

**SUMMARY OF PROFESSIONAL STANDARDS
GOVERNING MENTAL HEALTH SERVICES
IN PRISONS AND JAILS**

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INTRODUCTION:

There are approximately 1.6 million people incarcerated in prisons or jails in the United States, and the number continues to increase each year. Studies indicate that the incidence of mental illness is substantially greater in prison than in the community. At any given time at least 7% of all incarcerated individuals suffer from a major mental illness, and an additional 10 to 30% of the prison population is likely to require mental health services at some point during their incarceration. Despite the great need for mental health treatment in correctional facilities, however, available services in many, if not most, prisons and jails are woefully inadequate.

Since there is little public or political support for quality mental health care for offenders with mental illness, prisoners are almost entirely dependent on the courts for the protection of their right to treatment. However, it is often difficult for advocates who are not familiar with correctional environments to make an informed assessment of mental health services within a particular facility. The constitutional law in this area, although extensive, is often murky and inconsistent. See "Annotated List Of Cases Relating To Treatment For Persons With Mental Illness In Prisons And Jails," Center for Public Representation (1997). Moreover, since the Constitution only requires the absolute minimum level of services, an adequate mental health system may well demand something better.

In an effort to simplify the task of evaluating whether there are deficiencies in mental health care in correctional settings, we have compiled a comprehensive summary of available standards, established by professional organizations and accrediting bodies, that set forth the basic components of an adequate mental health system in a prison or jail. It is our hope that the summary can be used by advocates as a check-list to evaluate services to persons with disabilities in correctional settings. Although each professional organization has its own views on any particular aspect of mental health care, we have extracted from the professional standards an outline of the generally accepted essential components of an adequate correctional mental health system. We have then annotated each component with references to the relevant professional standards. Although the annotations generally quote the exact language of the relevant standard, in order to keep within manageable limits, the complete standard is not always provided, nor is every relevant standard necessarily listed. We have also omitted commentary and other supplementary material that appears in the publications of the professional organizations containing the standards. We therefore urge advocates to refer to the standards themselves for citation purposes, and to check for additional information that may not be in the summary. Advocates should also keep in mind that many states have their own statutes and regulations governing some or all aspects of prison mental health care. These statutes and regulations are often modeled on the professional standards.

Although the professional standards may well exceed the constitutional floor,

courts often utilize them both to analyze the quality of mental health care and to devise remedies for conditions found to be unlawful. Accordingly, the annotations contain citations to a selection of cases where the court has ruled that the substance of the standard coincides with constitutional mandate. The annotations also reference a selection of useful articles from law reviews or professional journals that bear on the subject.

We hope that this summary is helpful to advocates working in prisons and jails, and we welcome questions and comments from all who have the opportunity to use it.

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T. Howard Stone, *Therapeutic Implications Of Incarceration For Persons With Severe Mental Disorders: Searching For Rational Health Policy*, 24 Am. J. Crim. L. 283 (1997).

1. Introductory Principles

a. Mental health care should be available to all inmates who need it.

Standards for Health Servs. in Correctional Institutions., Mental Health Care Services § A, at 27 (American Pub. Health Ass'n 1976) ("*Principle*: Mental health services should be made available at every correctional institution. *Public Health Rationale*: Any person should be able to seek mental health care. Moreover, the very fact of incarceration may create or intensify the need for mental health services."); *Standards for Adult Correctional Institutions*. § 3-4331 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) (mandatory) ("Written policy, procedure, and practice provide for unimpeded access to health care."); *ABA Criminal Justice Mental Health Standards* § 7-2.6(a) (American Bar Association 1984) (postarrest obligations of police and custodial personnel) ("It is the responsibility of custodial officials to ensure that mental health and mental retardation services are provided for detainees."); *Standard Minimum Rules for the Treatment of Prisoners: Resolution of the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders*, E.S.C. Res. 663C, U.N. ESCOR, 24th Sess., Supp. No. 1, ¶ 22(1), U.N. Doc. A/CONF/611 (1955), amended by E.S.C. Res. 2076, U.N. ESCOR, 62d Sess., Supp. No. 1, at 35, U.N. Doc. E/5988 (1977) (medical services) ("At every institution there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry. The medical services . . . shall include a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality."); *id.*, ¶ 62 (prisoners under sentence) ("The medical services of the institution shall seek to detect and shall treat any physical or mental illnesses or defects which may hamper a prisoner's rehabilitation. All necessary medical, surgical and psychiatric services shall be provided to that end."); *id.*, ¶ 82(4) (insane and mentally abnormal prisoners) ("The medical or psychiatric service of the penal institutions shall provide for the psychiatric treatment of all other prisoners [than those removed to mental or specialized institutions] who are in need of such treatment.").

b. Mental health care available to inmates must be equivalent to that in the community.

National Comm'n on Correctional Health Care, *Position Statement: Mental Health Services in Correctional Settings* § 1 (1992) ("All correctional institutions should be required to meet recognized community standards for mental health services as promoted by standards set by organizations such as the National Commission on Correctional Health Care, the American Psychiatric Association, and the American Public Health Association"); American Psychiatric Ass'n, *Principles Governing the Delivery of Psychiatric Services in Lock-Ups, Jails and Prisons, in Psychiatric Services in Jails and Prisons, Task Force Report 29*, § B.1.a (1989) ("The fundamental policy goal should be to provide the same level of mental health services to patients in the criminal justice process that are available in the community"); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 32 discussion, at 109 (1980) ("Transfer . . . for clients who require intensive treatment should occur when the quality of available services within the correctional facility is not equivalent to that found in

local community facilities.");

c. Mental Health decision-makers must be independent of other prison officials.

Standards for Adult Correctional Insts. § 3-4327 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) (mandatory) ("Written policy, procedure, and practice provide that all medical, psychiatric, and dental matters involving medical judgement are the sole province of the responsible physician and dentist, respectively."); *id.*, § 3-4331 comment ("No member of the correctional staff shall approve or disapprove requests for attendance at sick call."); *Foundation/Core Standards for Adult Local Detention Facilities* § FC2-5076 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 1989) (mandatory) ("Medical, dental, and mental health matters involving medical judgements are the sole province of the responsible physician, dentist, and psychiatrist or qualified psychologist."); *Fed. Standards for Prisons and Jails* § 5.02 (U.S. Dept. of Justice 1980) ("The designated responsible physician is under no restrictions imposed by the facility administration regarding medical decisions; however, security regulations applicable to facility personnel also apply to health personnel"); *id.*, § 5.19 ("No inmate or correctional officer inhibits or delays an inmate's access to medical services or interferes with medical treatment"); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 05, at 89 (1980) (essential) ("The psychologists, and the staff activities for which these individuals are responsible, have professional autonomy regarding psychological services, within the constraints of appropriate security regulations applicable to all institutional personnel"); *id.* (discussion) ("Psychological services personnel need to be granted sufficient autonomy to practice their profession, since in these matters their training makes them the best qualified to make appropriate psychological judgments."); American Psych. Ass'n, *General Guidelines for Providers of Psychological Services* § 3.2, at 8 (1987) ("Psychologists pursue their activities as members of the independent, autonomous profession of psychology."); *id.* (illustrative statement) ("Psychologists, as member of an independent profession, are responsible both to the public and to their peers through established review mechanisms. Psychologists are aware of the implications of their activities for the profession as a whole."). *Standards for Health Services in Prisons*, National Comm'n on Correctional Health Care, P-03 (essential)(1997) ("Written policy and defined procedures require, and actual practice evidences, that clinical decisions and actions regarding the health services provided to inmates are the sole responsibility of *qualified health care professionals* and are not compromised for security reasons.")

2. Preliminary Mental Health Screening of Incoming Prisoners and Referrals for Treatment

a. Prisons and jails must have a system to screen incoming inmates to identify those with mental illness.

Standards for Adult Correctional Institutions, § 3-4343 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990);("Written policy, procedure, and

practice require medical, dental, and mental health screening to be performed by health-trained or qualified health care personnel on all inmates, excluding intrasystem transfers, upon the inmate's arrival at the facility."); *id.*, § 3-4343 (intrasystem transfers are to receive a health screening upon arrival); *Standards for Health Services in Prison*, National Comm'n on Correctional Health Care, P-32, at 41 (1997) ("Written policy and defined procedures require, and actual practice evidences, that *receiving screening* is performed by qualified health care personnel on all inmates immediately upon their arrival at the prison. Persons who are . . . mentally unstable, or otherwise urgently in need of medical attention are referred immediately for emergency care."); *Standards for Health Services in Jail*, National Comm'n on Correctional Health Care, J-30 (1996) (same);

American Psychiatric Ass'n, *Guidelines for Psychiatric Services in Jails and Prisons, in Psychiatric Services in Jails and Prisons, Task Force Report 29*, § C.1.b(1)(a) (jails) (1989) ("Immediately upon admission to the jail, inmates should be asked questions pertaining to their mental health"); *id.*, § D.1.b(1)(a) (prisons) ("Receiving mental health screening will be carried out immediately upon admission to the prison"); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 23, at 103 (1980) (essential) ("Receiving screening is performed on all inmates upon admission to facility before being placed in the general population or housing area. . . . Inmates identified as having mental problems are referred for a more comprehensive psychological evaluation."); *id.* (discussion) (screening must be done *immediately* at the time of booking or admission. Placing two or more inmates in a holding cell/room pending screening several hours later or the next morning fails to meet compliance); *Fed. Standards for Prisons and Jails* § 5.15 (U.S. Dept. of Justice 1980) ("Written policy and procedure provide that receiving screening is performed on all inmates by qualified health personnel or a specially trained correctional officer upon admission to the facility before the inmate is placed in the general population or housing area."); *Standard Minimum Rules for the Treatment of Prisoners: Resolution of the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders*, E.S.C. Res. 663C, U.N. ESCOR, 24th Sess., Supp. No. 1, ¶ 24, U.N. Doc. A/CONF/611 (1955), amended by E.S.C. Res. 2076, U.N. ESCOR, 62d Sess., Supp. No. 1, at 35, U.N. Doc. E/5988 (1977) (medical services) ("The medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary, with a view particularly to the discovery of physical or mental illness and the taking of all necessary measures; . . . the noting of physical or mental defects which might hamper rehabilitation"); James R.P. Ogloff et al., *Screening, Assessment, and Identification of Services for Mentally Ill Offenders, in Mental Illness in America's Prisons* 61, 64 (Henry J. Steadman and Joseph J. Cocozza eds. [National Coalition for the Mentally Ill in the Criminal Justice System], 1993) (writing that the mandated medical examination given at admission "must also include a screening for mental illness."); Fred Cohen, *The Legal Context for Mental Health Services, in Mental Illness in America's Prisons* 25, 56 (Henry J. Steadman and Joseph J. Cocozza eds. [National Coalition for the Mentally Ill in the Criminal Justice System], 1993) (stating that to learn how many seriously mentally ill inmates are in their care, prison officials must have "some type of initial screening and assessment, some regular follow-up, and some type of decent record-keeping. The epidemiological question is not satisfactorily answered by simply consulting medication lists, since in many jurisdictions

such lists include the dispensing of tranquilizers or sleep aides and, thus, are not parallel to a list of the mentally ill.").

See also *Madrid v. Gomez*, 889 F. Supp. 1146, 1218 (N.D. Cal. 1995) ("It is important that a mental health care system effectively identify those inmates in need of mental health services, both upon their arrival at the prison and during their incarceration. . . . [M]entally ill prisoners may not seek out help where the nature of their mental illness makes them unable to recognize their illness or ask for assistance."); *Langley v. Coughlin*, 715 F. Supp. 522, 540 (S.D.N.Y. 1989), *aff'd*, 888 F.2d 252 (2nd Cir. 1989) (finding "failure to take into account the inmate's prior psychiatric history" would be violation of Eighth Amendment); *id.* at 541 ("failure to inquire about the patient's prior history reflects a pattern of inadequate medical care to the mentally ill inmates housed on SHU [Special Housing Unit].");

Arnold on behalf of H.B. v. Lewis, 803 F. Supp. 246 (D. Ariz. 1992); *Balla v. Idaho State Bd. of Corrections*, 595 F. Supp. 1558, 1577 (D. Idaho 1984) (quoting *Ruiz*, 503 F. Supp. at 1545) (quoted in *Madrid v. Gomez*, 889 F. Supp. 1146, 1256-57 (N.D. Cal. 1995)) (stating that there must be a "systematic program for screening and evaluating inmates in order to identify those who require mental health treatment."); *Barnes v. Government of Virgin Islands*, 415 F. Supp. 1218 (D.V.I. 1976); *Coleman v. Wilson*, 912 F. Supp. 1282, 1995 WL 559109, *5 (E.D. Cal. 1995) (finding Eighth Amendment violation where "defendants do not have an adequate mechanism for screening inmates for mental illness, either at the time of reception or during incarceration."); *id.* at *12 ("The magistrate judge found that "[i]n order to provide necessary mental health care to prisoners with serious mental disorders, there must be a system in place to identify those individuals, both at the time they are admitted to the Department of Corrections and during their incarceration."); *Ruiz v. Estelle*, 503 F. Supp. 1265 (S.D. Tex. 1980), *aff'd in part and rev'd in part*, 679 F.2d 1115 (5th Cir. 1982), *cert. denied*, 460 U.S. 1042 (1983).

b. Contents of the Preliminary Mental Health Screening

Standards for Adult Correctional Institutions. § 3-4344 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) (mandatory) (preliminary screening) ("All findings are recorded on a screening form approved by the health authority. The screening includes at a minimum the following: Inquiry into whether the inmate is being treated for a medical, dental, or mental health problem; whether the inmate is presently on medication; whether the inmate has a current medical, dental, or mental health complaint; Observation of general appearance and behavior . . ."); National Comm'n on Correctional Health Care, *Standards for Health Services in Prison* P-32, at 41 (1997)(essential) (Receiving Screening) ("At minimum, the screening process includes the following: (1) Inquiry into current and past illnesses, health problems, and conditions including . . . mental illness including suicide risk. . . (2) Observation of the following: behavior, which includes state of consciousness, mental status (including suicidal ideation), appearance, conduct, tremors, [other indicators of medical problems] and needle marks or other indications of drug abuse. 4) Notation of the disposition of the patient, such as immediate referral to an appropriate health care service, placement in the general inmate population and the later referral to an appropriate health care service, or placement in the inmate population. 5)

