standards for Mental Health Services (MH-A-09, an important standard) requires that "mental health services are conducted in private and carried out in a manner designed to encourage the patient's subsequent use of services."

HCDF uses the special management unit as overflow housing for detainees with medical or mental health needs and is the default location for suicide watches. Detainees with significant mental illness are regularly placed into the special management unit. The method used to determine if the behavior necessitating discipline is related to the mental illness is inadequate and

results in detainees experiencing active symptoms of serious mental illness being housed in the special management unit.

While in the special management unit, staff report that efforts are made to ensure that residents receive the same property and privileges as those who are housed there for administrative segregation and are treated differently than those housed there for disciplinary segregation. However, the practice of housing detainees with mental health and medical needs, including suicidal ideation, in an environment geared toward discipline compromises care, causes psychological distress, and does not comply with standards.

While PBNDS 2011 does allow for utilization of the special management unit as a last resort, it does require the ability to directly observe and requires staff within constant sight and sound. This does not occur at HCDF and is a violation of the standards. The special management unit should also not be used to house incoming detainees who need an isolated status pending psychiatric consult for their mental health condition. HCDF should develop therapeutic treatment activities monitored through a formal treatment plan for detainees who are identified as at risk for suicide.

3. **All detainees who presented any suicide risk were placed on suicide watch, the highest level of observation, irrespective of the individual circumstances. When placement into an isolated status due to suicide risk is necessary, a qualified mental health practitioner should determine the level of supervision required based on the individual circumstances.**
4. **Each instance of suicide watch had the maximum level of restrictions for the detainee. Removal of all property should not be the standard. HCDF should use the least restrictive measures necessary to ensure the safety of the detainee while ensuring the security of the facility.**
5. **Every mental health consultation with detainees on suicide watch was conducted through the closed cell door in the special management unit. Mental health evaluation and treatment should be conducted in private without risk of being overheard by other detainees. (Level 1)**

Rationale: PBNDS 2011, Std. 4.6, Suicide Prevention and Intervention states in section V.D "This evaluation shall be conducted by a qualified mental health professional which will determine the level of suicide risk, level of supervision needed, and need for transfer to an inpatient mental health facility."

PBNDS 2011, Std. 4.6, Suicide Prevention and Intervention section V.K.1 notes: "Deprivations and restrictions placed on suicidal detainees must be kept at a minimum. Suicidal detainees may be discouraged from expressing their intentions if the consequence of reporting those intentions are unpleasant or understood to result in punitive treatment or punishment."

PBNDS 2011, Std. 4.6, Suicide Prevention and Intervention section V.K.2. specifies that "the qualified mental health professional shall assess the detainee to determine whether a suicide

smock is necessary. Detainees should be provided suicide smocks to wear only when clinically indicated."

NCCHC Standards of Mental Health for Correctional Facilities state in Appendix D: Suicide Prevention Protocols "To every extent possible, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary located close to staff. Furthermore, removal of an inmate's clothing (excluding belts and shoelaces) should be avoided whenever possible, and used only as a last resort when the inmate is physically engaging in self-destructive behavior. Housing assignments should be based on the ability to maximize staff interaction with the inmate, not on the decisions that heighten depersonalizing aspects of confinement" (p. 126).

HCDF routinely places detainees identified as having self-harm or suicidal ideation in suicide watch. The status, "suicide watch," necessitates that the detainee will "have their belongings and issued clothing removed, wear a suicide smock, use a suicide blanket, have a mattress to sleep on the floor or on a fixed bed, and are given food that can be consumed without the use of utensils" (IHSC OM 16-002). Detainees isolated due to risk of self-harm do not participate in out of cell activities and receive daily rounds by mental health staff while standing at the cell door which affords no privacy.

IHSC OM-16-002 identifies other potential statuses for managing self-harm behavior. "Constant watch" allows the same 1:1 supervision by security staff, but allows the detainee to retain assigned clothing, eat regular food, have regular bedding, and have books, treatment materials, or other property that can provide therapeutic benefit.

