IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 12-cv-01570-RPM

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JOHN J. POWERS,
ARNELL SHELTON,
and MARCELLUS WASHINGTON,

each individually and on behalf of all others similarly situated,

and

CENTER FOR LEGAL ADVOCACY,
D.B.A. DISABILITY LAW COLORADO

Plaintiffs,

vs.

FEDERAL BUREAU OF PRISONS,

Defendant.

PLAINTIFFS' UNOPPOSED MOTION FOR PRELIMINARY APPROVAL OF SETTLEMENT TERMS AND PROPOSED NOTICE TO THE CLASS

Plaintiffs respectfully move for entry of the accompanying order granting preliminary approval of the proposed terms described below, and the form of the notice to be delivered to the Plaintiffs and class members. In support of their motion, Plaintiffs incorporate the following facts and legal authorities. As previously discussed with the Court, Plaintiffs also intend to

submit an Appendix of additional supporting materials, including declarations from experts and counsel in further support of this motion. Those materials are still being developed, and will be provided before the fairness hearing scheduled for December 15 and 16, 2016.[1]

I. PROCEDURAL BACKGROUND

This putative class action involves the diagnosis and treatment of inmates with mental illness who are confined at ADX Florence, the federal "supermax" prison situated in Florence, Colorado. Plaintiffs contend that Defendant has not provided the level of mental health diagnosis and treatment required by the Eighth Amendment to the United States Constitution.

Plaintiffs filed their original Complaint on June 18, 2012. *See* DKT 1. On April 23, 2013, the Court denied Defendant's Motion to Dismiss. *See* DKT 58. Thereafter, Plaintiffs twice amended their Complaint, first on May 23, 2013, *see* DKT 67, and then again on June 15, 2015, *see* DKT 274.

Plaintiffs' Second Amended Complaint seeks sweeping injunctive relief concerning the diagnosis and treatment of mental illness among ADX inmates. *See* DKT 272. Plaintiff seek that relief on two distinct legal bases. First, a group of fourteen current and former ADX inmates request certification of a class and subclass under Fed. R. Civ. P. 23(b)(2) and 23 (c)(5). The proposed class consists of all inmates who were, as of the filing date of the original Complaint in this case, or are, or will be in the future, confined at ADX, *see* Second Amended Complaint, DKT 274, at ¶ 581, and seeks implementation of a constitutionally adequate program of mental health diagnosis and treatment, *see id*. at 194, §XIII, ¶ 2. The proposed subclass consists of all

[1] The Defendant has authorized the undersigned to represent that Defendant does not oppose Plaintiffs' request for entry of an order preliminarily approving the settlement agreement and proposed class member notice, or Plaintiffs' motion for final approval of the proposed settlement, including the payment of attorney's fees and costs. However, the Defendant does not adopt, join, or necessarily agree with the other statements set forth herein.

ADX inmates diagnosed by Defendant with mental illness or serious mental illness, as those terms are further detailed in ¶ 581 of the Second Amended Complaint. On behalf of the subclass, the Second Amended Complaint seeks implementation of a program of treatment for mental illness and serious mental illness, as detailed in § XIII, paragraph 3 of the Second Amended Complaint. *See* Amended Complaint, DKT 274, at 195.

Second, and independently, Plaintiff Center for Legal Advocacy d/b/a Disability Law Colorado ("DLC") asserts associational standing on behalf of the proposed class and subclass members to pursue claims for the same relief for the class and subclass members as has been requested by the putative class Plaintiffs. This standing arises from DLC's designation by the State of Colorado and its subsequent receipt of allotments pursuant to the Protection and Advocacy for Individuals with Mental Illness Act ("PAIMI Act"), 42 U.S. Code §§ 10801, *et seq*. By order dated November 3, 2015, the Court held that DLC has standing to pursue claims for declaratory and injunctive relief for prisoners with mental illness housed at ADX. DKT 324, at 4.

Plaintiffs are pleased to report that after more than three years of negotiations with Defendant, and with the extensive assistance of United States Magistrate Judge Michael Hegarty, the parties have reached a negotiated resolution of all issues before the Court. As a result, Plaintiffs now request that the Court grant preliminary approval of the proposed settlement and approve a procedure for notice to the class and the content of that notice, in anticipation of the previously scheduled December 15, 2016, hearing concerning final approval of the proposed settlement, including the provisions for payment of attorneys' fees and costs. The terms of the proposed settlement are reflected in the documents attached hereto as Exhibits 1, 2, 3, 4, 5, 6, 7 and 8. Versions of the proposed notice in English and Spanish are attached as

Exhibits 10 and 11. This motion collectively refers to these ten documents as the "Settlement Documents."

II. PRELIMINARY APPROVAL OF THE SETTLEMENT AGREEMENT IS NOW APPROPRIATE.

Under Fed. R. Civ. P. 23(e), a class action may not be dismissed or compromised without the approval of the court. A court considering dismissal or compromise of a class action "must direct notice in a reasonable manner" to members of the class who would be bound by the proposed settlement. Fed. R. Civ. P. 23(e)(1). Plaintiffs ultimately seek the Court's determination that, under the standards set forth in Fed. R. Civ. P. 23(e)(2), the proposed settlement is "fair, reasonable, and adequate."

As steps in that process, Plaintiffs now seek preliminary approval of the proposed settlement terms and approval of a form and method of notice to the class regarding the agreement. Although Fed. R. Civ. P. 23(e) does not specifically require that a court give preliminary approval to a proposed compromise or dismissal before providing for notice to the class, courts generally do so at the time that they order that notice be given to the class. *See* Federal Judicial Center, *Manual for Complex Litigation (Fourth)* §§ 21.632, 21.633 (2004); *DeJulius v. New England Health Care Employees Pension Fund,* 429 F.3d 935, 939 (10th Cir. 2005).

As in other jurisdictions, preliminary consideration and, where appropriate, preliminary approval of proposed settlement agreements, have been widely used within the Tenth Circuit. *See, e.g., Lucas v. Kmart Corp.*, 234 F.R.D. 688, 693 (D. Colo. 2006) (preliminarily approving a settlement agreement and scheduling a fairness hearing for a later date).

Plaintiffs respectfully submit that preliminary approval of the Settlement Documents is appropriate at this time. As detailed below, the Settlement Documents consist of a series of

policies implemented, or to be implemented, by Defendant, together with an "Addendum" that details the settlement terms, including terms providing for the certification of a class and subclass for settlement purposes, the appointment and compensation of two psychiatric experts to monitor Defendant's compliance with the settlement terms, the implementation of dispute resolution and enforcement provisions, and an award of attorneys' fees and costs. The Addendum also provides for conditional dismissal of this case pursuant to *Kokkonen v. Guardian Life Ins. Co. of Am.*, 511 U.S. 375, 379-382 (1994), and reflects the parties' stipulation that the settlement agreement complies with the provisions for prospective relief set forth in the Prison Litigation Reform Act, 18 U.S.C. § 3626(a) ("PLRA"). For the reasons discussed below, Plaintiffs' undersigned counsel respectfully submit that the Addendum and associated policies provide for a fair, reasonable, and adequate settlement of this matter.

A. The Proposed Class and Subclass Satisfy the Requirements of Fed. R. Civ. P. 23(a) and 23(b)(2).

Fed. R. Civ. P. 23(a) permits certification of a class only where the plaintiffs establish that: (1) the class is so numerous that joinder of all members is impracticable; (2) there are questions of law or fact that are common to the class; (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and (4) the representative parties will fairly and adequately protect the interests of the class. In this case, the proposed class Plaintiffs seek certification of the class and subclass under Rule 23(b)(2), on the basis that Defendant has acted and refused to act on grounds that apply generally to the class and subclass, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class and subclass as a whole.

In *Amchem Products, Inc. v. Windsor*, 521 U.S. 591 (1997), the United States Supreme Court observed as follows in evaluating whether and how a class may be certified in order to achieve settlement:

> Confronted with a request for settlement-only class certification, a district court need not inquire whether the case, if tried, would present intractable management problems, see Fed. Rule Civ. Proc. 23(b)(3)(D), for the proposal is that there be no trial. But other specifications of the Rule -- those designed to protect absentees by blocking unwarranted or overbroad class definitions -- demand undiluted, even heightened, attention in the settlement context. Such attention is of vital importance, for a court asked to certify a settlement class will lack the opportunity, present when a case is litigated, to adjust the class, informed by the proceedings as they unfold. See Rule 23(c), (d).

Id. at 620. The Court also noted that "proposed settlement classes sometimes warrant more, not less, caution on the question of certification," *Id*. n.16, and found that the purposes of Rule 23 mandate compliance with its terms, even for purposes of settlement: "Subdivisions (a) and (b) focus court attention on whether a proposed class has sufficient unity so that absent members can fairly be bound by decisions of class representatives. That dominant concern persists when settlement, rather than trial, is proposed." *Id*. at 621.

Plaintiffs submit that even under these demanding standards, the Court may and should certify the proposed Plaintiff class and subclass for settlement purposes. As detailed in the Second Amended Complaint, the diagnostic and treatment failures that led to this lawsuit were widespread and affected most, if not all, of the inmates sent to ADX. Defendants routinely failed to properly diagnose and treat mental illness, and frequently disregarded or failed to comply with related responsibilities concerning such matters as suicide prevention and inmate discipline. Although the experiences of inmates at ADX vary to some extent based on factors such as their mental health, the duration of their confinement at ADX, and other individualized factors, the failures alleged in the Second Amended Complaint are common, the claims of the class Plaintiffs are typical of those of other members of the class and subclass, and the legal and

factual issues underlying all class members' claims are similar, and rooted in the same policies and practices.

Given the systemic failures that gave rise to this case and the nature of the impact of those failures on members of the class and subclass, the central inquiry here, under Rule 23(a) and 23(b)(2), is whether the proposed settlement fairly, reasonably, and adequately remedies those failures.

B. The Settlement Appropriately Redresses the Legal Claims of the Class.

In broad terms, Plaintiffs' claims relate to deficiencies in at least five major areas: (1) BOP's failure to properly define the category of inmates whose mental illnesses could not be constitutionally treated at ADX and who therefore required exclusion from the institution; (2) BOP's failure to adequately diagnose mental illness among inmates before their placement at ADX, and failure to identify and diagnose mental illness that developed following inmates' placement at the facility; (3) BOP's failure to provide ADX inmates with constitutionally compliant medication, psychotherapy, and other mental health resources and services; (4) BOP's failure to manage discipline, suicide prevention, and other programs in a manner that protects the rights of inmates with mental illness; and (5) BOP's failure to train ADX staff members concerning mental illness. As set forth below, the Settlement Documents provide comprehensive relief to the class and subclass with respect to these failures, and also address a wide variety of other matters that impact the mental health of members of the class and subclass.

Before detailing many of the constitutional failures that precipitated this lawsuit, and describing how the proposed settlement seeks to resolve those failures, Plaintiffs believe that it is appropriate to acknowledge the strides that BOP has made to correct the conditions that existed at ADX at the outset of this dispute. By any measure, ADX is a different place than it

was in 2011. Nearly 100 mentally ill men have been transferred to other facilities. BOP has activated three new high security mental health treatment units in other facilities, which now house and care for many people with mental illness who spent years at ADX. On its own initiative, BOP is also exploring new programs for inmates who remain at ADX, including one designed to prepare inmates for release into the community and another designed to more humanely house long-term ADX inmates who have no recent history of institutional violence. Many staff members at ADX and elsewhere within the BOP now understand mental illness better, and deal more humanely with inmates who struggle with mental health problems. And many of the staff members at ADX are more open to ideas and information about inmates with mental illness than they used to be.

In particular Plaintiff's undersigned counsel wish to specifically and gratefully acknowledge in particular Chris Synsvoll and Kaitlin Turner of the BOP legal department at ADX, Amy Padden at the United States Attorneys' Office, and BOP General Counsel Kathy Kenney. As BOP gained an understanding of the issues this case set out to correct, these four individuals have, along with certain of their colleagues, responded to countless suggestions, requests, demands, concerns and complaints in a professional, receptive and humane fashion. Likewise, while certain abhorrent behavior by BOP personnel is referred to below to illustrate the necessity and efficacy of specific settlement terms, Plaintiffs' counsel also acknowledge that many of the correctional officers and other staff members who work at ADX do an excellent job in a challenging and dangerous environment.

Unfortunately, some problems remain. An inmate named Boyd Higginbotham, who had serious mental illness therefore should have been removed from ADX, was instead neglected by BOP mental health professionals and committed suicide at ADX on Christmas Eve 2015. Some

staff members – including at least one current ADX psychologist – remain resistant to the changes required by the proposed settlement, and appear likely to run afoul of the Monitors and enforcement processes. And other diagnostic and treatment problems continue to emerge. Plaintiffs believe that the monitoring and enforcement terms included in the Settlement Documents will improve conditions further. Despite the work that remain, Plaintiffs do not mean, by what follows, to discount the substantial effort that BOP has made, the many positive results that BOP has achieved, or the professionalism and decency of the many BOP representatives who have demonstrated a personal commitment to honoring the rights and dignity of inmates confined at ADX.

1. The settlement establishes exclusionary criteria and mental health care levels to facilitate the identification of inmates who, because of serious mental illness, cannot properly be treated at ADX and must therefore be excluded from the facility.

ADX is a purpose-built facility that is designed to house, and control, inmates considered by the BOP to be violent, dangerous, or otherwise in need of the highest level of security available in any BOP facility. The physical layout of the facility makes providing intensive mental health treatment difficult. In addition, most inmates at ADX live in extremely isolating conditions that are hard on even the most robust inmates, and can be psychologically devastating for inmates with mental illness. For these reasons, among others, BOP policy has for many years precluded the placement at ADX of inmates with serious mental illness.

However, previous BOP policies have not set forth clear standards for determining what constitutes "serious mental illness" for these purposes. BOP policies also failed to provide sufficient guidance concerning the specifics of the treatment to be afforded to inmates with varying degrees of psychological impairment. The policies included in the Settlement Documents address these shortcomings with specific exclusionary criteria and definitions of

mental health care levels and correlated treatment requirements. Plaintiffs believe that if BOP complies in good faith with those provisions of its revised policies, the goal of eliminating serious mental illness from ADX inmate population will be substantially achieved.[2]

2. Ensuring constitutionally adequate diagnosis before and after inmates arrive at ADX and providing a mechanism for the ongoing review of inmates' mental health.

BOP policy has long required that inmates being considered for placement at ADX receive a mental health evaluation and related "due process hearing" before being designated to ADX, and that inmates be screened for mental health problems after arriving and on a periodic basis thereafter. But in practice, when Plaintiffs' counsel began investigating in 2011, ADX was brimming with inmates who had mental illness, many of whose mental illness was serious by any reasonable interpretation. Some inmates never got a meaningful pre-transfer mental evaluation, and others received their "pre-transfer" evaluation months or in some cases years after arriving at ADX. Prevailing conditions at that time and continuing into 2012 and 2013 are detailed throughout the Second Amended Complaint and even more clearly in Plaintiff DLC's September 30, 2013, emergency motion for a preliminary injunction ordering Defendant to transfer ADX prisoner, Jonathan Francisco, for a medical evaluation, and treatment, DKT 99. In explaining why the transfer of Francisco was necessary, Plaintiffs' motion described in horrible detail the neglect of another inmate named Richie Hill, whom BOP has since admitted suffers from a severe and debilitating mental illness, but who was nevertheless allowed to languish at ADX for six years, much of which he spent encrusted in his own body waste and shuffling around his cell (or lying on its floor) in obvious and devastating psychological distress. All the

[2] Given the unique mission of ADX and the fact that it houses some inmates who are legitimately deemed to be extremely dangerous, the Settlement Documents do contemplate that an inmate may need to be housed at ADX despite serious mental illness, if his security needs cannot be managed anywhere else in the BOP. But in such circumstances the policies provide for the delivery of constitutionally adequate mental health care.

while, BOP personnel persistently failed to recognize his mental illness for what it was. He ultimately was transferred to a BOP medical facility only when he was literally near death, wracked by severe malnutrition and systemic staph infections that nearly resulted in the amputation of his legs. Unfortunately, the neglect of Mr. Hill as ADX was not an isolated incident; many other inmates with similarly obvious problems were similarly ignored, neglected and in many cases abused.

The proposed settlement addresses past screening and diagnostic failures by requiring, in detailed terms, mental health evaluations before an inmate may be placed at ADX, an evaluation following arrival, and ongoing review of inmate mental health in a fashion calculated to identify and facilitate the proper diagnosis of mental illness.

3. Ensuring constitutionally adequate mental health treatment.

Like BOP's systemic diagnostic failures, its treatment failures are detailed at length in the Second Amended Complaint. For example, longstanding BOP policy prohibited the placement of an inmate taking psychotropic medication in ADX Control Unit, the facility's most restricted and isolating housing unit. In practice, as of 2011 BOP personnel interpreted that well-intentioned policy to prohibit the administration of psychotropic medication to Control Unit inmates, whether or not they needed it. Consequently, inmates' prescribed medications were frequently discontinued in order to render them "eligible" for a Control Unit placement.

The record is literally saturated with details of like failures in virtually every aspect of ADX mental health treatment program. Inmates had no opportunity to speak privately with clinicians, and therefore frequently were unable to seek meaningful help for the debilitating effects of such traumas as childhood sexual abuse, which no one would be comfortable discussing where everyone within earshot could hear. Psychologists dressed in riot gear

sometimes participated as correctional officers in violent, calculated efforts to subdue inmates, a practice that eliminated any possibility of developing the trust needed between a clinician and a mentally ill patient. Medications were changed or discontinued on a whim, sometimes for disciplinary reasons, or were mixed up or not delivered at all. Desperate calls for help from suicidal inmates were never responded to. And at least 14 separate *pro se* lawsuits by ADX inmates seeking care for mental illness were ignored by the BOP and dismissed on technical grounds without ever receiving a serious examination, or precipitating an investigation by BOP into why so many ADX inmates were suing for the very same thing, year after year.

The proposed settlement addresses these and other known failures in a comprehensive fashion. The prohibition of psychotropic medication in the Control Unit has been eliminated. New polices regulate the administration of medication, prohibit clinicians from participating in calculated uses of force absent emergency circumstances, and impose specific timelines for responding to requests for mental health services. BOP has constructed and is using confidential spaces for secure, safe mental health consultations, as well as secure facilities for group mental health therapy. And the ADX mental health staff has more than doubled in size. Virtually every aspect of ADX mental health system and related processes – such as discipline for inmates with mental illness – has been reviewed, revised, and made more specific.

4. Improving ADX discipline, suicide prevention, recordkeeping, staff training, and other programs that protect the rights of inmates with mental illness.

Not long ago, ADX inmates who harmed themselves because of mental illness, or who attempted suicide, were often punished with the suspension of the scant privileges available to them, such as the opportunity to make two fifteen minute phone calls per month to friends and family members. One inmate who nearly killed himself by slashing his throat with a razor was stitched up and returned to the same cell, still fouled with his blood and with the razor still

sitting on the sink, from which the inmate retrieved it and again attempted to end his life. Another inmate literally ate his finger while in a fit of psychosis, and was asked by an ADX staff member what the finger tasted like. Yet another nearly died after he followed a BOP directive requiring that he report suicidal thoughts, was ignored, and then swallowed hundreds of pills. And BOP's oversight of inmates with mental illness was so deficient even after this case was filed that former ADX inmate Richie Hill was reduced to slithering naked on the floor of his cell, wallowing in his own body waste and suffering from malnutrition so severe that he had lost more than 50 pounds in six months and was reduced to eating pebbles and his own feces. At the very same time, he developed nearly lethal staph infections in both legs because he was delusionally trying to dig "diamonds" out of his flesh with filthy hands. He was finally evacuated on an emergency basis to a BOP hospital, where records reflect that he nearly died. Yet shortly before his evacuation, a BOP record authored by the then-chief psychologist at ADX noted nothing out of the ordinary and states that Hill "appeared alert and relaxed" and would "continue to be monitored during unit rounds."

These and the many other failures described in the record in this case resulted from a confluence of closely related problems with the institution's policies and staff. Staff members were not trained to recognize and properly address mental illness. They were conditioned to believe that inmates who acted out were faking mental illness for so-called "secondary gain." They administered ADX inmate discipline and suicide prevention policies – among other institutional protocols – without regard to the reality that, by 2011, at least a quarter of ADX population exhibited serious signs and symptoms of mental illness. And they were accountable to no one: they ran the prison they proudly called "the Alcatraz of the Rockies," housed the supposed worst of the worst, had terminated virtually all press access to the facility following

the 9/11 attacks, and were convinced that they had all the answers and needed not answer to anyone about anything.

The proposed settlement addresses these related problems in several ways. It requires the involvement of mental health professionals in disciplinary processes involving inmates with known or suspected mental health issues. The suicide prevention program has been substantially revised, as has been protocol for responding to urgent inmate requests for mental health counseling. The settlement requires specific staff training, and includes ongoing monitoring – described in greater detail below – by experts in correctional mental health who were involved in negotiating and drafting the policies they will be monitoring. And the fact and outcome of the litigation itself has informed the staff in unmistakable terms that people are watching, that mental illness does in fact occur in ADX inmate population, and that they will be held accountable when they fail to do what BOP policy and the Eighth Amendment require.

C. The Settlement Agreement Establishes Effective and Efficient Mechanisms to Implement Reform.

The parties spent substantial time developing effective mechanisms to produce the changes that both parties desire. First, perhaps the most critical characteristic of the proposed settlement is that, if adopted by the Court, it will be fully-enforceable by court order, because it complies with the requirements of the PLRA set forth in 18 U.S.C. § 3626(a)(1)(A). This ensures that the parties have the appropriate incentives and tools to achieve and sustain compliance in the minimum amount of time.

Court-enforceability, by itself, is not enough to produce compliance. In addition, the proposed settlement establishes a comprehensive enforcement structure that guides the litigation toward termination by establishing mechanisms to assist the BOP in achieving compliance with the terms of the settlement. One of the most important of these mechanisms is the designation of

two Monitors with professional training and experience in evaluation and supervision of correctional mental health programs in the areas covered by the proposed settlement. The proposed settlement also provides for a tiered dispute resolution process that is designed to allow compliance concerns to be quickly addressed in an efficient fashion, to involve Judge Hegarty as necessary to help mediate disputes that are not quickly resolved, and to bring to this Court any remaining compliance issues for timely and effective enforcement proceedings.

Both of the Monitors designated by the proposed settlement have outstanding credentials. Jeff Metzner and Sally Johnson are both psychiatrists. Each has decades of experience in correctional mental health, as reflected in the CVs attached as Exhibits 11 and 12, respectively.

Dr. Metzner both maintains a private psychiatry practice and serves on the faculty of the University of Colorado Medical School. He has practiced psychiatry for more than 35 years. Early in his career he was the Chief of Psychiatry at both the Colorado State Penitentiary and the Division of Forensic Psychiatry at the Colorado State Hospital. Since that time he has become one of the nation's most respected experts in correctional mental health. Among other professional engagements, he has served as an expert witness and/or consultant in a number of important jail and prison reform cases, consulted with various correctional systems on mental health management issues, advised judges as a court-appointed independent advisor in such matters as the seminal *Madrid v. Gomez* case, which involved mental health and other issues at California's Pelican Bay supermax facility, and has years of experience as a court appointed monitor in institutional reform cases, including one involving one of the largest jails in the United States. He has also been a Certified Correctional Health Professional for more than 20 years, was an Accreditation Surveyor for National Commission on Correctional Health Care

from 1995 to 2006, played a pivotal roles in formulating the formal position of the American Psychiatric Association on housing inmates with mental illness in solitary confinement, and has authored many scholarly publications on that and related issues.

Dr. Johnson is currently a Professor in the Department of Psychiatry at the University of North Carolina at Chapel Hill, where she helped develop the recently launched Forensic Psychiatry Program and Clinic. She conducts forensic evaluations in criminal and civil cases and consults regarding issues at the interface of psychiatry and law. Dr. Johnson also teaches within the psychiatry training programs at both UNC and Duke, and also has appointments the law schools of both UNC and Duke University, where she a Senior Lecturer in Law and teaches seminars in Psychiatry and Law. Dr. Johnson completed career service as a Captain in the United States Public Health Service, where she served as a psychiatrist and administrator for the BOP. During her tenure there she developed BOP's forensic evaluation and training program and served as associate warden for health services, administrating inpatient and outpatient medical and mental health programs. She has extensive experience conducting forensic evaluations and serving as an expert witness for the federal courts and has consulted with federal and state agencies and programs about psychiatric care and mental health needs of incarcerated individuals.

Importantly, Drs. Metzner and Johnson are already intimately familiar with this case and the issues that gave rise to it. Plaintiffs engaged Dr. Metzner in the summer of 2011 to advise on mental health and related correctional issues, and Dr. Johnson has served as the BOP's mental health expert in this case since at least 2013, if not earlier. Both were intimately involved in developing the Settlement Documents, attended multiple settlement meetings, and played key

roles in drafting the policies they are now being proposed to monitor. Both also played active roles in completing mental health evaluations of more than 130 ADX inmates in August 2014.

In short, the proposed Monitors are probably the two people on the planet best suited to monitor the proposed settlement. They also have the confidence of the parties, and enjoy a strong professional working relationship forged in this and other matters.