Documentation of the date and time when referral/placement actually takes place."); National Comm'n on Correctional Health Care, *Standards for Health Services in Jail* J-30, at 41 (1996) (same); American Psychiatric Ass'n, *Guidelines for Psychiatric Services in Jails and Prisons, in Psychiatric Services in Jails and Prisons, Task Force Report 29*, § C.1.a(1) (jails) (1989) ("Receiving mental health screening consists of observation and structured inquiry designed to prevent newly arrived inmates, who may be acutely or chronically mentally ill, from being admitted to the facility's general population and to refer these inmates rapidly for a more full scale mental health evaluation."); *id.*, § C.1.b(1)(a) (jails) ("Immediately upon admission to the jail, inmates should be asked questions pertaining to their mental health, i.e., suicide potential, prior psychiatric hospitalizations, and current medications, both being taken and prescribed."); *id.*, § D.1.a(1) (prisons) ("Receiving mental health screening consists of observation and structured inquiry designed to assure that the prisoner newly arriving at the facility or reception center, who may require mental health evaluation as a result of mental illness or developmental disability, is referred for mental health evaluation and is placed in the proper living environment."); *id.*, § D.1.b(1)(a) (prisons) ("Receiving mental health screening . . . will include the review of pertinent records accompanying the inmate. It will also include inquiry into past mental health treatment and screening questions designed to identify the signs of severe emotional, intellectual, and/or behavioral problems such as hallucinations, suicidal and/or homicidal thinking, severe thought disorganization, or bizarre behavior."); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons, 7 Crim. Just. & Behav.* 81, § 23, at 103 (1980) (discussion) ("The method of receiving screening should include: (a) a review of papers or records accompanying the inmate; (b) completion of the receiving screening form with the help of the inmate—i.e., a review of the inmate's history concerning suicidal behavior, sexual deviancy, mental health history (including alcohol and other substance abuse), mental hospitalizations, seizures, patterns of violence and aggression; and (c) visual observation of the inmate's behavior (looking for signs of delusions, hallucinations, communication difficulties, peculiar speech and/or posturing, impaired level of consciousness, disorganization, memory deficits, depression, and evidence of self-mutilation)."); *Fed. Standards for Prisons and Jails* § 5.15 (U.S. Dept. of Justice 1980) ("Where receiving screening is performed by a correctional officer and full exposure of the body is required, the officer is of the same sex as the inmate. The findings are recorded on a printed screening form approved by the health authority. The screening includes the following: . . . Behavioral observation, including state of consciousness and mental status, appearance, conduct, tremor and sweating.").

c. Preliminary screenings must be conducted in a confidential atmosphere.

Deborah L. Dennis, *The National Work Session: Recommendations for Action, in Mental Illness in America's Prisons* 213, 215 (Henry J. Steadman and Joseph J. Cocozza eds. [National Coalition for the Mentally Ill in the Criminal Justice System], 1993) ("Screening should be conducted in a setting respectful of the privacy and dignity of the inmate, and where sensitive and valid information may be obtained."). See also American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons, 7 Crim. Just. & Behav.* 81, § 06, at 90 (1980) (discussion) ("Physical arrangements should be conducive to human dignity, self-respect, and promoting the optimal functioning

of both the inmate clients and the professional staff members. [Necessary equipment includes] a desk, a desk chair, . . . at least one comfortable chair (preferably with armrests) for the clients, . . . an office with walls to the ceiling and no windows (or with drapes which can be drawn for privacy).").

d. Screeners need training in mental illnesses.

American Psychiatric Ass'n, *Guidelines for Psychiatric Services in Jails and Prisons, in Psychiatric Services in Jails and Prisons, Task Force Report 29*, § C.1.b(1)(c) (1989) (jails) ("Receiving mental health screening is usually done primarily by the booking officer. Special training in mental health screening should be provided to the officers who perform this task."); *id.*, § b(1)(e) (jails) ("Psychiatrists [role includes] (ii) training officers to use the screening instrument."); *id.*, b(2)(c) (jails) ("The intake mental health screening should be performed by a member of the health care staff."); *id.*, § D.1.b(1)(c) (prisons) ("Receiving mental health screening should be performed by a qualified mental health professional or by a trained correctional officer at the time of admission."); *id.*, b(1)(e) ("Psychiatrists' role in the provision of receiving mental health screening [includes (ii)] ongoing training of correctional officers and health and mental health personnel in the use of receiving mental health screening forms and procedures."); *id.*, b(2)(c) (prisons) ("The intake mental health screening should be performed by a member of the health care staff."); *id.*, b(2)(e) (stating that psychiatrists' primary roles in intake mental health screening includes "(i) the development of the appropriate intake mental health screening forms and informational material [and] (ii) the training of health care staff in the use of mental health screening forms and the informational (orientation) materials."); *id.*, b(3)(c) ("Mental health evaluations or consultations are performed by an appropriately trained mental health professional").

See also *Langley v. Coughlin*, 715 F. Supp. 522 (S.D.N.Y. 1989), *aff'd*, 888 F.2d 252 (2nd Cir. 1989); *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995) (stating that screening must be performed by people with proper training and background).

3. Mental Health Assessment of All Inmates

a. All newly committed inmates should receive a detailed mental health evaluation shortly after admission.

Standards for Adult Correctional Institution § 3-4345 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) (Full Health Appraisal) ("Written policy, procedure, and practice require that health appraisal for each inmate, excluding intrasystem transfers, is completed within 14 days after arrival at the facility."); *Standards for Health Services in Prison*, National Comm'n on Correctional Health Care P-35, at 46 (1997)(essential) (mental health evaluation) ("Written policies and defined procedures require, and actual practice evidences, post-admission evaluation of all inmates by qualified mental health personnel [physicians, psychiatrists, psychologists, nurses, physician assistants, psychiatric social workers, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients] within 14 days of admission."); *Standards for Health Services in Jail*, National Comm'n on Correctional Health Care P-39, at 50 (1996) (same); American

Psychiatric Ass'n, *Guidelines for Psychiatric Services in Jails and Prisons, in Psychiatric Services in Jails and Prisons, Task Force Report 29*, § C.1.b(2)(a) (1989) (jails) ("Intake mental health screening should take place within 24 hours of admission to a jail."); *id.*, § D.1.a(2) (prisons) ("Intake mental health screening may take place somewhat later [than receiving mental health screening]."); *id.*, § D.1.b(2)(a) (prisons) ("Intake mental health screening should take place within seven days of admission to a prison or reception center."); *Fed. Standards for Prisons and Jails* § 5.16 (U.S. Dept. of Justice 1980) ("Health appraisal data collection is completed for each inmate within fourteen days after admission to the facility . . . If a health appraisal as required herein has been completed within the previous 90 days prior to admission to the facility and all results have been transferred, the recollection of this data may be waived at the discretion of the responsible physician."); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons, 7 Crim. Just. & Behav.* 81, § 24, at 104 (1980) (essential) ("In a prison setting, all newly committed inmates with sentences over one year shall be given a psychological evaluation within one month of admission.").

b. Contents of Mental Health Assessment

National Comm'n on Correctional Health Care, *Standards for Health Services in Prison* P-34, at 44 (1997)(essential) (health assessment) ("A full health assessment . . . includes these items: a review of the receiving results; the collection of additional data to complete the medical, dental, and mental health histories; . . . a physical examination including comments about mental status"); *id.*, P-35, at 46 (mental health evaluation)(discussion)("The post-admission mental health assessment includes: (1) a structured interview by *mental health staff* in which inquiries into the items listed below are made: history of psychiatric hospitalization and outpatient treatment; current psychotropic medications; suicidal ideation and history of suicidal behavior, drug usage, alcohol usage, history of sex offenses; history of expressly violent behavior; history of victimization, special education placement, history of cerebral trauma or seizures, and emotional response to incarceration"); National Comm'n on Correctional Health Care, *Standards for Health Services in Jail*, J-39, at 50-51 (1996) (same); *Standards for Adult Correctional Institutions*. § 3-4345 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) (Full Health Appraisal) ("Health appraisal includes the following: review of the earlier receiving screening; collection of additional data to complete the medical, dental, mental health, and immunization histories; . . . other tests and examinations as appropriate; medical examination, including review of mental and dental status; . . . initiation of therapy when appropriate."); American Psychiatric Ass'n, *Guidelines for Psychiatric Services in Jails and Prisons, in Psychiatric Services in Jails and Prisons, Task Force Report 29*, § C.1.a(2) (1989) (jails) ("Intake mental health screening is a component of the full scale admission workup and consists of a detailed medical and mental health examination."); *id.*, § D.1.a(2) (prisons) "Intake mental health screening . . . consists of a more detailed, thorough, and structured mental health examination which is administered to all recently arriving prisoners as part of the facility's admission process."); *Fed. Standards for Prisons and Jails* § 5.16 (U.S. Dept. of Justice 1980) ("Health appraisal data collection . . . includes . . . additional data to complete the medical, immunization, and mental health history."); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in*

Adult Jails and Prisons, 7 *Crim. Just. & Behav.* 81, § 24, at 104 (1980) (essential) ("Such routine [psychological] evaluations are brief and include (but are not necessarily limited to) behavioral observation, a records review, group testing to screen for emotional and intellectual abnormalities, and a written report of initial findings. Referral for more intensive, individual assessment is made when appropriate.").

4. Follow up Referrals from Preliminary Screening and Mental Health Assessment

a. Inmates should receive a thorough psychiatric evaluation within a short period after staff make a referral

Standards for Adult Correctional Insts. § 3-4349 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) ("Written policy, procedure, and practice, approved by the health authority, provide for comprehensive individual evaluation by a multidisciplinary mental health team for specially referred inmates. The evaluation is completed within 14 days after the date of referral and includes at least the following: review of mental health screening and appraisal data; direct observations of behavior; collection and review of additional data from individual diagnostic interviews and tests assessing personality, intellect, and coping abilities; compilation of the individual's mental health history; development of an overall treatment/management plan with appropriate referral."); American Psychiatric Ass'n, *Guidelines for Psychiatric Services in Jails and Prisons*, in *Psychiatric Services in Jails and Prisons*, Task Force Report 29, § D.1.b(1)(c) (1989) ("Where receiving mental health screening is done primarily by a trained correctional officer, written policies and procedures will define a mechanism for prompt referral to and evaluation by a mental health professional where appropriate."); *id.*, b(2)(e)(iii) (stating that psychiatrists' primary role in intake mental health screening includes "the development of written referral procedures for inmates identified during the intake mental health screening as [sic] process as requiring mental health evaluation"); *id.*, b(3)(a) ("Specific written procedures providing for . . . referral shall be part of the facilities [sic] mental health services plan."); *id.*, § C.1.a(3) (1989) (jails) ("Mental health evaluation is a comprehensive mental health examination which is appropriate to the particular, suspected level of disability and which is focused on the suspected mental illness or developmental disability."); *id.*, § C.1.b(3)(a) (jails) ("Mental health evaluation shall be provided within 24 hours from the time of referral. In cases of urgency, provision shall be made for immediate evaluation upon referral. Referral may be made by (i) a screening procedure, (ii) custodial staff, or (iii) self-referral."); *id.*, § D.1.b(3)(a) (prisons) ("Mental health evaluation or an appropriate alternative response shall be provided in no more than 24 hours from the time of referral. In cases of urgency, provision shall be made for immediate evaluation upon referral."); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 27, at 106 (1980) (essential) ("Crisis evaluations should be conducted as soon as possible, but not later than 24 hours after the staff member has been notified. Subsequently, a report of the session(s) is written and appropriately filed."); *id.* (discussion) ("Qualified psychological services personnel conduct these crisis evaluations. Facility staff should have sufficient training to provide adequate supportive care until the evaluation can be made."); *id.*, § 26, at 105-06

(essential) ("The individual assessment of all inmates referred for a special comprehensive psychological appraisal is completed within 14 days after the date of the referral. . . . This standard as applied in a prison setting includes: (a) Reviewing earlier screening information and psychological evaluation data. (b) Collecting and reviewing any additional data to complete the individual's mental health history, (c) collecting additional data from observations by correctional staff, (d) administering tests which assess levels of cognitive and emotional functioning and the adequacy of coping mechanisms, (e) writing a report describing the results of the assessment procedures, including an outline of a recommended plan of treatment which mentions any indication by the inmate of a desire for help, (f) communicating results to referral source, and (g) writing and filing a report of findings and recommendations.").

5. Monitoring and Diagnosis of Inmates with Mental Illness

a. Every correctional facility must have procedures for custody staff and inmates to refer inmates needing mental health treatment or evaluation.

American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 22, at 102 (1980) (essential) ("There is a written, implemented policy approved by the chief psychologist (and in accordance with headquarters guidelines in a multifacility system) regarding access to psychological services for (1) postadmission inmates with emergency problems and for (2) daily referrals of nonemergency problems covering both scheduled and unscheduled care."); *id.* (discussion) ("Institution staff should refer to psychological services personnel those inmates in the general population who are suspected of emotional disturbance. Correctional officers or jailers, all of whom should be trained in recognition of symptoms of mental disturbance, provide 24-hour-a-day observation and are available to receive complaints of this nature from inmates. The obligation of these staff members is to pass this information along to psychological services personnel for screening/triaging or assignment of treatment priorities, followed by referrals for treatment as indicated."); *Foundation/Core Standards for Adult Local Detention Facilities* § C2-5182 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 1989) (certification standard) ("Written policy and procedure require postadmission screening and referral for care of mentally ill or retarded inmates whose adaptation to the correctional environment is significantly impaired."); American Psychiatric Ass'n, *Guidelines for Psychiatric Services in Jails and Prisons*, in *Psychiatric Services in Jails and Prisons*, Task Force Report 29, § C.1.b(3)(a) (1989) (jails) ("Mental health evaluation shall be provided within 24 hours from the time of referral. In cases of urgency, provision shall be made for immediate evaluation upon referral. Referral may be made by . . . (ii) custodial staff, or (iii) self-referral. Specific written procedures providing for these types of referral shall be part of the facility's mental health services plan."); *ABA Criminal Justice Mental Health Standards* § 7-2.6(b) (American Bar Association 1984) (postarrest obligations of police and custodial personnel) ("When arresting or custodial officers or other personnel observe a detainee whose conduct or demeanor is indicative of mental illness or mental retardation, mental disturbance, disorientation or distress, or whose behavior is self-injurious or is indicative of the possibility

of suicide, such officers or personnel have a duty to report those observations promptly to the official in charge of the detention or holding facility. Such official, after promptly confirming the need to do so, should summon a mental health or mental retardation professional to provide emergency evaluation, treatment, or habilitation."); *Fed. Standards for Prisons and Jails* § 5.29 (U.S. Dept. of Justice 1980) ("Written policy and procedure require that screening and referral for care are provided to mentally ill or retarded inmates whose adaptation to the correctional environment is significantly impaired.").