The overarching goal of placing a detainee in suicide monitoring status is to ensure the safety of the detainee while attempting to address the conditions and concerns leading to the expression of suicidal or self-harm ideation. Reducing risk of current or future self-harm necessarily relies on the willingness of the detainee to report distress. Placing a detainee who is experiencing psychological distress, including suicide or self-harm concerns, in an environment associated with discipline exacerbates that distress and reduces the likelihood that the detainee will report self-harm ideation in the future. Further, using the most restrictive monitoring guidelines that include use of suicide smock and finger food, and removal of all other property, including that which could distract from distressful thoughts, is unnecessarily punitive and can reduce the willingness of the detainee to honestly discuss concerns in the future, or increase the likelihood of the detainee falsely reporting improvement as a means of getting away from the punitive setting. Additionally, offering no out-of-cell mental health programming and engaging in all clinical contacts at cell-side reduces the ability of the detainee and the clinician to address the issues that led to the self-harm concern. The risk reduction and therapeutic value of the observational placement is reduced by utilization of "suicide watch" as it is currently constructed.

In sum, the use of "suicide watch" as the default status for all detainees placed in isolation for self-harm is overly punitive and violates PBNDS 2011 and NCCHC standards.

6. **Given the current layout of HCDF's intake unit, detainees do not have any privacy when asked sensitive questions by officers. HCDF should modify the intake space to allow for privacy during the initial officer screening of the detainee. (Level 2)**

Rationale: PBNDS 2011, Std. 4.3, Medical Care section II.25 states "Medical and mental health interviews, screenings, appraisals, examinations and administering of medication shall be conducted in settings that respect detainee's privacy in accordance with safe and orderly operations of the facility."

NCCHC Standards for Mental Health Services (MH-A-09, an important standard) require that "mental health services are conducted in private and carried out in a manner designed to encourage the patient's subsequent use of services."

The space used by officers to conduct initial interviews of arriving detainees allows for no privacy. Detainees are asked personal details about mental health needs, traumatic experiences, and sexual orientation, among others, while standing or sitting at a desk surrounded by other detainees or facility staff. The effectiveness of the intake process in gathering vital information for others to use in housing and treatment decisions is negatively impacted by the lack of privacy and results in serious mental health needs of incoming detainees being missed at intake.

7. **The 2014 onsite investigation report and findings from this onsite identify reports by detainees of concern of reprisal by both care and custody staff if complaints are expressed. HCDF should identify and implement a means of monitoring and reviewing complaints to ensure that reprisal is not occurring, and to try to eliminate the perception that it is.**

Rationale: PBNDS 2011, Std. 6.2, Grievance System, §II.8. states "No detainee shall be harassed, disciplined, punished or otherwise retaliated against for filing a complaint or grievance."

Two detainees reported concern of reprisal by care and custody staff if they expressed a complaint about care requested or received. They were unable or unwilling to identify specific instances for immediate investigation. However, their reports and the history of concerns expressed during the 2014 review suggest that ongoing independent investigation is needed.

Best Practice

Recommendation: A significant proportion of detainees arrive at HCDF without a medical transfer summary. HCDF should actively seek transfer summaries for detainees arriving from another facility.

A transfer summary is a continuity of care document aimed at identifying mental and physical health needs as soon as possible at arrival. The intent of privacy during intake interviews related to mental health and medical concerns is to attempt to gather sufficient information with which to make determinations about treatment needs which, in turn, mitigates the risk of a negative

client outcome. NCCHC Standards for Mental Health Services (MH-E-03, an essential standards) states "A transfer screening is performed on all intrasystem transfers." Intrasystem transfer is defined by NCCHC as inmates being transferred from one facility to another, individual returning from furlough, and other individual brought to the facility an already established health/mental health record for their current incarceration.

Recommendation: A number of detainees interviewed during this investigation were not familiar with the mental health services at HCDF or how to access them. HCDF should develop a process for ongoing notification of detainees regarding how to access mental health care services.

The process for requesting sick call, including requesting mental health care, is detailed in the detainee handbook. There is not a written sick call process and no signage in detainee areas providing ongoing reminders about available mental health opportunities. Several detainees interviewed while onsite who did not express mental health needs at intake or access mental health services soon after reading the detainee handbook reported they did not know how to request mental health services and were not familiar with what services were available.

Recommendation: Quality improvement activities focus primarily on health care quality and there is a paucity of mental health care quality improvement activities that could assist in identifying, correcting, and monitoring concerns noted in the recommendation section above. HCDF should develop a robust mental health quality improvement program.

The HSA oversees quality improvement activities for health care staff that include medical practice review, peer review, and review of other medical quality indicators. The mental health leadership reportedly participates in quality improvement committees but except for ensuring that timelines are met for weekly special management unit detainee monitoring, there were no identifiable systematic quality assurance initiatives focused on mental health care. A robust mental health quality assurance/quality improvement program including routine monitoring, targeted improvement studies, and case review would assist in identifying and addressing many of the issues noted in the onsite review.