The Settlement Documents empower the proposed Monitors to fulfill their obligations. Both proposed Monitors were directly involved in the terms of the proposed settlement that provide them with guaranteed access to the records and other information they say they need to monitor compliance. They will also conduct on-site inspections no less frequently than three times per year during the first two years, meet with representatives of both parties following each such inspection, and issue written compliance reports, which will be available in the event of a compliance dispute.

The Settlement Documents are also structured to not only produce evidence related to compliance, but also to promptly and effectively resolve any disputes about compliance. In particular, the proposed settlement creates a specific, time-limited structure for raising and escalating any compliance issues, culminating with the involvement of Judge Hegarty and, if necessary, this Court, which will remain vested with the full power to enforce the settlement terms.

The Settlement Documents also provide for additional monitoring by DLC of inmate complaints regarding the implementation of the Addendum. DLC will draft a notice letter and Defendant will distribute the letter advising current ADX inmates and new inmates that arrive during the compliance period of its existence and availability to receive complaints regarding the implementation of the Addendum. DLC is also empowered to resolve any complaints that it

receives in accordance with the provisions of the Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. §10801, et seq. and the dispute resolution section of the Addendum.

Finally, the proposed settlement is designed to not only ensure compliance at ADX, but also to protect the rights of ADX inmates with mental illness who are or will be transferred to three high security mental health programs that BOP has created in response to this case. Those units, located at the United States Penitentiaries in Florence, Colorado, Atlanta, Georgia, and Allenwood, Pennsylvania, collectively house about 80 inmates, many of whom are or were members of the class and subclass defined in the Second Amended Complaint. Although participants in these programs no longer are housed at ADX and likely never will return there, Plaintiffs' counsel insisted that the settlement provide in some meaningful way for the continuing well-being former class members while housed in the new programs.

The proposed settlement addresses that priority in two ways. First, the Settlement Documents provide that the proposed Monitors will monitor policy compliance not only at ADX but also at the specialized high security mental health program at USP Florence, which is known as the Secure STAGES Program. The Secure STAGES Program focuses on inmates who have been diagnosed with borderline personality disorder and have a history of self-harm. Under the proposed settlement, the program will be monitored by the proposed Monitors subject to the same terms, conditions and enforcement protocols that apply to ADX.

The other new programs, at USP Atlanta and USP Allenwood, are subject to a different oversight process. They will not be monitored, but instead are subject to the Agreement attached as Exhibit 9. The parties do not seek formal Court approval of that Agreement, because it is not formally among the Settlement Documents and is not subject to enforcement in the same way as

the other Settlement Documents.[3] But the fact that the settlement negotiations yielded the Agreement is nevertheless material as a further indicator that the settlement is fair and reasonable to the inmates involved in this case, even if they no longer reside at ADX.

In summary, the proposed settlement promises to comprehensively remedy the many violations of the rights of the class and subclass regarding mental health care at ADX, and to do so as quickly and efficiently as possible, while providing Defendant with expertise to assist in these tasks, and ensuring expert assistance to the Court in evaluating the parties' claims of compliance and non-compliance. As such, it is a model of a "fair, reasonable, and adequate" settlement of the claims of the class.

D. Other Relevant Factors Support Approval of the Settlement Agreement.

In addition to considering the relief afforded the class and subclass in comparison to their legal claims, courts consider factors related to the circumstances of the parties' negotiations in evaluating whether a class settlement should be approved. In particular, courts examine whether there is any probability that the settlement is collusive. 7B Charles Alan Wright et al., *Federal Practice and Procedure* § 1797.1 (3d ed. 2005). A court may take into account class counsel's recommendation regarding the proposed settlement, but must be vigilant to assure that class counsel is truly acting in the interest of the class. *Id*. Thus, this court should examine the adequacy of the representation of the class and similar matters that, aside from the merits of the proposed settlement, shed light on the probability that the settlement is in the interest of the class.

[3] During this litigation, BOP objected to this Court's the exercise of jurisdiction over inmates that BOP chose to move to facilities outside Colorado. In response, Plaintiffs noted, among other things, that the Court has jurisdiction over BOP, and thus has the power to direct the BOP to take action, including action concerning inmates who were in Colorado when the case was pending but whom the BOP moved elsewhere. The Agreement does not resolve this dispute; rather, it preserves all parties' positions if the issue needs to be litigated in the future. *See* Exhibit 9, at ¶¶ 5 and 6(b).

This analysis includes how well informed class counsel were when they negotiated the settlement and whether counsel engaged in arm's-length negotiations. *See Wilkerson v. Martin Marietta Corp.*, 171 F.R.D. 273, 284-90 (D. Colo. 1997) (approving a settlement agreement after considering factors related to assessing whether the settlement was reached as a result of good-faith bargaining without collusion and with a full exploration of the merits of the claim by Plaintiffs' counsel who possessed sufficient experience to evaluate the claim accurately, as well as an objective assessment of additional factors that bear on the determination that the settlement is in the interest of the class). The specific factors that must be considered by the court in assessing whether the settlement is fair and reasonable under Rule 23 include: "(1) whether the proposed settlement was fairly and honestly negotiated; (2) whether serious questions of law and fact exist, placing the ultimate outcome of the litigation in doubt; (3) whether the value of an immediate recovery outweighs the mere possibility of future relief after protracted and expensive litigation; and (4) the judgment of the parties and their counsel that the settlement is fair and reasonable." *Jones v. Nuclear Pharmacy, Inc.*, 741 F.2d 322, 324 (10th Cir. 1984). The record in this case supports a conclusion that the proposed settlement is appropriate in light of these four factors.

1. The settlement was fairly and honestly negotiated.

This settlement resulted from hard-fought negotiations over more than three years, pursued by counsel with undivided loyalty to the class. The agreement was negotiated only after Plaintiffs' counsel had engaged in an extensive investigation of conditions at ADX, reflected in substantial evidence of constitutional violations summarized in the Second Amended Complaint DKT 274, Plaintiffs' Motion for Class Certification, and the Declarations supporting that Motion DK 148, and Plaintiff DLC's Emergency Motion for a Preliminary Injunction

concerning Jonathan Francisco DKT 99. Before completing the negotiations, Plaintiffs received substantial informal discovery from Defendant, including access to medical and psychology records of class members and former class members. Class counsel also conducted hundreds of inmate interviews, received thousands of letters from current and former ADX inmates, and received tens of thousands of pages of records from inmates and under FOIA.

Plaintiffs were also advised in connection with the settlement by a highly qualified panel of experts and consultants, including, over time, the following:

- Jeff Metzner, MD, whose qualifications are summarized above and in Exhibit 12.
- Doris Gundersen, MD, a noted forensic psychiatrist who, at Plaintiffs' expense, conducted more than 30 forensic evaluations of ADX inmates and participated actively in the settlement negotiations.
- Craig Haney, PhD, a psychologist who has devoted his 40-plus year career to correctional mental health, generally, and to studying solitary confinement and its impact on inmates, in particular.
- Phil Wise, a former Assistant Director of the BOP who during his long tenure with the BOP oversaw the agency's psychology program, served as Warden of a BOP medical facility, and played a key role in developing and executing BOP policy as a member of the agency's executive staff.
- Mark Bezy, a retired BOP Warden who served in many correctional roles at high security BOP facilities, including USP Marion, which preceded ADX as the BOP's highest security institution, and USP Terre Haute, which houses the federal death row and, as such, is responsible for the secure housing of some of BOP's more dangerous inmates.
- Steve Cambra, a longtime corrections official and expert who spent his career in high-security corrections in California, including serving as the Warden of the Pelican Bay supermax facility charged with implementing the court orders in the *Madrid v. Gomez* case,[4] and as Acting Director of the California Department of Corrections.

Plaintiffs also conferred extensively with nationally recognized experts in prison reform, including in particular David Fathi, head of the National Prison Project of the American Civil

[4] 889 F. Supp. 1146 (N.D. Cal. 1995)

Liberties Union and one of the most experienced prison reform litigators in the world; John Boston, who literally wrote the book on the Prison Litigation Reform Act and related legal issues impacting prison litigation; and Margo Schlanger, a University of Michigan law professor who is a leading authority on civil rights issues and civil and criminal detention, and a former lawyer in the Civil Rights Division of the United States Department of Justice who, in that capacity, was involved in litigating prison civil rights cases brought by DOJ against state and local correctional systems. She also has served as the Officer for Civil Rights and Civil Liberties at the U.S. Department of Homeland Security, and is currently the court-appointed settlement Monitor for *Adams v. Kentucky Department of Corrections*, a statewide civil rights lawsuit dealing with conditions of confinement for Kentucky's deaf prisoners. While the form and content of the Settlement Documents are the responsibility of Plaintiffs' counsel, the foregoing resources significantly informed the course and proposed resolution of this case, and provide further assurance that the outcome is fair, reasonable, and informed.

The negotiations were also meticulous, and at times contentious. Formal mediation sessions lasted at least 200 hours over dozens of sessions. The parties' representatives also had many additional hours of less formal negotiations between mediation sessions. Both sides produced multiple edited drafts of the settlement agreement and related policies, as well as various communications responding to inquiries from Magistrate Judge Hegarty. At times, it was unclear whether, even with Judge Hegarty's help, the parties could find a path forward to agreement. Indeed, as the Court is aware, the parties broke off negotiations for nearly a year, from 2015 until early 2016.

Moreover, in order to separate fee considerations in every way possible from negotiations of the substantive provisions of the settlement, Plaintiffs' counsel refused to

negotiate fees until after reaching agreement on the merits. A review of the provisions for partial payment of the attorneys' fees and expenses of Plaintiffs' counsel demonstrates that the circumstances do not suggest self-dealing by Plaintiffs' counsel. The one area in which Plaintiffs' counsel were forced to make significant compromises with Defendants was in the provisions for attorneys' fees, in which Plaintiffs' counsel settled for a sum far below their actual claim. *See* § III, *infra*. Moreover, all fees paid to Plaintiffs' principal counsel at Arnold & Porter are being donated to charitable causes. Accordingly, the first factor supports preliminary approval.

2. Serious questions of law and fact exist, placing the ultimate outcome of the litigation in doubt.

This is a complex case, both legally and factually. Chief among the legal complications is the PLRA, which severely restricts the remedies available in a case like this, and limits the Court's enforcement powers. Another potential legal hurdle lies in the concepts of voluntary cessation and mootness. It is undisputed that since 2011 BOP has changed many things at ADX. Although strong arguments against mootness exist, there is no assurance that this court or the Tenth Circuit Court of Appeals would conclude that none of Plaintiffs' claims are moot. Yet another challenge for Plaintiffs arises from the *Shook* decisions, with which the Court is intimately familiar. While Plaintiffs believe that class certification is appropriate for the reasons set forth in the class certification motion they filed, there is no assurance that this Court – or the Tenth Circuit – would concur. Likewise, DLC's involvement in the case – and in particularly its associational standing claim – raise novel legal issues on which there is scant decisional authority. Plaintiffs contend that this Court correctly resolved those issues in Plaintiffs' favor, but again there is no assurance that an appellate court would reach the same conclusion. Finally, in this as in all prison conditions cases, proving Eight Amendment violations and substantiating

the need for related remedies can be challenging, given the applicable "deliberate indifference" standard. For these and myriad other reasons, the legal landscape of this case is littered with uncertainty and potential pitfalls and appellate issues.

The factual background here is also complicated, because it involves almost countless individual medical judgments and diagnostic determinations concerning very complex people who live in a surreal setting. Many of the Plaintiffs have multiple psychological problems, and a number also have medical or neurological issues that affect both the symptoms they present and the proper overall program of care for their various conditions. They all live in one of the most isolating places in civilization, a fact that itself impacts how they feel and act. Many also have engaged in violence even in high security environments, which complicates how clinicians interact with them and thus are able to diagnose and treat their conditions. Some have a propensity for exaggeration or outright manipulation, and many experience volatile moods that interrupt their ability and inclination to interact with Plaintiffs' counsel. Others see, hear, and believe things that are rooted in paranoia that may result from a mental health problem, but also may result from a quite real fear of potential harm. And even without the complications created by ADX and the individual Plaintiffs' correctional histories, by definition many of the inmates involved in this case have mental illness and therefore present unique and sometimes serious challenges with respect to how they perceive, recall, and report events. Those realities obviously would affect the content and quality of their testimony in any trial, which in turn may impact how their claims are understood and resolved.

3. The value of an immediate recovery outweighs the mere possibility of future relief after protracted and expensive litigation.

The third adequacy factor, involving the anticipated duration and expense of additional litigation and what might result from continuing the lawsuit, strongly weighs in favor of approval of the proposed settlement. While Plaintiffs have developed strong evidence of multiple violations of the Eighth Amendment, further litigation would involve substantial additional discovery and completion of class certification briefing and argument. A trial that would be lengthy, factually complex, and probably unprecedented from the perspective of security logistics, given the nature of the class members. As well, any trial of all the claims that are resolved by the proposed settlement would involve substantial expenditures relating to testimony by a number of experts on each side, as well as the eventual attorneys' fees that such a trial would be likely to entail. As demonstrated in the previous subsections of this motion, the relief obtained on each substantive issue is essentially co-extensive with the relief that could have been obtained after litigation, so that litigation would not have gained a mandate for more extensive relief. Thus, the value of immediate recovery supports approval of the proposed settlement.

4. Most of the Plaintiffs, and all of their lawyers, believe that the settlement is fair and reasonable.

This fourth factor, involving the parties' judgement, weighs in favor of approval of the proposed settlement. As the Court is aware and as will be evident at the fairness hearing, not all of the Plaintiffs fully support the proposed settlement, and one, Harold Cunningham adamantly opposes it. However, as noted above, Plaintiffs' lawyers consulted with independent experts in the course of negotiating the settlement, so that counsel's negotiations were consistently pursued with a full understanding of the range of litigation options available to the class. In addition to Plaintiffs' attorneys' consultations with experts, Plaintiffs' counsel interviewed the plaintiffs and

many other class members to ensure that they also had a voice in determining the priorities of Plaintiffs' counsel in negotiating a settlement. While it obviously is too early to assess whether other class members will express opposition to the proposed agreement after they receive notice, this factor is simply not relevant to a Court's consideration of whether preliminary approval of a proposed settlement should be granted, and Plaintiffs' counsel submit that in the end their judgment about the virtues of the proposed settlement is supported by all available evidence. *See Lucas*, 234 F.R.D. at 695 ("[c]ounsels' judgment as to the fairness of the agreement is entitled to considerable weight.") Counsel have devoted more than five years of backbreaking effort to protecting some of the most damaged and vulnerable people in our society, and have taken great care to consider all relevant information in formulating and negotiating the proposed settlement. Counsel respectfully submit that those efforts, and the absence of any economic or other personal motive on their part, justify placing great weight on their collective conviction that the proposed settlement is fair, reasonable, and adequate.

III. THE PROPOSED AWARD OF ATTORNEYS' FEES AND COSTS IS REASONABLE

Pursuant to Fed. R. Civ. P. 23(h) and 54(d)(2), at the fairness hearing Plaintiffs will request that the Court approve the award of attorneys' fees and costs included in the proposed settlement. The requested award is authorized by Rule 23(h), which provides that "[i]n a certified class action, the court may award reasonable attorney's fees and nontaxable costs that are authorized by law or by the parties' agreement."[5]

The proposed settlement awards Plaintiffs' counsel a total of $916,221 in costs and $2,933,779 in fees, in full satisfaction of their claim for attorney fees and costs for work that led

[5] Other out-of-pocket expenses incurred during federal civil rights litigation may be awarded as attorneys' fees if: "(1) the expenses are not absorbed as part of law firm overhead but are normally billed to a private client, and (2) the expenses are reasonable." *Jane L. v. Bangerter*, 61 F.3d 1505, 1517 (10th Cir. 1995).

to the proposed settlement. Plaintiffs' forthcoming Appendix of further materials in support of the proposed settlement will include detailed information concerning the request for fees and costs, including supporting declarations from independent experts. Those materials will show that Plaintiffs' counsel has thus far invested more than $17 million in attorney time, and more than $1 million in out-of-pocket costs, in the course of this matter. Given the massive investment of time and effort that was needed to bring this matter to a successful conclusion, the proposed award, which totals roughly 17% of the fees incurred and all of the out of pocket costs, is eminently reasonable and should be approved.

1. In a case such as this, which involves a negotiated fee award, the Court should apply the lodestar method to assess whether the fee and cost award negotiated by the parties is fair and reasonable to the class members.

"[T]here are two generally accepted means for awarding attorneys' fees in class action suits, the so called lodestar method—determining fees based on the hours worked and a reasonable hourly fee—and the percentage-of-the-fund method—awarding fees based on a reasonable percentage of the overall award." *Ramah Navajo Chapter v. Babbitt*, 50 F. Supp. 2d 1091, 1095 (D.N.M. 1999). The Supreme Court has noted that "the lodestar figure includes most, if not all, of the relevant factors constituting a 'reasonable' attorneys' fee." *Perdue v. Kenny A. ex rel. Winn*, 559 U.S. 542, 553 (2010) (internal quotation marks omitted).

Under the lodestar method:

> To determine a reasonable attorneys fee, the district court must arrive at a 'lodestar' figure by multiplying the hours plaintiffs' counsel reasonably spent on the litigation by a reasonable hourly rate. The fee applicant bears the burden of establishing entitlement to an award and documenting the appropriate hours expended and hourly rates."
>
> As to services provided by non-lawyers, if "law clerk and paralegal services are ... not reflected in the [attorney's fee], the court may award them separately as part of the fee for legal services. The court should scrutinize the reported hours and the suggested rates in the same manner it scrutinizes lawyer time and rates." Thus,

> under the rubric of 42 U.S.C. § 1988 "attorney's fees," the fees for attorneys, law clerks, and legal assistants are all determined in the same fashion: multiplying reasonable hours by reasonable rates to reach a "lodestar" amount.

Case v. Unified School District No. 233, 157 F.3d 1243, 1249 (10th Cir. 1998) (citations omitted).

The Court's determination of whether the fees provision is fair and reasonable, in light of the lodestar method, should be informed by a number of factors that support deferring to the parties' agreement here. First, it is well settled that district courts have considerable discretion in awarding attorneys' fees. *See Brown v. Phillips Petroleum Co.*, 838 F.2d 451, 453 (10th Cir. 1988) (citing *United States v. Anglin & Stevenson*, 145 F.2d 622, 630 (10th Cir. 1944), *cert. denied*, 324 U.S. 844 (1945)). Because there has been no objection to the attorney fee agreement and because both Plaintiffs' and Defendant's counsel handled the case with "responsibility, thoroughness, and diligence," the parties' agreement as to attorneys' fees should be approved. *In re King Res. Co. Sec. Litig.*, 420 F. Supp. 610, 636 (D. Colo. 1976). The Court's duty in such a situation is to be "fair to class members . . . and the attorneys whose efforts and professional abilities have produced the recovery." *Id.* at 636. In addition, the potential award of a much larger attorneys' fee; the comprehensive relief afforded by the proposed settlement agreement; the experience of Plaintiffs' counsel; and the years of hard-fought litigation prior to the settlement all point to the reasonableness of the negotiated fee. *See id.* at 629.

In sum, the Court's task is not to independently determine how much to award, but rather to assess whether the negotiated amount is fair and reasonable in the overall context of the case, and settlement terms:

> [T]he court's task in reviewing negotiated fees is different from the court's task in fashioning fee awards from scratch. The court is simply to determine whether the negotiated fee is facially fair and reasonable. This task requires the court to review the settlement agreement as a whole, including the fee award, to ensure

> that it was fairly and honestly negotiated, is not collusive, and adequately protects the interests of the parties.

Stratton v. Glacier Ins. Admin'rs, Inc., No. 1:02-CV-06213 OWW DLB, 2007 WL 274423, at *17 (E.D. Cal. Jan. 29, 2007) (citing *Robbins v. Alibrandi*, 25 Cal. Rptr. 3d 387, 397 (Cal. App. 2005)).[6] Under the unique circumstances of this case, the agreed-upon fee and cost amounts are more than fair, and eminently reasonable.

2. For purposes of the lodestar analysis the hourly rate for professionals' time must be calculated under the Equal Access to Justice Act.

In this and any other case seeking injunctive relief against the federal government, the hourly rates used in the lodestar calculation are set by the Equal Access to Justice Act (EAJA), 28 U.S.C. § 2412. As pertinent here, the EAJA provides:

> Except as otherwise specifically provided by statute, a court shall award to a prevailing party other than the United States fees and other expenses . . . incurred by that party in any civil action (other than cases sounding in tort), including proceedings for judicial review of agency action, brought by or against the United States in any court having jurisdiction of that action, unless the court finds that the position of the United States was substantially justified or that special circumstances make an award unjust.

28 U.S.C. § 2412(d)(1)(A).

Both pre-litigation and litigation conduct may form the basis of a fee award. For the purposes of the EAJA, "the position of the United States" refers to both the "position taken by the United States in the civil action, [and] the action or failure to act by the agency upon which the civil action is based." *Hackett v. Barnhart,* 475 F.3d 1166, 1172 (10th Cir. 2007) (authorizing fees based, in part, on an Administrative Law Judge misrepresenting expert testimony in the social security benefit decision that was the basis of the action). Fees "should be

[6] *See also Staton v. Boeing Co.,* 327 F.3d 938, 963 (9th Cir. 2003) ("Attorneys' fees provisions included in proposed class action settlement agreements are, like every other aspect of such agreements, subject to the determination whether the settlement is fundamentally fair, adequate, and reasonable.") (internal citations omitted).

awarded where the government's underlying action was unreasonable even if the government advanced a reasonable litigation position." *Id*. at 1174 (internal quotation marks omitted).

Without litigating or agreeing on the existence, substantial or otherwise, of a justification of the BOP's conduct, the parties have agreed that a fee award is appropriate. That agreement is reasonable for several independent reasons, each of which independently reflects the absence of substantial justification for the government's pre-litigation decisions and actions, and certain aspects of its conduct during the litigation.

First, Plaintiffs' counsel approached the government concerning a potential resolution both very early in Plaintiffs' investigation and shortly after the original Complaint was filed, but was unable to interest the government in settlement discussions until after the case had been pending for more than a year and had necessitated intensive effort by Plaintiffs' counsel. Second, the record makes clear that many of the failures that led to this case and propelled it forward cannot in any way, shape, or form be deemed substantially justified. Rather, the BOP officials responsible for ADX were willfully blind, for years, to a human tragedy that was plainly evident in an inmate population that is one of the most closely monitored groups of human beings in the world. Third, before this case was commenced, BOP had been sued at least 14 times for the same basic issues by pro se ADX inmates. In every case, the BOP sought and was granted a procedural dismissal, and then did nothing to investigate the underlying merits of any of the cases. Fourth, for years ADX inmates literally flooded the in-boxes of BOP officials at ADX, the BOP's regional office and the BOP's central office with hundreds, if not thousands, of administrative remedy requests that literally begged for mental health treatment. Few, if any, of those requests received any meaningful review or response. Instead, BOP characteristically

sought to reject them on such technical grounds as they raised too many issues, or attached too many supporting pages.

For these and other reasons, the conduct of BOP that precipitated this case was not substantially justified. A fee award is therefore authorized under EAJA.

The EAJA requires that hourly fee rates be based on prevailing market rates, subject to the limitation that:

> attorney fees shall not be awarded in excess of $125 per hour unless the court determines that an increase in the cost of living or a special factor, such as the limited availability of qualified attorneys for the proceedings involved, justifies a higher fee.

28 U.S.C. § 2412(d)(2)(A).

Cost of living enhancements are routinely applied, as the EAJA rate has not been updated since 1996. Cost of living enhancements are calculated at the rate for the years during which the service was rendered. *Pettyjohn v. Chater*, 888 F. Supp. 1065, 1069 (D. Colo. 1995). Courts determine adjustments "by using the 1996 annual CPI index as the base factor (or divisor/denominator) and the annual CPI index for the year in which services were rendered as the comparison factor (or numerator) and using that quotient as a multiplier of $125 to produce an adjusted hourly rate." *Hayden v. Astrue*, No. 01–cv–01861–WDM–PAC, 2009 WL 4563120, at *5 (D. Colo. Dec. 3, 2009).

The annual CPI indices are available at Bureau of Labor Statistics–Consumer Price Index: All Urban Customers 1996-2014, http://www.bls.gov/cpi/cpid1609.pdf (last visited November 14, 2016). The annual CPI index in 1996 was $156.90. Using the above formula with yearly CPI indices, hourly rates for this case would be calculated as such:

	Annual CPI Index[7]	Adjusted Hourly Rate

[7] Note that these rates represent the national CPI; rates are also available for individual metropolitan areas.

2010	$ 218.056	$173.72
2011	$ 224.939	$179.20
2012	$ 229.594	$182.91
2013	$ 232.957	$185.59
2014	$ 236.736	$188.01
2015	$ 237.017	$188.83
2016	$ 238.778 (first half)	$190.23

Id.

Section § 2412(d)(2)(A) allows fees to be enhanced when there is "limited availability of qualified attorneys for the proceedings involved." A fee enhancement under this exception requires an attorney to have "some distinctive knowledge or specialized skill needful for the litigation in question—as opposed to an extraordinary level of the general lawyerly knowledge and ability useful in all litigation." *Pierce v. Underwood*, 487 U.S. 552, 572 (1988). Enhancements may be appropriate if an attorney has "an identifiable practice specialty such as patent law, or knowledge of foreign law or language." *Id*.