See also *Madrid v. Gomez*, 889 F. Supp. 1146, 1219 (N.D. Cal. 1995)(It is insufficient for a prison to rely upon mental health referrals from custody staff and inmates; staff psychiatrists and psychologists should visit the cellblocks regularly.); *Langley v. Coughlin*, 715 F. Supp. 522, 541 (finding that "an absence of criteria for DOCS [Department of Correctional Services] personnel to follow concerning when to make referrals to OMH [Office of Mental Health] "reflects a pattern of inadequate medical care to the mentally ill inmates housed on SHU [Special Housing Unit]."); James R.P. Ogloff et al., *Screening, Assessment, and Identification of Services for Mentally Ill Offenders, in Mental Illness in America's Prisons* 61, 64 (Henry J. Steadman and Joseph J. Cocozza eds. [National Coalition for the Mentally Ill in the Criminal Justice System], 1993) ("[M]any inmates, who develop mental health problems after being incarcerated, or whose problems become more severe under those circumstances, fall between the cracks left open by limiting mental health assessments to the time of admission and following crisis episodes. For this reason, it is important for prisons to implement a comprehensive screening and evaluation program, and to involve all personnel working with inmates in prisons in the process of continuously identifying inmates who may display symptoms of mental illness and who may require intervention." "[I]t is important for mental health programs in prisons to include formal and informal mechanisms for personnel to make referrals to the programs. For example, corrections officers should be able to talk with mental health personnel about an inmate who they notice to have undergone serious changes in mood or behavior. Likewise, there should be a formal process for staff and duty officers to refer inmates to the mental health program").

6. Mental Health Treatment Modalities

a. Correctional facilities must provide a range of treatment modalities to inmates with mental disabilities.

Standards for Adult Correctional Institutions. § 3-4380 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990), § 3-4386 ("Treatment offerings should include group therapy and group and individual counseling."); *Fed. Standards for Prisons and Jails* § 5.30 (U.S. Dept. of Justice 1980) ("Special programs exist for . . . (2) inmates with severe emotional disturbances, and (3) retarded and developmentally disable inmates who require close medical, psychiatric, psychological, or habilitative supervision. A written individualized plan for each of these inmates is approved by a physician or qualified mental health professional after appropriate multidisciplinary consultation and in accord with written policy. The plan includes directions to medical and nonmedical personnel regarding their roles in the care, supervision and habilitation of these inmates."); American

Psychiatric Ass'n, *Guidelines for Psychiatric Services in Jails and Prisons*, in *Psychiatric Services in Jails and Prisons, Task Force Report 29*, § D.3.a(1) (1989) (prisons) ("Given the relatively long-term nature of prison confinement, a wider range of mental health treatment modalities [than needed in lock-ups and jails] will be called for. These include: (1) a full range of appropriate mental health treatment services as described in the principles." (citing American Psychiatric Ass'n, *Principles Governing the Delivery of Psychiatric Services in Lock-Ups, Jails and Prisons*, in *Psychiatric Services in Jails and Prisons, Task Force Report 29*, § F.5 (referring to "a. an acute care program, b. a chronic care program, c. a transitional care program, and d. an outpatient treatment program." As part of providing a therapeutic milieu, prisons must assure "the availability of mental health personnel and regular access to such personnel by the inmate population." "Psychotherapies of different types, including individual and group, supportive, and insight, should be available as needs require and resources can provide. Group therapy programs have been found to be especially suitable in these settings and to particular patient populations including substance abusers, sex offenders, etc. . . . Behavior modification programs may be helpful, but they must require informed consent and must have external, independent, professional monitoring. Family therapy programs are to be especially encouraged.")); American Psychiatric Ass'n, *Guidelines for Psychiatric Services in Jails and Prisons*, in *Psychiatric Services in Jails and Prisons, Task Force Report 29*, § C.3.a (jails) ("Considering the short-term nature of most jail confinements, treatment will generally emphasize the prescription of psychotropic medications. For those inmates whose pre-trial confinements or sentences may be of longer term, some verbal therapies may also become part of the treatment regimen."); *Standards for Health Servs. in Correctional Institutions*, Mental Health Care Services § C, at 31-32 (American Pub. Health Ass'n 1976) ("*Principle*: Direct treatment services should be provided in a context of varied modalities, with emphasis on eclectic breadth. . . . *Satisfactory Compliance*: The following direct treatment services shall be made available as a minimum: 1. Crisis intervention . . . 2. Brief and extended evaluation/assessment. 3. Short-term Therapy: Group and individual. 4. Long-term Therapy: Group and Individual. 5. Therapy with family and significant others. 6. Counseling must be available for all inmates. . . . 7. Medication. . . . 8. De-toxicification. 9. In-patient hospitalization for the severely disturbed."); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 37, at 112 (1980) (essential) ("The facility will provide a multiplicity of appropriate programs."); *id.* (discussion) ("The requirement that there be a reasonable number of alternative programs is intended to recognize the complexity and uniqueness of each inmate client and to prevent exclusive reliance upon any particular treatment modality, such as group or milieu therapy. This is not intended to mandate that every facility provide every conceivable treatment program; it does require a reasonable number of alternatives based upon the institution's characteristics and the needs of its inmates.").

b. Treatment must consist of more than just medication.

Standards for Adult Correctional Institutions. § 3-4341 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) (mandatory) ("Written policy, procedure, and practice provide for the proper management of pharmaceuticals and address the following subjects: . . . prescription practices, including requirements that (1)

psychotropic medications are prescribed only when clinically indicated as one facet of a program of therapy."); *Foundation/Core Standards for Adult Local Detention Facilities* § FC2-5087 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 1989) (mandatory) (Prescription practices that require "(a) psychotropic medications are prescribed only when clinically indicated as one facet of a program of therapy."); National Comm'n on Correctional Health Care P-27.5(h), at 34 (1997) (essential) (Pharmaceuticals) ("The prescribing of psychotropic or behavior-modifying medications only when clinically indicated (as one facet of a program of therapy) and not for disciplinary reasons."); *Standards for Health Services in Jail*, National Comm'n on Correctional Health Care, J-30.5(h) (1996) (same).

See also Marnie E. Rice & Grant T. Harris, *Treatment for Prisoners with Mental Disorder, in Mental Illness in America's Prisons* 91, 97 (Henry J. Steadman and Joseph J. Cocozza eds. [National Coalition for the Mentally Ill in the Criminal Justice System], 1993) ("[I]n the end, though an essential part of the clinical arm[am]entarium, it must be concluded that drugs will not suffice as the only clinical tool for prisoners with mental disorder." (citing G.T. Harris, *The Relationship Between Neuroleptic Drug Dose and the Performance of Psychiatric Patients in Maximum Security Token Economy Program*, 20 *J. Behavior Therapy & Experimental Psychiatry* 57 (1989), M.E. Rice et al., *Violence in Institutions: Understanding, Prevention, and Control* (1989), M.E. Rice et al., *Planning Treatment Programs in Secure Psychiatric Facilities, in Law and Mental Health: International Perspectives* 162 (D. Weisstub ed., 1990))).

See also *Langley v. Coughlin*, 715 F. Supp. 522, 540 (S.D.N.Y. 1989), *aff'd*, 888 F.2d 252 (2nd Cir. 1989) (finding "failure to provide any meaningful treatment other than medication" would violate Eighth Amendment); *Madrid v. Gomez*, 889 F. Supp. 1146, 1218 (N.D. Cal. 1995) (finding constitutional violations in system where "[t]reatment for seriously ill inmates is primarily limited to medication management through use of antipsychotic or psychotropic drugs, and intensive outpatient treatment is not available").

c. Each inmate must have an individualized treatment plan.

American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 31 at 108 (1980) (essential) ("A written treatment plan exists for all inmates requiring psychological services. This is developed by a psychologist in collaboration with other personnel and includes directions for nonpsychological services personnel regarding their roles in the care and supervision of these prisoners."); *id.* (discussion) ("A treatment plan is a series of written statements which specify the particular course of therapy and the roles of all personnel in carrying out the plan. It should also include future planning for the management of a specific condition. The plan may be brief or as long as necessary to provide proper care. Jail inmates with short stays may have less detailed plans than prisoners confined in long-term facilities. The treatment plan should be goal-oriented and should specify, in addition to any nonpsychological activities, at least the following: the extent and nature of the formal psychotherapeutic modality being used, provision for interim progress notes, and a termination summary."); *Standards for Health Services in Prison*, National Comm'n on Correctional Health Care P-51 at 65 (1997)(Special Needs Treatment Plans (essential) ("Written policy and defined procedures guide the care of inmates with *special needs*

requiring close medical supervision and/or multidisciplinary care. Included among special needs patients are the following: . . . inmates with serious mental health needs and the developmentally disabled. For each of these special needs patients there is a written individualized treatment plan, developed by a physician or other qualified health practitioner."); *id* (discussion) ("Inmates with serious mental health needs include people with basic psychotic disorders (e.g. manic-depressives); self-mutilators; the aggressive mentally ill; and suicidal inmates. . . A *treatment plan* is a series of written statements specifying the particular course of therapy and the roles of qualified health care professionals in carrying it out. It is individualized, typically multidisciplinary, and based on an assessment of the patients needs, a statement of short and long-term goals as well as the methods by which these goals will be pursued. When clinically indicated, the treatment plan gives inmates access to the range of supportive and rehabilitative services (such as . . . individual or group counseling, and self-help groups) that the treating practitioner deems appropriate."); *Standards for Health Services in Jails*, National Comm'n on Correctional Health Care, J-49 at 63 (1996)(same); *Fed. Standards for Prisons and Jails* § 5.30 (U.S. Dept. of Justice 1980)(Inmates with mental disabilities must have a "written individualized plan . . . approved by a physician or qualified mental health professional after appropriate multidisciplinary consultation and in accord with written policy. The plan includes directions to medical and nonmedical personnel regarding their roles in the care, supervision and habilitation of these inmates.").

See also Coleman v. Wilson, 912 F. Supp. 1282, 1995 WL 559109, *5 (E.D. Cal. 1995) (finding Eighth Amendment violation where magistrate judge found that medical records contained incomplete or nonexistent treatment plans).

d. Prisons must have written policies to assure timely delivery of needed mental health services.

Fed. Standards for Prisons and Jails § 5.19 (U.S. Dept. of Justice 1980) ("Written policy and procedure require that inmates' medical complaints are processed, reviewed and responded to daily by health trained personnel according to priority of need. In all cases, inmates receive treatment for medical problems promptly by the appropriate level of health personnel. No inmate or correctional officer inhibits or delays an inmate's access to medical services or interferes with medical treatment.").

See also Coleman v. Wilson, 912 F. Supp. 1282, 1995 WL 559109, *5 (E.D. Cal. 1995) (finding Eighth Amendment violation where "[t]here are significant delays in, and sometimes complete denial of, access to necessary medical attention.").

e. Mental health care should be available on a 24-hour basis.

Standards for Adult Correctional Institutions. § 3-4350 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) (mandatory) ("Written policy, procedure, and practice provide for 24-hour emergency medical, dental, and mental health care availability as outlined in a written plan. The plan includes arrangements for . . . use of one or more designated hospital emergency rooms or other appropriate health facilities; emergency on-call physician, dentist, and mental health professional services when the

emergency health facility is not located in a nearby community; security procedures providing for the immediate transfer of inmates when appropriate."); American Psychiatric Ass'n, *Guidelines for Psychiatric Services in Jails and Prisons, in Psychiatric Services in Jails and Prisons, Task Force Report 29*, § C.2.b (1989) (jails) (crisis intervention) ("Essential [crisis intervention] mental health services [include] (2) twenty-four hour availability of mental health professionals to conduct evaluations, . . . (5) twenty-four hour availability of a psychiatrist to clinically evaluate patients, after initial evaluation, and to prescribe emergency medication."); *id.*, § D.2.b (prisons) (crisis intervention) ("Essential [crisis intervention] mental health services [include] (2) availability of a psychiatrist to consult with on a 24-hour basis with reference to inmate management, (3) twenty-four hour availability of a qualified physician to prescribe emergency medications when indicated."); American Pub. Health Ass'n 36 (1986)("It shall be the responsibility of the Mental Health Unit to insure that a program is developed which will be capable of responding 24 hours a day, seven days a week, to inmates in acute emotional or mental distress. This program shall include . . . the capability for immediate hospitalization of severely psychotic individuals or suicide risks . . .").

f. *Inmates must be provided with information about mental health services in a language they can understand.*

Fed. Standards for Prisons and Jails § 5.18 (U.S. Dept. of Justice 1980) ("At the time of admission to the facility, inmates are informed orally and in writing of the procedures for gaining access to health care services and the processing of complaints regarding health care services. This information is made available to non-English speaking inmates in a language they can understand. Where the number of non-English speaking inmates is significant and there is another language known to a substantial number of them, the information is provided in writing in that language."); *Standard Minimum Rules for the Treatment of Prisoners: Resolution of the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders*, E.S.C. Res. 663C, U.N. ESCOR, 24th Sess., Supp. No. 1, ¶ 51, U.N. Doc. A/CONF/611 (1955), *amended by* E.S.C. Res. 2076, U.N. ESCOR, 62d Sess., Supp. No. 1, at 35, U.N. Doc. E/5988 (1977) (institutional personnel) ("(1) The director, his deputy, and the majority of the other personnel of the institution shall be able to speak the language of the greatest number of prisoners, or a language understood by the greatest number of them. (2) Whenever necessary, the services of an interpreter shall be used."); American Psych. Ass'n, *General Guidelines for Providers of Psychological Services* § 1.3, at 3 (1987) (illustrative statement) ("To facilitate the effectiveness of services by increasing the level of staff sensitivity and professional skills, the psychologist who is designated as director participates in the selection of professional and support personnel whose qualifications include sensitivity and consideration for the language, cultural and experiential background, affectional orientation, ethnic identification, age, and gender of the users . . ."). See *also*, *Franklin v. District of Columbia*, -- F.Supp. --, 1997 WL 194453 (D.D.C. 1997).