Appendix 1. REVIEW OF HEALTHCARE RECORDS

List of Files Reviewed:

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Details of File Reviews:

(b) (6)

The initial intake into the facility occurred on 4/5/2016. The detainee entered the facility with a history of schizophrenia noted, reporting monthly doses of injectable psychiatric medications. He received that medication until 4/13/2016 when he is transferred to the hospital after exhibiting significant psychotic symptoms. He returned from the hospital on 5/24/2016. He remained on general housing unit until 6/24/2016 when he was admitted to the medical housing unit after refusing medications, releasing from the medical housing unit on 6/30/3016 after resuming medication compliance. He participated in regular psychiatric consultation visits while in general population until 10/29/2016 when he reported to the psychiatrist that he was not taking his medications. A 10/25/2016 note by the LCSW indicates clearance for placement into the special management unit due to unspecified disciplinary reasons and he was seen by mental health staff on 10/26/2016 and 11/1/2016 but was released from the special management unit on 11/2/2016. He requested protective custody on 11/5/2016 and remained with regular rounds until 11/21/2016 when he began exhibiting signs of active psychosis. Notes by psychology and psychiatry between 11/22/2016 and 1/3/2017 reflect some initial improvement followed by noted decompensation and transfer to the local mental health facility on 1/10/2017. He returned from the hospital on 2/11/2017 and was placed into the medical housing unit temporarily until moving to protective custody in the special management unit again on 2/13/2017. He remains in protective custody at the facility.

(b) (6)

Admitted 10/28/2016 with no accompanying transfer summary, the detainee reported a history of depression and schizophrenia for 14 years, managed with medications. She refused her first psychiatric consult on 11/1/2016 but was seen by psychiatry on 11/2/2016 after being placed into the special management unit for threatening an officer. She admitted experiencing significant symptoms of psychotic illness and agreed to take medications but was seen on 11/3/2016 again after refusing medications the previous night. She remained in the special management unit for disciplinary purposes, with sporadic medication refusal and clearly symptomatic. Notes by mental health staff between 11/22/2016 and 12/13/2016 reflect efforts to get approval for an order for forced medication through ICE channels due to continuing signs of active mental illness. Weekly special management rounds were conducted from 12/13/2016 through 1/10/2017. Notes by mental health providers on 1/10/2017, 1/17/2017, 1/24/2017, and 1/25/2017 reflect continuing medication refusal and symptomatic behavior until an application is submitted to the local mental health facility for placement on 1/27/2017 with another follow-up on 1/31/2017. However the detainee was removed to Cameroon on 2/6/2017.

(b) (6)

Admitted originally on 11/30/2016, the intake review noted history of self-harm and mental health concerns. He was then transferred to another facility. He returned to HCDF on 1/5/2017 and engaged in a fight with another detainee on 1/6/2017 resulting in a physical injury necessitating nurse intervention. He was placed into the special management unit and during nursing rounds the detainee reported hearing voices and expressed suicidal ideation with no plan. He was placed into suicide watch in the special management unit, released 1/9/2017 by psychiatry. During regular post-suicide watch rounds the detainee was injured while banging his face on the wall and was sent to the hospital for psychiatric evaluation and medical treatment. He returned 2/3/2017 and was placed in the medical housing unit, discharged by psychiatry on 2/6/2017, but moved back to the medical housing unit after reporting increasing symptoms of mental illness and requesting to be placed back at the hospital. He was seen by mental health staff on 2/8/2017, 2/9/2017, 2/16/2017, and 2/17/2017 while housed in the special management unit.

(b) (6)

Admitted 3/5/2016. The detainee identified as transgender during the 3/5/2016 intake interview. The 3/8/2016 consult by the social worker notes that the detainee expressed no interest in surgical reassignment and wanted to remain in regular general population housing. No mental health services were requested by the detainee during the length of detention.

(b) (6)

Admitted 11/3/2016, the detainee denied being transgender during the intake interview by officer staff but acknowledged the status during the interview with mental health staff. The detainee was seen by mental health providers on 11/8/2016, 11/15/2016, 11/30/2016, and 12/20/2016 and transferred to another facility on 12/27/2016.