As noted below, it is not necessary to determine whether the law justifies an EAJA enhancement in order to approve the negotiated fee award. That said, Plaintiffs' counsel respectfully submits that given the nature of the class members, the ADX, the Defendant, and the challenges presented by the governing law, among other factors, there might not be more than a couple of law firms in the country that both would have considered taking this case on and have the resources and skill to have litigated it to a successful conclusion. On that basis, an EAJA enhancement might indeed be warranted here, were one necessary to justify the negotiated fee award.

3. The negotiated fee award reflects a reasonable expenditure of time, given the nature of this case.

The forthcoming Appendix will reflect that more than 30,000 hours of attorney time and other professionals' time hours have been devoted to this case. Multiplying that number by the 2010 EAJA hourly rate of $173.72, without continued CPI adjustments or a "specialized skill" adjustment, yields an appropriate award of no less than $5,211,600, far in excess of the proposed fee award of $2,933,779. The Appendix will also provide ample evidence that each of Plaintiffs' counsel have customary rates significantly in excess of the EAJA authorized rate as described here. As such, the proposed fee award is a significant downward departure from what counsel would customarily bill for comparable work.

In assessing the nature of the matter to determine reasonableness, the lodestar approach takes into account the twelve factors discussed in *Johnson v. Georgia Highway Express, Inc.*, 488 F.2d 714, 717–19 (5th Cir. 1974), which have been endorsed by the Supreme Court in *Hensley v. Eckerhart*, 461 U.S. 424, 430 (1983) and the Tenth Circuit in *Gottlieb v. Barry*, 43 F.3d 474, 483 (10th Cir. 1994). These factors are:

> (1) the time and labor required; (2) the novelty and difficulty of the issues; (3) the skill requisite to perform legal services properly; (4) the preclusion of employment by the attorney due to acceptance of the case; (5) the customary fee or rates; (6) whether the fee is fixed or contingent; (7) time limitations imposed by the client or circumstances; (8) the amount in controversy and results obtained; (9) the experience, reputation and ability of the attorneys; (10) the undesirability of the case; (11) nature and length of the professional relationship with the client; and (12) awards in similar cases.

See Tuten v. United Airlines, Inc., 41 F. Supp. 3d 1003, 1008 (D. Colo. 2014) (citation omitted). The *Johnson* factors support the requested fee award.

1. Time and labor required. For the reasons outlined above, representing a fluid class of hundreds of inmates in a case involving mental health care at the most secure prison in the United States has required thousands of hours of time and labor over the course of more than

five years. Many class members are mistrustful and/or volatile, requiring the investment of countless hours to build rapport and trust, and overcome setbacks in the relationship between counsel and their clients. The security practices at ADX often result in substantial delays in bringing inmates out to meet with counsel. Defendant has vigorously defended this case with able and committed counsel. And the settlement process has necessarily been long, detailed, and time consuming, involving as it does hundreds of issues and both legal and clinical complexities. These and other factors necessitated the investment of the thousands of hours that counsel has spent on this case.

2. Novelty and difficulty of the issues. As detailed above, this is a legally and factually challenging case, involving complicated people, countless factual details, and careful analysis of many complicated legal issues. It also involves a number of novel issues, including the law applicable to the DLC's associational standing and the class certification challenges posed by the *Shook* line of cases.

3. Skill requisite to perform legal services properly. Both class actions and prison and jail conditions litigation are recognized as complex and specialized areas of the law in which counsel must have considerable skill in order to competently represent their clients.

4. Preclusion of employment. Undertaking a massive class action like this case necessarily imposes significant limitations on the other cases an attorney is able to take on. In particular, it has consumed more than half of the working time of Plaintiffs' lead counsel for more than 5 years, and the travel involved in meeting with the individual plaintiffs and other class members have been intensive and highly disruptive.

5. Customary fee or rates. As discussed *above*, the EAJA caps hourly rates at a level far below the market rates for plaintiffs' counsel in this case.

6. Whether the fee is fixed or contingent. This factor is immaterial here given the reality that most of the fees in question will be donated to charity and Arnold & Porter never intended to retain any portion of the fee award, as a matter of firm practice.

7. Time limitations imposed by the client or circumstances. This factor has little application to this case, except the urgency associated with addressing extreme and deteriorating conditions at ADX at the beginning of this case.

8. Amount in controversy and results obtained. At stake in this case are the health, safety, and human dignity of hundreds of persons who are or were incarcerated at ADX. As discussed in detail *supra,* counsel have obtained excellent results for the Plaintiff class and subclass.

9. Experience, reputation, and ability of attorneys. As the Court is personally familiar with the lawyers most directly involved in litigating this case, Plaintiffs add only that Arnold & Porter is one of the leading litigation firms in the country, the Washington Lawyers Committee is a pre-eminent prisoners' rights advocacy organization, and DLC has extensive experience advocating for the constitutional rights of inmates with mental illness, as Colorado's federally mandated protection and advocacy system.

10. Undesirability of the case. Many lawyers consider representing prisoners to be undesirable because of the unpopularity and impecuniousness of the clients and the many restrictions imposed by the EAJA, among other factors. The people involved in this case present an even greater challenge than the "ordinary" prison case, given the conditions in which they live, the personal characteristics and criminal pasts of many of them, the exposure of counsel to quite real threats of violence and other associated risks, the brutal and often tragic facts to which counsel have been exposed, and the quite real risk that sometime during the case one or more of

counsels' clients would give up and commit suicide, precisely because of mental illness and perhaps because of the problems the case was brought to address. Sadly, that risk has been realized repeatedly during the course of this case, including twice in the last year.

11. Nature and length of the professional relationship with the client. Plaintiffs' counsel have represented the class in this case for more than five years, and in that time have formed strong and necessary professional relationships with many putative class members.

12. Awards in similar cases. In many respects, this case is unparalleled. Nevertheless, the forthcoming Appendix of supporting materials will include a Declaration from the Director of the ACLU's National Prison Project that will attempt to place this case in a relative context for purpose of evaluating the proposed fee award.

For all of these reasons, and as will be further detailed in the forthcoming Appendix, application of the lodestar here supports an award far in excess of that provided for in the proposed settlement.

4. The negotiated fee award should be made directly to counsel, as outlined in the settlement.

Courts routinely recognize that the attorney-client relationship, the fee/retainer agreement, and the purpose and nature of EAJA can give rise to an express or implied obligation for the client to pay his or her attorney any court ordered EAJA fee award. *See Turner v. Comm'r of Soc. Sec.*, 680 F.3d 721, 725 (6th Cir. 2012) (holding that "litigants 'incur' fees under the EAJA when they have an express or implied legal obligation to pay over such an award to their legal representatives, regardless of whether the court subsequently voids the assignment

provision under the [Anti-Assignment Act]").[8] That reality is rooted in the nature of reform litigation such as this case:

> "[A]llowing fee awards to *pro bono* counsel under the EAJA 'serves to insure that legal services groups, and other *pro bono* counsel, have a strong incentive to represent indigent . . . claimants.' If attorneys' fees to *pro bono* organizations are not allowed in litigation against the federal government, it would more than likely discourage involvement by these organizations in such cases, effectively reducing access to the judiciary for indigent individuals. Such a result surely does not further the goals of the EAJA."

Cornella v. Schweiker, 728 F.2d 978, 986–87 (8th Cir. 1984).[9] For these reasons, the Court should approve the settlement provisions requiring payment of fees directly to counsel. *Briggs v. United States*, No. C 07-05760 WHA, 2010 WL 1759457, at *6-8 (N.D. Cal. Apr. 30, 2010) (awarding $500,000 in EAJA fees to attorneys who settled a class action after determining the settled award was fair, adequate, and reasonable).

5. The Court should approve the negotiated award of costs.

The Appendix will reflect that counsel have paid, out of pocket, approximately $1 million during the five year course of this case. Most of that sum went to pay for physicians, psychologists, and other professional consultants who evaluated dozens of inmates, reviewed

[8] *Accord Ed. A. Wilson, Inc. v. GSA*, 126 F.3d 1406, 1409 (11th Cir. 1997) (affirming that an EAJA fee award is appropriate where there is an express or implied agreement that any fee award will be paid to the legal representative); *Phillips v. GSA*, 924 F.2d 1577, 1583 (Fed. Cir. 1991) ("we hold that to be "incurred" within the meaning of a fee shifting statute, there must also be an express or implied agreement that the fee award will be paid over to the legal representative."); *see also Arredondo v. Holder*, No. 08-73835, slip op. at 17 (9th Cir. Nov. 30, 2012) (finding litigant's and attorneys' declarations sufficient to establish an implied agreement to pay the fee award directly to counsel).

[9] *See also Moreno-Gutierrez v. Napolitano*, No. 10-CV-00605-WJM-MEH, 2013 WL 3233574, at *6 (D. Colo. June 26, 2013) ("circuits have similarly awarded EAJA fees to attorneys or organizations that have taken on a representation *pro bono*."); *FDL Techs., Inc. v. United States*, 967 F.2d 1578, 1580 n.1 (Fed. Cir. 1992) ("Cases from other courts where attorney fee awards, under various statutes, have been paid directly to counsel. . . . [a]ll involve *pro bono* counsel where the award was paid directly to counsel in order to avoid giving the prevailing parties, usually prisoners or indigents, a windfall.")

tens of thousands of records, and provided critically important professional input into the formulation of the policies negotiated as part of the settlement. The balance was spent on necessary travel, the recovery of medical and other records, duplication costs, and other expenses necessarily incurred in prosecuting this case.

The settlement reimburses Plaintiffs' counsel for all of those out-of-pocket expenses, which are recoverable under the EAJA. *See* 28 U.S.C. § 2412(d)(2)(A) (expenses include "the reasonable expenses of expert witnesses" and "the reasonable cost of any study, analysis, engineering report, test, or project.") The examples set forth in 28 U.S.C. § 2412(d)(2)(A) are not, however, an exclusive listing. *See Oliveira v. United States*, 827 F.2d 735, 744 (Fed. Cir. 1987). "Congress enlarged, rather than contracted, the category of expenditures that are reimbursable under the EAJA. . . . The limitation on the amount and nature of such expenses is that they must be necessary to the preparation of the [prevailing] party's case." *Jean v. Nelson*, 863 F.2d 759, 778 (11th Cir. 1988), *aff'd sub nom. Comm'r, I.N.S. v. Jean*, 496 U.S. 154 (1990) (rejecting the government's argument that telephone, travel, postage, and research expenses are not compensable under the EAJA) (internal citation omitted).[10]

IV. THE COURT SHOULD PROVIDE THE CLASS WITH NOTICE

Fed. R. Civ. P. 23(e)(1) provides that "[t]he court must direct notice in a reasonable manner to all class members who would be bound by the proposal." Versions of the proposed notice to class members, in English and Spanish, are attached as Exhibits 10 and 11. The notice explains the basic nature of the proposed settlement, including the attorneys' fees, how to obtain a copy of the agreement, how to contact Plaintiffs' counsel, and how to comment in support of,

[10] *See also Int'l Woodworkers of Am. v. Donovan,* 792 F.2d 762, 767 (9th Cir. 1985) (expenses routinely billed to a client—telephone, air courier, attorney travel—are recoverable under the EAJA); *Aston v. Secretary of Health and Human Servs.,* 808 F.2d 9, 12 (2d Cir. 1986) (affirming award of telephone, postage, travel and photocopying expenses under EAJA).

or in opposition to, approval of the settlement. Plaintiffs propose that this notice be as specified in Section 14 of the Addendum, Exhibit 1 hereto.

Plaintiffs' proposed method for providing notice is consistent with the letter and spirit of Rule 23:

> [T]here is no single way in which the notice must be transmitted. Of course, notice by mail to all of the identified class members informing them of the proposed action and indicating that they have a right to participate and voice their objections will suffice. But other approaches including the use of television, radio, the internet, and various print publications also may be utilized. In some cases, such as in prisoner litigation, when the class members are all in one location, posting or other publication may be deemed sufficient.

7B Charles Alan Wright, et al., *Federal Practice and Procedure,* § 1797.6 (2005). The proposed notice is also reasonable in light of the circumstances, and consistent with what has been approved in other cases. *See, e.g. Cody v. Hillard,* 88 F. Supp. 2d 1049, 1051-52 (D.S.D. 2000) (involving a settlement at the South Dakota State Penitentiary); *Ruiz v. McKaskle,* 724 F.2d 1149, 1152-53 (5th Cir. 1984) (publishing notice and summary of settlement in prison newspaper and posting notices in prison housing units of the availability of the settlement was sufficient to give notice in 23(b)(2) case); *Ahrens v. Thomas,* 570 F.2d 286, 288 (8th Cir. 1978) (posted notice in jail sufficient in 23(b)(2) case); *Gaddis v. Campbell,* 301 F. Supp. 2d 1310, 1312 (M.D. Ala. 2004) (approving notice to prison class placed on community bulletin boards and other places to which prisoners had access, with individual notice to prisoners in segregation).

CONCLUSION

For the above reasons, Plaintiffs request that the Court grant preliminary approval to the Settlement Documents, including the parties' agreement as to fees and costs, and order notice to the class in the form and manner requested herein.

Dated: November 16, 2016.

Respectfully submitted,

ARNOLD & PORTER LLP

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on this 16th day of November, 2016, the foregoing **PLAINTIFFS' UNOPPOSED MOTION FOR PRELIMINARY APPROVAL OF SETTLEMENT TERMS AND PROPOSED NOTICE TO THE CLASS** was filed with the Clerk of the Court using the CM/ECF system which will send notification of such filing to all counsel of record as follows:

Amy L. Padden
U.S. Attorney's Office - Denver
1225 Seventeenth Street, Suite 700
Denver, CO 80202
amy.padden@usdoj.gov

/s/ Portia Pullen

EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 12-cv-01570-RPM

HAROLD CUNNINGHAM,
PERCY BARRON,
ALPHONSO BLAKE,
JABBAR CURRENCE,
CARLTON DUNBAR,
SCOTT FOUNTAIN,
SEAN GILLESPIE,
CHARLES HIPPS,
JOHN LAMB,
HERBERT PERKINS,
JOHN J. POWERS,
ARNELL SHELTON, and
MARCELLUS WASHINGTON,

Each individually and on behalf of all others similarly situated,

and

DISABILITY LAW COLORADO,
COLORADO'S PROTECTION AND ADVOCACY SYSTEM,

Plaintiffs,

vs.

FEDERAL BUREAU OF PRISONS,

Defendant.

ADDENDUM TO JOINT MOTION TO APPROVE SETTLEMENT

I. INTRODUCTION

1. On June 15, 2015, Plaintiffs Harold Cunningham, Percy Barron, Alphonso Blake, Jabbar Currence, Carlton Dunbar, Scott Fountain, Sean Gillespie, Charles Hipps, Ronnie Houston, John Lamb, Herbert Perkins John J. Powers, Arnell Shelton and Marcellus

Washington, each individually and on behalf of others similarly situated, and Disability Law Colorado (collectively "Plaintiffs") filed a Second Amended Complaint ("Complaint") alleging that the treatment of inmates with mental illness by the Federal Bureau of Prisons (hereafter "Defendant" or "Bureau") at the United States Penitentiary, Administrative Maximum, located in Florence, Colorado ("ADX"), has failed to meet the minimum level of care necessary to satisfy the Eighth Amendment to the U.S. Constitution. Since June 2012, Plaintiffs and Defendant (collectively "the Parties"), through their respective counsel identified on the signature page below, have exchanged information and conducted discovery, both under the Freedom of Information Act ("FOIA") and by way of voluntary and informal disclosures of information.

2. Plaintiffs define in their Complaint two different classes of inmates for whom this lawsuit was brought. Plaintiffs first define a class regarding screening as "[a]ll persons who are now, or will be in the future, confined to the custody of the Federal Bureau of Prisons at [ADX]." Plaintiffs next define a subclass regarding treatment as "[a]ll persons who are now, or will be in the future, confined to the custody of the Bureau [at the ADX] and have been diagnosed by the [Bureau] or its representative personnel [or contractors] with [a mental illness]."

3. Defendant denies the allegations in the Second Amended Complaint. The issue of liability has not been litigated. Defendant, prior to and since the initiation of this litigation, commenced significant initiatives to enhance the delivery of mental health services to inmates housed in the ADX and that process has been ongoing throughout this litigation. Defendant represented the interests of the Bureau of Prisons, which include decisions regarding its constitutional duty to provide care for mentally ill inmates and to protect their safety, along with

the safety of its staff and the public. Defendant does not concede that the policies and initiatives contained within this Addendum are required by the Constitution.

4. This Addendum is also the result of nearly four years of collaborative, arm's length settlement negotiations by energetic and experienced counsel for the Parties and their respective consultants and experts, aided by an experienced United States Magistrate Judge, to resolve the claims raised by this action. The Parties, without conceding any infirmity in their claims or defenses, engaged in extensive arm's length settlement negotiations to implement changes related to the constitutional violations alleged in the Second Amended Complaint. Plaintiffs' counsel received sufficient formal and informal discovery prior to and during settlement negotiations to enable them to make informed decisions. The Parties also benefited from the informed advice of two psychiatrists, Jeffrey Metzner, M.D., and Sally Johnson, M.D., with correctional experience, who have significant experience as expert witnesses and monitors in corrections mental health litigation, as well as other outside and Bureau experts. This collaborative attitude allowed Defendant to address the issues raised in association with the alleged constitutional violations with practical creativity.

5. Defendant's voluntary, significant initiatives, and the Parties' collaborative work resulted in the following:

a. The creation, revision, and implementation of the following Program Statements and Institutional Supplements (the "Policies"), which contain negotiated substantive provisions regarding, among other matters, screening and diagnosis of mental illness, provision of mental health care, suicide prevention, and conditions of confinement to reduce the risk of development or exacerbation of mental illness:

i. Program Statement 5310.16, *Treatment and Care of Inmates with Mental Illness*.

ii. Institutional Supplement FLM 5310.16, *Treatment and Care of Inmates with Mental Illness*.

iii. Institutional Supplement FLM 5324.08, *Suicide Prevention Program*.

iv. Institutional Supplement FLP 53310.11A, *Secure Steps Toward Awareness Growth and Emotional Strength (STAGES) Program*.

v. Institutional Supplement FLM 5212.07J, *Control Unit Programs*.

vi. Institutional Supplement FLM 5321.07(1)B, *General Population and Step-Down Unit Operations*.

vii. Institutional Supplement FLM 5321.07(4)A, *High Security Adult Alternative Housing Program*.

b. The development and activation of the following units for mental health treatment:

i. A secure mental health unit at the United States Penitentiary in Atlanta, Georgia.

ii. A second secure mental health unit at the United States Penitentiary in Allenwood, Pennsylvania.

iii. A Secure Steps Toward Awareness Growth and Emotional Strength (STAGES) Program at the United States Penitentiary, High Security, in Florence, Colorado.

c. The undertaking of the following significant initiatives:

i. The development and implementation of privilege incentive programs for inmates housed at ADX.

ii. The continued use and enhancement of an at-risk recreation program to identify inmates who are not participating in any recreation programs, attempting to educate them on wellness, and encouraging their participation in a structured recreation program.

iii. Constructing, maintaining, and employing facilities for group therapy at ADX.

iv. Constructing, maintaining, and employing areas for private psychological and psychiatric counselling sessions in all housing units at ADX.

v. Changes to the manner in which telepsychiatry is conducted at ADX to allow those sessions to take place in private without the presence of correctional officers.

vi. The screening of all inmates housed at ADX as of August 2014, to determine, among other things, whether the inmates have a mental illness. This included a screening record review of all inmates and in-depth clinical interviews of approximately 130 inmates by outside psychiatrists and non-ADX Bureau psychologists.

vii. Clarifying that psychotropic medications will be available to any inmate for whom such medication is prescribed, regardless of the inmate's housing assignment (i.e., Control Unit)

viii. Taking steps to ensure that inmates receiving psychiatric medications at the ADX are seen by a psychiatrist, physician, or psychiatric nurse every ninety (90) days, or more often as clinically indicated for, at a minimum, the first year.

ix. Taking steps to ensure that the screening and classification of inmates prior to, and when, they arrive at ADX, to ensure those inmates with mental illness are identified, provided accurate diagnosis, and assessed to determine the severity of any mental illness and any suicide risk.

x. The development and implementation of procedures to ensure that Health Services notifies the psychiatrist, psychiatric mid-level provider, psychiatric nurse, or physician and Psychology Services of inmates who refuse or consistently miss doses of their prescribed psychotropic medications.

xi. Health Services staff taking steps to ensure that psychotropic medications are prescribed so that they are distributed on pill line.

xii. The periodic assessment of all inmates at ADX to determine whether mental illness has developed since the last screening.

xiii. The use of mental health care levels as defined in Program Statement 5310.16, *Treatment and Care of Inmates with Mental Illness*, dated May 1, 2014, for classification of inmates housed at ADX.

xiv. The exclusion of certain inmates with a Serious Mental Illness, as defined in the Bureau's Program Statement 5310.16, *Treatment and Care of Inmates with Mental Illness*, from ADX, except when extraordinary security needs exist; when extraordinary security needs exist, ensuring those inmates are provided treatment and care commensurate with their mental health needs, which includes the

development of an individualized treatment plan in accordance with the Policies.

xv. Taking steps to ensure the prompt identification of inmates who develop signs or symptoms of possible mental illness while incarcerated at ADX, to permit timely and proper diagnosis, care, and treatment.

xvi. Taking steps to ensure the reasonable access to clinically appropriate mental health treatment for all inmates with mental illness at ADX.

xvii. Considering a commitment order under 18 U.S.C. § 4245, or other applicable statute or regulation, for inmates who have a need for, but who do not agree to participate in, a Secure Mental Health Unit or for a treatment program at a Medical Referral Center. An inmate's refusal to be designated to a Secure Residential Mental Health Unit or Medical Referral Center, or a court's denial of a commitment order, is not grounds or justification to house an inmate with a Serious Mental Illness at ADX. However, if a court denies commitment or determines that an inmate does not have a Serious Mental Illness, permitting that inmate to be placed at ADX if needed for security and safety reasons and providing treatment commensurate with his mental health care level.

xviii. Housing certain inmates in need of inpatient psychiatric care (CARE4-MH) at a Medical Referral Center.

xix. If an inmate with Serious Mental Illness who continues to be housed at ADX due to extraordinary security needs declines treatment consistent with his mental health care level, taking steps to develop and implement a treatment plan that includes regular assessment of the inmate's mental status, rapport-building activities, and other efforts to encourage engagement in a treatment process, and, at a minimum, a weekly attempt to engage the inmate.

xx. Offering inmates with Serious Mental Illness who continue to be housed at ADX due to extraordinary security needs between 10 and 20 hours of out-of-cell therapeutic and recreational time per week consistent with their individualized treatment plan.

xxi. Taking steps to support inmates with mental illness through creation of wellness programs and recreational activities, specialized training of staff, and care coordination teams.

xxii. The development of procedures for heightened review of requests and referrals for mental health services.

xxiii. Ensuring that any calculated use of force or use of restraints involving an inmate at ADX with a mental illness is applied appropriately to an inmate with such conditions, as set forth in the Policies.

xxiv. The exclusion of mental health clinicians from participation as a use of force team member in a calculated use of force situation, other than for confrontation avoidance.

xxv. The merging of the Bureau's Electronic Medical Record (BEMR) and Psychology Data System (PDS).

xxvi. The staffing and hiring of 3 additional full-time psychologists, one psychiatric nurse, and one psychology technician. One of the 3 additional full-time psychologist positions is to facilitate trauma-informed psychological programming (Resolve Treatment (Trauma) Coordinator).

xxvii. The ADX Care Coordination and Reentry (CCARE) Team meeting monthly, pursuant to the applicable section ADX Institutional Supplement regarding *Treatment and Care of Inmates with Mental Illness*.

xxviii. Taking steps to ensure the completion of a Mental Health Transfer Summary in BEMR/PDS every time an inmate with mental illness (CARE2-MH, CARE3-MH, and CARE4-MH) transfers out of ADX, pursuant to the ADX Institutional Supplement regarding *Treatment and Care of Inmates with Mental Illness*.

xxix. Taking steps to ensure the collaboration of Psychology and Health Services staff, beginning no later than 12 months before an inmate's anticipated release with Community Treatment Specialist (CTS) regarding ADX inmates CARE2-MH or higher releasing to an residential re-entry center or home detention, pursuant to the applicable section of the ADX Institutional Supplement regarding *Treatment and Care of Inmates with Mental Illness*.

xxx. Hiring a full-time Social Worker for FCC Florence, whose priority is those inmates housed at ADX and who provides Reentry Planning Services within 1 year of an inmate's projected release date, as appropriate, and pursuant to the applicable section of the ADX Institutional Supplement regarding *Treatment and Care of Inmates with Mental Illness*.

xxxi. Taking steps to ensure that discipline is applied appropriately to inmates with Serious Mental Illnesses or Mental Illness, as set forth in the Policies.

xxxii. Enhancing mental health training provided to Bureau staff.

6. The Parties believe the Addendum is fair, reasonable, and adequate to protect the interests of all parties.

7. Nothing in this Addendum requires Defendant to compel an inmate to accept treatment (including medication) for a mental illness over the inmate's objections; provided that this paragraph shall not limit or otherwise affect the rights or obligations of Defendant or any inmate under 18 U.S.C. § 4245.