7. Medication

a. Psychotropic medication must be prescribed only by a psychiatrist and in accordance with contemporary medical standards

Standards for Health Servs. in Correctional Institutions., Mental Health Care Services § B.1, at 28 (American Pub. Health Ass'n 1976) ("Psychotropic medication must be prescribed only by a psychiatrist in accordance with generally accepted pharmacological principals and contemporary national standards."); *id.*, § C, at 31, 32 ("The following direct treatment services shall be made available as a minimum: . . . 7. Medication. In all instances psychotropic medication shall be prescribed in accordance with generally accepted pharmacological principles and standards of good practice in the general community, including biochemical monitoring where indicated and evaluation of efficacy in all cases."). *Standards for Health Services in Prison*, National Comm'n on Correctional Health Care P-27 at 34 (1997)(essential) (Policy should require the "prescribing of psychotropic or behavior-modifying medications only when clinically indicated (as one facet of a program of therapy) and not for disciplinary reasons."); *Fed. Standards for Prisons and Jails* § 5.35 (U.S. Dept. of Justice 1980) ("Written policy and procedure require that psychotropic medications are prescribed only by a psychiatrist who has examined the inmate and only when clinically indicated."); *Standards for Adult Correctional Institutions*. § 3-4342 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) ("Psychotropic drugs, such as antipsychotics, antidepressants, and drugs requiring parenteral administration, are prescribed only by a physician or authorized health provider by agreement with the physician, and only following a physical examination of the inmate by the health provider.")

b. Psychiatrists or physicians should monitor all inmates on psychotropic medications.

Fed. Standards for Prisons and Jails § 5.35 (U.S. Dept. of Justice 1980) ("Written policy and procedure require that psychotropic medications are prescribed only by a psychiatrist who has examined the inmate and . . . that there is an appropriate procedure for monitoring reactions."); American Psychiatric Ass'n, *Guidelines for Psychiatric Services in Jails and Prisons, in Psychiatric Services in Jails and Prisons, Task Force Report 29*, § C.3.b(5) (1989) (jails) (stating that essential mental health services include requiring that "the prescription and monitoring of psychotropic medications should be done by a psychiatrist, rather than a general practitioner."); *id.*, § D.3.a(6) (prisons) ("Prescribing and monitoring of psychotropic medications is carried out by a qualified psychiatrist except in emergency situations when a non-psychiatrist physician may prescribe these medications."); American Pub. Health Ass'n 40 (1986) ("Every inmate receiving psychotropic medication shall be seen and evaluated by a psychiatrist at least once a week until stabilized and thereafter at least every two weeks."); *Madrid v. Gomez*, 889 F. Supp. 1146, 1258 (N.D. Cal. 1995) ("Psychotropic or behavior-altering medication should only be administered with appropriate supervision and periodic evaluation."); *Coleman v. Wilson*, 912 F. Supp. 1282, 1995 WL 559109, *17 (E.D. Cal. 1995) (finding constitutional violations in part because "inmates on psychotropic medication are not adequately monitored"); *Ruiz*, 503 F. Supp. at 1339.

c. A psychiatrist must re-evaluate prescriptions before renewal.

Fed. Standards for Prisons and Jails, § 5.34 (U.S. Dept. of Justice 1980) ("The facility's standard operating procedures for the proper management of pharmaceuticals include . . . [r]e-evaluation by the prescribing provider prior to renewal of a prescription."); *Standards for Adult Correctional Instns.* § 3-4341 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) (mandatory) ("Written policy, procedure, and practice provide for the proper management of pharmaceuticals and address the following subjects: . . . prescription practices, including requirements that . . . (3) the prescribing provider reevaluates a prescription prior to its renewal."); *Foundation/Core Standards for Adult Local Detention Facilities* § FC2-5087 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 1989) (mandatory) ("Written policy, procedure, and practice provide for the proper management of pharmaceuticals and address the following subjects: . . . (2) Prescription practices that require . . . (c) the prescribing provider reevaluates a prescription prior to its renewal."); *Foundation/Core Standards for Adult Local Detention Facilities* § FC2-5087 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 1989) (mandatory) ("Written policy, procedure, and practice provide for the proper management of pharmaceuticals and address the following subjects: . . . 2(b) 'Stop order' time periods are required for all medications."); *Standards for Health Services in Prison*, National Comm'n on Correctional Health Care P-27.5(e), at 34 (1997) (Pharmaceuticals)(essential) ("Automatic drug stop orders or required review of all orders for DEA-controlled substances, psychotropic drugs, or any other drug that should be restricted because it lends itself to abuse of [sic] for any other reason dictating that patient compliance be monitored."); *Standards for Health Services in Jails*, National Comm'n on Correctional Health Care J-26.5(e), at 33 (1996) (same).

d. The formulary should contain a range of psychotropic medications.

American Psychiatric Ass'n, *Guidelines for Psychiatric Services in Jails and Prisons, in Psychiatric Services in Jails and Prisons, Task Force Report 29*, § C.3.b(4) (1989) (jails) (stating that essential mental health services include "a full range of psychotropic medications."); *id.*, § D.3.a(6) (prisons) (stating that prison mental health systems must assure "availability of a full range of psychotropic medications"); *Coleman v. Wilson*, 912 F. Supp. 1282, 1995 WL 559109, *17 (E.D. Cal. 1995) (finding constitutional violations in part because "it appears that some very useful medications are not available because there is not enough staff to do necessary post-medication monitoring. . . . [T]he evidence in the record demonstrates that some medications that are very effective in the treatment of serious mental disorders are not available.").

e. Prisoners must receive prescribed medications without interruption.

Fed. Standards for Prisons and Jails § 5.46 (U.S. Dept. of Justice 1980) ("Inmates receive all medication in the form and at the times prescribed when they are in the facility,

including administrative segregation and disciplinary detention, or when they are temporarily off the facility grounds."); *id.*, § 5.34 ("The facility's standard operating procedures for the proper management of pharmaceuticals include . . . [p]rocedures for medication dispensing and administration or distribution."); American Psychiatric Ass'n, *Guidelines for Psychiatric Services in Jails and Prisons*, in *Psychiatric Services in Jails and Prisons*, Task Force Report 29, § D.3.a(6) (1989) ("Psychiatrists, along with the facility's pharmacy, should develop and monitor procedures to assure that psychotropic medications are appropriately distributed."); *Standards for Health Services in Prison*, National Comm'n on Correctional Health Care P-21, at 27 (1997)(essential) (Medication Administration Training) ("Written policy and defined procedures require, and actual practice evidences, that personnel who administer medication are trained to do so. They must receive training approved by the prison administrator, or his/her designee, regarding matters of security. In addition, they must receive from the responsible physician training regarding accountability for administering medications in a timely manner according to physicians' orders, and recording the administration of medications in a manner and on a form approved by the health authority."); *Fed. Standards for Prisons and Jails* § 5.36 (U.S. Dept. of Justice 1980) ("The person administering medication has training approved by the health authority; is accountable for administering medications according to orders; and records the administration of medications in a manner and on a form approved by the health authority. In no event does an inmate dispense or administer medication.").

f. A system must be in place for the involuntary administration of psychiatric medications in appropriate circumstances.

Standards for Health Services in Prison, National Comm'n on Correctional Health Care P-67, at 84 (1997) (essential) (forced psychotropic medication) ("Written policy and defined procedures guide the use of forced psychotropic medication in an emergency situation. This policy and these procedures, while governed by the laws applicable in the jurisdiction, include requirements for authorization by a physician and specification of the duration of the regimen; when, where, and how the procedures may be used; and treatment plan goals for less restrictive treatment alternatives as soon as possible. Actual practice is consistent with the policy and procedures."); *Standards for Health Services in Jails*, National Comm'n on Correctional Health Care P-65, at 84 (1996) (same); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 15, at 97 (1980) (essential) ("Written policies and procedures exist and are implemented which outline the provision of involuntary treatment in accordance with state and federal laws and regulations applicable to the jurisdiction. These are approved by the chief psychologist and are in conformity with professional ethics and principles promulgated by the American Psychological Association . . . The decision to apply such techniques shall be documented and based on (or, if time pressure precludes this, followed by) interdisciplinary review."); *id.* (discussion) ("In those instances when an involuntary treatment technique is applied, it should be one which has evidence of being effective, without side effects, of the least restrictive nature appropriate to the problems being dealt with, and productive of changes that, had the client been more rational, the individual would have sought."); *Standards for Health Servs. in Correctional Institutions.*,

Mental Health Care Services § B.1, at 28 (American Pub. Health Ass'n 1976) ("When by virtue of mental disorder, the public safety is threatened, the public, including the individual who is mentally disordered, shall be protected [by imposing involuntary treatment]. . . . *Satisfactory Compliance*: 1. Each correctional facility shall provide for the hospitalization and treatment of persons who require it because of mental illness."); *ABA Criminal Justice Mental Health Standards* § 7-2.7(b) (American Bar Association 1984) (voluntary and involuntary transfer) ("A detainee who is unable to make the kind of informed decision set forth in paragraph (a), or who objects to treatment or habilitation, or who objects to transfer to a mental health, mental retardation, or other appropriate facility should not be transferred or required to accept treatment or habilitation services except: . . . (ii) when reasonably believed by the responsible professional to be necessary in an emergency to prevent death or serious physical injury to the detainee or others. An involuntary transfer hearing should be initiated not later than [forty-eight] hours after an emergency transfer is effected.") (brackets in original) (emphasis added).

See also *Madrid v. Gomez*, 889 F. Supp. 1146, 1221 (N.D. Cal. 1995) (ruling that a prison must have protocols or procedures in place to administer needed involuntary psychiatric medication promptly, subject to the protections set forth by the Supreme Court in *Washington v. Harper*, to prevent inmates from "suffer[ing] for an extended period of time before they receive treatment that should be provided immediately."); *Coleman v. Wilson*, 912 F. Supp. 1282, 1995 WL 559109, *19 (E.D. Cal. 1995) (finding constitutional violations in part because of magistrate judge's finding "(1) that some institutions do not have protocols for the use of involuntary medication and (2) that involuntary medication is underutilized, which causes harm to inmates decompensating as a result of mental illness, which in turn, results in the de facto denial of the procedural safeguards to which mentally [ill] inmates are entitled.").

g. *Prisoners with serious mental disorders must be transferred to a hospital or to a specialized unit within the prison system.*

Standards for Health Services in Prisons, National Comm'n on Correctional Health Care P-35, at 46 (1997) (essential) (Mental Health Assessment) ("Inmates thought to be suffering from serious mental illness or developmental disability are immediately referred for evaluation by a qualified mental health professional. Those who require acute mental health services beyond that available at the prison or whose adaptation to the correctional environment is significantly impaired are transferred to an appropriate facility as soon as the need for such treatment is determined by qualified mental health personnel."); *Standards for Health Services in Jails*, National Comm'n on Correctional Health Care J-39, at 50 (1996)(same); *Standards for Adult Correctional Institutions*. § 3-4367 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) ("Inmates who are severely disturbed and/or mentally retarded are referred for placement in appropriate noncorrectional facilities or in units specially designated for handling this type of individual."); *id.*, comment ("Inmates who are severely disturbed and/or mentally retarded are vulnerable to abuse by other inmates and require a inordinate amount of personal attention. An individual is considered severely disturbed when he or she is a danger to self or others or is incapable of attending to basic physiological needs."); *Standard Minimum*

Rules for the Treatment of Prisoners: Resolution of the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, E.S.C. Res. 663C, U.N. ESCOR, 24th Sess., Supp. No. 1, ¶ 82, U.N. Doc. A/CONF/611 (1955), amended by E.S.C. Res. 2076, U.N. ESCOR, 62d Sess., Supp. No. 1, at 35, U.N. Doc. E/5988 (1977) ("(1) Persons who are found to be insane shall not be detained in prisons and arrangements shall be made to remove them to mental institutions as soon as possible. (2) Prisoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialized institutions under medical management. (3) During this stay in prison, such prisoners shall be placed under the special supervision of a medical officer."); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 32, at 109 (discussion) ("Transfer to a more appropriate institution for clients who require intensive treatment should occur when the quality of available services within the correctional facility is not equivalent to that found in local community facilities. Jails and prisons, generally, are inappropriate places to house mentally ill and mentally retarded individuals."); *id.*, 81, § 30, at 107 (1980) (essential) ("Inmates awaiting emergency evaluation and/or treatment are housed in a specially designated area with close-staff or trained-volunteer supervision and sufficient security to protect these individuals."); *id.* at 108 (discussion) ("In collaboration with the correctional facility's administration, it is the responsibility of the psychological services staff to make the necessary provisions which will ensure the safety and security of inmates suspected of being mentally disturbed. Such individuals are particularly vulnerable to abuse in jail and prison settings."); *id.*, § 33, at 109 (important) ("Prison systems will have their own resources for handling severely disturbed inmates, either in a separate facility or specially designated units."); *id.*, discussion ("Psychotic inmates should be transferred to mental health institutions. However, many state mental hospitals are becoming more open facilities and resist the admission of disturbed inmates for whom secure housing is required. This standard . . . recognizes a growing trend for correctional systems to develop their own psychiatric facilities. "Severe disturbance" means that, in response to mental processes, the individual is a danger to hm/herself, to others, or is incapable of attending to basic physiological needs."); *ABA Criminal Justice Mental Health Standards* § 7-9.7(a) (American Bar Association 1984) (treatment for mentally ill and mentally retarded offenders sentenced to imprisonment) ("Mental health and mental retardation services should be available within the adult correctional facility for offenders whose mental illness or retardation is not severe enough to necessitate commitment to a mental health or mental retardation facility."); American Pub. Health Ass'n 37 (1986) ("Appropriately staffed and designated special housing areas should be provided for inmates in need of mental health observation or awaiting mental health evaluation, or in alcohol or drug withdrawal. Mental health observation areas shall allow for maximum observation of all patients and constant observation of persons who are potentially suicidal. All inmates placed in mental observation areas shall be evaluated by a mental health professional within 12 hours and, in the event that they remain there, shall have a treatment plan developed for them. All patients housed in mental observation shall be interviewed initially by a psychiatrist and evaluated at least every other day by a mental health professional.").

h. *Inmates may not be transferred to a mental hospital without due process*

American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 34, at 109-10 (1980) (essential) ("Transfers which result in inmates being placed in either facilities (or special units within institutions) which are specifically designated for the care and treatment of the severely mentally disturbed shall follow due process procedures, as specified in state/federal statutes, prior to the move being effected."); *Standards for Health Services in Prisons*, National Comm'n on Correctional Health Care P-35, at 44 (1992) (Mental Health Evaluation) (discussion) ("Acutely suicidal and psychotic inmates are emergencies and should be placed immediately in a treatment setting within the prison if one is available, or transferred to an appropriate facility if not."); Fred Cohen, *The Legal Context for Mental Health Services, in Mental Illness in America's Prisons* 25, 49-50 (Henry J. Steadman and Joseph J. Cocozza eds. [National Coalition for the Mentally Ill in the Criminal Justice System], 1993) (summarizing the minimum safeguards established by the Supreme Court in *Vitek v. Jones*, 445 U.S. 480, 493-94 (1980)). See also *Madrid v. Gomez*, 889 F. Supp. 1146, 1220 (N.D. Cal. 1995) (Prisoners who have been sent to other institutions for psychiatric care should not be returned in the condition which required care, and should not be allowed quickly to relapse into the same condition once returned); *Arnold on behalf of H.B. v. Lewis*, 803 F.Supp. 246 (D.Ariz. 1992) (characterizing as "barbaric" treatment of female prisoner who was shuffled back and forth between prison and mental facility).