(b) (6)

Admitted 2/8/2017 with no transfer summary and no noted mental health needs. The detainee identified as transgender during the initial intake interview and received weekly mental health follow up through 2/24/2017. The detainee has been released from the facility.

(b) (6)

Admitted 2/16/2017 with no accompanying transfer summary. The intake interview noted no mental health needs, trauma history, criminal victimization, or other details indicative of a need for services. There were no clinical contacts requested since intake.

(b) (6)

Admitted 1/17/2017 with no accompanying transfer summary. The intake interview noted no mental health needs or traumatic history. He was placed into the special management unit on 1/31/2017 for disciplinary purposes and seen by mental health staff for rounds on 2/7/2017 before being removed on 2/9/2017.

(b) (6)

Admitted 12/19/2016 with no accompanying transfer summary. The intake interview noted no mental health needs, trauma history, criminal victimization, or other details indicative of a need for services. The initial mental health interview by psychiatry on 12/21/2016 noted history of depression and trauma and a diagnosis was noted. The detainee was seen by mental health staff on 1/5/2017 and 1/20/2017. She was placed into special management with no mental health needs noted and seen for regular rounds through 2/21/2017.

(b) (6)

Admitted 12/5/2016 with no accompanying transfer summary. The intake interview noted no mental health needs, trauma history, criminal victimization, or other details indicative of a need for services. The detainee was placed into the special management unit during his first week at the facility where he participated in mental health rounds and was noted to have no mental health needs. A referral was made to the psychiatrist by the LCSW who observed odd behavior but evaluation resulted in no diagnosis or medical intervention. Regular weekly rounds occurred until 2/8/2017 when the detainee fell in the shower and security staff identified that it was the first time the detainee showered in several months. 2/14/2017 and 2/21/2017 rounds were conducted as normal. On the dates of this onsite investigation, the detainee was noted by several staff – including mental health and security staff who were clearly aware of the concerns – to regularly engage in masturbatory behavior when out of his cell and to smear feces on his head routinely. He was in that state on the date of the visit.

(b) (6)

Admitted 4/13/2016 accompanied by a transfer summary. The psychiatrist noted a history of depression since 2009 after the detainee was attacked by a gang, a diagnosis of depression and PTSD was given, and psychiatric medication initiated. Routine psychiatric notes indicate stability on medications. Mental health contact by LCSW was refused on 1/27/2017.

(b) (6)

Admitted 12/13/2016 with no accompanying transfer summary. An interpreter was used for the 12/16/2016 intake interview where the detainee reported history of bipolar depression and schizophrenia. Psychiatric visit on 12/19/2016 offers a diagnosis of adjustment disorder with a trial of psychiatric medication. He was placed into the special management unit for fighting, released, and put into the unit again on 1/11/2017 after threatening a staff member. Regular rounds followed through 1/31/2017 and he remains at the facility in general population housing.

(b) (6)

Admitted 11/4/2016 with a known history of serious mental illness. A medication order arrived ahead of the detainee and he was placed at intake in the medical housing unit until interviewed by psychiatry on 11/7/2016 and placed into general population housing. He has participated in regular psychiatric follow up through 1/27/2017 with no medication changes.

(b) (6)

Admitted 1/29/2016 identifying as transgender but with no traumatic history, mental health needs, or history of hospitalization noted during the initial officer intake screen. The 2/5/2016 mental health intake interview noted a history of treatment for depression with history of suicide attempts. Medication was offered and follow up visits with psychiatrist occurred routinely through 6/3/2016 until release from detention.

(b) (6)

Latest admission date was 5/27/2015. He was seen by mental health staff for their initial interview on 6/10/2015 at the referral of a security officer. No mental health history was noted at that interview. The detainee requested mental health services on 6/13/2015 for reported anxiety and received supportive psychoeducation with follow-up by the mental health practitioner two days later. He was removed later that month on 6/29/2015.

(b) (6)

Admitted 1/7/2017 with no accompanying transfer summary and the timely intake interview noted no mental health needs. On 1/13/2017, he was seen by mental health staff after complaining of conditions in the detainee intake area including lack of phone calls, dirty toilets, and sleeping on the floor. He inflicted a superficial laceration on his left wrist with a razor blade and was transported to the emergency room where he refused medical treatment. He returned to the facility and was placed into the special management unit on suicide watch with a suicide smock and minimum property. Mental health staff conducted rounds on 1/14 and 1/15/2017 when the detainee indicated that the self-harm behavior was "attention seeking" and he was released from suicide watch. He remained in the special management unit for two additional days receiving mental health rounds and on 1/19/2017. Mental health staff reported he had been moved to the dorms and was experiencing no mental health concerns. The detainee was removed later that month on 1/24/2017.