8. Nothing in this Addendum prevents the Defendant from modifying the above referenced Policies. Defendant maintains its right to amend the Policies without approval of Plaintiffs. However, during the Compliance Period (as defined in paragraph 36, below), the Defendant agrees that any modifications to these Policies will not diminish the standards for screening or standards for services and treatment specified in the Policies. Defendant further agrees to inform Plaintiffs' counsel and the Monitor in writing in advance of any changes to the Policies during the Compliance Period. Compliance with any revised policy or procedure that is consistent with the preceding sentences in this paragraph shall not be deemed a breach of this Addendum. Any dispute concerning whether services, standards, or treatment provided to inmates have been diminished shall be resolved pursuant to the paragraphs set forth in sections IX (**DISPUTE RESOLUTION) and X (ENFORCEMENT)** of this Addendum.

9. The Parties acknowledge that certain documents in this case were produced subject to the Protective Orders entered by the Court, Docket Nos. 73, 85, 167, 213 (collectively, "the Protective Orders"). The Parties agree that the Protective Orders will remain in effect throughout the term of this Addendum. The Parties further agree that any inmate-specific medical or psychology records previously produced or that are produced in connection with the implementation of this Addendum will be considered "Confidential"—whether or not they are so

marked—and subject to the Protective Orders. At the conclusion of the Compliance Period, the procedures in Paragraph 18 of Docket No. 85 will apply to all documents covered by the protective order.

II. PRISON LITIGATION REFORM ACT (PLRA), 18 U.S.C. § 3626

10. The Parties agree that this Addendum will be submitted to the Court for approval as provided below, and that it will not be effective until approved by the Court, following a hearing and a finding that it is fair, reasonable, and adequate pursuant to Rule 23(e) of the Federal Rules of Civil Procedure.

11. The Parties agree that a finding by the Court that the Addendum is fair, reasonable, and adequate does not mean this Addendum is a "consent decree" under 18 U.S.C. § 3626(c)(1).

III. CLASS CERTIFICATION

12. Class Certification. For the purposes of this Addendum only, the Parties agree to the certification by the Court of a Plaintiff class regarding screening and a Plaintiff subclass regarding treatment of inmates with a Covered Mental Illness (as defined below), pursuant to Federal Rule of Civil Procedure 23(b)(2).

13. Preliminary approval. Following the execution of this Addendum, Plaintiffs will file an unopposed motion with this Addendum, requesting that the Court preliminarily approve this Addendum, and further requesting that upon such preliminary approval the Court will schedule a hearing pursuant to Rule 23(e) of the Federal Rules of Civil Procedure (hereinafter referred to as the "Fairness Hearing"), after which the Court will determine whether to grant its final approval of the Addendum. That motion will include an unopposed request that the Court modify the order of reference in this case pursuant to 28 U.S.C. § 636 to permit Magistrate Judge

Hegarty (or his successor) to perform the duties set forth in paragraphs 50-51 and 85-86 of this Addendum. At the same time, Plaintiffs will move for certification of the Class and Subclass defined above, with such Certification being for the purposes of this Addendum only and being conditional upon final approval of this Addendum.

14. Notice of Proposed Class Action Settlement and Fairness Hearing**.** Within thirty (30) days after the date on which the Court preliminarily approves this Addendum, the Bureau will hand-deliver a Notice of Proposed Class Action Settlement and Fairness Hearing (a copy of which is attached as Ex. A) to each inmate then-housed at ADX and to named Plaintiffs not at that time housed at the ADX, and will also provide a copy of the Notice to any inmate who arrives at ADX after the Notice is initially provided but prior to the time the Addendum is approved by the Court. The language of the Notice has been agreed to by the Parties. The Notice contains a brief description of the claims advanced by Plaintiffs and the Bureau's denial of liability for such claims, a summary of the terms of this Addendum, and information regarding the upcoming Fairness Hearing. The Bureau shall bear the cost of distributing the Notice as required by this section.

15. Class and Subclass. The Screening Class and the Treatment Subclass are each defined in section **V**, **DEFINITIONS**.

16. Upon certification of the Screening Class and Treatment Subclass, all the Screening Class and Treatment Subclass members will be bound by the terms of this Addendum subject to the limitations on the preclusive effect of this Addendum specified in paragraphs 73, below.

17. The relief provided in this Addendum is for the benefit of all Screening Class and Treatment Subclass members.

IV. CLA – ACKNOWLEDGEMENT & ROLE

18. The District Court in this case has held that the CLA has standing to pursue claims for declaratory and injunctive relief for inmates with mental illness housed at ADX. (Doc. 324.) For the purposes of this Addendum only, Defendant does not object to the CLA's standing to pursue claims for declaratory and injunctive relief for inmates with mental illness housed at ADX

19. Defendant shall distribute to all inmates at ADX, within thirty days from the Effective Date, a letter drafted by CLA, and approved by the Parties. Generally, the letter will advise inmates that CLA is available, at the inmate's request, to represent inmates in connection with complaints concerning the implementation of this Addendum, and will provide CLA's contact information. Defendant will provide CLA with the names and registration numbers of all inmates who arrive at ADX after the Effective Date and during the Compliance Period, to permit CLA to contact them and advise them of CLA's availability. Such information shall be provided at the earliest practicable date, but in all events no more than 30 days after each such inmate arrives at ADX.

20. CLA shall take reasonable steps to resolve any complaints it receives from inmates concerning the implementation of this Addendum in accordance with the provisions of the Protection and Advocacy for Individuals With Mental Illness Act, 42 U.S.C. §§ 10801, *et seq*., and the paragraphs set forth in section IX, **DISPUTE RESOLUTION,** and section **X, ENFORCEMENT**.

21. Except as specifically set forth in paragraph 73, below, this Addendum does not restrict the CLA's ability to seek remedies outside of this litigation on behalf of inmates with

mental illness or compromise the authority of CLA to pursue such remedies through other litigation, legal action, or other forms of advocacy.

V. DEFINITIONS

22. The term "ADX" means the United States Penitentiary, Administrative Maximum, Florence, Colorado.

23. The term "USP Florence" means the United States Penitentiary, High Security, Florence, Colorado.

24. The term "FCC Florence" means the Federal Correctional Complex, Florence, Colorado.

25. The term "Covered Mental Illness" means a mental disorder as defined in the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders* that results in classification of the inmate as a CARE2-MH or higher.

26. The term "Serious Mental Illness" is defined as in the Bureau's current Program Statement regarding the *Treatment and Care of Inmates with Mental Illnes*s.

27. The Mental Health Care Levels are defined in the Bureau's current Program Statement regarding the *Treatment and Care of Inmates with Mental Illness*.

28. The term "Serious Suicide Attempt" means an incident of serious self-harm coupled with suicidal intent that requires medical treatment.

29. The term "Screening Class" means all persons who are confined at ADX at any time between the Effective Date and the last day of the Compliance Period.

30. The term "Treatment Subclass" means all persons who are confined at ADX at any time between the Effective Date and the last day of the Compliance Period and have been

diagnosed by the Bureau or its representative personnel or contractors with a Covered Mental Illness, as defined in paragraph 25 above.

31. "Secure Mental Health Unit," or "Secure Mental Health Program" means a residential psychology treatment program that provides mental health treatment for male inmates who (1) have a Serious Mental Illness, diagnosed by the Bureau; (2) do not require inpatient treatment, but have been classified as a CARE3-MH or as a CARE2-MH with SMI and in need of enhanced mental health treatment, and require intensive, specialized psychiatric services or psychological interventions in a residential setting; and (3) have a history of violent behavior resulting in a referral, or consideration for referral, to ADX Florence or a Special Management Unit (SMU).

32. The term "Secure STAGES" means a residential, unit-based Psychology Treatment Program for inmates with Borderline Personality Disorder or Other Specified Personality Disorders, as diagnosed by the Bureau, who have a chronic history of self-injurious behavior or do not function effectively in a prison setting.

33. The term "Legally Privileged Information" means information that is classified or implicates national security concerns or that is protected by one or more of the following privileges or doctrines: the attorney-client privilege, the attorney work product doctrine, the law enforcement privilege, or the deliberative process privilege.

34. The term "Effective Date" shall mean the date that the United States District Court for the District of Colorado (herein, the "Court") enters an Order pursuant to Federal Rules of Civil Procedure 23(e), finding the Addendum is fair, reasonable, and adequate, and thereby approves this Addendum.

35. The term "Expiration Date" means the date upon which the parties' obligations and the Court's jurisdiction under this Addendum terminates as set forth in section VIII below.

36. The term "Compliance Period" means the period of time starting on the Effective Date and ending on the Expiration Date.

37. The term "Site Visit" shall mean a visit by the Monitor(s) to FCC Florence to visit either the ADX, the Secure STAGES Program at USP Florence, or both.

38. The term "Monitored Initiatives" means all provisions of the policies and procedures, which are applicable to ADX and the Secure STAGES Program at USP Florence only, with respect to which the Monitor(s) will assess compliance pursuant to sections 43, 44 and 45, below.

VI. MONITORING & REPORTING

39. The parties agree that Sally Johnson, M.D., and Jeffrey Metzner, M.D. will serve as co-Monitors in this action, to assess Defendant's compliance with the Monitored Initiatives. If Dr. Johnson or Dr. Metzner becomes unavailable to monitor Defendant's obligations under the Monitored Initiatives, the Parties shall, within 30 days, jointly decide whether to proceed with one monitor, or if both Dr. Johnson and Dr. Metzner become unavailable, the parties will jointly select one or two other Monitors. If the Parties are unable to agree upon a replacement Monitor, the Court will appoint one after receiving one suggestion from each of the Parties and remaining Monitor, if any.

40. The Monitor(s) shall not be liable for any claim, lawsuit or demand arising out of a Monitor's performance pursuant to this Addendum.

41. Defendant agrees to pay all reasonable fees and costs incurred by the Monitors, subject to the Monitors complying with the appropriate payment procedures, up to a maximum

of 330 hours of work a year for Dr. Johnson (or any replacement expert who resides outside of the state of Colorado), and 290 hours of work a year for Dr. Metzner (or any replacement expert who resides within the state of Colorado). The Monitor(s) will be paid an hourly rate of no more than $450. In the event that the Monitor(s) reasonably believe that time in excess of the foregoing limitations will be necessary to complete the work contemplated by this Addendum, they shall notify the Parties, who will confer concerning the matter. If the Parties are unable to agree on a modification of the foregoing limitations, Plaintiffs may file an appropriate motion with the Court, which may be granted for good cause shown.

42. Except as may be provided in a separate Agreement signed by the Parties, the Monitor(s) shall only have access to, and shall only monitor Defendant's policy compliance with respect to, the ADX and the Secure STAGES Program at USP Florence. Defendant intends to continue to house the Secure STAGES Program at USP Florence during the Compliance Period. Defendant will provide Plaintiffs' counsel with advance notice if Defendant decides that it needs to move the program to a different institution.

43. Monitoring:

a. Monitoring at ADX: The Monitor(s) will assess and report on Defendant's compliance with all of the following Monitored Initiatives at the ADX during the first two Site Visits and will assess and report on Defendant's compliance with any or all (as they deem appropriate) of the following Monitored Initiatives at the ADX during subsequent Site Visits:

i. Application of the definition of Serious Mental Illness to mental disorders diagnosed by Defendant. Pursuant to paragraph 26, above, Serious Mental Illness is defined as in the Bureau's current Program Statement regarding the *Treatment and Care of Inmates with Mental Illness*, which at the Effective Date of this Addendum is located in section 1 of the Program Statement and section IV(F) of the ADX Institutional Supplement regarding the *Treatment and Care of Inmates with Mental Illness*.

ii. Screening

1. The screening of inmates pursuant to **Mental Health Care Levels**, **Psychology Intake Screening**, **Assignment and Change of Mental Health Care Level Assignment, ADX Referral Review Procedures**, and **Extended Restrictive Housing Reviews** sections of the Bureau's Program Statement regarding the *Treatment and Care of Inmates with Mental Illness*, which at the Effective Date of this Addendum are sections 5, 6(c)-(e), 8(b)(2), 8(d), respectively.

2. The requirements concerning the screening of inmates pursuant to **Procedures for Assessment, Identification, and Referral** section of the ADX Institutional Supplement regarding the *Treatment and Care of Inmates with Mental Illness*, which at the Effective Date of this Addendum is section IX.

iii. Exclusion

1. The requirement that inmates diagnosed with Serious Mental Illness, as determined by Defendant, are only designated to the ADX if the inmates have extraordinary security needs, as determined by Defendant, pursuant to the **SMU/ADX Exclusionary Criteria** of the Bureau's Program Statement regarding *Treatment and Care of Inmates with Mental Illness*, which at the time of this Addendum is section 8(c).

2. The requirement that inmates diagnosed with a Serious Mental Illness while housed at the ADX, as determined by Defendant, only remain at the ADX if the inmates have extraordinary security needs, as determined by Defendant, pursuant to the ADX exclusion criteria and ADX removal process sections of the Bureau Program Statement and ADX Institutional Supplement regarding *Treatment and Care of Inmates with Mental Illness*, which at the effective date of this Addendum are sections 8(e), and VII and X, respectively.

3. The requirement that inmates classified as CARE4-MH are not placed at, or are removed from, the ADX as provided in section X of the ADX Institutional Supplement regarding *Treatment and Care of Inmates with Mental Illness*.

4. The requirement that ADX inmates who, while housed at ADX, are diagnosed by Defendant as suffering from a Serious Mental Illness, and who do not have extraordinary

security issues as determined by Defendant, are referred to an alternative, appropriate placement outside ADX, pursuant to section X(E) of the ADX Institutional Supplement regarding the *Treatment and Care of Inmates with Mental Illness*.

iv. Treatment

1. The requirement that inmates diagnosed with a Serious Mental Illness by Defendant and who must remain at the ADX due to extraordinary security needs are housed and treated in accordance with the **Treatment and Care for Inmates with Serious Mental Illnesses Remaining at ADX Due to Extraordinary Security Concerns** section of the ADX Institutional Supplement regarding *Treatment and Care of Inmates with Mental Illness*, which at the Effective Date of this Addendum is section XI(F).

2. The following sections of ADX Institutional Supplement regarding the *Treatment and Care of Inmates with Mental Illness*: **Responsibilities**; **Mental Health Staffing**; **Team Approach to Care**; **Individual Counseling/Therapy**; **Group Treatment**; **Psychiatric Services**; **Turning Point Protocol**; **Adjunctive In-Cell Therapeutic Activities**; and **Achievement Awards & Incentives**, which at the effective date of this Addendum are sections V-VI, VIII, XI(A)-(E), and XV.

3. The *following* sections of Bureau Program Statement regarding the *Treatment and Care of Inmates with Mental Illness* as they are implemented at the ADX: **Recovery-Oriented Program Model**; **Evidence-Based Practices**; **Team Approach to Care**; **Services for Inmates in Restrictive Housing**; **Mental Health Treatment Achievement Awards**; and **Continuity of Care Between Institutions**, which at the Effective Date of this Addendum are sections 3, 4, 7, 8(a), 12, and 13(b).

4. Defendant's maintenance and use of suitable facilities for group therapy at ADX.

5. Defendant's maintenance and use of suitable private areas for psychiatric and psychological consultation sessions in all units at ADX.

6. The **Between Bureau Institutions** section of ADX Institutional Supplement regarding the *Treatment and Care*

of Inmates with Mental Illness, which at the effective date of this Addendum is section XVI(C).

7. The **Behavioral Health Committee Meeting (BHCM)** section of ADX Institutional Supplement regarding the *Treatment and Care of Inmates with Mental Illness*, which at the effective date of this Addendum is section XVI(B).

8. The **Calculated Use of Force** section of ADX Institutional Supplement regarding the *Treatment and Care of Inmates with Mental Illness*, which at the effective date of this Addendum is section XIV.

v. Reentry Planning Services

1. The following applicable sections of the Bureau Program Statement regarding *Treatment and Care of Inmates with Mental Illness* that pertain to **Reentry**, which at the effective date of this Addendum are sections 14(a)-(e).

2. The following sections of the ADX Institutional Supplement regarding *Treatment and Care of Inmates with Mental Illness*: **Community Treatment Services**; and **Reentry Planning Services**, which at the effective date of this Addendum are sections XVI(D)-(E).

vi. Discipline: The inmate discipline section of the ADX Institutional Supplement regarding the *Treatment and Care of Inmates with Mental Illness*, which at the effective date of this Addendum is section XIII, **Inmate Discipline**.

vii. Suicide Prevention

1. The following sections of the Bureau's Program Statement regarding the *Suicide Prevention Program*: 7, 8(a), 14(a), 14(d), and 15.

2. The ADX Institutional Supplement regarding *Suicide Prevention Program*.

3. The following sections of ADX Institutional Supplement regarding the *Treatment and Care of Inmates with Mental Illness*: **Inmates Who Are Known to Require Special Precautions** and **Suicide Prevention**, which at the effective date of this Addendum are sections XVI(A), and (F).

viii. Training: The **Mental Health Training** section of ADX Institutional Supplement regarding the *Treatment and Care of Inmates with Mental Illness*, which at the effective date of this Addendum is section XII.

ix. Quality Improvement: The **Quality Improvement** section of ADX Institutional Supplement regarding the *Treatment and Care of Inmates with Mental Illness*, which at the effective date of this Addendum is section XVI(G).

b. Monitoring at Secure STAGES: The Monitor(s) will assess and report on Defendant's compliance with all of the following Monitored Initiatives at the Secure STAGES program during the first two Site Visits and will assess and report on Defendant's compliance with any or all (as they deem appropriate) of the following Monitored Initiatives at the Secure STAGES program during subsequent Site Visits:

i. The following sections of USP Florence's Institutional Supplement regarding the *Secure Steps Toward Awareness Growth and Emotional Strength (STAGES) Program*: **Program Overview** and **Program Responsibilities**, which at the effective date of this Addendum are sections IV and V.

ii. The requirement of USP Florence's Institutional Supplement regarding the *Secure Steps Toward Awareness Growth and Emotional Strength (STAGES) Program* that only inmates affiliated with Secure STAGES program are allowed to live in the Program Unit, which at the effective date of this Addendum is the first sentence of subsection B(1) of section VI.

iii. The requirement of USP Florence's Institutional Supplement regarding the *Secure Steps Toward Awareness Growth and Emotional Strength (STAGES) Program* concerning community meetings, which at the effective date of this Addendum is subsection B(2) of section VI.

iv. The provisions of USP Florence's Institutional Supplement regarding the *Secure Steps Toward Awareness Growth and Emotional Strength (STAGES) Program* concerning Admission and Orientation, which at the effective date of this Addendum is subsection C of section VI.

v. The following subsections of the **Conditions of Confinement** section of USP Florence's Institutional Supplement regarding the *Secure Steps Toward Awareness Growth and Emotional Strength (STAGES) Program*: **Residential Program Unit**, **Recreation**, and **Mental Health Care**, which at the effective date of this Addendum are subsections A, K, and T of section VI.

vi. The **Treatment Assessment Procedures** section of USP Florence's Institutional Supplement regarding the *Secure Steps Toward Awareness Growth and Emotional Strength (STAGES) Program*, which at the effective date of this Addendum is section VIII.

vii. The **Treatment Phases**, **Program Completion**, **Program Withdrawals**, **Program Incompletes**, and **Program Expulsions** sections of USP Florence's Institutional Supplement regarding the *Secure Steps Toward Awareness Growth and Emotional Strength (STAGES)* Program, which at the effective date of this Addendum are sections IX, XII-XV.

viii. The **Security Levels** section of USP Florence's Institutional Supplement regarding the *Secure Steps Toward Awareness Growth and Emotional Strength (STAGES) Program*, which at the effective date of this Addendum is section X.

ix. The **Psychology Treatment Program Achievement Awards** section of USP Florence's Institutional Supplement regarding the *Secure Steps Toward Awareness Growth and Emotional Strength (STAGES) Program*, which at the effective date of this agreement is section XI.

x. Subsections C, E, and F of the **Secure STAGES Companions** section of USP Florence's Institutional Supplement regarding the *Secure Steps Toward Awareness Growth and Emotional Strength (STAGES) Program*, which at the effective date of this Addendum is section XVI.

xi. The **Discipline Procedures** section of USP Florence's Institutional Supplement regarding the S*ecure Steps Toward Awareness Growth and Emotional Strength (STAGES) Program*, which at the effective date of this Addendum is section XVIII.

xii. The Bureau's Program Statement regarding the *Suicide Prevention Program*, except that because sections 7(a), 7(b), 7(c) and 14(b) of that Program Statement do not apply to the Secure STAGES Program, they will not be monitored.

xiii. The **Program Participant Appeal Rights** section of USP Florence's Institutional Supplement regarding the S*ecure Steps Toward Awareness Growth and Emotional Strength (STAGES) Program*, which at the effective date of this Addendum is section XIX.

xiv. The **Staff Training** section of USP Florence's Institutional Supplement regarding the S*ecure Steps Toward Awareness Growth*

and Emotional Strength (STAGES) Program, which at the effective date of this Addendum is section XX.

xv. The **Inmate Monitoring Form** section of USP Florence's Institutional Supplement regarding the S*ecure Steps Toward Awareness Growth and Emotional Strength (STAGES) Program*, which at the effective date of this Addendum is section XXI.

xvi. The **Reentry** section of the Bureau's Program Statement regarding the *Treatment and Care of Inmates with Mental Illness*, which at the effective date is section 14.

44. With respect to both the ADX and the Secure STAGES Program, the Monitor(s) may access, review, and utilize other sections within the following Bureau Program Statements and Institutional Supplements to inform their assessment of the Defendant's compliance, where, when, and if applicable, with the initiatives identified in paragraph 43, above:

a. Bureau Program Statement regarding *Psychiatric Services*.

b. Bureau Program Statement regarding *Psychiatric Evaluation and Treatment*.

c. USP Florence Institutional Supplement regarding S*ecure Steps Toward Awareness Growth and Emotional Strength (STAGES) Program*.

45. In monitoring the Secure STAGES Program, the Monitor(s) shall not monitor and report on compliance with the conditions of confinement provisions in section VI(D), (F)-(J), and (L)-(S) of USP Florence's Institutional Supplement regarding the *Secure Steps Toward Awareness Growth and Emotional Strength (STAGES) Program*, unless (1) Plaintiffs' counsel or the CLA has alleged that Defendant has substantially failed to comply with one of more of these sections, or (2) a Class or Subclass Member has raised, during a Site Visit, an issue that Defendant has substantially failed to comply with one of more of these sections. In such circumstances, if the Monitor(s) agree that the alleged failures materially interfered with the effective delivery of mental health services to participants in the Secure STAGES Program, the

Monitor(s) may request access to records that the Monitor(s) reasonably determine are relevant to this issue, with the exception of Legal Privileged Information, which may be redacted.

46. In the event that the Bureau modifies any Program Statement or Institution Supplement that sets forth any Monitored Initiative in a manner that affects section or paragraph references, the Monitor(s) will monitor the applicable provisions of revised document subject to the same monitoring subject matters and subject matter limitations set forth in paragraphs 43, 44 and 45, above. For clarity, and as an example, if the Bureau revises its Program Statement regarding the *Treatment and Care of Inmates with Mental Illnes*s such that SMU referrals are addressed in a paragraph other than 8(b)(1), then the Monitor(s) shall not monitor the SMU referral section of the revised program statement, wherever it appears. Likewise, if the revised Program Statement addresses the investigation of inmate suicides in section 8(b)(1) of the revised Program Statement, then the Monitor(s) will monitor the revised section 8(b)(1), notwithstanding the specific paragraph references in this Addendum.

47. The Monitor(s) shall have access to the ADX as provided herein. While inside the ADX, the Monitor(s) will be escorted by staff pursuant to the institution's standard security procedures. While inside the ADX, the Monitor(s) may, upon request, be escorted into each housing unit other than the Special Security Unit and Units/Ranges exclusively housing inmates in the Special Security Unit Program, except as authorized in paragraphs 50 and 51, below. While inside the ADX, the Monitor(s) may also request to inspect Health Services, Psychology Services, the group therapy area, the tele-psychiatry area, the visiting room, and receiving and discharge. While inside the ADX, the Monitor(s) may request and will have the ability to speak confidentially to any inmate who is not housed in the Special Security Unit or Units/Ranges exclusively housing inmates in the Special Security Unit Program; provided that if Defendant

reasonably believes that an inmate with whom the Monitor(s) wishes to communicate confidentially poses a serious risk of harm to Bureau staff members or the Monitor(s) that cannot be managed using procedures and facilities ordinarily used for confidential mental health consultations, then Defendant may employ security measures reasonably necessary to safeguard staff members and the Monitor(s), and in so doing the confidentiality of the communication shall be maintained to the greatest extent possible. These visits will take place either in the confidential rooms in which therapy takes place, or, if not available in a particular unit, the visiting room.

48. The Monitor(s) shall have access to USP Florence as specified in this paragraph. While inside USP Florence, the Monitor(s) may, upon request, be escorted into the unit that houses the Secure STAGES Program, Health Services, the visiting room, receiving and discharge and any other area at USP Florence that the Monitor(s) reasonably determine he, she or they need to visit to carry out their duties concerning the Secure STAGES Program. While inside the Secure STAGES housing unit at USP Florence, the Monitor(s) will be escorted by staff pursuant to the institution's standard security procedures. While in the Secure STAGES housing unit at USP Florence, the Monitor(s) may request and will have the ability to speak confidentially to inmates; provided that if Defendant reasonably believes that an inmate with whom the Monitors wishes to communicate confidentially poses a serious risk of harm to Bureau staff members or the Monitors that cannot be managed using procedures and facilities ordinarily used for confidential mental health consultations, then Defendant may employ security measures reasonably necessary to safeguard staff members and the Monitor(s), and in so doing the confidentiality of the communication shall be maintained to the greatest extent possible.