8. Informed Consent

a. *Patients must be given the information necessary to make an informed decision about whether to accept a particular treatment.*

Standards for Health Services in Prison, National Comm'n on Correctional Health Care P-70, at 86 (1997)(important) ("written policy and defined procedures require, and actual practice evidences, that all examinations, treatment, and procedures governed by informed consent practices applicable in the state are observed for inmate care. The informed consent of next of kin, guardian, or legal custodian applies when required by law."); *Fed. Standards for Prisons and Jails* § 5.51 (U.S. Dept. of Justice 1980) ("Therapeutic medical treatment specifically designed to benefit an individual inmate is permitted provided that . . . (2) the inmate gives full voluntary and informed written consent after being informed of the treatment's likely effects, the likelihood and degree of improvement and/or remission, the hazards of the treatment, the reasonable alternatives to the treatment, and the inmate's ability to withdraw from the treatment without penalty at any time."); *id.*, § 5.44 ("Informed consent of inmates is required for all examinations, treatments, and medical procedures for which informed consent is required in the jurisdiction."); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 14, at 96 (1980) (essential) ("All psychological examinations, treatments, and procedures affected by the principle of informed consent in the jurisdiction are likewise observed for inmate care. . . . An appropriate form will be used to document compliance."); *id.* (discussion) ("Informed consent is the permission granted by the client to a staff member for the performance of a

specified treatment, examination, or procedure after receiving the material facts regarding the nature, consequences, risks, alternatives, and the level of confidentiality surrounding the proposed technique."); *Foundation/Core Standards for Adult Local Detention Facilities* § FC2-5085 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 1989) ("All examinations, treatments, and procedures affected by informed consent standards in the community are likewise observed for inmate care."); *Standards for Adult Correctional Insts.* § 3-4372 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) ("Written policy, procedure, and practice provide that all informed consent standards in the jurisdiction are observed and documented for inmate care."); *id.*, comment ("The facility's policy regarding informed consent . . . should take into account informed versus implied consent."); American Pub. Health Ass'n 40 (1986) (quoted in *Standards: Legal Issues and the Mentally Disordered Inmate* 19 (n.d.)) ("Female inmates shall be informed of the potential risks of taking psychotropic medication while pregnant . . .").

9. Seclusion and Restraint

a. *Correctional Facilities Must Have Policies and Procedures Governing the Use of Seclusion and Restraint*

Standards for Adult Correctional Insts. § 3-4362 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) ("Written policy and procedure govern the use of restraints for medical and psychiatric purposes."); *id.*, comment ("Where restraints are part of a health care treatment regimen, the restraints used should be those that would be appropriate for the general public within the jurisdiction. Written policy should identify the authorization needed and when, where, and how restraints may be used and for how long."); American Correctional Ass'n § 2-4185-1 at 43 (1984 Supp. [sic; other cites in *Standards: Legal Issues* to an ACA supplement are to 1994]) (quoted in *Standards: Legal Issues and the Mentally Disordered Inmate* 6 (n.d.)) ("Written policy, procedure, and practice provide that when an offender is placed in a four-point restraint . . . advance approval must be obtained from the warden/superintendent or designee. Approval must also be obtained from the designated health authority or designee."); American Correctional Ass'n § 2-4185-1 at 42 (1994 Supp.) ("Four-point restraints should be used only in extreme circumstances and only when other types of restraint have proven to be ineffective."); *id.*, § 2-4312 at 53 ("Written policy and procedure govern the use of restraints for medical and psychiatric purposes. At a minimum, the policy will address the following: conditions under which restraints may be used types of restraints to be applied for specific conditions, identification of person or persons who may authorize the use of restraints, monitoring procedures for inmates in restraints. When restraints are part of a health care treatment regimen, the restraints used should be those that would be appropriate for the general public within the jurisdiction. Written policy should identify the authorization needed and when, where, and how restraints may be used and for how long."); American Psychiatric Ass'n, *Principles Governing the Delivery of Psychiatric Services in Lock-Ups, Jails and Prisons, in Psychiatric Services in Jails and Prisons, Task Force Report 29*, § F.5.d ("(1) Written guidelines for the use of seclusions and restraints are necessary. These should include criteria and indications as well as staff responsibilities, limitations on time, periodic evaluations, etc., as they apply to that specific facility. Particular attention must be devoted to distinctions between the use of these modalities for custodial-administrative purposes and for mental health therapeutic purposes. (2) Orientation of patients should include a careful delineation of the policies on seclusions and restraints. (3) Custodial staff as well as mental health staff should receive special and continuing education in regard to these policies and procedures."); *Standards for Health Services in Prisons*, National Comm'n on Correctional Health Care P-66, at 83 (1997) (essential) (Medical Restraints and Therapeutic Seclusion) ("Written policy and defined procedures require, and actual practice evidences, the appropriate use of medical restraints and therapeutic seclusion for patients under treatment for a mental illness. They specify the type(s) of restraint that may be used and when, where, how, and for how long restraints or seclusion may be used. Use is authorized in each case by a physician upon reaching the conclusion that no other less restrictive treatment is appropriate. For restrained or secluded patients, the treatment plan addresses the goal of removing the inmate from restraint or seclusion as soon as possible."); *id.* (discussion) ("This standard applies to those situations where the restraints are part of health care treatment. Generally an order for therapeutic restraint should not exceed 12 hours. There should be 15 minute checks by trained personnel or qualified health professionals. The same kinds of restraints that would be appropriate for individuals treated in the community may likewise be used for medically restraining incarcerated

individuals: for example, fleece-lined leather, rubber, or canvas hand and leg restraints, and strait-jacket. Mental [sic] or hard plastic devices (such as handcuffs and leg shackles) should not be used for therapeutic restraint. Persons should not be restrained in an unnatural position (for instance, hog-tied, face-down, spread eagled.); *Standards for Health Services in Jails*, National Comm'n on Correctional Health Care P-466, at 83 (1996)(same); American Pub. Health Ass'n 41 (1986)("The use of restraints shall be instituted only when all attempts to calm the inmate have failed and when, in the judgment of a psychiatrist or physician, the threat of serious injury to self and others is so severe as to warrant such a response. Restraints shall be used only on the order of a psychiatrist, physician or licensed health professional."); Fred Cohen, *The Legal Context for Mental Health Services, in Mental Illness in America's Prisons* 25, 57 (Henry J. Steadman and Joseph J. Coccozza eds. [National Coalition for the Mentally Ill in the Criminal Justice System], 1993) ("Policy and procedure on these practices should encompass the following matters: 1. Isolation and restraint are temporary measures to combat an individual's danger to self or others. 2. A properly trained clinician should authorize the measures using a least intrusive means approach, as well as previously articulated clinical criteria. 3. The time and frequency of use of these measures must be clearly articulated and of a relatively short duration. 4. There must be clear policy on monitoring, re-evaluation and documentation. 5. There must be staff training in all of these aspects of the process."); *Standard Minimum Rules for the Treatment of Prisoners: Resolution of the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders*, E.S.C. Res. 663C, U.N. ESCOR, 24th Sess., Supp. No. 1, ¶ 33, U.N. Doc. A/CONF/611 (1955), amended by E.S.C. Res. 2076, U.N. ESCOR, 62d Sess., Supp. No. 1, at 35, U.N. Doc. E/5988 (1977) (instruments of restraint) ("[C]hains or irons shall not be used as restraints. Other instruments of restraint shall not be used except in the following circumstances: (a) As a precaution against escape during a transfer, provided that they shall be removed when the prisoner appears before a judicial or administrative authority; (b) On medical grounds by direction of the medical officer; (c) By order of the director, if other methods of control fail, in order to prevent a prisoner from injuring himself or others or from damaging property; in such instances the director shall at once consult the medical officer and report to the higher administrative authority."); *id.*, ¶ 34 ("The patterns and manner of use of instruments of restraint shall be decided by the central prison administration. Such instruments must not be applied for any longer time than is strictly necessary.").

b. Seclusion and Restraint may not be used as punishment.

Standard Minimum Rules for the Treatment of Prisoners: Resolution of the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, E.S.C. Res. 663C, U.N. ESCOR, 24th Sess., Supp. No. 1, ¶ 33, U.N. Doc. A/CONF/611 (1955), amended by E.S.C. Res. 2076, U.N. ESCOR, 62d Sess., Supp. No. 1, at 35, U.N. Doc. E/5988 (1977) (instruments of restraint) ("Instruments of restraint, such as handcuffs, chains, irons and strait-jacket, shall never be applied as a punishment."); American Correctional Ass'n § 3-4183 at 60 (1994 Supp.)("Instruments of restraint, such as handcuffs, irons, and straight [sic] jackets, are never applied as punishment."); American Pub. Health Ass'n 41 (1986) ("Restraints may not be ordered for punitive purposes.");

Standards for Health Services in Prison, National Comm'n on Correctional Health Care, P-66 (1997) (essential) ("Written policy and defined procedures require, and actual practice evidences, the appropriate use of therapeutic restraints and therapeutic seclusion for patients under treatment for mental illness. They specify the types of restraint that may be used and when, where, how, and for how long restraints or seclusion may be used. Use is authorized by a physician, or other qualified health care professional where permitted by law, upon reaching the conclusion that no less restrictive treatment is appropriate. For restrained or secluded patients, the treatment plan addresses the goal of removing the inmate from restraint or seclusion as soon as possible. The health care staff does not participate in the non-medical restraint of inmates except for monitoring their health status."); American Psychiatric Ass'n, *Principles Governing the Delivery of Psychiatric Services in Lock-Ups, Jails and Prisons*, in *Psychiatric Services in Jails and Prisons*, Task Force Report 29, § F.5.d(1) (1989) ("Particular attention must be devoted to distinctions between the use of [restraint and seclusion] for custodial-administrative purposes and for mental health therapeutic purposes.").

10. Suicide Prevention

- a. *Correctional facilities must have a basic program for identifying, treating, and supervising inmates with suicidal tendencies.***

Standards for Adult Correctional Insts. § 3-4364 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) ("There is a written suicide prevention and intervention program that is reviewed and approved by a qualified medical or mental health professional. All staff with responsibility for inmate supervision are trained in the implementation of the program."); *id.*, ("The program should include specific procedures for intake screening, identification, and supervision of suicide-prone inmates."); *Foundation/Core Standards for Adult Local Detention Facilities* § C2-5180 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 1989) (certifiable standard) ("There is a written suicide and intervention program that is reviewed and approved by a qualified medical or mental health professional. All staff with responsibility for inmate supervision are trained in the implementation of the program."); *Standards for Health Services in Prison*, National Comm'n on Correctional Health Care P-53, at 68 (1997) (essential) (Suicide Prevention) ("Written policy and defined procedures require, and actual experience evidences, that the prison has a program for identifying and responding to suicidal individuals. The program components include: identification, training, assessment, monitoring, housing, referral, communication, intervention, notification, reporting, review and critical incident debriefing"); *id.* (discussion) ("Key components of a suicide prevention program include the following: (1) Training. All staff members who work with inmates should be trained to recognize verbal and behavioral cues that indicate potential suicide. (2) Identification. The receiving screening form should contain observation and interview items related to the inmate's potential suicide risk. (3) Monitoring. The plan should specify the facility's procedures for monitoring an inmate who has been identified as potentially suicidal. Regular, documented supervision should be maintained. (4) Referral. The plan should specify the procedures for referring potentially suicidal inmates and attempted suicides to mental health care providers or facilities. (5) Evaluation. This should be conducted by a qualified mental health professional, who designates the inmate's level of suicide risk. (6) Housing. A suicidal inmate should not be housed or left alone unless constant supervision can be maintained. If a sufficiently large staff is not available that constant supervision can be provided when needed, the inmate should not be isolated. Rather, s/he should be housed with another resident or in a dormitory and checked every 10-15 minutes by correctional staff. The room should be as nearly suicide-proof as possible (that is, without protrusions of any kind that would enable the inmate to hang him/herself). (7) Communication. Procedures for communication between health care and correctional personnel regarding the status of the inmate should exist, to provide clear and current information. (8) Intervention. The plan should address how to handle a suicide in progress, including appropriate first-aid measures. (9) Notification. Procedures for notifying prison administrators, outside authorities, and family members of potential, attempted, or completed suicides should be in place. (10) Reporting. Procedures for documenting the identification and monitoring of potential or attempted suicides should be detailed, as should procedures for reporting a completed suicide. (11) Review. The plan should specify procedures for medical and administrative review if a suicide does occur."). *Standards for Health Services in Prison*, National Comm'n on Correctional Health Care P-51, at 65 (1996)(same).

See also Fred Cohen, *The Legal Context for Mental Health Services, in Mental Illness in America's Prisons* 25, 58 (Henry J. Steadman and Joseph J. Coccozza eds.