(b) (6)

The detainee arrived on 11/4/2016 with no accompanying transfer summary. He acknowledge a 12-year history of depression. He was seen by a LCSW and Psychiatrist on 11/7. The detainee noted a history of suicide attempts, most recently in 2012, and he reported to the psychiatrist that he had been treated for Bipolar Disorder with psychotropic medications that he had not taken for three or four days. He reported a mental health history significant for psychiatric hospitalization, residential treatment, crisis intervention episodes, and multiple medication trials. Medications were prescribed that day. Two weeks later the detainee was seen again at the referral of medical staff, complaining that medications were not successful. He also made a complaint against an officer that resulted in a reported written complaint. He was seen by mental health staff twice in early December and was placed into the special management unit on 1/2/2017 for fighting. He received follow up appointments by psychologist and psychiatrist at weekly intervals until he refused psychology on 1/25/2017 and psychiatrist consult on three occasions -- 2/6/2017, 2/7/2017, and 2/9/2017. A 2/17/2017 note by psychiatrist indicates he was seen for another

suicide watch assessment after having been released from the special management unit for the previous fighting episode, engaging in another fight resulting in harm to another detainee, was placed back into the special management unit for disciplinary reasons, and attempted to hang himself. He was seen for mental health rounds on each of the following four days, released from suicide watch, and at the time of this onsite investigation, had experienced no further episodes.

(b) (6)

Admitted 1/20/2017 with prior history of placement at the facility. In 2014, there was noted to be multiple suicide watch placements and treatment in the local hospital prior to being removed that year. No transfer summary arrived with this detainee at the 1/20/2017 intake. He was noted at the intake screening to be experiencing suicidal ideation and indicated a history of schizophrenia currently receiving psychiatric medications. He was placed immediately in suicide watch in the special management unit. The detainee was seen by both nursing staff and psychologist on 1/21/2017, giving disparate reports regarding suicidality. Reports to nurse practitioner and psychiatrist the following three days indicated no self-harm concerns. He was removed from suicide watch on 1/24/2017 and removed that day.

(b) (6)

Admitted 12/30/2016 with no accompanying transfer summary. Medical staff ordered placement into the medical housing unit to evaluate for TB; the detainee indicated he would kill himself and was then put in suicide watch in the special management unit. He was seen by mental health staff the following two days and was released from suicide watch but placed in medical housing unit due to TB concerns on 1/2/2017. The detainee refused testing. On 1/12/2017 he cut his arm, demanding to be released from the medical housing unit and requesting to be removed. He was transported to the local hospital for a suicide risk assessment and treatment for TB, returned to the facility and placed in suicide watch in the medical housing unit where he remained on suicide watch until 1/16/2017 when he was released from that status but remained in the medical housing unit during planning for his deportation the week of 1/20/2017.

(b) (6)

Admitted 12/2/2016, the detainee arrived with no transfer summary and the intake interview noted no mental health needs, trauma history, or other details indicative of a need for services. On 12/18/2016, a nurse noted the presence of suicidal ideation and the detainee was put on suicide watch in the special management unit. The psychologist reviewed the detainee in suicide watch on 12/19/2016 and identified that he was low risk. There is no clear indication of the date the detainee was removed from suicide watch but mental health follow-up rounds occurred on 12/20/2016, 12/27/2016, and 12/28/2016. A 1/20/2017 psychology note indicated that there was no longer a need for mental health care. He remained at the facility at the time of this onsite investigation.

(b) (6)

Admitted 11/30/2016 with no accompanying transfer summary. At the 12/9/2016 intake visit by psychiatrist, the detainee reported suicidal ideation and a history of depression. He was placed

into suicide watch in the special management unit later that day and on 12/10/2016 he was seen by the nurse practitioner and reported that he was having a "crazy moment" and was not suicidal. He was removed from suicide watch, participated in follow-up appointments on 12/12/2016 and 12/15/2016. He was removed on 1/13/2017.

(b) (6)

Admitted 12/5/2016. The detainee identified at intake that he was having suicidal ideation and had a plan to stab himself. The psychologist placed him into suicide watch in the special management unit. He was returned to the general population the following day and seen on 12/7/2016, 12/9/2016, and 1/5/2017 by psychology with no concerns and no need for follow-up noted. He was discharged from the facility on 1/20/2017.