49. There shall be no more than three Site Visits to FCC Florence per year. On one such visit each year, only the FCC Complex Warden and the Supervisory Attorney, currently Jack Fox and Christopher B. Synsvoll, respectively, shall have prior knowledge of the date and time of the visit. The Monitor(s) will coordinate the hours of the visits with Warden Fox and Mr. Synsvoll. Each visit may last for up to four consecutive business days, if necessary.

50. **Procedures applicable to the Special Security Unit and Any Unit/Range Housing Special Security Unit Program Inmates**. For any Site Visit, if requested by the Monitor(s), the Monitor(s) will be brought into the "bubble area" of the Special Security Unit and will be permitted to look down the ranges, but not to communicate with any inmate at that time. Magistrate Judge Hegarty (or his successor) may accompany the Monitor(s) on such a visit, and the Magistrate Judge will be permitted to enter the range on the Special Security Unit and to speak with any of the inmates there, unless such communication is prohibited by a Special Administrative Measure or an applicable court order.

51. **Procedures applicable to inmates subject to Special Administrative Measures (SAMs), court-imposed communication restrictions, or who are subject to Bureau special security measures.** Magistrate Judge Hegarty (or his successor) will also be permitted to conduct inmate interview(s) of inmates subject to Special Administrative Measures (SAMs), court-imposed communication restrictions, or who are subject to Bureau special security measures, unless prohibited by law or regulation. Magistrate Judge Hegarty may seek input from the Monitor(s) before and after the interview. These visits will be conducted in the visiting room area and will be subject to the monitoring terms of the SAMs. The inmates selected for such interviews have the right to decline to consent to the interviews.

52. The Monitor(s) will conduct a close-out meeting with Christopher Synsvoll and/or the Complex Warden, or their designees, and one or more representatives designated by Plaintiffs after each visit, which Plaintiffs' designees may attend in person if they are available, and otherwise by telephone.

53. The Monitor(s) will be permitted to conduct a baseline visit within 120 days of their appointment. This baseline visit may last for up to four business days. The hours of the visit will be coordinate with Warden Fox and Mr. Synsvoll. Defendant shall provide the Monitor(s) with an orientation to the ADX, and the Monitors may request additional information concerning background matters reasonably related to the Monitored Initiatives. The Monitor(s) shall have access to all records during the baseline visit as set forth below. The Monitor(s) may, upon request, meet one-on-one with inmates during the baseline visit. The inmates selected for such meetings have the right to decline to consent to the meetings. Upon the request of the Monitor(s) or any inmate, any such meeting shall be conducted confidentially; provided that if Defendant reasonably believes that an inmate with whom the Monitor(s) wishes to communicate confidentially poses a serious risk of harm to Bureau staff members or the Monitor(s) that cannot be managed using procedures and facilities ordinarily used for confidential mental health consultations, then Defendant may employ security measures necessary to safeguard staff members and the Monitor(s) but shall maintain the confidentiality of the communication to the greatest extent possible.

54. Defendant will direct all employees to cooperate fully with the Monitor(s), subject to any restrictions set forth herein.

55. Prior to any Site Visit during the Compliance Period, Defendant will provide the Monitor(s) data and documents collected by Defendant to track compliance with the Monitored Initiatives.

56. During the Compliance Period, the Monitor(s) shall also have reasonable access to the medical (BEMR) and psychology (PDS) records for Class and Subclass members housed at ADX or Secure STAGES at USP Florence and to additional records that the Monitor(s) reasonably determine are relevant to the Monitored Initiatives (such as disciplinary records, recreation logs, medication compliance records, and relevant information from inmates' Central Files), with the exception of Legal Privileged Information, which may be redacted, and documents relating to inmates assigned to the Special Security Unit Program. The Monitor(s) may also make reasonable requests for additional reports and documents to be compiled from existing data.

57. If documents are requested in conjunction with a Site Visit and the Monitor(s) requests the documents at least thirty (30) days prior to the visit, Defendant will provide these documents to the extent feasible within ten (10) business days prior to the visit.

58. The Monitor(s) will be provided with and sign an acknowledgement form for the confidentiality and Privacy Act Protective Orders entered by the Court. The Monitor(s) will keep the information he or she learns during the course of monitoring confidential as provided by those Orders, regardless of whether the information provided is specifically designated as confidential. Excepting only in connection with proceedings to enforce the terms of this Addendum, the Monitor(s) shall not testify in any other litigation or proceeding with regard to any act or omission of Defendant or any of its agents, representatives, or employees related to

this Addendum, nor testify regarding any matter or subject that he or she may have learned as a result of his or her performance under this Addendum.

59. Following each visit, the Monitor(s) will provide to the Parties with a joint written report concerning the Defendant's compliance with the Monitored Initiatives, which may be organized by those subject matter headings (e.g., Screening, Exclusion, Treatment, Reentry Services Planning, Discipline, Suicide Prevention, Training, Quality Improvement, and Secure STAGES). Each report may also include additional advice, suggestions or proposals in the nature of quality assurance or quality improvement as the Monitor(s) deem appropriate. The Monitor(s) will provide each report to the Parties in draft form for comment before finalizing the report, and will allow the Parties two weeks to comment. These reports shall be written with due regard for the privacy interests of individual inmates and staff.

60. To assess the current conditions, the Monitor(s) may review pertinent documents; interview necessary staff; and interview a sufficient number of inmates, all as determined by the Monitor(s) in his, her, or their reasonable discretion. The Monitor(s) may independently verify representations from Defendant and examine supporting documentation, where applicable. The Monitor's(s') Report may describe the steps taken to analyze conditions and implementation of the Monitored Initiatives, including documents reviewed and individuals interviewed, and the factual basis for each of the Monitor's(s') findings. If the Monitor(s) reports that Defendant is not in compliance with any Monitored Initiative, the Monitor(s) shall make recommendations as to actions the Monitor(s) believes necessary to meet the terms of the provision or provisions.

61. The report issued by the Monitor(s) shall not be admissible against Defendant or any current or former employee or contractor of Defendant in any other proceeding other than a proceeding related to the enforcement of this Addendum.

62. Although Defendant will give full consideration to advice, suggestions, and proposals offered by the Monitor, all decisions concerning the specific diagnosis or assignment of mental health care-levels will be made by the Bureau's mental health providers in accordance with this applicable Bureau policies, including the Monitored Initiatives, and any applicable legal requirements.

63. In the event that a suicide attempt or incident of self harm is determined by ADX to be serious, the event will be reported to the Monitor(s) within three (3) business days after it occurs. At the time of the report, the Bureau shall provide the Monitor(s) with the Suicide Risk Assessment or other relevant medical record. Upon request, the Bureau shall provide the Monitor(s) with additional information about the incident , with the exception of any Legally Privileged Information. After consulting with the Defendant, the Monitor(s) may in his or her reasonable discretion provide copies of the documents to Plaintiffs' counsel. Such documents will be considered "Confidential"—whether or not they are so marked—and subject to the Protective Orders previously entered by the Court.

64. Any suicide will be reported to the Monitor(s) within three business days and will be investigated in accordance with Bureau policy. The identity of the inmate will not be disclosed until the next of kin has been contacted or until seven days have elapsed since the death and reasonable efforts to locate the next of kin have failed. All medical and psychological records about the inmate during the time he was housed at ADX shall be made available promptly to the Monitors. In addition, Defendant shall provide to the Monitors all after-action, incident, and other internal reports, investigations or conclusions concerning the suicide, with the exception of any Legally Privileged Information, within three business days after such materials are completed. After consulting with the Defendant, the Monitor(s) may in his or her reasonable

discretion provide copies of the documents to Plaintiffs' counsel. Such documents will be considered "Confidential"—whether or not they are so marked—and subject to the Protective Orders previously entered by the Court.

65. In the event that the Monitor(s) believe(s) that this Addendum unreasonably restricts his or her ability to monitor Defendant's implementation of the Monitored Initiatives , or to otherwise adequately perform the obligations imposed by this Addendum on the Monitor(s), the Parties agree to negotiate in good faith in an effort to remedy the Monitor's('s) concerns. Any such issues not resolved following such good-faith negotiations shall be resolved as specified by section IX, Enforcement, below.

VII. CONSTRUCTION AND IMPLEMENTATION

66. Underlying Efforts and Collaboration. This Addendum reflects the substantial, voluntary efforts by Defendant to enhance the mental health services available to the members of the Class and Subclass, and the initiatives developed in collaboration with Plaintiffs' counsel and experts.

67. Initial Substantial Compliance. Except where otherwise specifically indicated, Defendant shall achieve substantial compliance with all Monitored Initiatives by the time of the Baseline Visit.

68. Communication to Bureau Staff. Within 30 days following the Effective Date, Defendant shall communicate to Bureau employees, and any contractors involved in providing mental health treatment to inmates at the ADX or in the Secure Stages Program at USP Florence, the requirements set forth in this Addendum that are applicable to their respective jobs.

69. Application to Transferred Inmates. Nothing in this Addendum shall be deemed to limit any existing authority of Defendant to transfer inmates to other state or federal

jurisdictions. If Defendant transfers any inmate who is a member the Screening Class or Treatment subclass and who is diagnosed with a Serious Mental Illness to a facility outside the District of Colorado, the Parties each reserve all of their respective rights and claims concerning the jurisdiction and powers of the United States District Court for the District of Colorado with respect to such inmate and specifically whether any failure to comply with the Policies during the time that inmate was housed at ADX or Secure STAGES constitutes a violation of this Addendum.

70. Admission, Waiver, and Sovereign Immunity. Neither this Addendum, nor any policies or procedures established thereunder, shall define any federal constitutional rights, be deemed an admission, or a waiver of sovereign immunity.

71. Governing Law. This Addendum shall be governed by federal law as enunciated or applicable in the Tenth Circuit, and to the extent that state law applies to any issue arising under, by the laws of the State of Colorado.

72. No Third Party Beneficiaries. No person or entity is intended to be a third-party beneficiary of this Addendum for purposes of any civil, criminal, or administrative action. This Addendum is not intended to impair or expand the right of any person or entity to seek relief against Defendant or its officials, employees or agents for their conduct, except as specifically provided in this Addendum. Moreover, the Parties will not contend that any of the provisions, policies, and procedures stated herein define clearly established constitutional rights of inmates. This Addendum is not intended to alter legal standards governing any such claims. Accordingly, this Addendum is not intended to have any preclusive effect except between Plaintiffs, Screening Class Members and Treatment Subclass Members on the one hand, and Defendant on the other

hand, with respect to the relief provided for in this Addendum, other than as provided in paragraph 73, below.

73. Legal Release**.** Plaintiffs, the members of Screening Class and Treatment Subclass, and their heirs, administrators, representatives, successors, and assigns, and each of them hereby release, waive, acquit, and forever discharge the United States, the Federal Bureau of Prisons, and its employees in their official capacities from, and are hereby forever barred and precluded from prosecuting, any and all claims, causes of action, or requests for any injunctive or declaratory relief, including costs, attorneys' fees, expenses, and/or interest, whether presently known or unknown, that have been asserted in this litigation, or that pertain to the treatment of ADX inmates' mental health; provided that in no event shall this Release be deemed to release or otherwise affect in any way: (1) any claim for money damages; (2) any claim by any inmate for a judicial determination concerning the inmate's personal mental health diagnosis; or (3) any claim based in whole or substantial part on events occurring during the Compliance Period and that does not concern one of the Monitored Initiatives.

74. Inmates Must Comply With Policies and Procedures. This Addendum in no way waives or otherwise affects, limits or modifies the obligations of inmates to comply with Bureau regulations, Program Statements, and Institutional Supplements; or any current or future federal law governing the rights and obligations of incarcerated persons.

75. Possible Conflict with Legal Obligations or Collective Bargaining Agreements. Nothing in this Addendum shall be deemed to require or permit Defendant to violate the laws of the United States, or to violate any terms or conditions of any collective bargaining agreement to which Defendant is a party. Defendant is not aware of any conflict between any of the

provisions of this Addendum and any such law or collective bargaining agreement referred to in this section.

76. Entire Agreement. This Addendum shall constitute the entire integrated agreement of the parties; provided that the parties may enter into one or more separate agreements concerning any subject, which shall be enforceable according to their terms. No prior contemporaneous communications, oral or written, or prior drafts shall be relevant or admissible for any purpose in this litigation or in any other proceeding.

77. Successors and Assigns. This Addendum shall be applicable to, and binding upon, all Parties, their officers, agents, employees, assigns, and their successors in office.

78. Partial Invalidity. If any provision of this Addendum is declared invalid for any reason by a court of competent jurisdiction, said finding shall not affect the remaining provisions of this Addendum.

79. Use of Addendum in Other Proceedings. Neither the fact of this Addendum nor any statements contained herein may be used in any way, including in any other case or administrative proceeding, by any person, whether or not a party to this action, except that Defendant and its employees reserve the right to use this Addendum and the language herein to assert issue preclusion, res judicata, satisfaction, and release in other litigation matters seeking class or systemic relief regarding mental health services at ADX.

VIII. DURATION

80. Defendant shall not move to terminate the parties' obligations and/or the Court's jurisdiction under this Addendum before the second anniversary of the Effective Date.

81. Defendant shall not move to terminate the parties' obligations and the Court's jurisdiction under this Addendum at any time on or after the second anniversary and before the

third anniversary of the Effective Date, unless Plaintiffs consent, in advance, in writing. A motion filed pursuant to this paragraph may seek to terminate all or portions of the obligations under this Addendum. Defendant may request that the Parties meet and confer about termination or partial termination at any time. Plaintiffs will consider in good faith any request by Defendant to terminate made under this paragraph, will not unreasonably withhold their consent to such a request, and if they do withhold consent will provide Defendant with the reason(s) consent was withheld, stated in reasonable detail. In the event the parties are unable to reach agreement on a request or partial request to terminate under the paragraph, either party may invoke the dispute resolution procedures in section IX below.

82. In the event that there is no motion filed and granted pursuant to the prior paragraph, the Parties' obligations under this Addendum and the Court's jurisdiction shall terminate on the third anniversary of the Effective Date; provided, however, that the Court may order a one-time, one-year extension of the Term of the Addendum (i.e., to a total term of four years from the Effective Date) for a specific obligation(s), upon a motion by Plaintiffs filed prior to the end of the three-year presumptive term. Such a motion may only be filed if the District Court has previously determined, based on a motion filed pursuant to paragraphs 92 or 93, below, that Defendant was not in substantial compliance during the first three years of the agreement, or if there is a pending appeal by Plaintiffs challenging the denial of such a motion. The parties will meet and confer prior to the filing of any such motion. In the event the parties are unable to reach agreement Plaintiffs' proposed motion, either party may invoke the dispute resolution procedures in section IX below. If the motion is granted by the Court, the one-year, one-time extension shall apply only to the specific obligation(s) that was/were the subject of the motion to enforce compliance. Under no circumstances will the term of any

provision of this Addendum, the parties' obligations thereunder, or the Court's jurisdiction extend beyond four years.

IX. DISPUTE RESOLUTION

83. If Plaintiffs' counsel believes Defendant is not in substantial compliance with any Monitored Initiative and/or provision of this Addendum as it relates to a Class or Subclass member, Plaintiffs' counsel shall contact Christopher Synsvoll or successor, or his designee, by email or telephone in an effort to resolve the matter informally.

84. If the foregoing informal effort does not resolve Plaintiffs' counsel's concerns within five (5) days, then Plaintiffs' counsel shall notify Defendant in writing of the specific reasons why they believe Defendant is not in substantial compliance, including a reference to any finding of the Monitor(s) if Plaintiffs are relying on those findings or opinions. Defendant shall investigate and respond in writing within thirty (30) calendar days; provided that if Plaintiffs' counsel reasonably believe that an issue presents a substantial risk of death or serious injury, then Defendant shall investigate and provide a preliminary verbal response as soon as practicable and in all events within five (5) business days, and shall provide a written response as soon thereafter as is practicable. Defendant's response shall contain a description of the steps it took to investigate the issues addressed in the notification, the results of the investigation and whether or not Defendant proposes corrective action (and if so, a specific plan for addressing the issues).

85. If Plaintiffs' counsel contend that Defendant's response does not adequately resolve the issue, they shall request a prompt meet and confer with Defendant, unless the Parties have already met and conferred on such issue prior to Defendant's written response. Either Party may request at any time that Magistrate Judge Hegarty, or his successor, participate in a meet

and confer, or in a meeting subsequent to a meet and confer, in order to facilitate informal resolution of the issue.

86. If the Parties are unable to resolve informally a claim that Defendant is not in substantial compliance with one or more of the Monitored Initiatives or provisions of the Addendum, either side may seek mediation by Magistrate Judge Hegarty, or his successor, or by a private mediator, to mediate the dispute; or alternatively, may invoke the procedures in the "Enforcement" section, above.

87. If the Court enters an order pursuant to paragraph 92 and Plaintiffs contend that Defendant has not complied with that order, the procedures in paragraphs 83-86, above, will apply.

X. ENFORCEMENT

88. The parties stipulate and agree that this Addendum complies in all respects with the requirements for prospective relief under the Prison Litigation Reform Act, 18 U.S.C. § 3626(a), and that Act shall govern the terms of this Addendum. Except to enforce, modify, or terminate this Addendum, this Addendum, and any findings made to effectuate this Addendum, will not be admissible against the Bureau or its current or former employees in any court for any purpose. Moreover, this Addendum is not an admission of any liability on the part of United States and/or its employees, agents, and former employees and agents, or any other persons, and will not constitute evidence of any pattern or practice of wrongdoing.

89. This Addendum will be filed in the United States District Court as part of an unopposed motion by Plaintiffs pursuant to Federal Rule of Civil Procedure 23(e) and 41(a)(2) to approve this Addendum and to dismiss the Complaint subject to the parties' compliance with the terms of this Addendum, as contemplated by *Kokkonen v. Guardian Life Insurance Co. of*

America, 511 U.S. 375 (1994). This case will remain on the Court's inactive docket for the Compliance Period. The Court will retain jurisdiction only to enforce the terms of this Addendum.

90. The Court shall be the sole forum for enforcement of this Addendum. The Parties agree to continue to work collaboratively and in good faith to avoid enforcement actions. The Bureau agrees that Christopher Synsvoll, Supervisory Attorney at the Federal Correctional Complex, Florence, Colorado, will remain the principal point of contact for any enforcement-related issues, regardless of whether he later holds a different position within the Bureau. If Mr. Synsvoll is no longer employed as an attorney by the Bureau, the successor Supervisory Attorney at the Federal Correctional Complex in Florence will undertake this role.

91. The Parties agree that temporary or isolated incidents of non-compliance shall not constitute substantial non-compliance. The Parties also agree that Defendant is in substantial compliance unless there is evidence of something more than failure to comply with technicalities. However, the Parties agree that intermittent compliance during a period of sustained non-compliance shall not constitute substantial compliance.

92. If the Parties are unable to resolve informally a claim by Plaintiffs that Defendant is not in substantial compliance with one or more Monitored Initiatives or provisions of this Addendum pursuant to the procedures in the "Informal Resolution" section above, Plaintiffs, and only through counsel, may petition the Court to effect substantial compliance with such Monitored Initiatives or provision of this Addendum, but not through a petition for contempt, and only on the provision or provisions in which Plaintiffs claim Defendant is in substantial non-compliance through the dispute resolution process. Any relevant report of the Monitor(s) may be filed with the Court in connection with such a petition. The only issue before the Court will be

whether Defendant is or is not in substantial compliance with a specific provision or provisions of the Monitored Initiatives or this Addendum. No petition may raise any claim for money damages or any claim by any inmate for a judicial determination concerning the inmate's personal mental health diagnosis. If the Court determines that Defendant is not in substantial compliance, the Court may enter an order within the Court's equitable or inherent authority to remedy the substantial non-compliance, but Plaintiffs may not seek an order of contempt.

93. If the Court enters an order pursuant to the preceding paragraph and Plaintiffs contend that Defendant has not complied with that order, they may, after reasonable notice to Defendant and an opportunity to cure, seek further relief from the Court. Reasonable notice shall include written notice providing specific facts and at least a 14-day time period to cure. Such further relief may include further equitable orders. Nothing in this paragraph purports to (i) limit the remedies or orders available to the Court in enforcing an order entered pursuant to the preceding paragraph; or (ii) waive the sovereign immunity of the United States.

XI. MODIFICATION

94. If, at any time, any party to this Addendum desires to modify this Addendum for any reason, that party will notify the other party in writing of the proposed modification and the reasons for it thirty (30) days before filing any motion seeking a modification. No modification will occur unless there is written agreement by the parties and unless the Court approves the modification under Fed. R. Civ. P. 23.

XII. ATTORNEYS' FEES AND COSTS

95. The Parties do not agree as to the prevailing party in this matter. Defendant maintains its position was substantially justified.

96. Nevertheless, upon the Effective Date of this Addendum, Defendant will:

a. pay the Washington Lawyers Committee for Civil Rights and Urban Affairs the sum of $30,424 to reimburse it for out-of-pocket expenses incurred and paid by that organization in connection with the Lawsuit, and make a separate lump sum payment of $73,704 to the Washington Lawyers Committee for Civil Rights and Urban Affairs to defray the attorneys' fees incurred by that organization in connection with the case; and

b. pay Disability Law Colorado the sum of $5,500 to reimburse it for out-of-pocket expenses incurred and paid by that organization in connection with the Lawsuit, and make a separate lump sum payment of $48,217 to Disability Law Colorado to defray the attorneys' fees incurred by that organization in connection with the case; and

c. pay Arnold & Porter LLP the sum of $3,692,155, which includes $880,297 to reimburse it for expert witness fees and other out-of-pocket expenses incurred and paid by that firm in connection with the Lawsuit. Of this total amount, Arnold & Porter will request the Court to approve a transfer of a lump sum payment of $2,811,858 to the Arnold & Porter LLP Foundation, which funds various public interest legal services efforts using money recovered from its work on pro bono matters.

97. Plaintiffs and their counsel agree not to seek further fees and costs with respect to work incurred prior to the Effective Date of this Addendum.

98. The parties shall bear their own costs and attorney's fees for any subsequent proceedings following the Effective Date, other than Plaintiffs reserve their rights to seek fees and costs in only two circumstances: (1) if Defendant files a motion to terminate this Addendum prior to the second anniversary of the Effective Date, or (2) Plaintiff files and prevails on a motion to enforce based on substantial non-compliance.

IT IS SO STIPULATED AND AGREED.

For Plaintiffs:

DATED: 11.11.2016

Edwin P. Aro
Partner
Arnold & Porter LLP

DATED: _____

_____
Deborah Golden
Project Director, D.C. Prisoners' Project
Washington Committee for Civil Rights and Urban Affairs

DATED: _____

_____
Mark Ivandick
Managing Attorney / Program Coordinator
Disability Law Colorado

IT IS SO STIPULATED AND AGREED.

For Plaintiffs:

DATED: _____ _____

Edwin P. Aro
Partner
Arnold & Porter LLP

DATED: 11 / 11 / 2016 _____

Deborah Golden
Project Director, D.C. Prisoners' Project
Washington Committee for Civil Rights and Urban Affairs

DATED: _____ _____

Mark Ivandick
Managing Attorney / Program Coordinator
Disability Law Colorado

IT IS SO STIPULATED AND AGREED.

For Plaintiffs:

DATED: _____

_____
Edwin P. Aro
Partner
Arnold & Porter LLP

DATED: _____

_____
Deborah Golden
Project Director, D.C. Prisoners' Project
Washington Committee for Civil Rights and *Urban Affairs*

DATED: 11/11/2016

_____
Mark Ivandick
Managing Attorney / Program Coordinator
Disability Law Colorado

For Defendants:

DATED: 11/10/16

Kathleen M. Kenney
Assistant Director / General Counsel
Office of the General Counsel
Federal Bureau of Prisons

DATED: 11/9/16

Amy L. Padden
Acting Executive Assistant U.S. Attorney
Deputy Chief, Civil Division
U.S. Attorney's Office, District of Colorado

EXHIBIT 2

U.S. Department of Justice
Federal Bureau of Prisons

P R O G R A M S T A T E M E N T
OPI: RSD/PSB
NUMBER: 5310.16
DATE: May 1, 2014

Treatment and Care of Inmates With Mental Illness

/s/
Approved: Charles E. Samuels, Jr.
Director, Federal Bureau of Prisons

1. **PURPOSE AND SCOPE**

This Program Statement provides policy, procedures, standards, and guidelines for the delivery of mental health services to inmates with mental illness in all Federal Bureau of Prisons (Bureau) correctional facilities.

For the purpose of this Program Statement, mental illness is defined as in the most current *Diagnostic and Statistical Manual of Mental Disorders*:

"A mental disorder is a syndrome characterized by clinical significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities."