[National Coalition for the Mentally Ill in the Criminal Justice System], 1993) ("Suicide screening instruments are easily available through the National Center on Institutions and Alternatives and just as easily used."); James R.P. Ogloff et al., *Screening, Assessment, and Identification of Services for Mentally Ill Offenders, in Mental Illness in America's Prisons, supra*, 61, 63 ("Suicide is one of the most severe threats to inmates' safety in prisons. Therefore, any mental health evaluation program must attempt to identify those inmates who are at a risk for suicide. Unfortunately, due to the low base-rate of suicides in prisons, it is difficult to identify inmates who will likely attempt to take their own lives.").

See also *Madrid v. Gomez*, 889 F. Supp. 1146, 1222 (N.D. Cal. 1995) (finding inadequate a suicide prevention training program consisting of "a three-hour course entitled "Unusual Inmate Behavior," which includes a short section on how to identify inmates susceptible to suicide and what to do after identifying such an inmate or discovering an attempted suicide . . . a "Suicide Prevention Handbook" [where all staff] were required to read the handbook and complete an accompanying quiz[,] and some [sporadic] additional in-service training."); *Coleman v. Wilson*, 912 F. Supp. 1282 1995 WL 559109, *5 (E.D. Cal. 1995).

11. Mental Health Staff

a. The correctional facility must have sufficient numbers of qualified health personnel of varying types to provide adequate evaluation and treatment consistent with contemporary standards of care.

Standards for Adult Correctional Institutions. § 3-4336, comment (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) ("An adequate number of qualified staff members should be available to deal directly with inmates who have severe mental health problems as well as to advise other correctional staff in their contacts with such individuals."); Association of State Correctional Administrators, *Policy Guidelines: Health Services, reprinted in Medical Care of Prisoners and Detainees* app. at 220 (Ciba Found. Symposium 16 (n.s.), 1973) ("Each facility should have available appropriate mental health personnel or services to diagnose, prescribe and treat mental health problems."); *Standards for Health Services in Prisons*, National Comm'n on Correctional Health Care P-24, at 28 (1997)(important) (Staffing Levels) ("Written policies and defined procedures require, and actual practice evidences, that there is a written staffing plan that assures a sufficient number of health services staff of varying types is available to provide adequate evaluation and treatment consistent with contemporary standards of care."); *id.* (discussion) ("The number and types of health care professionals required at a facility depend upon the size of the facility, the types (medical, nursing, dental, mental health) and scope (outpatient, specialty care, inpatient) of services delivered, the needs of the inmate population, and the organizational structure (e.g., hours of service, use of assistants, scheduling). Also, special consideration should be given to the number of patients in segregated housing, since the more restricted inmates' movement is, the more demands there are on staff time. These factors should be addressed in the facility's health service staffing plan. It is important to ensure that there is sufficient physician time."); *Standards for Health Services in Jails*, National Comm'n on Correctional Health Care P-23,

at 29 (1996) American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 12, at 94 (1980) (essential) ("The ratio of staff to inmates is at least one full-time psychologist for every 200-250 prisoners. In specialized units (e.g., drug treatment) the minimally acceptable ratio is one full-time psychologist for every 100-125 inmates. Additionally, staff shall reflect ethnic, racial, and lin[g]uistic characteristics of clients, to the greatest degree possible."); American Psych. Ass'n, *General Guidelines for Providers of Psychological Services*, § 2.1.2, at 4 (1987) ("A psychological service unit strives to include sufficient numbers of professional psychologists and support personnel to achieve its goals, objectives, and purposes."); *Standard Minimum Rules for the Treatment of Prisoners: Resolution of the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders*, E.S.C. Res. 663C, U.N. ESCOR, 24th Sess., Supp. No. 1, ¶ 49(1), U.N. Doc. A/CONF/611 (1955), amended by E.S.C. Res. 2076, U.N. ESCOR, 62d Sess., Supp. No. 1, at 35, U.N. Doc. E/5988 (1977) (institutional personnel) ("So far as possible, the personnel shall include a sufficient number of specialists such as psychiatrists, psychologists, social workers, teachers and trade instructors."); American Psychiatric Ass'n, *Guidelines for Psychiatric Services in Jails and Prisons*, in *Psychiatric Services in Jails and Prisons*, Task Force Report 29, § C.3.b(2) (jails) (1989) ("[Essential mental health services include] seven-day-a-week mental health coverage (including at least three days with board-certified or board-eligible psychiatrist)."); *id.*, § D.3.a(4) (prisons) ("[Required mental health modalities include] seven-day-a-week mental health coverage which includes 24 hour availability of consultation with a psychiatrist (Unless otherwise demonstrated as unnecessary, the presence of a psychiatrist on site should be at least once a week. Larger facilities or facilities with in-patient care will require considerably more on-site psychiatric coverage.)"); National Comm'n on Correctional Health Care P-20, at 23 (1992) ("It is recommended that there be at least one full-time-equivalent physician in prisons with an average daily population of 750 or greater."); American Psych. Ass'n, *General Guidelines for Providers of Psychological Services* § 1.1, at 3 (1987) ("Each psychological service unit offering psychological services has available at least one professional psychologist and as many more professional psychologists as are necessary to assure the quality of services offered.").

See also *Coleman v. Wilson*, 912 F. Supp. 1282, 1995 WL 559109, *16 (E.D. Cal. 1995) (finding Eighth Amendment violation where Department of Corrections "is seriously and chronically understaffed in the area of mental health care"); *Arnold on behalf of H.B. v. Lewis*, 803 F. Supp. 246 (D. Ariz. 1992); *Balla v. Idaho State Bd. of Corrections*, 595 F. Supp. 1558 (D. Idaho 1984); *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980), *aff'd in part and rev'd in part*, 679 F.2d 1115 (5th Cir. 1982), *cert. denied*, 460 U.S. 1042 (1983) (ruling that trained mental health professionals must be employed in "sufficient numbers to identify and treat in an individualized manner those treatable inmates suffering from serious mental disorders"); *Madrid v. Gomez*, 889 F. Supp. 1146, 1218 (N.D. Cal. 1995) (finding "particularly problematic [that] staffing levels are not sufficient to enable mental health staff to quickly and effectively respond when inmates exhibit serious mental health problems"); *French v. Owens*, 777 F.2d 1250, 1254 (7th Cir. 1985) (finding that gross deficiencies in staffing may constitute deliberate indifference); *Lightfoot v. Walker*, 486 F. Supp. 504, 524-25 (S.D. Ill. 1980)(finding that staff shortages may render medical

services below constitutional level).

b. *Mental health staff must receive appropriate training, including training in the administration of medications.*

Standards for Health Services in Prisons, National Comm'n on Correctional Health Care P-19, at 25 (1997) (essential) (Continuing Education for Qualified Health Services Personnel) ("Written policy and defined procedures require, and actual practice evidences, that all qualified health care professionals annually receive at least 12 hours of continuing education or staff development appropriate to their positions; American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 13, at 95 (1980) (essential) ("A written plan, approved by the chief psychologist, exists, is implemented . . . , and requires psychology staff to receive orientation training and regular continuing education appropriate to their activities. Documentation of these training experiences will be maintained."); American Correctional Ass'n [*Standards for Adult Correctional Institutions*, § 3-4082, at 24 ("Written policy, procedure, and practice provide that all professional specialist employees who have inmate contact receive 40 hours of training in addition to orientation training during their first year of employment and 40 years [sic] of training each year thereafter."); American Psychiatric Ass'n, *Principles Governing the Delivery of Psychiatric Services in Lock-Ups, Jails and Prisons*, in *Psychiatric Services in Jails and Prisons*, Task Force Report 29, § C.2 (1989) (Specialty Education and Training) ("Ideally, the practitioner should receive specialty education and training at various levels prior to undertaking employment in a correctional setting. Education and training in correctional psychiatry should be available in medical schools and psychiatric residencies. The correctional psychiatrist should seek out relevant courses as continuing medical education, or, at minimum, the literature that is to be found in textbooks and journals."); *Standards for Health Services in Prisons*, National Comm'n on Correctional Health Care P-21 (1997), at 27 (essential) (Medication Administration Training) ("Written policy and defined procedures require, and actual practice evidences, that personell who administer medications are trained to do so.")

12. Training of Custodial Staff

a. *All custodial staff must be trained to recognize signs of mental illness*

Standards for Health Services in Prisons, National Comm'n on Correctional Health Care P-20, at 26 (1997)(Training for Correctional Officers) ("Written policy and defined procedures require, and actual practice evidences, that a training program established or approved by the responsible health authority in cooperation with the prison administrator guides the health related training of all correctional officers who work with inmates. Training is ongoing (i.e., each officer is trained at least every two years), documented, and includes at least the following areas: . . . recognizing the signs and symptoms of mental illness, suicide prevention . . ."); *Fed. Standards for Prisons and Jails* § 5.29 (U.S. Dept. of Justice 1980) ("All staff with custodial and program responsibility are trained regarding recognition of symptoms of mental illness and retardation."); *ABA Criminal Justice Mental Health*

Standards § 7-2.6(a) (American Bar Association 1984) (postarrest obligations of police and custodial personnel) ("[T]raining for all custodial personnel . . . should include instruction in the identification of symptoms and behavior indicative of mental illness and mental retardation."); *id.*, § 7-2.8(c) (specialized training) ("All custodial personnel, whether civilian or sworn, should receive training in identifying and responding to the symptoms and behaviors, including self-injurious behavior, associated with mental illness and mental retardation. Emphasis should be placed on those symptoms and behaviors that arise or are aggravated by the fact of incarceration, particularly as they relate to suicide prevention."); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 44, at 116 (1980) (important) ("Written standard operating procedures are implemented which provide for and require psychological services to participate in training facility staff with respect to the following: types of potential psychological emergency situations, signs and symptoms of various mental disturbances, procedures for making referrals to psychological services, and program areas (e.g., drug treatment, counseling"); *id.* (discussion) ("Facility personnel must be made aware of potential emergency situations and of their responsibility for the early detection of mental disturbance. Emergencies include (but are not limited to) such conditions as: suicidal behavior, acute psychosis, changes in consciousness, disorientation, acute regression states, and self-mutilation. . . . Care must be exercised to include in training programs continuing staff psychologist supervision and instruction in recognition of signs which warrant referral to the professional psychologist."); Joint Comm'n on Accreditation of Healthcare Org., 1 *1993 Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services* § FC.3 at 62 (1993) (forensic services) ("[S]taff with no clinical training or experience who may become involved in activities that could support or hinder the therapeutic goals for individuals served, apply . . . FC.3.1.2 knowledge of procedures for responding to unusual clinical events and incidents; FC.3.1.3 knowledge of the organization's channels of clinical, security, and administrative communication; . . . FC3.1.5 understanding of the range of treatment needed by individuals served; and FC.3.1.6 knowledge of available treatment resources and their appropriate use."); *Foundation/Core Standards for Adult Local Detention Facilities* § FC2-5080 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 1989) (mandatory) ("A training program is established by the responsible health authority in cooperation with the facility administrator to provide instruction in the following areas: . . . (5) Recognition of signs and symptoms of mental illness, retardation, emotional disturbance, and chemical dependency."); American Pub. Health Ass'n 38 (1986) ("Because medical and correctional personnel are in frequent and close contact with the inmate population, they shall receive special training from the mental health staff in the identification of individuals with possible emotional and mental disorders."); *ABA Criminal Justice Mental Health Standards* § 7-2.8(c) (American Bar Association 1984) (specialized training) ("All custodial personnel, whether civilian or sworn, should receive training in identifying and responding to the symptoms and behaviors, including self-injurious behavior, associated with mental illness and mental retardation. Emphasis should be placed on those symptoms and behaviors that arise or are aggravated by the fact of incarceration, particularly as they relate to suicide prevention.").

See also James R.P. Ogloff et al., *Screening, Assessment, and Identification of Services for Mentally Ill Offenders, in Mental Illness in America's Prisons* 61, 65-66 (Henry J. Steadman and Joseph J. Cocozza eds. [National Coalition for the Mentally Ill in the Criminal Justice System], 1993) ("All staff who work with inmates in prisons should receive adequate training in identifying symptoms of mental illness and managing inmates with mental illness. Although corrections officers are likely to be the ones who have the most day-to-day contact with inmates, other personnel, including teachers, librarians, nurses and others, should also receive this training."); *Coleman v. Wilson*, 912 F. Supp. 1282, 1995 WL 559109, *28 (finding constitutional violations in part because of "inadequate training of the custodial staff so that they are frequently unable to differentiate between inmates whose conduct is the result of mental illness and inmates whose conduct is unaffected by disease.").

13. Housing, Segregation, and Discipline

a. Mental health staff must be allowed to influence cell housing decisions.

Standards for Adult Correctional Insts. § 3-4369 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) ("Written policy and practice require that, except in emergencies, there shall be joint consultation between the warden/superintendent (or designee) and the responsible physician (or designee) prior to taking action regarding identified mentally ill or retarded patients in the following areas: housing assignments When an emergency action has been required, joint consultation to review the appropriateness of the action occurs as soon as possible but no later than the next work day."); *Foundation/Core Standards for Adult Local Detention Facilities* § C2-5183 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 1989) (certification standard) ("Written policy and procedure require consultation between the facility administrator and the responsible physician or designee prior to the following actions being taken regarding patients who are diagnosed as having a psychiatric illness: (1) housing assignments."); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 35, at 110 (1980) (important) ("There are written and implemented policy and procedure which require that the responsible psychologist be consulted prior to taking the following actions with respect to emotionally disturbed inmates: housing assignment changes, program assignment changes, disciplinary sanctions, transfers in and out of the facility."); *Fed. Standards for Prisons and Jails* § 5.16 discussion (U.S. Dept. of Justice 1980) ("Information regarding the inmate's physical and mental status [identified during health appraisal within fourteen days of admission] may dictate housing and activity assignments."); American Psychiatric Ass'n, *Guidelines for Psychiatric Services in Jails and Prisons, in Psychiatric Services in Jails and Prisons, Task Force Report 29*, § D.1.a(1) (1989) (stating that receiving mental health screening should assure that a newly arriving prisoner "who may require mental health evaluation as a result of mental illness or developmental disability . . . is placed in the proper living environment."); *Standards for Health Services in Prison*, National Comm'n on Correctional Health Care P-08, at 10 (1997) (essential) ("Written policy and defined procedure require, and actual practice evidences, communications between

the prison administration and the treating clinician regarding patients who have significant special needs that should be taken into account in deciding the following: housing assignments, work assignments, program assignments, disciplinary measures, and admissions to and transfers from institutions. Included among those who have special needs are the following: . . . inmates with *serious mental health needs*, and the *developmentally disabled*.")