(b) (6)

Admitted 11/6/2015 with no accompanying transfer summary. At intake the detainee noted a history of anxiety. On 11/17/2015, he wrote mental health providers demanding to be classified in "orange" status and threatening a hunger strike. No further information regarding that threat was in the file. On 12/3/2015, staff identified that the detainee was engaging in a hunger strike and he was placed into the special management unit noting on 12/4/2015 that he would not eat until he received medications and better food. Crushed medications were ordered on 12/8/2015 following an episode of misusing medications and he was released from the special management unit on 12/15/2015. He was placed back into the special management unit soon after for disrespecting an officer. He remained in the special management unit receiving timely mental health and medical rounds until 2/3/2016 when he threatened suicide and was placed into suicide watch in the special management unit, seen by psychiatry, and identified as having a serious mental illness. He had timely mental health rounds until 2/11/2016 when he complained about an officer, and then had consults with mental health practitioners five times between 2/15/2016 and 3/16/2016. He was placed back into the special management unit on 3/16/2016 after reporting suicidal ideation to the psychiatrist. He was moved back into general population after 4/1/2016, returned to the unit after fighting with another detainee, had psychiatry consult on 4/18/2016 and 4/19/2016, and was seen by mental health staff on 4/20/2016 when he reported another hunger strike. He was seen by metal health providers in the special management unit on six occasions between 4/20/2016 and 5/24/2016, then seen in general population on 5/26/2016 and 5/31/2016. On 7/26/2016 the detainee again threatened misbehavior if he did not get better food but remained in general population for his next psychiatric visit on 8/24/2016. The detainee called in a suicide threat to the ICE hotline on 9/7/2016 and was placed into suicide watch in the special management unit that day, released from that status 9/9/2016 with normal mental health rounds on 9/9/2016, 9/11/2016, and 9/15/2016 and on 10/4/2016 for medication management. He was placed back into the special management unit on 11/2/2016 and received weekly rounds through 1/16/2017 when he again complained about an officer. Rounds continued weekly through 2/26/2017 when he again announced a hunger strike with follow-up by nursing staff on 2/27/2017. He remains at the facility.

(b) (6)

Admitted 1/7/2016, the intake process identified no mental health needs or medications upon arrival. On 6/13/2016, the detainee was placed into the special management unit for fighting and seen by psychology for normal timely rounds through 8/30/2016 when he requested to remain in the special management unit for protective custody. He was seen weekly from 8/30/2016 through 2/28/2017 for typical mental health rounds with no issues ever noted. He remains at the facility.

(b) (6)

Admitted 8/10/2015, the intake process identified no mental health needs and she was initially placed into the dorms. At a 9/17/2015 contact, mental health staff noted adjustment difficulty in the dorm. The detainee acknowledge traumatic history and requested therapeutic intervention. She remained in the dorm until 11/12/2015 when she requested protective custody, seeking to be away from others in the general housing unit. Weekly rounds were routinely conducted after she was placed into the special management unit until 12/16/2015. There was no documentation of mental health contact from 12/16/2015 through 7/19/2016. Regular weekly rounds were documented again beginning 7/19/2016 through 2/21/2017, with additional contacts noted during which the LCSW attempted to encourage contact in the medical clinical on several occasions in an effort to support interaction with other detainees. On at least one occasion on which the detainee was scheduled to come to the medical clinic (12/21/2016) the appointment had to be cancelled due to male detainees being in the clinic. On another occasions the detainee refused the visit. The detainee remains in protective custody in the special management unit.

(b) (6)

Admitted 1/27/2016 with no transfer summary, at intake the detainee noted a history of schizophrenia and mood disorder, and indicated that he is intimidated by "intelligent people." He was seen by psychiatry for intake visit on 1/29/2016 with added diagnosis of low IQ and followed again 2/5/2016 by the LCSW. On 2/23/2016 he was placed into the special management unit and received regular rounds on 2/24/2016 and 3/2/2016. Psychiatric follow-up occurred on 3/8, 3/9, 3/15, 3/24, 4/14, 4/21, and 5/26/2016 as medications were adjusted. The detainee requested protective custody on 7/5/2016 and participated in weekly rounds and timely medication consultation through 2/21/2017. He remains at the facility in protective custody.

Appendix 2. LIST OF DETAINEES INTERVIEWED

(b) (6)

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