Classification of an inmate as seriously mentally ill requires consideration of his/her diagnoses; the severity and duration of his/her symptoms; the degree of functional impairment associated with the illness; and his/her treatment history and current treatment needs. Mental illnesses not listed below may be classified as seriously mentally ill on a case-by-case basis if they result in significant functional impairment.

The following diagnoses are generally classified as serious mental illnesses:

- Schizophrenia Spectrum and Other Psychotic Disorders.

- Bipolar and Related Disorders.
- Major Depressive Disorder.

In addition, the following diagnoses are often classified as serious mental illnesses, especially if the condition is sufficiently severe, persistent, and disabling:

- Anxiety Disorders.
- Obsessive-Compulsive and Related Disorders.
- Trauma and Stressor-Related Disorders.
- Intellectual Disabilities and Autism Spectrum Disorders.
- Major Neurocognitive Disorders.
- Personality Disorders.

The primary purpose of this Program Statement is to ensure that inmates with mental illness are identified and receive treatment to assist their progress toward recovery, while reducing or eliminating the frequency and severity of symptoms and associated negative outcomes of mental illness, such as exacerbation of acute symptoms, placement in restrictive housing, need for psychiatric hospitalization, suicide attempts, and death by suicide.

The secondary purpose of this Program Statement is to address dynamic risk factors associated with recidivism in inmates with mental illness to increase pro-social and adaptive living skills and the likelihood of successful reentry to the community.

a. **Summary of Changes**

Policy Rescinded
P5310.13 Institution Management of Mentally Ill Inmates (3/31/95)

This reissuance incorporates the following modifications:

- Evidence-Based Practices for the treatment and care of mentally ill inmates are detailed and Priority Practices are established.
- The mental health care level system is operationalized. Mental health care level definitions are provided, which include diagnostic, impairment, and intervention-based criteria. In addition, care level-based treatment and documentation requirements are noted.
- A team approach to mental health care is established, including introduction of an institution Care Coordination and Reentry (CCARE) Team with joint Psychology Services and Health Services membership.
- Enhanced procedures for screening, evaluation, and intervention with inmates in restrictive housing settings are detailed.

- Procedures for providing mental health training for staff are outlined, including basic training for all staff as well as specialty training for interested staff.
- A mental health companion program is established to provide peer assistance and support to inmates with mental illnesses.
- Achievement awards for inmate participation in mental health programming are introduced.
- Designation, transfer, and release procedures for mentally ill inmates are updated and refined, with an emphasis on continuity of care – both across institutions and to the community.

b. **Program Objectives**

- To identify inmates with mental illness through screening and classification upon their entry into the Bureau and again upon their arrival at an institution to achieve an accurate diagnosis and determine the severity of mental illness and suicide risk.
- To ensure Psychology Treatment Programs and mental health interventions prescribed in treatment plans ordinarily rely on evidence-based practices for the treatment of inmates with mental illness and rehabilitation needs.
- To extend support for inmates with mental illness beyond traditional professional services through creation of specific supportive communities, specialized staff training, inmate peer support programs, care coordination teams, and institutions with specialized mental health missions.
- To enhance continuity of care through a network of accessible, interrelated interventions and communication among care providers when inmates transfer between institutions, to a Residential Reentry Center (RRC), to home confinement, or to the community.
- To reduce the proportion of inmates with mental illness in restrictive housing settings through informed disciplinary processes, initial screening procedures, enhanced treatment in these settings, and strategies for successful reintegration into the general population.
- To increase rates of successful reentry among inmates with mental illness through accurate identification of at-risk inmates, effective skill building in prison, and comprehensive release plans.

2. **RESPONSIBILITIES**

a. **Psychology Services Branch and Health Services Division**. The Psychology Services Branch (Branch), Reentry Services Division, and Health Services Division (HSD) provide oversight and consultation regarding institution treatment and care of inmates with mental illness through remote reviews of the Psychology Data System (PDS) in the Bureau Electronic Medical Record (BEMR) and other BEMR documentation; remote reviews of inmates in restrictive housing; recommendations regarding transfers and designations of mentally ill inmates; and

direct consultation with Chief Psychologists, Psychiatrists, other Health Services staff, and Executive Staff.

The Branch is responsible for developing Annual Refresher Training lesson plans that provide staff with information about working with mentally ill inmates. They also develop and disseminate supplemental staff training materials for use by the Mental Health Treatment Coordinator during staff recalls, lunch and learn events, department head meetings, etc. The Branch also identifies and disseminates evidence-based practices, described below.

b. **Warden**. Each Warden is responsible for the appropriate management of mentally ill inmates in his/her institution. He/she must provide the Mental Health Treatment Coordinator with adequate time to educate staff about the need to detect and report any unusual inmate behaviors that might suggest mental illness. For example, this education should occur at department head meetings, staff recalls, lieutenants' meetings, and annual training.

c. **Chief Psychologist**. Each Chief Psychologist ensures the provisions of this Program Statement are implemented, including designation of a psychologist to serve as Mental Health Treatment Coordinator, and informing institution staff of the designation. The Chief Psychologist is also responsible for ensuring information about the availability of mental health services is disseminated to inmates during Admission and Orientation. Specifically, the Chief Psychologist ensures the Admission and Orientation lesson plan developed by the Psychology Services Branch is utilized to convey this information. In addition, the Chief Psychologist is responsible for ensuring basic psychological services (e.g., mental health screening, brief counseling), as detailed in the Program Statement **Psychology Services Manual**, are made available to inmates.

d. **Mental Health Treatment Coordinator**. The Mental Health Treatment Coordinator is a licensed doctoral-level psychologist who manages the treatment and care of inmates with mental illness and ensures that all provisions of this Program Statement are implemented. A licensed doctoral-level psychologist has satisfactorily completed all the requirements for a doctoral degree directly related to full professional work in psychology (i.e., a Ph.D. or Psy.D. in Clinical or Counseling Psychology), and has obtained a license to practice as a psychologist.

e. **Social Worker**. The institution Social Worker is a licensed professional who may provide individual or group counseling in support of this policy. Additionally, the institution Social Worker or Regional Social Worker may develop comprehensive release plans to ensure continuity of care for inmates with mental illness who transition to the community without the benefit of Residential Reentry or Home Confinement placement. In this capacity, Social Workers coordinate with United States Probation Officers, Courts, community mental health professionals, and families to identify appropriate placements and to address reentry needs.

f. **Psychiatrist/Psychiatric Nurse Practitioner**. Health Services organizes, conducts, and administers psychiatric services. The Psychiatrist/Psychiatric Nurse Practitioner accepts referrals through BEMR for cases believed to be in need of psychiatric medication evaluations. Regular interdisciplinary communication is maintained between the Mental Health Treatment Coordinator and Health Services staff, including contract psychiatrists, to optimize treatment efficacy.

g. **Health Services Administrator**. In facilities that use contract psychiatric services, the Health Services Administrator is responsible for contract development and oversight with input from the Mental Health Treatment Coordinator.

h. **Clinical Director**. The Clinical Director will ensure that the general medical needs of each inmate are addressed and that HSD staff rounding in the units and conducting sick call and clinics have received the necessary training to recognize signs and symptoms of mental illness.

i. **Community Treatment Services (CTS)**. CTS is responsible for the establishment and oversight of community-based mental health, substance abuse, and sex offender treatment services.

j. **Residential Reentry Management Branch (RRMB).** RRMB is responsible for coordinating with the Psychology Services Branch, in particular CTS staff, to ensure mentally ill inmates releasing through Residential Reentry Centers and Home Confinement are placed appropriately.

j. **Care Coordination and Reentry (CCARE) Team**. The CCARE Team is a multidisciplinary team that uses a holistic approach to ensure that critical aspects of care for inmates with mental illness are considered and integrated. The CCARE Team is responsible for identifying potential concerns affecting inmates with mental illness in a correctional environment.

j. **All Staff**. Any staff member who observes unusual behavior in an inmate that may indicate mental illness should report these observations to the Chief Psychologist or Mental Health Treatment Coordinator.

3. RECOVERY-ORIENTED PROGRAM MODEL

Consistent with the recommendations of the President's New Freedom Commission on Mental Health, the Bureau has identified recovery as a guiding principle in the treatment and care of inmates with mental illness. Mental health recovery refers to the process by which people are able to live, work, learn, and participate fully in their communities. For some individuals,

recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.

According to the National Consensus Statement on Mental Health Recovery, there are ten fundamental components of recovery. The Bureau strives to integrate these components into its Psychology Treatment Programs (PTPs), mental health interventions, and treatment plans for inmates with mental illness. The components of recovery are: self-direction, individualized and person-centered care, empowerment, holistic treatment, non-linear progression, strengths-based focus, peer support, respect, responsibility, and hope.

4. **EVIDENCE-BASED PRACTICES (EBPs)**

Psychology Treatment Programs, mental health interventions, and individualized treatment plans for inmates with mental illness rely on evidence-based clinical practices that have been demonstrated to reduce the symptoms of mental illness. EBPs are quickly evolving and cannot be fully listed in the present policy. Therefore, the Bureau maintains a database of EBPs on Sallyport, which is updated as indicated by professional literature. The Psychology Services Branch facilitates implementation of EBPs with materials, education, training, and consultation.

Holistic, recovery-oriented care for inmates with mental illness involves assessing their need for both mental health treatment and rehabilitation programs that reduce the risk of recidivism; services are provided in each of these areas as appropriate. EBPs are selected based on their adherence to this model. Consistent with evidence-based practice, the delivery of mental health services is prioritized for inmates classified as CARE2-MH, CARE3-MH, and CARE4-MH.

a. **Cognitive Behavioral Therapy (CBT)**. The Bureau's treatment programs and mental health services are unified clinical activities organized to treat inmates' complex psychological and behavioral problems throughout the course of incarceration. The Bureau has chosen CBT as a theoretical model because of its proven effectiveness with inmate populations. This guiding model creates theoretical continuity, ensuring that learning and practice are built upon similar principles regardless of the institution, treatment provider, or treatment program in which they occur.

CBT emphasizes the learning and practice of skills associated with improved mental health and adaptive, pro-social behavior. Therefore, inmates who participate in CBT and related interventions (e.g., Dialectical Behavior Therapy [DBT]) are better able to achieve goals the Bureau has for all inmates, including responsibility, self-awareness, and independence.

b. **Group Treatment.** Group treatment has proven to be both clinically effective and an efficient use of resources in the treatment of mental illness. Group treatments have the benefit of modeling by the facilitator and other participants, building social support, and allowing the

immediate practice of new skills. A number of EBPs supported by the Bureau were designed specifically for or can be adapted to a group format. Mental health clinicians are encouraged to provide treatment using a therapeutic group format.

For the purposes of mental health care in the general population, therapeutic groups may be open or closed, are evidence-based, and ordinarily:

- Use an established Bureau protocol.
- Are facilitated by a mental health clinician (i.e., psychologist, psychiatrist, social worker, mental health treatment specialist, psychology intern).
- Meet at least every other week.
- Have a continuity in membership, no greater than 12 participants.
- Provide a therapeutic intervention (not just to "check in" with the therapist).
- Hold rapport building and mutual concern among members as a primary goal.

Following participation in therapeutic groups, it may be appropriate to place an inmate in a maintenance group. Maintenance groups have the same characteristics as therapeutic groups, except that their goal is to maintain progress on therapeutic goals and they may meet less frequently (but at least monthly).

c. **Priority Practices.** The Psychology Services Branch designates certain EBPs as Priority Practices – EBPs delivered in group format that address core needs of the inmate population. They prioritize services for inmates with the most severe forms of mental illness and give consideration to a balanced offering of groups that address mental illness and criminal thinking. They may differ across institutions, based on security level, care level, and mission. The Psychology Services Branch places information regarding Priority Practices for each type of institution on Sallyport.

Ordinarily, Psychology Services departments are actively engaged in the provision of Priority Practices as a vital function. Priority Practices are offered before other types of groups. At a minimum, Psychology Services departments offer at least one Priority Practice therapeutic group each quarter, in addition to groups offered in PTPs. For complexes, each institution is considered independently. Satellite facilities are excluded, unless a full-time clinical staff member is assigned.

d. **Skills Training**. The Bureau emphasizes the learning and practice of skills as an important component of treatment for inmates with mental illness. Treatments that emphasize developing new skills (e.g., CBT, DBT, Illness Management and Recovery, Anger Management) encourage responsibility, empowerment, and independence upon reentry.

e. **Criminal Thinking and Risk**. For most inmates with mental illness, the treatment of mental health symptoms is necessary but not sufficient to reduce the risk of recidivism. Holistic treatment considers which empirically validated dynamic risk factors associated with recidivism must be included in the treatment plan (e.g., criminal thinking errors, substance use, antisocial associates, lack of leisure and recreation activities, school or work functioning).

f. **Peer Support**. Peer support is an EBP and core component of the Mental Health Recovery Model; it functions as an adjunct to professional interventions by extending the mental health system. Inmates who underuse professional services may actively engage in peer support activities that benefit their mental health and that of their peers.

5. MENTAL HEALTH CARE LEVELS

Mental health care levels are used to classify inmates based on their need for mental health services. The contact frequencies described below refer to contacts where psychosocial interventions are provided.

a. Definitions

(1) **CARE1-MH: No Significant Mental Health Care.** An individual is considered to meet CARE1-MH criteria if he/she:

- Shows no significant level of functional impairment associated with a mental illness and demonstrates no need for regular mental health interventions; and
- Has no history of serious functional impairment due to mental illness or if a history of mental illness is present, the inmate has consistently demonstrated appropriate help-seeking behavior in response to any reemergence of symptoms.

(2) **CARE2-MH: Routine Outpatient Mental Health Care or Crisis-Oriented Mental Health Care.** An individual is considered to meet CARE2-MH criteria if he/she has a mental illness requiring:

- Routine outpatient mental health care on an ongoing basis; and/or
- Brief, crisis-oriented mental health care of significant intensity; e.g., placement on suicide watch or behavioral observation status.

(3) **CARE3-MH: Enhanced Outpatient Mental Health Care or Residential Mental Health Care.** An individual is considered to meet the criteria for CARE3-MH if he/she has a mental illness requiring:

- Enhanced outpatient mental health care (i.e., weekly mental health interventions); or

- Residential mental health care (i.e., placement in a residential Psychology Treatment Program).

(4) **CARE4-MH: Inpatient Psychiatric Care.** A mentally ill inmate may meet the criteria for CARE4-MH and require acute care in a psychiatric hospital if the inmate is gravely disabled and cannot function in general population in a CARE3-MH environment.

b. **Determination of Mental Health Care Levels**. All current mental health illnesses should be diagnosed in a Diagnostic and Care Level Formulation note in PDS, including personality disorders and intellectual disabilities. The cumulative impact of the disorders on functioning is taken into account when assigning a mental health care level.

To assign a care level, staff consider the inmate's current, recent, and historical need for services. However, this is not the only indicator, as it must be balanced with the inmate's diagnosis and anticipated need for future services. For example:

- Inmates diagnosed with major mental illnesses and/or currently taking antipsychotic medications are not ordinarily classified as CARE1-MH due to their risk of relapse and the lack of resources to address such a relapse at a CARE1-MH facility.
- Inmates releasing from Medical Referral Centers (MRCs) where they received treatment for acute mental health problems are ordinarily classified as CARE3-MH, due to the resources required to assist them in adjusting to a mainline institution.

Discrepancies in the Record. Occasionally there are diagnostic discrepancies between providers. When this occurs, the Mental Health Treatment Coordinator or treating psychologist attempts to reconcile these differences. The Mental Health Treatment Coordinator or treating psychologist reviews the record, consults with other treatment providers (including Health Services staff), performs a clinical interview, and observes symptoms and behaviors. The Coordinator or psychologist then integrates the data, noting alternate conceptualizations; attempts to reach consensus between care providers; enters a diagnosis in the Diagnostic and Care Level Formulation note in PDS; and provides a rationale for the decision. If the discrepancy cannot be resolved at this level, the Chief Psychologist and Chief Psychiatrist, if applicable, will review the case, resolve the discrepancy, and document their findings.

A supplemental Mental Health Care Level Training Guide is available on Sallyport. The guide is also disseminated during Psychologist Familiarization Training and annual mental health training events. This guide is designed to assist psychologists in determining appropriate mental health care levels.

c. **Treatment Requirements for Mental Health Care Levels.** The required treatment detailed below is not necessarily provided exclusively by the Mental Health Treatment Coordinator; for example, another psychologist may provide this care.

(1) **Mental Health Care Level One.** Inmates classified as CARE1-MH are not required to receive any regular mental health services or to have a treatment plan. When mental health services are provided to these inmates, they are documented in PDS.

(2) **Mental Health Care Level Two.** Required services include, but are not limited to:

- A diagnosis and mental health care level for each inmate will be documented in a Diagnostic and Care Level Formulation note in PDS.
- A rationale for the diagnosis and assigned care level will also be documented in the Diagnostic and Care Level Formulation note in PDS.
- A collaborative, individualized treatment plan that describes the inmate's problems and goals, and the interventions planned to assist with goal attainment will be developed, reviewed, and updated at least every 12 months.
- Evidence-based psychosocial interventions on at least a monthly basis (if group treatment is offered, it should occur at least every other week, to provide continuity of care).

(3) **Mental Health Care Level Three.** Required services include, but are not limited to:

- A diagnosis and mental health care level for each inmate will be documented in a Diagnostic and Care Level Formulation note in PDS.
- A rationale for the diagnosis and assigned care level will also be documented in the Diagnostic and Care Level Formulation note in PDS.
- A collaborative, individualized treatment plan that describes the inmate's problems and goals, and the interventions planned to assist with goal attainment, will be developed, reviewed, and updated at least every 6 months.
- Evidence-based psychosocial interventions on at least a weekly basis are provided via enhanced outpatient care or on a scheduled basis consistent with a residential Psychology Treatment Program.

(4) **Mental Health Care Level Four.** This treatment takes place only in a Medical Referral Center. Required services include, but are not limited to:

- A diagnosis and mental health care level for each inmate will be documented in the Diagnostic and Care Level Formulation note in PDS.
- A rationale for the diagnosis and assigned care level will also be documented in the Diagnostic and Care Level Formulation note in PDS.

- A collaborative, individualized treatment plan that describes the inmate's problems and goals, and the interventions planned to assist with goal attainment will be developed, reviewed, and updated at least every 90 days.
- Evidence-based psychosocial interventions and/or individual mental health contacts will occur on at least a weekly basis.

At CARE4-MH sites, for inmates too cognitively impaired to engage in traditional psychosocial interventions (i.e., severe neurocognitive disorders), supportive contacts from a broad variety of providers may be the most appropriate care plan. Frequency and type of care will be determined on an individual basis for these cases.

d. **Treatment Refusal.** If an inmate declines treatment consistent with his/her mental health care level, a treatment plan is developed and implemented to frequently assess the inmate's mental status, build rapport, and encourage engagement in a treatment process. Ordinarily, the treatment plan will include a monthly attempt to engage the inmate. Rapport building strategies may include: group leisure activities; visits to the inmate's unit or work site; and "drop-in" group for informal socialization with peers.

An inmate who refuses mental health treatment consistent with his/her mental health care level may be considered for involuntary commitment.

6. IDENTIFICATION AND PLACEMENT OF MENTALLY ILL INMATES

All Bureau facilities employ psychologists skilled in the screening, diagnosis, and treatment of mental disorders. Although the Bureau concentrates mental health resources at some institutions, all institutions, regardless of care level, are expected to provide services for inmates with mental illness.

Psychology Services and Health Services departments within each institution ensure every inmate with a clinically identified need for psychological treatment has access to mental health care. They ensure inmates undergo appropriate screening, assessment, and referral to identify and address their mental health, substance abuse, and other behavioral health needs. Psychology Services departments offer a variety of services and programs for inmates – psycho-educational groups, brief counseling, individual and group psychotherapy, crisis intervention, suicide prevention, and residential treatment programs. Health Services departments provide inmates with access to appropriate psychiatric medications to address identified mental health conditions.

a. **Pre-Designation Screening**. Newly designated inmates are screened by Designation and Sentence Computation Center (DSCC) staff based on information in their Pre-Sentence Report (PSR). This screening matches the inmate's estimated need for mental health services with an institution's resources at the time of initial designation.

b. **Initial Care Level Assignment**. Mental health screen assignments (SCRNX-MH) are part of the designation process. The assignments are generated by DSCC staff using the medical calculator and are based on review of the PSR, information received from outside sources, a review of other records, etc.

c. **Medical Staff Screening**. Medical staff provide an initial screening for physical and mental health concerns, including suicide ideation, symptoms of mental illness, and sexual victimization. They document their findings in BEMR and advise Psychology Services of any concerns.

d. **Psychology Intake Screening**. Psychology Intake Screening occurs within the timeframes specified in the Program Statement **Psychology Services Manual** and is documented in PDS. At this time the mental health screen assignment is replaced with the mental health care level assignment in SENTRY, and the mental health care level is documented in Psychology Intake Screening, along with a rationale. If the care level is CARE2-MH, CARE3-MH, or CARE4-MH, a Diagnostic and Care Level Formulation note is entered into PDS. In addition, Psychology Services staff notify Health Services staff of any relevant concerns; e.g., a recommendation for a psychiatric medication consultation.

e. **Assignment and Change of Mental Health Care Level Assignment**. Bureau psychologists, psychiatrists, and qualified mid-level practitioners (i.e., a physician assistant or nurse practitioner who is licensed in his/her field of medicine and has specialized training in mental health care) can determine a mental health care level following a review of records and a face-to-face clinical interview. Therefore, assigned mental health care levels represent clinical information about an inmate and are not changed for administrative, designation, or transfer purposes. If there is not agreement regarding an inmate's mental health care level assignment, refer to Section 5b of this policy to resolve any discrepancies.

Mental health care levels are to be entered into SENTRY by Bureau psychologists. As applicable, information provided by Bureau psychiatrists will inform decisions regarding mental health care level assignments. To assign or change a mental health care level a psychologist, psychiatrist, and qualified mid-level practitioner must:

- Review the clinical record.
- Conduct a clinical interview.
- Establish a diagnosis or indicate the absence of a diagnosis.
- Indicate and explain the type and frequency of mental health care contacts required.
- Document this information in the Diagnostic and Care Level Formulation note.

Mental health care level assignments, and changes to these assignments, are not required for inmates housed in non-Bureau facilities; i.e., private correctional institutions, Residential Reentry Centers, and other contract facilities. In addition, these assignments are not required for inmates in transit. If it becomes clear that a mental health care level assignment needs to be updated to accurately represent the inmate's needs upon return to a Bureau facility, Psychology Services Branch staff update the code and enter a note in PDS describing what is known about the situation and the inmate's mental health needs.

f. **Facilities with Pretrial Inmates.** Psychology Services staff are not required to enter mental health care level assignments for all pretrial inmates. However, they must enter assignments for the following pretrial inmates:

- Inmates who undergo a Psychology Intake Screening on the basis of their endorsements on the Psychology Services Inmate Questionnaire (PSIQ).
- Inmates who self-refer or are referred to Psychology Services due to mental health symptoms.
- Inmates who have a recently completed forensic evaluation by a Bureau psychologist or psychiatrist.
- Inmates who require a Suicide Risk Assessment.

If a pretrial inmate does have a care level assignment, it is expected that he/she will receive mental health services consistent with the frequency requirements of that care level. The creation of a treatment plan is clinically appropriate for inmates for whom a long stay is anticipated. However, due to the rapid and unpredictable turnover associated with pretrial facilities, treatment plans are not required.

If the DSCC receives a request for an initial designation and a pretrial facility has already classified a mental health care level for the inmate, the DSCC does not modify this assignment or change it back to a screen code.

7. TEAM APPROACH TO CARE

Due to their potential vulnerability in a correctional setting, inmates with mental illness may require special accommodation in areas such as housing, discipline, work, education, designations, transfers, and reentry to ensure their optimal functioning. The Bureau uses a team approach to ensure the needs of inmates with mental illness are identified and addressed.

The institution Care Coordination and Reentry (CCARE) Team is a multidisciplinary team that uses a holistic approach to ensure critical aspects of care for inmates with mental illness are considered and integrated. It is a required component at all CARE2-MH, CARE3-MH, and CARE4-MH institutions. It is not required at pretrial facilities or Federal Transfer Centers.

The CCARE Team identifies potential concerns affecting inmates with mental illness in a correctional environment, such as:

- Mental health symptoms that are unreported or unidentified by the inmate.
- Housing problems or cellmate conflicts.
- Work and/or leisure time deficits.
- Criminal thinking and behavior.
- Bullying or abuse by other inmates.
- Escalating patterns of destructive or dangerous behavior.

The CCARE Team also identifies strategies and supports to mitigate potentially negative interactions between inmates with mental illness and the correctional environment, such as:

- Positive reinforcers for behavior consistent with treatment goals.
- Social supports (cellmates, positive staff relationships, spiritual community, mental health companion program).
- Housing accommodations.
- Meaningful ways to spend time (work, supported employment, recreation, drop-in group).

The CCARE team considers how these strategies and supports might be applied to improve functioning and enhance opportunities for recovery. Meetings are ordinarily held no less than once a month and may be held in conjunction with the SHU Meeting.

Every CARE4-MH inmate is reviewed by the team at least quarterly. Every CARE3-MH inmate is reviewed by the team as needed and at least semi-annually. CARE2-MH inmates are reviewed by the team as needed and at least annually. If an inmate participates in a residential PTP, his/her case may be staffed in that setting at the discretion of the Mental Health Treatment Coordinator.