See also Madrid v. Gomez, 889 F. Supp. 1146, 1221 (N.D. Cal. 1995) ("There are instances where it may be critical, from a medical standpoint, to alter an inmate's housing assignment (e.g., from the SHU [Segregated Housing Unit] to another environment or from double to single cell housing), in order to effectively address an inmate's serious mental health problems. [P]sychiatrists and psychologists [should be] allowed input into cell housing decisions, [especially] when the inmate is suffering acute symptoms and the mental health staff believe that a change in housing conditions is potentially necessary to the effective treatment of the inmate's disorder.")

b. *Inmates confined to segregation units must be evaluated and monitored by mental health professionals.*

Standards for Health Services in Prison, National Comm'n on Correctional Health Care P-39, at 51 (1997) (essential) (Health Evaluation of Inmates in Disciplinary Segregation) (discussion) ("Inmates placed in disciplinary segregation who have been receiving mental health treatment should be evaluated by qualified mental health professionals within 24 hours after being placed there, and followed regularly thereafter. The evaluation should be documented and placed in the health record. Also, "Daily evaluations ensure that the inmate's health status does not decline while in segregation. . . . Owing to the possibility of injury and depression during segregation, the daily evaluations should include notation of bruises or other trauma markings, comments regarding the inmate's attitude and outlook (particularly as they might relate to suicide intention), and any health complaints."); American Correctional Ass'n § 3-4244 at 71 (1994 Supp.)("Written policy, procedure, and practice provide that a qualified mental health professional personally interviews and prepares a written report on any inmate remaining in segregation for more than 30 days. If confinement continues beyond 30 days, a mental health assessment by a qualified mental health professional is made at least every three months—more frequently if prescribed by the chief medical authority.").

See also Madrid v. Gomez, 889 F. Supp. 1146, 1219 (N.D. Cal. 1995) ("[T]he need for effective screening and monitoring in the SHU [Security Housing Unit] is particularly critical in order to ensure that inmates suffering from mental illness are not experiencing a deterioration in their condition.");

Security and segregation units tend to exacerbate pre-existing mental illnesses. *Langley v. Coughlin*, 715 F. Supp. 522, 541 (finding that "placement of inmates on SHU [Special Housing Unit] when such assignment would predictably cause exacerbation of already several mental disorders" "reflects a pattern of inadequate medical care to the mentally ill inmates housed on SHU [Special Housing Unit]."); *Coleman v. Wilson*, 912 F. Supp. 1282, 1995 WL 559109, *29 (E.D. Cal. 1995) ("use of administrative segregation and segregated housing at Pelican Bay SHU and statewide to house mentally ill inmates violates the Eighth Amendment because mentally ill inmates are placed in administrative segregation and

segregated housing without any evaluation of their mental status").

c. *Mental health staff must be consulted about decisions to discipline mentally ill prisoners.*

Standards for Adult Correctional Institutions. § 3-4369 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) ("Written policy and practice require that, except in emergencies, there shall be joint consultation between the warden/superintendent (or designee) and the responsible physician (or designee) prior to taking action regarding identified mentally ill or retarded patients in the following areas: . . . disciplinary measures When an emergency action has been required, joint consultation to review the appropriateness of the action occurs as soon as possible but no later than the next work day."); *Standards for Health Services in Prison*, National Comm'n on Correctional Health Care P-08, at 10 (1997) (essential).

14. Mental Health Records

a. *Mental Health Records must be accurate, complete, and well-organized.*

Standards for Adult Correctional Institutions. § 3-4376 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) ("The health record file contains the following items: completed receiving screening form; health appraisal data forms; all findings diagnoses, treatments, dispositions; record of prescribed medications and their administration; . . . signature and title of documenter; consent and refusal forms; . . . place, date, and time of health encounters; health service reports, e.g., dental, mental health, and consultations; treatment plan, including nursing care plan; progress reports; discharge summary of hospitalization and other termination summaries."); *Fed. Standards for Prisons and Jails* § 5.38 (U.S. Dept. of Justice 1980) (discussion) ("The record is to be complete and all findings recorded including notations concerning psychiatric, dental and consultative services."); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 49, at 119 (1980) (essential) ("The psychological record (excluding raw data) is part of the inmate's central file. It contains the completed receiving screening form, all findings, diagnoses, treatments, dispositions, and terminations from long- or short-term psychological treatment. The uniform method of recording entries and the form and format of the psychological record are approved by the chief psychologist."); *id.* (discussion) ("The record is complete and all findings recorded. . . . Any intervention after the initial screening requires the initiation of a psychological record. The importance of documentation cannot be overemphasized. Not only do such records provide a sound basis for postrelease continuity of treatment (if needed), but they also supply protection for staff from litigious inmates."); *id.* § 50, at 119-20 (1980) (discussion) ("Records kept regarding psychological services may include (but not be limited to) identifying data, dates and types of services, and significant actions taken. Such information is to be recorded within a specified, reasonable time (not to exceed one month) after completion of the activity."). *Standards for Adult Correctional Institutions*. § 3-4376 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed.

1990) (comment) ("All findings, including notations concerning mental health, dental, and consultative services, should be recorded at the time of service delivery or no later than 14 days from the time of discharge or termination of treatment.").

See also *Ruiz v. Estelle*, 503 F. Supp. 1265 (S.D. Tex. 1980), *aff'd in part and rev'd in part*, 679 F.2d 1115 (5th Cir. 1982), *cert. denied*, 460 U.S. 1042 (1983); *Langley v. Coughlin*, 715 F. Supp. 522 (S.D.N.Y. 1989), *aff'd*, 888 F.2d 252 (2nd Cir. 1989); *Madrid v. Gomez*, 889 F. Supp. 1146, 1219 (N.D. Cal. 1995) (finding that notes of mental health examinations should be substantive, that documentation of monitoring should be systematic, that entries should always account for prior diagnoses when making discrepant new diagnoses, and that psychiatric records should include suicide watch records); *Coleman v. Wilson*, 912 F. Supp. 1282, 1995 WL 559109, *5 (E.D. Cal. 1995) (finding Eighth Amendment violation where magistrate judge found that "the medical records system maintained by defendants is extremely deficient."); *id.* at *22 ("[a]t most of the prisons in the class there are serious deficiencies in medical recordkeeping, including disorganized, untimely and incomplete filing of medical records, insufficient charting, and incomplete or nonexistent treatment plans.").

b. Past psychiatric records must be obtained.

Arnold on behalf of H.B. v. Lewis, 803 F. Supp. 246 (D. Ariz. 1992); *Madrid v. Gomez*, 889 F. Supp. 1146, 1219 (N.D. Cal. 1995) (Efforts should be made to obtain important information missing from psychiatric records forwarded other institutions, especially about prior psychiatric hospitalizations); *Coleman v. Wilson*, 912 F. Supp. 1282, 1995 WL 559109, *22 (E.D. Cal. 1995) (finding constitutional violations in part because, although "[t]he evidence of record shows that some physicians on the CDC [California Department of Corrections] staff can and do take steps to obtain medical records from county jails when inmates arrive at the CDC without them[, s]uch steps are not standard practice.") *id.*

c. Inmate's mental health records must be kept confidential.

Standards for Adult Correctional Institutions. § 3-4377 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) ("Written policy and procedure uphold the principle of confidentiality of the health record."); *id.* (comment) ("The principle of confidentiality protects inmate patients from disclosure of confidences entrusted to a physician or other health care provider during the course of treatment."); American Psychiatric Ass'n, *Principles Governing the Delivery of Psychiatric Services in Lock-Ups, Jails and Prisons*, in *Psychiatric Services in Jails and Prisons*, Task Force Report 29, § E.3 (1989) ("In light of these special considerations [in lock-ups, jails, and prisons], it is particularly important that specific, written policies should be developed and maintained in regard to issues relating to confidentiality. In facilities where no written policy exists, it is the responsibility of the psychiatrist to clarify these issues with the institutional authorities and to develop working policies as to the degree to which confidentiality of information can be assured."); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 16 at 98

(1980) (essential) ("A written policy exists and is implemented which outlines the degree to which confidentiality of information can be assured."); *id.* (discussion) ("It is essential that psychological service providers be given the authority to maintain the confidentiality of their client's records."); *id.* § 50, at 120 (discussion) ("All persons functioning as psychological services personnel (including paraprofessionals and students) who have access to psychological records shall have an understanding of, and maintain confidentiality about (to the extent permitted by law) those records as a condition of continuing employment."); *Standards for Health Services in Prisons*, National Comm'n on Correctional Health Care P-61, at 78 (1997)(essential) (confidentiality of health information) ("Written policy and defined procedures establish, and actual practice evidences, the principle of confidentiality of health records."); *Fed. Standards for Prisons and Jails* § 5.39 (U.S. Dept. of Justice 1980) (discussion) ("The principle of confidentiality protects the patient from disclosure of confidences entrusted to a physician during the course of treatment."); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 48, at 119 (1980) (essential) ("Psychological files containing test and interview data on pretrial detainees are destroyed if the individual involved is subsequently adjudicated as being not guilty"); *id.*

d. Only a limited number of factors justify breaching a patient's confidentiality.

American Psychiatric Ass'n, *Principles Governing the Delivery of Psychiatric Services in Lock-Ups, Jails and Prisons*, in *Psychiatric Services in Jails and Prisons*, Task Force Report 29, § E.2 (1989) ("The following is a list of situations where the usual rules of confidentiality might not be applicable: (a) where the patient is suicidal, (b) where the patient is homicidal or assaultive, or (c) where the patient presents a clear and present risk of escape or the creation of internal disorder or riot. This list is not meant to be all inclusive and can be supplemented in accordance with the special needs of the patient or the institution. Additionally, certain situations that are part of the mental health treatment process may require changes from the usual rules of confidentiality. Such situations would include a patient receiving psychotropic medication; a patient requiring movement to a special unit for observation, evaluation, or treatment of an acute episode; or a patient requiring transfer to a treatment facility outside the lock-up, jail, or prison; *id.* at § E.2 (1989) ("A distinction must be drawn between information obtained by a mental health professional in the course of treatment and information obtained from the inmate in the course of a forensic or other evaluation for non-treatment purposes (e.g., an evaluation for the parole board). In the latter case, the usual rules in regard to confidentiality may not apply."). *Standards for Health Servs. in Correctional Institutions*, Mental Health Care Services § B.3, at 30 (American Pub. Health Ass'n 1976) ("Full confidentiality of all information obtained in the course of treatment should be maintained at all times with the only exceptions being the normal legal and moral obligations to respond to a clear and present danger of grave injury to the self or others, and the single issue of escape."); *id.*, § B.3, at 30-31 (satisfactory compliance) ("In all therapeutic relationships, the mental health professional shall explain the confidential guarantee, including precise delineation of the limits (as stated in the exceptions above) and periodically review the guarantee and its limits, to insure continued awareness. . . The prisoner who reveals information that falls outside the guarantee of confidentiality shall be told, prior to the disclosure, that such information will be disclosed. If informing the prisoner of the therapist's intent to disclose information will increase the likelihood of grave injury, the therapist may delay informing the treated prisoner of that disclosure."); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 16 at 98 (1980) (discussion) ("In order to continue an effective working relationship and to satisfy professional, ethical obligations, psychology staff should not be required (except in life-threatening emergencies) to disclose their records to correctional officials without the informed consent of the client. Confidentiality is an ethical principle which protects the client from disclosure of confidences entrusted to a professional during the course of treatment unless the professional is required by law to reveal the information to protect the welfare of the individual or the community. In a correctional setting, potentially life-threatening situations, such as escape plans, would be included. The psychologist's good common sense and professional judgment will play a heavy role in making decisions of this nature."); *id.*, § 16 at 98 (1980) (discussion) ("All involved parties shall be informed, *in advance*, of any limitations on maintaining confidentiality, and the inmate should be told, "You will have to trust my judgment concerning what information I may have to pass." (emphasis in original)); *Fed. Standards for Prisons and Jails* § 5.39 (U.S. Dept. of Justice 1980) (discussion) ("The health authority should share with the facility administrator information regarding an inmate's medical management and security; the administrator should share

that information with staff on a need[-]to-know basis.").

e. To preserve confidentiality, mental health records must be kept separate from confinement and custody records.

American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 50, at 119-20 (1980) (essential) ("Psychological test protocols and other raw data are maintained separately from the confinement record, are kept in a secured file controlled by the chief psychologist, and are not made available to untrained laymen or to any inmate."); *id.* (discussion) ("Records kept regarding psychological services may include (but not be limited to) identifying data, dates and types of services, and significant actions taken. . . "Raw data" is test information not accompanied by interpretive statements made in a report by qualified psychological services personnel. Computer-generated statements are considered raw data."); *id.* § 47, at 118 (1980) (essential) ("There is a written, implemented policy approved by the chief psychologist . . . that specifies which psychological reports are placed in the inmate's central file. Additionally, it specifies which reports/materials are maintained in other secured files."); *Standards for Health Services in Prisons*, National Comm'n on Correctional Health Care P-61, at 78 (1997) (essential) (confidentiality of health information) ("Health records stored in the prison are maintained under secure conditions, separate from custody records. Access to health records is controlled by the health authority consistent with applicable local, state, and federal law."); *Fed. Standards for Prisons and Jails* § 5.39 (U.S. Dept. of Justice 1980) ("Written policy and procedure provide that access to the health record is controlled by the health authority and that the health record is not in any way part of the confinement record."); *id.* (discussion) ("The principle of confidentiality protects the patient from disclosure of confidences entrusted to a physician during the course of treatment. Accordingly, it is necessary to maintain health record files under security and completely separate from the patient's confinement record."); *Standards for Adult Correctional Institutions*. § 3-4377 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) ("Written policy and procedure uphold the principle of confidentiality of the health record and support the following requirements: (1) The active health record is maintained separately from the confinement case record. (2) Access to the health record is controlled by the health authority. (3) The health authority shares with the superintendent/warden information regarding an inmate's medical management, security, and ability to participate in programs."); *Standards for Health Servs. in Correctional Institutions*, Mental Health Care Services § B.3, at 30 (American Pub. Health Ass'n 1976) (satisfactory compliance) ("Mental health data shall be entered into the unit health records to be handled in accordance with the provisions of the Records Section of the overall standards. The mental health data shall be restricted to the facts of treatment, diagnosis, prognosis, treatment plan, and medication. Sensitive or highly personal data shall not be included in the medical record.").

f. Mental health providers should have access to inmates' custodial and confinement records when necessary for providing care.