At a minimum the CCARE Team includes:

- Mental Health Treatment Coordinator (CCARE Team co-leader).
- Provider of psychiatric services (CCARE Team co-leader).
- Treating psychologist.
- Institution Social Worker (if applicable).
- Pharmacist.

In addition, the Mental Health Treatment Coordinator invites the following staff, and others as deemed appropriate, to attend CCARE Team meetings:

- Clinical Director. Clinical Directors are strongly encouraged to attend, particularly at CARE4-MH facilities.
- Supervisor of Recreation.
- Applicable unit managers.
- Correctional Services Supervisor.
- Supervisory Chaplain.

The following staff serve on the CCARE Team in special circumstances, as detailed below:

- Regional Social Workers and Community Treatment Services (CTS) staff are required to attend only when reentry needs are being discussed. They may attend via video or teleconference.
- The Disciplinary Hearing Officer (DHO) may attend if a mentally ill inmate is facing serious disciplinary action.
- Depending on the focus of the meeting, other staff may be invited, such as work supervisors or teachers.

In Psychiatric Referral Centers team composition may vary. However, the team model is used.

8. **RESTRICTIVE HOUSING**

The Bureau strives to avoid prolonged placement of inmates with serious mental illness in settings such as Special Housing Units (SHU) and the Special Management Unit (SMU). However, sometimes such placement of inmates is required due to safety and security needs. If, due to safety and/or security needs, an inmate with a serious mental illness needs to be placed in restrictive housing, he/she will continue to receive mental health care commensurate with his/her treatment needs.

a. **Services for Inmates in Restrictive Housing.** Ordinarily, all critical contacts, regardless of an inmate's mental health care level, will, to the extent possible, be conducted in a private area. These include:

- Diagnostic assessments.
- Suicide risk assessments.
- Crisis intervention contacts.
- Protective custody reviews.
- Sexual assault prevention intervention.
- Mental health treatment contacts as indicated by the treatment plan.
- Any other service that addresses potentially sensitive issues or high-risk behaviors.

Additionally, all inmates with mental illness in restrictive housing units (e.g., SHU, SMU, ADX) will receive, at a minimum, face-to-face mental health contacts consistent with the type and

frequency indicated by their care level, to the extent feasible. These contacts take place in a manner that protects an inmate's privacy to the extent that safety and security of staff are not compromised. Contacts should be consistent with the goals of the treatment plan, and are in addition to any critical contacts or contacts required by policy (e.g., SHU Review).

Exceptions to private critical contacts and mental health treatment contacts should be made in cases where the inmate is behaving in an aggressive manner or when institutional safety and security considerations are determined to require an exception. Contacts should be suspended if an inmate becomes aggressive, such that the staff member is concerned about his/her safety. The contact is reinitiated once additional security is in place or when the inmate has regained control of his/her behavior. Exceptions are not made due to logistical issues concerning moving the inmate out of his/her cell or difficulty locating a private space.

The Bureau recognizes that an inmate's mental health may deteriorate during a restrictive housing placement. Potential issues are mitigated through a variety of strategies that are applied collaboratively by staff across disciplines:

- During rounds, all staff will make themselves available for brief conversations that demonstrate concern and their availability to provide assistance.
- Except in unique circumstances, mental health clinicians will not participate as a team member in a calculated use of force situation.
- Inmates are removed from their cells for private or extended interviews with Psychology and Psychiatry Services staff as a standard procedure.
- In-cell activities (e.g., books, puzzles, games, audio/video entertainment and programming [if applicable]) will be provided by the corresponding departments.
- Close attention will be paid to the importance of out of cell, unstructured recreation time specific to inmates' needs and encouraging inmates to take advantage of out of cell activities.

If restrictive housing appears to have a negative impact on the inmate's mental health, the Mental Health Treatment Coordinator actively works with the CCARE Team to mitigate the negative impact or identify an appropriately secure alternative placement.

b. **Extended Restrictive Housing Placement Reviews**. Inmates referred for extended placement in restrictive housing (i.e., SMU, ADX) must be reviewed by Psychology Services staff to determine if mental health issues exist that preclude placement in this setting. Psychiatry Services staff may be consulted in making this determination. In addition, inmates housed in restrictive housing for an extended period of time receive an enhanced mental health review, detailed below. The Psychology Services Branch provides oversight of mentally ill inmates in restrictive housing through the procedures and reviews described below.

(1) **SMU Referral Review Procedures**. The following SMU referrals are reviewed by the Psychology Services Branch in collaboration with the Chief Psychiatrist, Health Services Division, as applicable, prior to placement:

- Inmates classified as CARE2-MH, CARE3-MH, and CARE4-MH in SENTRY.
- Inmates classified as PSY ALERT in SENTRY.
- Inmates noted to be receiving psychiatric medications.
- Any inmate for whom the institution Chief Psychologist requests a review based on mental health or cognitive limitation concerns.
- Any inmate for whom the DSCC requests a review based on mental health or cognitive limitation concerns.

In conducting this review, the Branch applies the exclusionary criteria noted below (SMU/ADX Exclusionary Criteria) to identify any inmates precluded from SMU placement.

(2) **ADX Referral Review Procedures**. A mental health evaluation is a required component of **all** referral packets for the ADX Florence Control Unit and ADX Florence General Population (per the Program Statements **Control Unit Programs** and **Inmate Security Designation and Custody Classification**, respectively).

The mental health evaluation is conducted by a licensed doctoral level psychologist. An interview of the inmate and psychological testing (the current version of the Personality Assessment Inventory) are required components. In addition, screening for intellectual disability is required (the current version of the Kaufman Brief Intelligence Test) and, if indicated, further testing (the current version of the Wechsler Adult Intelligence Scale). Before the interview, a notice of psychological evaluation must be provided. Notification forms are BP-A1055, Notice of Psychological Evaluation – ADX Control Unit, and BP-A1056, Notice of Psychological Evaluation – ADX General Population. If the inmate refuses to cooperate with the interview or psychological testing, the evaluation proceeds. This refusal is noted in the report.

The required format for the mental health evaluation report is outlined below:

ADX Mental Health Evaluation

- **Identifying Data**. Identifying data includes: inmate name and register number, gender, race, ethnicity, languages spoken, date of birth and age, current sentence, and projected release date. In addition, the identifying data section indicates the date and place of the evaluation and the name of the evaluator.
- **Notice of Psychological Evaluation**. Confirms the inmate was provided with the Notice of Psychological Evaluation. If he/she refused to sign, the information is noted in this section.

- **Assessment Procedures**. Lists the assessment procedures used, including: Notice of Psychological Evaluation, clinical interview, PSR and Central File review, collateral information and observations by other staff, and psychological testing (specify tests administered; e.g., PAI, WAIS-IV, KBIT-2). *Note*: An attempt to interview the inmate and conduct psychological testing must occur in all cases. If the inmate refuses to cooperate, his/her refusal is noted in this section and in the psychological testing section.
- **Psychosocial History**. Briefly addresses the inmate's psychosocial history, as relevant to this report, noting not only significant deficits or limitations, but also areas of specific strength. Topics that may be addressed include:

  - **Family History**. Describes family of origin; any noteworthy criminal, psychiatric, or medical history of relatives; any history of abuse or trauma in the family; and marital history if applicable.
  - **Educational History**. Briefly notes the inmate's educational history, with emphasis on noted intellectual disabilities, cognitive impairments, and results of intelligence testing.
  - **Employment History**. Briefly describes the inmate's employment history, including any prior military experience.

- **Medical History**. Briefly notes significant medical conditions, such as chronic illnesses or disabilities.
- **Mental Health History**. Typically contains a greater level of detail and includes the following (if applicable): historical information related to psychiatric hospitalizations, past mental health diagnoses, use of psychiatric medication, history of suicidal behavior/gestures, mental health treatment history prior to and within the Bureau, and history of mental health deterioration during confinement in a restrictive housing setting. *Note*: PSR and PDS/BEMR review are mandatory in the preparation of this section.
- **Substance Abuse History**. Briefly describes any substance abuse issues.
- **Psychosexual History**. Briefly describes any deviant sexual interests, history of sexually abusive behavior or victimization, and history of sexual crimes.
- **Criminal History**. Describes the inmate's criminal history, including juvenile and adult crimes, escape attempts, and incident reports. Special attention is given to crimes, escape attempts, and incident reports contributing to the ADX referral. In addition, this section addresses the inmate's view of his/her criminal activity, including the incident(s) associated with the referral. *Note*: It is not necessary to list every arrest, conviction, and incident report in this section. The evaluator may summarize information. For example, "Inmate Smith has received 37 incident reports in the past 3 years, the majority of which involve insolence and possession of intoxicants."
- **Interview/Mental Status Examination**. Summarizes findings from the clinical interview and mental status examination. If the inmate refuses to participate in the clinical interview

and mental status examination, his/her refusal is noted in this section and all pertinent observations are recorded.

- **PAI Results**. Summarizes PAI results. If the inmate refuses to complete the PAI, his/her refusal is noted in this section.
- **Case Formulation**. Contains an analysis and synthesis of the data, which integrates psychological testing results with history, mental status, and clinical observations. Diagnostic impressions should be fully supported. If prior documentation of a mental illness exists, but is no longer valid, or if the evaluator believes it was never valid, this should be noted and supported by the evaluator. The case formulation also includes the evaluator's conclusion whether any psychological factors would preclude the inmate's placement at the ADX.
- **Diagnostic and Care Level Formulation**. Lists any diagnoses and notes the inmate's mental health care level.

The completed mental health evaluation report is entered in the PDS in the "Evaluations" section; the document is titled "ADX Referral Mental Health Evaluation." The report is entered directly into PDS; it is not entered as a Word attachment. Psychological testing data are scanned into PDS as an attachment linked to the evaluation note. Once the report is entered into PDS, an email notification is sent to the Psychology Services Branch at *BOP-RSD/Psychology SVCS~*. The inmate's name and register number are included in the subject line. The Psychology Services Branch reviews the report, psychological testing results, and the PDS records. Any concerns are discussed with the Chief Psychologist or Clinical Director at the inmate's facility. If no concerns are noted, a concurrence email is sent to the Chief Psychologist and the Warden for inclusion in the referral packet.

c. **SMU/ADX Exclusionary Criteria**. Ordinarily, seriously mentally ill inmates (classified as CARE3-MH) are diverted from SMU or ADX placement and CARE4-MH inmates are not placed in these facilities. Inmates who are identified as seriously mentally ill will not be designated to or housed at the ADX or SMUs, except as noted below. Placement of a seriously mentally ill inmate in the ADX or a SMU will only occur if extraordinary security needs are identified that cannot be managed elsewhere. In such circumstances, an individualized mental health treatment plan will be developed commensurate with the inmate's treatment needs. The decision to exclude a seriously mentally ill inmate from the ADX or a SMU is not contingent on his/her willingness to participate in a mental health treatment program. In addition, the Psychology Services Branch, in collaboration with the Chief Psychiatrist, Health Services Division, will generally recommend against SMU or ADX placement in the following instances:

- A review of documentation suggests SMU or ADX placement would interfere with the inmate's participation in necessary mental health treatment interventions.

- A review of documentation suggests the inmate's mental health disorder or cognitive limitations make it unlikely he/she could successfully progress through the phases of the SMU or ADX.
- A review of documentation suggests SMU or ADX placement is likely to exacerbate an inmate's mental health condition.

Inmates identified as in need of inpatient psychiatric care (CARE4-MH) are not referred for placement in a SMU or the ADX. The appropriate placement for these inmates is a Psychiatric Referral Center.

If a seriously mentally ill inmate is determined to be unable to function in a less restrictive setting due to special safety and security needs, he/she will continue to receive mental health services commensurate with his treatment needs while in restrictive housing.

d. **Extended Restrictive Housing Reviews**. Inmates in restrictive housing placements for an extended period will receive regular mental health evaluations. These evaluations occur when the inmate is continuously housed:

- In SHU for 6 months.
- In the ADX for 12 months.
- In a SMU for 18 months.

The mental health evaluation is completed by an institution psychologist and includes a review of the records, behavioral observations, clinical interview, and psychological testing if clinically indicated.

If the inmate refuses to cooperate with the interview or psychological testing, the evaluation proceeds and this refusal is noted in the report. The required protocols for the mental health evaluation reports are found in BP-A1057, Restrictive Housing Mental Health Evaluation – Initial Review, and BP-A1058, Restrictive Housing Mental Health Evaluation – Follow-Up Review; the results of these reports are documented in the Diagnostic and Care Level Formulation in PDS.

Updates are conducted for subsequent anniversaries; for example, an inmate continuously housed in SHU for 18 months would receive an evaluation when he/she has been housed in SHU for 6 months, with updates at 12 and 18 months.

The documentation associated with this review is entered in PDS under the note type "Restrictive Housing Mental Health Evaluation" and the results documented in PDS as an update of the

Diagnostic and Care Level Formulation note. This information is entered in PDS within 14 days of the applicable due date.

Based on the findings of this evaluation, the Chief Psychologist, in collaboration with the CCARE Team (if applicable) may immediately initiate local actions to address identified mental health concerns.

On a monthly basis, the Psychology Services Branch reviews Restrictive Housing Mental Health Evaluations to determine if mental health concerns are appropriately addressed. In conjunction with these reviews, Branch staff consult as necessary with institution staff and with the Bureau's Chief Psychiatrist. Branch staff also document concurrence with the evaluation findings or additional recommendations in PDS.

e. **SHU/SMU/ADX Removal Criteria**. If an inmate's mental health appears to have deteriorated during restrictive housing placement, the Mental Health Treatment Coordinator actively works with the CCARE Team (if applicable) and the Psychology Services Branch (if applicable) to mitigate the impact or identify an alternative placement. As necessary, the Psychology Services Branch will consult with the Bureau's Chief Psychiatrist. This deterioration may be identified through the mental health evaluation described above, or through more emergent factors; e.g., acute mental illness leading to the need for an emergency psychiatric transfer.

In addition, the Psychology Services Branch, in collaboration with the Chief Psychiatrist, Health Services Division, reviews inmates for possible removal from a SMU or the ADX in the following circumstances:

- Any inmate who is transferred from a SMU or the ADX to an MRC on an emergency psychiatric transfer.
- Any inmate who, upon arrival to a SMU or the ADX, is judged by the Chief Psychologist or Psychiatrist to have significant mental health issues or cognitive limitations that may make him/her inappropriate for this placement.
- Any inmate who begins to experience symptoms of a serious mental illness following placement in a SMU or the ADX.

f. **Discipline**. An inmate's mental health symptoms may contribute to institution rule infractions that could result in disciplinary sanctions, including SHU placement or the extension of SHU placement. In these cases it is the responsibility of the Mental Health Treatment Coordinator to provide consultation to the DHO to ensure the disciplinary process is applied appropriately to inmates with mental illness.

The DHO refers the following incident reports to a psychologist for determination of competence and responsibility:

- Any incident report received by a CARE3-MH or CARE4-MH inmate.
- Any incident report received by a CARE2-MH inmate where there appears to be a mental health concern.
- Any incident reports for Code 228 involving self-harm.
- Any incident report for Code 302, Misuse of Authorized Medication.

The Mental Health Treatment Coordinator indicates whether the inmate is competent or responsible and whether some types of sanctions are inappropriate based on his/her mental health needs. Sanctions that limit social support (e.g., SHU placement, loss of visits, or loss of phone calls) should be considered on a case-by-case basis and may not be appropriate for inmates with mental illness who use these supports as a component of their treatment or recovery.

9. **MENTAL HEALTH TRAINING**

Mental health training for all staff is included in Introduction to Correctional Techniques I and II and Annual Training. Mental health training is also provided on a quarterly basis to SHU officers.

Additional Mental Health Specialty Training will be made available in select CARE2-MH, CARE3-MH, CARE4-MH, and administrative institutions. To support this specialized training, adequate Psychology Services staffing must be in place. With adequate Psychology Services staffing and sufficient staff interest, this training is offered annually. This program supports the development of an optimal environment for effective treatment and care of offenders with mental illness, in which mental health professionals and other staff work collaboratively to support treatment. The training promotes early identification of mental health problems and more effective de-escalation and support when problems arise. While this training is not required to work a post on a mental health unit, it will be especially beneficial for staff who work these posts.

Staff may apply to take advantage of this additional Mental Health Specialty Training by submitting an application to the Human Resource Manager following the announcement of this training opportunity.

This additional Mental Health Specialty Training will include 24 hours of specialized mental health training, including suicide prevention, understanding mental illness, cultural diversity and sensitivity, psychiatric medications, behavior management principles, confidentiality, communication skills, de-escalation skills, and building collaborative relationships.

10. MENTAL HEALTH COMPANION PROGRAM

Mental Health Companions are trained inmates who provide assistance and support to inmates with mental illness under the direction of the Psychology Services Department. Mental Health Companion Programs are initiated at the discretion of the Warden. They may take a variety of forms, including a cadre residing on a mental health treatment unit, supporting a drop-in center, or participating in individual pairings with inmates who need additional support.

The Mental Health Treatment Coordinator is responsible for the selection, training, assignment, and removal of individual companions. Inmates selected as companions are considered to be on an institution work assignment when they are on their scheduled shift and receive performance pay for time spent providing support to inmates with mental illness.

a. **Selection of Inmate Mental Health Companions**. Because of the sensitive nature of such assignments, the selection of Mental Health Companions requires considerable attention. They must be able to provide companionship and assistance to mentally ill inmates, protect their privacy, and report significant safety concerns and suicide warning signs to staff. In the Mental Health Treatment Coordinator's judgment, they must be reliable individuals who have credibility with both staff and inmates and are able to perform their duties with minimal need for direct supervision. In addition, any inmate who is selected as a Mental Health Companion must not:

- Have committed a 100-level prohibited act within the last three years.
- Be in Financial Responsibility Program (FRP), GED, or Drug Ed Refuse status.
- Have a history of sex offense against an adult.

As part of the selection process, the Mental Health Treatment Coordinator takes the following steps and documents the findings in PDS:

- Interview the inmate.
- Review the inmate's disciplinary history.
- Review the inmate's PSR.
- Review the inmate's PDS documentation.
- Consult with the Special Investigative Supervisor (SIS).
- Consult with the inmate's current work supervisor.
- Consult with the Unit Team.

b. **Training Mental Health Companions**. Each companion receives at least four hours of initial suicide prevention training and an additional four hours of initial Mental Health Companion training before assuming Mental Health Companion duties. Each Companion also

receives at least four hours of refresher training every six months. Each training session reviews policy requirements and instructs the inmates on their duties and responsibilities as a Mental Health Companion, including:

- Basic information about mental illness.
- Modeling and supporting recovery from mental illness.
- Reducing stigma.
- Communication skills.
- Warning signs for suicide and other mental health problems that should be reported to staff immediately.

An inmate may serve as both a Mental Health Companion and a Suicide Watch Companion. However, these are separate work assignments with different tasks and challenges. Therefore, some portions of training may be combined and others must be individualized. Mental Health Companions may participate in the initial Suicide Watch Inmate Companion training provided by the Suicide Prevention Coordinator to complete the suicide prevention portion of their initial training. In semi-annual training, the components common to both Suicide Watch Companions and Mental Health Companions may be covered in a combined two-hour training, if two additional hours of specialized training are provided to each group.

c. **Meetings with Mental Health Treatment Coordinator**. Mental Health Companions with an active work assignment meet at least weekly with the Mental Health Treatment Coordinator or designee to debrief their work, review procedures, discuss issues, and supplement training. This meeting may occur in a group setting.

d. **Records**. The Mental Health Treatment Coordinator maintains a record in PDS containing:

- An agreement of understanding and expectations signed by each Companion.
- Documentation of attendance and topics discussed at semi-annual trainings and weekly meetings.

Verification of pay for those who have an assignment is also maintained.

e. **Supervision of Inmate Mental Health Companions**. Although Mental Health Companions are selected on the basis of their emotional stability and level of personal responsibility, they still require staff supervision while performing their duties. This supervision is provided by the Mental Health Treatment Coordinator during meetings. In support of the program, the Mental Health Treatment Coordinator provides staff with a roster of Companions (e.g., via TRUSCOPE, memorandum, or Sallyport).

f. **Removal**. The Mental Health Treatment Coordinator or designee may remove any Inmate Mental Health Companion from the program at his/her discretion. Removal of a companion is documented in the PDS records.

11. PTP ACHIEVEMENT AWARDS

Mental Health PTPs offer achievement awards for inmates who participate in them, as defined in the Program Statement **Psychology Treatment Programs**. Achievement awards are offered to participants who demonstrate behaviors that reflect a commitment to treatment, conformity with program norms, progress on treatment plan goals, and behaviors that are expected in the general society.

a. **Earning Achievement Awards**. Inmates enrolled in PTPs must:

- Be on time for all treatment activities.
- Have no unexcused absences.
- Not leave treatment activities without approval from the facilitator.
- Dress appropriately.
- Be an active participant in treatment activities.
- Put forth positive efforts in accomplishing treatment plan goals, as determined by the treatment provider.
- Comply with education and FRP obligations.
- Not receive a sanction for a sustained incident report.

b. **Specific Achievement Awards**

- **Limited financial awards**. An inmate may earn a financial award to offset time lost from work. The amount is $50 for each phase of treatment, as defined in the Program Statement **Psychology Treatment Programs**. A financial award may be reduced by the treatment team based upon the inmate's unsatisfactory participation and progress. However, a financial award is never to exceed $50.
- **Nearer release transfer**. Formal consideration may be given for a nearer release transfer following successful program completion.
- **Local incentives**. Institutions may offer incentives such as preferred living quarters, "early chow," washer/dryer or exercise equipment on unit, etc.
- **Tangible incentives**. With the Warden's approval, tangible incentives may be given (e.g., books, t-shirts, notebooks, pencil pouches, mugs with program logo, food and hygiene items that are not sold in commissary).
- **Token economy**. Mental Health PTPs may choose to run a token economy in which inmates are able to earn tangible incentives based on their participation.

- **Transition ceremony/ritual**. For the completion of a Mental Health PTP, institutions may offer a structured transition ceremony for the inmates.

12. MENTAL HEALTH TREATMENT ACHIEVEMENT AWARDS

Achievement awards are available to CARE3-MH inmates in all settings and CARE2-MH/CARE3-MH inmates at the ADX. Achievement awards are offered to participants who demonstrate behaviors that reflect sustained efforts toward recovery, progress on treatment goals, and pro-social attitudes and behaviors.

a. **Earning Achievement Awards**. Inmates must:

- Attend treatment activities on time.
- Make positive efforts in accomplishing treatment plan goals, as determined by the treatment provider.
- Comply with education and FRP obligations.
- Not receive a sanction for a sustained incident report.

b. **Specific Achievement Awards**

- **Local incentives**. Institutions may offer incentives such as preferred living quarters, "early chow," washer/dryer or exercise equipment on a unit where CARE3-MH inmates live, etc.
- **Tangible incentives**. With the Warden's approval, tangible incentives may be given, (e.g., books, t-shirts, notebooks, pencil pouches, mugs with program logo, food and hygiene items that are not sold in commissary).
- **Token economy**. CARE3-Mental Health sites may choose to run a token economy in which inmates are able to earn tangible incentives based on their participation in treatment.

13. REDESIGNATIONS OF INMATES WITH MENTAL ILLNESS

Inmates with mental illness are transferred using specialized procedures to ensure they are housed in institutions that have resources to meet their needs.

a. **CARE3-MH Inmates**. Ordinarily, designations of CARE3-MH inmates are processed at the DSCC and reviewed by Psychology Services staff, who recommend a placement or placements that have appropriate resources to meet the inmate's mental health needs.

CARE3-MH inmates are, on occasion, transferred via program completion transfers (325) in order to manage the CARE3-MH populations at sites with PTPs for the mentally ill, such as the Mental Health Step Down Program and STAGES Program.

If a CARE3-MH inmate needs a transfer to a psychiatric referral center to manage acute psychiatric symptoms, the BP-A0770 (Medical/Surgical and Psychiatric Referral Request) is submitted to the Office of Medical Designations and Transfers (OMDT), Health Services Division. The mental health care level code is not changed to CARE4-MH by the sending institution.

Inmates classified as CARE3 in regard to both physical and mental health are referred for transfer and designation through OMDT.

b. **Continuity of Care Between Bureau Institutions**. To promote continuity of care for inmates with mental illness as they transfer, a Mental Health Transfer Summary must be completed in PDS every time a mentally ill (CARE2-MH, CARE3-MH, and CARE4-MH) inmate transfers within the Bureau – to an RRC, home confinement, or directly to the community. Pretrial facilities are exempt from this requirement if the inmate has been at the facility for less than six months.

- **Transfers between mainline institutions**. A Mental Health Transfer Summary must be entered into PDS by the Mental Health Treatment Coordinator, or treating psychologist, for all CARE2-MH, CARE3-MH, and CARE4-MH inmates before submission to the DSCC for transfer.
- **Psychiatric transfers to MRCs**. If an inmate is accepted for Emergency or Routine Psychiatric Transfer, the BP-A0770 is submitted to OMDT and entered into PDS; the Mental Health Transfer Summary is not required.
- **Psychiatric transfers from MRCs**. When psychiatric treatment at an MRC is complete, Psychology staff complete a treatment summary and update the Diagnostic and Care Level Formulation in PDS.