Standards for Health Services in Prisons, National Comm'n on Correctional Health Care P-62, at 79 (1997) (essential) (confidentiality of health information) ("Written policy provides that the physician or his/her designee has access to information contained in the inmate's confinement record when the physician believes such information may be relevant to the inmate's health and course of treatment.").

g. *Inmates must have access to their own records*

Fed. Standards for Prisons and Jails § 5.40 (U.S. Dept. of Justice 1980) ("Written policy and procedure provide that inmates are given access to non-evaluative material in their medical and dental records and to evaluate [sic] summaries, but not raw data, from psychiatric and psychological assessments in their health files. All materials in the inmate's health file are made available to the inmate's private physician upon request, with the authorization of the inmate."); American Psych. Ass'n, *General Guidelines for Providers of Psychological Services* § 2.3.7, at 6-7 (1987) (illustrative statement) ("Users have the right to information in their agency records and to be informed as to any regulations that govern the release of such information. . . . Users have the right to examine such psychological records. Preferably such examination should be in the presence of a psychologist who judges how best to explain the material in a meaningful and useful manner."); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 47, at 118 (1980) (discussion) ("Since absolute confidentiality cannot be guaranteed, all psychological reports should be written with the understanding that they may be read by the inmate involved.").

h. *When an inmate is transferred to another institution, his records must be sent to the receiving facility to insure continuity of care.*

American Psychiatric Ass'n, *Guidelines for Psychiatric Services in Jails and Prisons, in Psychiatric Services in Jails and Prisons, Task Force Report 29*, § D.4.b(4) (1989) (prisons) ("Written policies and procedures, approved by the medical authority of the facility, govern the transfer of medical records and medical information."); *Standards for Health Services in Prisons*, National Comm'n on Correctional Health Care P-64, at 80 (1997)(important) (transfer of health records) ("Written policy and defined procedures require, and actual practice evidences, that when an inmate is transferred to another correctional facility within the same correctional system, the inmate's health record is sent to the facility to which the inmate is transferred either before or at the same time as the inmate. . . . Summaries or copies of the inmate's health record are sent with the inmate upon referral to an off-site health care provider."); *Fed. Standards for Prisons and Jails* § 5.43 (U.S. Dept. of Justice 1980) ("When an inmate is transferred from one correctional facility to another, summaries or copies of the health record file are routinely sent to the facility to which the inmate is transferred. . . . Health record information is also transmitted to specific and designated physicians or medical facilities on the written authorization of the inmate."); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 53, at 121 (1980)

(important) ("Implemented, written policies and procedures, approved by the chief psychologist (and in conformity with headquarters policy in multi-institution systems) require the transfer of psychological records and summaries within a multifacility system whenever an inmate is transferred."); *id.* (discussion) ("It is important that the transfer of psychological information occur smoothly and rapidly and that all staff members know the procedures. Transfer of this material helps ensure continuity of treatment and avoids unnecessary duplication of tests and evaluations."); *id.* § 54, at 121-22 (essential) ("When mentally disturbed inmates are transferred . . . to another facility, the prisoner's record arrives at the receiving institution either before or with the inmate."); *id.*, at 122 (discussion) ("When a disturbed inmate is transferred, every effort shall be expended to minimize the transfer's disruptive effects and ensure continuity of treatment. The chief psychologist at the sending facility should: (a) contact the receiving institution and give advanced notice of the impending transfer, preferably by letter; (b) ensure that the inmate's psychological records are forwarded in order to reach the receiving institution before, or at the same time as, the client; and (c) provide for receiving staff to acknowledge receipt of the records."); *Standards for Adult Correctional Institutions*. § 3-4361 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) ("When travel is approved [to transfer an inmate to another facility], pertinent data (including medication, behavior management procedures, and other treatment or special requirements for observation and care during travel) are documented in a manner readily accessible to and easily understood by transportation staff or others who may be called upon to attend inmates during travel and on reception at the receiving institution. Medications or other special treatment required enroute, along with specific written instructions for administration, are furnished to transportation staff."); *id.* § 3-4378 ("Written policy, procedure, and practice regarding the transfer of health records require the following: (1) Summaries, originals, or copies of the health record accompany the inmate to the facility to which he or she is transferred."); *id.* (comment) ("Transfer of health records assures continuity of care and avoids duplication of tests and examinations.").

i. *Inmates must give written consent before their records are transferred to third parties outside of the correctional system.*

Standards for Health Services in Prisons, National Comm'n on Correctional Health Care P-64, at 80 (1997)(important) (transfer of health records) ("Written authorization by the inmate is required for the transfer outside the correctional system of medical records and information, unless otherwise provided by law or administrative regulation."); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 51, at 120 (1980) (essential) ("Written authorization by the inmate is necessary for transfer of psychological record information to any third party, unless otherwise provided for by law or administrative regulation having the force and effect of law."); *id.* (discussion) ("Even after consent has been obtained to release the psychological information, such material should clearly indicate to the recipient its confidential nature."); American Psych. Ass'n, *General Guidelines for Providers of Psychological Services* § 2.3.7, at 6 (1987) (illustrative statement) ("Psychologists do not release confidential information, except with the written consent of the user involved, or of

his or her legal representative, guardian, or other holder of the privilege on behalf of the user, and only after being assured by whatever means may be required that the user has been assisted in understanding the implications of the release. Even after the consent has been obtained for the release, psychologists clearly identify such information as confidential for the recipient of the information."); *Standards for Adult Correctional Institutions*. § 3-4330 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) (comment) ("When health care is transferred to providers in the community, appropriate health information should be shared with the new providers in accord with consent requirements."); *id.*, § 3-4378 ("Written policy, procedure, and practice regarding the transfer of health records require the following: . . . (2) Health record information also is transmitted to specific and designated physicians or medical facilities in the community upon the written authorization of the inmate."); *id.*, § 3-4096, at 30 ("The institution uses a release of information consent form that complies with applicable federal and state regulations. Unless the release of information is required by statute, the inmate signs the consent form prior to the release of information and a copy of the form is maintained in the inmate's case record.").

15. Discharge planning

a. Prison mental health services must provide appropriate discharge plans.

Standards for Health Services in Prisons, National Comm'n on Correctional Health Care P-44, at 54 (1997) (important) (Continuity of Care) ("Written policy and defined procedures require, and actual practices evidence, continuity of care from admission to the prison through discharge from it, including referral to community resources when indicated."); National Comm'n on Correctional Health Care, *Position Statement: Mental Health Services in Correctional Settings* § 3 (1992) ("[C]orrectional facilities and community based programs should work together to assure continuity of care for the inmate after release. Case management services should be available to assure access to mental health and substance abuse treatment programs as well as to integrate family oriented treatment where possible."); American Psychiatric Ass'n, *Guidelines for Psychiatric Services in Jails and Prisons*, in *Psychiatric Services in Jails and Prisons*, Task Force Report 29, § C.4.a (jails) ("Discharge/transfer planning in a jail setting includes all procedures through which inmates in need of mental health care at the time of release from jail to community are linked with appropriate community agencies capable of providing on-going treatment, or at the time of transfer to a prison, are made known to mental health service providers in the prison. Case management services include: 1) appointments arranged with mental health agencies for all mentally ill inmates or a specific subgroup such as those receiving psychotropic medication; 2) referrals arranged for inmates with a variety of mental health problems; 3) notification of reception centers at state prisons; and 4) arrangements made with hometown pharmacies to have prescriptions renewed."); *id.*, § C.4.b (jails) (stating that essential mental health services require that "(1) Discharge/transfer planning is carried out by a regularly assigned mental health professional. (2) Every inmate released who has received mental health crisis intervention or treatment services is assessed for

appropriateness of a community referral."); *id.*, § D.4.a (prisons) ("Discharge and/or transfer planning are those mental health services by which inmates in need of further mental health services at the time of transfer to another institution or discharge to the community are assured continuity of care."); *id.*, § D.4.b(1) (1989) (prisons) ("Discharge planning and transfer planning operations are carried out in a timely fashion by regularly assigned, qualified mental health personnel."); *id.*, § D.4.b(2) (1989) (prisons) ("The following elements should be met before a patient is transferred or discharged: (a) Criteria are contained in a written policy approved by both the mental health authority and the correctional facility administration. (b) Medications or other special treatments required en route and specific written instructions for administration are furnished to transportation staff. (c) Appropriate mental health records accompany the patient with precautions taken to protect confidentiality."); *Standards for Adult Correctional Institutions*. § 3-4330 (American Correctional Ass'n & Comm'n on Accreditation for Corrections 3rd ed. 1990) ("Written policy, procedure, and practice require continuity of care from admission to discharge from the facility, including referral to community care when indicated."); *Standard Minimum Rules for the Treatment of Prisoners: Resolution of the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders*, E.S.C. Res. 663C, U.N. ESCOR, 24th Sess., Supp. No. 1, ¶ 83, U.N. Doc. A/CONF/611 (1955), *amended by* E.S.C. Res. 2076, U.N. ESCOR, 62d Sess., Supp. No. 1, at 35, U.N. Doc. E/5988 (1977) (insane and mentally abnormal prisoners) ("It is desirable that steps should be taken, by arrangement with the appropriate agencies, to ensure if necessary the continuation of psychiatric treatment after release and the provision of social-psychiatric after-care");

American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 39, at 113 (1980) (important) ("There are written, implemented policies and procedures which require psychological services personnel to ensure that provisions are made for postrelease follow-up care where appropriate."); *id.* § 38, at 112 (1980) (important) ("There is a written, implemented procedure which provides for the orderly discharge of inmate clients from treatment. It includes (but is not limited to) the writing and filing of a treatment summary report within one month after treatment terminates.") *id.* (discussion) ("When inmates who have a continuing need for psychological services are released, the responsible psychologist (in collaboration with other appropriate staff) should ensure that follow-up treatment services are arranged as part of the individual's release plan."); Joint Comm'n on Accreditation of Healthcare Org., 1 *1993 Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services* § FC.2.3.1.5, at 62 (1993) (forensic services) (requiring that a mechanism exist to coordinate legal, correctional, and/or administrative decisions affecting an individual's treatment with clinical decisions about the individual, including "plan for discharge and continuing care.");

16. Quality assurance

a. *The correctional mental health system must have a quality assurance plan.*

American Psychiatric Ass'n, *Principles Governing the Delivery of Psychiatric Services in Lock-Ups, Jails and Prisons*, in *Psychiatric Services in Jails and Prisons*, Task

Force Report 29, § B.2.a (1989) ("Each facility or each administrative authority should have prepared a quality assurance plan that describes the mission and goals of the mental health service delivery system, the means by which these goals are to be achieved, and the means of evaluation of these objectives. This may be regarded as the formal aspect of quality assurance."); American Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons*, 7 *Crim. Just. & Behav.* 81, § 09, at 92 (1980) (essential) ("The quality of psychological services are [sic] reviewed at least annually and the results are reported in writing. The chief psychologist is responsible for overseeing this internal quality assurance program at the institutional level."); *id.* (discussion) ("Preferably, such an internal audit would be done semiannually, but under no circumstances should the chief psychologist permit the service to undergo its annual external audit (see standard 10) without a prior internal one. Quality assurance should include (but not necessarily be limited to) a review of procedures, resources, and outcomes."); *id.*, § 40, at 113 (important) ("There are implemented written policy and procedures which require formal evaluation of the effectiveness of psychological services treatment programs."); American Psych. Ass'n, *General Guidelines for Providers of Psychological Services* § 3.3, at 8 (1987) ("There are periodic, systematic, and effective evaluations of psychological services."); *id.* (illustrative statement) ("When the psychological service unit is a component of a larger organization, regular assessment of progress in achieving goals is provided in the service delivery plan. Such evaluation could include consideration of the effectiveness of psychological services relative to costs in terms of time, money, and the availability of professional and support personnel. Evaluation of the psychological service delivery system could be conducted both internally and, when possible, under independent auspices. Descriptions of therapeutic procedures and other services as well as outcome measures should be as detailed as possible. This evaluation might include an assessment of effectiveness (to determine what the service accomplished), costs, continuity (to ensure that the services are appropriately linked to other human services), availability (to determine appropriate levels and distribution of services and personnel), accessibility (to ensure that the services are barrier-free to users), and adequacy (to determine whether the services meet the identified needs of users). In such evaluations, care is taken to maintain confidentiality of records and privacy of users. It is highly desirable that there be a periodic reexamination of review mechanisms to ensure that these attempts at public safeguards are effective and cost-efficient and do not place unnecessary encumbrances on providers or unnecessary additional expense on users or sanctioners [sic] for services rendered."); *Madrid v. Gomez*, 889 F. Supp. 1146, 1222 (N.D. Cal. 1995) ("[A] Quality Assurance program is designed to enable a medical institution or department to review, on an ongoing basis, staff medical decisions and practices in order to assess whether corrective measures are necessary or appropriate. Such a program is considered 'standard practice' in virtually every health care facility in the country and is considered a 'fundamental part' of a health care operation."); *id.* at 1259 ("Defendants' callous and deliberate indifference to inmates' needs is particularly evinced by their failure to institute any substantive quality control. Quality control procedures represent the first critical steps of self-evaluation that could help defendants remedy widespread deficiencies; yet, at the time of trial, there were still no such procedures in operation."); *Coleman v. Wilson*, 912 F. Supp. 1282, 1995 WL 559109, *16 (E.D. Cal. 1995) (finding Eighth

Amendment violation where "defendants have no effective method for insuring the competence of their mental health staff and, therefore, for insuring that inmates have access to competent care," and holding that "development of a quality assurance program is an appropriate remedy for constitutional deficiencies in the delivery of prison health care"); *Grubbs v. Bradley*, 821 F. Supp. 496, 500 (M.D. Tenn. 1993).