14. REENTRY

The Bureau is committed to helping inmates prepare for reintegration into their communities by transferring inmates with mental illness through RRCs or home confinement placements. However, each inmate should first be reviewed for suitability for community placement and continuity of care needs.

Each Warden is strongly encouraged to approve inmates who successfully complete Mental Health PTPs for RRC/Home Confinement placement, consistent with the recommendations of PTP staff.

a. **Assessment of Psychological Suitability**. The CCARE team considers community placement for all inmates with mental illness on an individual basis. However, some inmates may not be suitable for community placements. Others may be suitable, but may not benefit from community placements due to their mental health conditions, or may need special

consideration given to the type of community placement. The following conditions indicate an inmate is potentially unsuitable for RRC or home confinement placement:

- Ongoing inpatient psychiatric treatment.
- Uncontrolled mental health symptoms (e.g., psychosis with no insight, non-adherent with medication).
- Acute suicidal ideation with accompanying plans or recent attempts of moderate to high lethality.
- Inability to perform routine activities of daily living (bathing, dressing, eating, toileting, general hygiene, and mobility).

Continuity of care is also a primary consideration in placement decisions. For inmates who are particularly vulnerable to environmental changes or stressors, the following situations indicate caution should be taken regarding the inmate's placement and the inmate's needs, strengths, and weaknesses should be considered as part of the CCARE team planning process:

- There is no RRC in the inmate's community, causing him/her to have to relocate for RRC placement and again to return to his/her community.
- The inmate has a history of struggling to adapt to new environments.
- Community supports or mental health services are limited in the area to which the inmate is transferring.

At a minimum, the institution's CCARE Team assesses all CARE2-MH, CARE3-MH, and CARE4-MH inmates for suitability at the time of the RRC Referral Process and when the Mental Health Transfer Summary is prepared (30 to 60 days before RRC placement). If there are any concerns regarding the inmate's ability to be successful in a community placement, the team consults with CTS and Residential Reentry Management Branch staff.

Clinically manageable in the community is defined as having mental health symptoms that can be treated on an outpatient basis through pre-arranged linkages to family/community support, counseling, and psychiatric medications as needed.

When the CCARE Team determines the disposition for an inmate having one or more of the above-listed conditions, the team takes the actions below consistent with their decision:

- **Clinically manageable**. If an inmate's mental health needs are determined to be manageable in the community, the institution CCARE Team continues to monitor his/her status at intervals set by the team. If no complications arise, RRC or home confinement referral proceeds as planned by the Unit Team. If symptoms increase significantly, a reassessment occurs.
- **Clinically unmanageable**. If an inmate's mental health needs are determined to be unmanageable in the community, the Unit Manager will submit a request to Residential Reentry Management Branch staff to revoke or retard the RRC date. Clinically

unmanageable in the community is defined as not having the requisite family/social network, health care facility, clinical or specialty services, or access to prescribed medications to maintain or improve an inmate's mental health status as assessed at the time of release to RRC or home confinement placement. The institution CCARE Team continues to monitor the inmate's mental health at intervals set by the team and changes his/her status if his/her mental health improves such that he/she has clinically manageable needs.

If the inmate is releasing to supervision under the United States Probation Office (USPO) or Court Services Offender Supervision Agency (CSOSA), and his/her mental health needs remain unmanageable in the community up to the point of release from custody, the treating psychologist must ensure contact is made with USPO or CSOSA. The treating psychologist ensures they are informed of the inmate's status and provides the Mental Health Transfer Summary as documented in PDS. The treating psychologist then makes a referral to the social worker, who will develop a comprehensive release plan, as detailed below. If the inmate is releasing directly to the community with no supervision requirement, a Bureau social worker takes responsibility for coordinating a release plan, as detailed below.

If an inmate with mental illness is releasing from a CARE1-MH institution with no CCARE team, the Mental Health Treatment Coordinator coordinates with staff from other disciplines, as needed, and ensures continuity of care during the inmate's release is consistent with the practices described in this policy.

b. **Community Treatment Services**. CTS staff determine which inmates with moderate, serious, or acute mental health needs releasing to community placements are appropriate for community treatment services by consulting with institution CCARE teams and running rosters of CARE2-MH, CARE3-MH, and CARE4-MH and Psychology Alert assignments. CTS staff review inmate PDS files, including the Mental Health Transfer Summary, which recommend follow-up treatment in the community. They arrange appropriate services to support inmates with mental illness who are placed in RRCs or in home confinement.

c. **Social Workers**. Social workers, in collaboration with the inmate and the institution CCARE Team, create comprehensive release plans for inmates who are releasing from Bureau custody with no community placement. The release plan identifies community treatment providers in the areas of psychiatry, mental health treatment, family counseling, substance abuse, and sex offender treatment, as recommended by the treating psychologist and as available in the community. Some institutions have locally based social workers; those that do not rely on Regional Social Workers. Social workers may consult with CTS staff regarding resources available in the community to which the inmate is releasing.

d. **Continuity of Care to Community Placements**. Procedures for transfer to community placements are detailed below.

- **Transfers to RRCs and Home Confinement**. When CARE2-MH, CARE3-MH, and CARE4-MH inmates are between 30 and 60 days from an RRC date, the Mental Health Transfer Summary is completed by the treating psychologist and entered in PDS. If CTS staff determine this form is not present in PDS 30 days prior to the RRC date, they notify the Chief Psychologist of the discrepancy. The Chief Psychologist ensures the summary is completed before the inmate's transfer. If there is sufficient concern regarding the inmate's mental health condition, CTS staff also consult with the Residential Reentry Manager (RRM), who may retard the RRC date until adequate information is available to ensure continuity of care.
- **Release to the Community with Supervision**. When a CARE2-MH, CARE3-MH, or CARE4-MH inmate releases directly to the community under the supervision of the USPO or CSOSA, the treating psychologist completes the Mental Health Transfer Summary in PDS and ensures the supervising USPO or CSOSA receives a copy. The treating psychologist completes this summary 30-60 days before the inmate's release. If the inmate requires mental health aftercare services, the treating psychologist will make a referral to the institution Social Worker or Regional Social Worker, who will assist with reentry planning.
- **Release to the Community without Supervision**. When a CARE2-MH, CARE3-MH, or CARE4-MH inmate releases directly to the community with no supervision requirement, the treating psychologist completes the Mental Health Transfer Summary in PDS 30-60 days before the inmate's release. If the inmate requests, the treating psychologist forwards it to a community treatment provider, following completion of the release of information. Such a request can also be made by the inmate following his/her release. If the inmate is on psychiatric medication and needs linkage to community resources, the psychologist should make a referral to the institution Social Worker or Regional Social Worker to enhance continuity of care.

e. **Return to Custody Due to Mental Illness**. Sometimes inmates experience mental health crises or behavioral problems in an RRC setting and are no longer able to be managed in the community. When this occurs:

- The RRM staff must immediately notify and consult with CTS regarding any CARE2-MH, CARE3-MH, or CARE4-MH inmate **or** any CARE1-MH inmate exhibiting symptoms of mental illness, for whom the RRC placement or home confinement may be terminated.
- CTS staff in turn consult with Psychology Services Branch mental health staff and document the consultation in PDS.
- Psychology Services Branch mental health staff adjust the care level assignment, if necessary, by entering a mental health assignment that better approximates the inmate's need for services.
- Psychology Services Branch mental health staff make a recommendation regarding whether the inmate should be transferred to an MRC for treatment of acute mental illness, returned to

a mainline institution, continued in the current placement with additional supports, or housed in a contract facility until the end of his/her sentence.

- The RRM staff work with the OMDT or the DSCC to identify and return the inmate to the parent institution or, if necessary, identify an alternate institution. If the inmate needs emergency psychiatric care at a Psychiatric Referral Center, RRM staff prepare the BP-A0770 in consultation with CTS and the Psychology Services Branch.

If the inmate is returned to an institution, release planning begins again immediately upon his/her arrival.

15. AGENCY ACA ACCREDITATION PROVISIONS

- American Correctional Association Standards for Adult Correctional Institutions, 4th Edition: 4-4142, 4-4143, 4-4144, 4-4305, 4-4368, 4-4370, 4-4371, 4-4372, 4-4373, 4-4374, 4-4399, 4-4429, 4-4429-1.
- American Correctional Association Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-2A-32, 4-ALDF-4C-8, 4-ALDF-4C-19, 4-ALDF-4C-27, 4-ALDF-4C-28, 4-ALDF-4C-29, 4-ALDF-4C-30, 4-ALDF-4C-31, 4-ALDF-4C-32, 4-ALDF-4C-34, 4-ALDF-4C-40, 4-ALDF-6B-05, 4-ALDF-6B-06, 4-ALDF-6B-07, 4-ALDF-6B-08.
- American Correctional Association Standards for Administration of Correctional Agencies, 2nd Edition: 2-CO-4B-04.

REFERENCES

Program Statements

P5070.12 Forensic and Other Mental Health Evaluations (4/16/08)
P5100.08 Inmate Security Designation and Custody Classification (9/12/06)
P5212.07 Control Unit Programs (2/20/01)
P5270.09 Inmate Discipline Program (7/8/11)
P5270.10 Special Housing Units (7/29/11)
P5290.14 Admission and Orientation Program (4/3/03)
P5310.12 Psychology Services Manual (8/13/93)
P5324.08 Suicide Prevention Program (3/15/07)
P5330.11 Psychology Treatment Programs (3/16/09)
P5370.11 Inmate Recreation Programs (6/25/08)
P6031.03 Patient Care (8/23/12)
P6340.04 Psychiatric Services (1/15/05)

Other References

President's New Freedom Commission on Mental Health, 2003
National Consensus Statement on Mental Health, 2004
Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition, 2013

BOP Forms

BP-A0770	Medical/Surgical and Psychiatric Referral Request
BP-A1055	Notice of Psychological Evaluation – ADX Control Unit
BP-A1056	Notice of Psychological Evaluation – ADX General Population
BP-A1057	Restrictive Housing Mental Health Evaluation – Initial Review
BP-A1058	Restrictive Housing Mental Health Evaluation – Follow-Up Review

Records Retention Requirements

Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) on Sallyport.

EXHIBIT 3

U.S. Department of Justice
Federal Bureau of Prisons
United States Penitentiary,
Administrative Maximum
Florence, Colorado

INSTITUTION SUPPLEMENT

OPI: Psychology Services/Health Services
NUMBER: FLM 5310.16A
DATE: July __, 2016

Treatment and Care of Inmates with Mental Illness

/s/
Approved: J. Fox, Complex Warden
FCC Florence

I. PURPOSE AND SCOPE

This Institution Supplement provides institutional guidelines for the treatment and care of inmates with mental illness at the United States Penitentiary, Administrative Maximum (ADX), Florence, Colorado, consistent with the Bureau's current Program Statement regarding the *Treatment and Care of Inmates with Mental Illness*.

Adhering to the guidelines within this Institution Supplement ensures that the inmates with mental illness housed at the ADX are identified and receive treatment, with the goal of reducing or eliminating the frequency and severity of symptoms and associated negative outcomes of mental illness.

II. PROGRAM OBJECTIVES

- To screen and classify inmates when they arrive at the ADX to identify those with mental illness, provide accurate diagnoses, determine the severity of mental illness, and assess suicide risk.
- To exclude inmates with serious mental illness, as defined in the Bureau's current Program Statement regarding the *Treatment and Care of Inmates with Mental Illness*, from the ADX, except when the inmate has extraordinary security needs that cannot be managed elsewhere, and when extraordinary security needs exist, to provide treatment and care commensurate with their mental health needs.

- To provide reasonable access to mental health assessment for all inmates at the ADX.
- To promptly identify any inmate who develops signs or symptoms of possible mental illness while incarcerated at the ADX, and to permit timely and proper diagnosis, care, and treatment.
- To provide reasonable access to clinically appropriate mental health treatment for all inmates at ADX.
- To support inmates with mental illness through creation of wellness programs and recreational activities, specialized staff training, and care coordination teams.

III. REFERENCES

A. Program Statements

P4200.10, *Facilities Operations Manual* (1/24/06)
P5070.12, *Forensic and Other Mental Health Evaluations* (4/16/08)
P5100.08, *Inmate Security Designation and Custody Classification* (9/12/06)
P5270.09, *Inmate Discipline Program* (7/8/11)
P5290.14, *Admission and Orientation Program* (4/3/03)
P5310.12, *Psychology Services Manual* (8/13/93)
P5310.16, *Treatment and Care of Inmates with Mental Illness* (5/1/14)
P5324.08, *Suicide Prevention Program* (3/15/07)
P5330.11, *Psychology Treatment Programs* (3/16/09)
P5370.11, *Inmate Recreation Programs* (6/25/08)
P5566.06, Use of Force and Application of Restraints (11/30/05)
P6031.04, *Patient Care* (6/3/14)
P6340.04, *Psychiatric Services* (1/15/05)

B. Institutional Supplements

FLM 5324.08, *Suicide Prevention Program* (10/31/14)

C. Bureau Forms

BP-A0770, Medical/Surgical and Psychiatric Referral Request
BP-A1057, Restrictive Housing Mental Health Evaluation – Initial Review
BP-A1058, Restrictive Housing Mental Health Evaluation – Follow-Up Review

D. Agency ACA Accreditation Provisions

American Correctional Association Standards for Adult Correctional Institutions, 4th Edition: 4-4142, 4-4143, 4-4144, 4-4305, 4-4368, 4-4370, 4-4371, 4-4372, 4-4373, 4-4374, 4-4399, 4-4429, 4-4429-1.

American Correctional Association Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-2A-32, 4-ALDF-4C-8, 4-ALDF-4C-19, 4-ALDF-4C-27, 4-ALDF-4C-28, 4-ALDF-4C-29, 4-ALDF-4C-30, 4-ALDF-4C-31, 4-ALDF-4C-32, 4-ALDF-4C-34, 4-ALDF-4C-40, 4-ALDF-6B-05, 4-ALDF-6B-06, 4-ALDF-6B-07, 4-ALDF-6B-08.

American Correctional Association Standards for Administration of Correctional Agencies, 2nd Edition: 2-CO-4B-04.

IV. DEFINITIONS

A. The term "Bureau" means the Federal Bureau of Prisons.

B. The term "ADX" means the United States Penitentiary, Administrative Maximum, Florence, Colorado.

C. The term "USP Florence" means the United States Penitentiary, High Security, Florence, Colorado.

D. The term "FCC Florence" means the Federal Correctional Complex, Florence, Colorado.

E. The term "mental illness" is defined in the Bureau's current Program Statement regarding the *Treatment and Care of Inmates with Mental Illness*.

F. The term "serious mental illness" is defined in the Bureau's current Program Statement regarding *Treatment and Care of Inmates with Mental Illness*. Consistent with the Program Statement, serious mental illness generally falls into one of two categories:

1. The inmate's diagnosis is automatically considered a SMI, regardless of assigned care level, when a Bureau clinician currently diagnoses the inmate with a schizophrenia spectrum or other psychotic disorder, or with bipolar or related disorder. If the inmate has a current diagnosis of major depressive disorder by a Bureau clinician that is categorized severe, that is non-responsive to treatment, or that results in the inmate being classified as CARE3-MH, the inmate will also automatically be considered to have a SMI..

2. The inmate's current diagnosis, when combined with the effect the illness has on the inmate's functioning, may rise to the level of SMI. A current diagnosis of the following may qualify as a serious mental illness when the illness is severe, persistent, and disabling to the inmate: an anxiety

disorder, obsessive-compulsive and related disorders, trauma and stressor-related disorders, intellectual disabilities and autism spectrum disorders, major neurocognitive disorders, or personality disorders. An inmate who is assigned a care level of CARE3-MH will generally be considered to have a SMI.

G. The Mental Health Care Levels are defined in the Bureau's current Program Statement regarding the *Treatment and Care of Inmates with Mental Illness*. These levels apply to inmates at the ADX.

H. "Secure STAGES" means a residential, unit-based Psychology Treatment Program for inmates with Borderline Personality Disorder or Other Specified Personality Disorders, as diagnosed by the Bureau, who have a chronic history of self-injurious behavior or do not function effectively in a prison setting, which is currently operating at USP Florence.

V. RESPONSIBILITIES

A. **Warden**. The Warden is responsible for ensuring relevant mental health program statements and procedures are implemented at the ADX.

B. **Chief Psychologist**. The Chief Psychologist implements this Institution Supplement and the duties outlined in the Bureau's current Program Statement regarding the *Treatment and Care of Inmates with Mental Illness*.

C. **Mental Health Treatment Coordinator**. As outlined in the Bureau's current Program Statement regarding the *Treatment and Care of Inmates with Mental Illness*, the Chief Psychologist may designate a Mental Health Treatment Coordinator, who is a licensed, doctoral-level ADX Psychologist, to oversee the management, treatment, and care of inmates with mental illness and to ensure all provisions of this Institution Supplement and the national Program Statement are implemented. Regular interdisciplinary communication is maintained between the Mental Health Treatment Coordinator and Health Services staff, including staff and contract psychiatrists and psychiatric mid-level providers, to optimize treatment efficacy. The Chief Psychologist may choose to serve as the Mental Health Treatment Coordinator rather than designating another psychologist to serve in this role.

D. Psychiatrist/Psychiatric Mid-Level Provider/Psychiatric Nurse. Health Services organizes, conducts, and administers psychiatric

services. The Psychiatrist/Psychiatric Mid-Level Provider/Psychiatric Nurse accepts referrals through the Bureau Electronic Medical Record/Psychology Data System (BEMR/PDS) for inmates in need of psychiatric assessments and/or services, including medication prescription and management. When in-person psychiatric services are not available at ADX, psychiatric services may be provided to the ADX inmates by telepsychiatry – i.e., by video conferencing. Telepsychiatry services will be made available to the ADX inmates as needed during any period when in-person psychiatry services are unavailable at the ADX. Telepsychiatry will be provided in accordance with the Bureau's telepsychiatry guidelines, and the telepsychiatrist, to the extent possible, will participate in the Care Coordination and Reentry (CCARE) team. Attention will be paid to ensuring continuity of telepsychiatry care providers and a telepsychiatrist will conduct intermittent on-site visits to the ADX to see inmates in person.[A1]

E. **Health Services Administrator.** If contract psychiatric services are used, the Health Services Administrator is responsible for contract development and oversight with input from the Mental Health Treatment Coordinator.

F. **Clinical Director**. The Clinical Director will ensure the general medical needs of each inmate are addressed and that Health Services staff conducting rounds, sick call, and clinics has received the necessary training to recognize signs and symptoms of mental illness and understand the referral process to ensure that mental health needs are promptly addressed.

G. **Care Coordination and Reentry (CCARE) Team**. The CCARE Team is a multidisciplinary team that uses a holistic approach to ensure that critical aspects of care for inmates with mental illness are considered and integrated. The CCARE Team is responsible for identifying potential concerns affecting inmates with mental illness.

H. **All Staff**. All staff members are responsible for detecting and reporting the signs or symptoms of an inmate's possible mental illness. If a staff member suspects an inmate's behavior indicates active symptoms of psychological distress, the staff member will promptly contact one of the following for assistance in obtaining a mental health evaluation of the inmate: the Chief Psychologist; any ADX Psychologist, Psychiatrist, contract Psychiatrist, Psychiatric Mid-Level Provider; or a Correctional Services Supervisor. If the Correctional Services Supervisor is the initial contact, he or she will promptly contact the Chief Psychologist or on-call mental health care provider.

VI. MENTAL HEALTH STAFFING: Psychology Services at the ADX ordinarily includes at least four full-time, doctoral-level psychologists and a psychology technician, who are supervised by the Chief Psychologist and who are assigned specifically to the ADX on a full-time basis. Health Services staffing for the complex also includes a full-time staff, consultant, or contract psychiatrist and a social worker, and may include a psychiatric mid-level provider, such as a nurse practitioner or psychiatric nurse. Adequate Health Services staff will be available to meet the mental health mission. Emergency mental health services will be provided by an on-call psychologist or psychiatrist assigned to FCC Florence when the ADX psychologists and psychiatrist are not on duty. Staffing will be reviewed annually by Central Office psychology and health services administrators, and will include an analysis of data concerning current mental health service demands and demands for the past year.

VII. ADX EXCLUSION CRITERIA

A. Consistent with the Bureau's current Program Statement regarding the *Treatment and Care of Inmates with Mental Illness*, and this supplement, ordinarily, inmates diagnosed with a serious mental illness are to be diverted or removed from the ADX. Placement or continued housing of an inmate with serious mental illness at the ADX will only occur if extraordinary security needs are identified that cannot be managed elsewhere.

B. Consistent with the Bureau's current Program Statement regarding the *Treatment and Care of Inmates with Mental Illness*, and this supplement, inmates classified as CARE4-MH are not to be placed at and will be removed from the ADX as provided in Section X, below.

VIII. TEAM APPROACH TO CARE: Consistent with the Bureau's current Program Statement regarding the *Treatment and Care of Inmates with Mental Illness*, the ADX's multidisciplinary CCARE Team uses a holistic approach to ensure that all critical aspects of care for inmates with mental illness are considered. The ADX CCARE team will:

A. Meet weekly to review cases and identify strategies to mitigate the potentially negative impact of the correctional environment on inmates with mental illness. Every inmate at the ADX will be reviewed at least once a month. The CCARE team will also review all inmates with a serious mental illness awaiting transfer to determine what care the inmate needs while awaiting transfer.

B. Review and update inmates' individual treatment plans. All inmate

plans are reviewed by the treatment team at the six-month or annual treatment plan review. In conjunction with the review, the treating clinician will interview the inmate and present the case to the team. The CCARE team, in collaboration with the treating clinician, will identify any proposed changes to the treatment plan and the treating clinician will discuss this with the inmate.

C. Review and resolve discrepancies between Health Services and Psychology Services; update diagnoses as necessary; discuss and review medications to ensure they are consistent with diagnoses.

D. Ordinarily consists of the following staff:

- Chief Psychologist
- Provider(s) of Psychiatric Services, Assistant Health Services Administrator/Supervisory Nurse, and/or Psychiatric Nurse
- ADX Psychologists
- Chief Pharmacist/Clinical Pharmacist
- Social Worker
- ADX Unit Managers
- Correctional Services Supervisor

In addition, the Mental Health Treatment Coordinator may invite the following staff, and others as deemed appropriate, to attend CCARE Team meetings:

- Warden
- Associate Wardens
- Attorney Advisor
- Clinical Director
- Supervisor of Recreation
- Supervisory Chaplain
- Staff members involved in pre-release planning for the ADX inmates with mental illness who are scheduled for release within the following 12 months.

Community Treatment Services (CTS) staff, Discipline Hearing Officers (DHO), department heads, and teachers may be included under special circumstances, as explained in the Bureau's current Program Statement concerning the *Treatment and Care of Inmates with Mental Illness*.

E. Prior to this meeting, the Assistant Health Services Administrator (AHSA)/Supervisory Nurse will ensure proper documentation of medical observations is placed in BEMR by medical staff. The AHSA/Supervisory Nurse will provide updates to the Mental Health

Treatment Coordinator on future medical appointments and medical concerns. The pharmacist will provide information regarding medication compliance and any medication concerns.

IX. PROCEDURES FOR ASSESSMENT, IDENTIFICATION, & REFERRAL: Psychology Services and Health Services ensure every ADX inmate with a clinically identified need for psychological treatment has access to mental health care. The inmates at the ADX will undergo appropriate screening, assessment, and referral to identify and address their mental health, substance abuse, and other behavioral health needs as follows:

A. **Intake Mental Health Assessment/Evaluation.** Mental health assessment for inmates at the ADX will consist of the following:

1. **Health Services Mental Health Intake Assessment**. Upon arrival, Health Services clinical staff will conduct an initial screening for physical **and** mental health concerns.

a. The mental health intake screening/assessment seeks to identify mental health care problems and needs which include, but is not limited to presence of psychosis, hallucinations, suicidality, history of self-injury, mood disturbance, sexual victimization, and psychotropic medication use.

b. The Health Services staff member who conducts the intake screening/assessment will review the inmate's BEMR record to determine whether the inmate has a current prescription for psychotropic medication and, if so, will promptly take all steps necessary to ensure the inmate receives all necessary medication on a timely basis following arrival, at least until the inmate is seen by a Psychiatrist/Psychiatric Mid-Level Provider/Psychiatric Nurse.

c. In addition to the questions the Health Services staff member who conducts the intake screening/assessment must ask, the Health Services staff member will ask the following questions:

i. Have you ever taken any psychiatric medications?
ii. Have you ever been diagnosed with a mental illness?
iii. Have you ever been in a psychiatric hospital?
iv. Have you ever received mental health

services?

v. Have you ever received mental health treatment from a psychiatrist, psychologist, or other mental health provider?

vi. Do you hear voices no one else can hear?

vii. Have you ever tried to harm or kill yourself?

viii. Are you thinking about hurting yourself now?

The Health Services staff member will document the responses to the questions in BEMR and immediately advise Psychology Services, AHSA/Supervisory Nurse, and the Psychiatrist/Psychiatric Mid-Level Provider/Psychiatric Nurse of any concerns.

d. The Health Services staff member who conducts the health services intake screening/assessment will document their findings in BEMR/PDS and immediately advise Psychology Services, AHSA/Supervisory Nurse, and the Psychiatrist/Psychiatric Mid-Level Provider/Psychiatric Nurse of any concerns.

e. Health Services staff will also complete a written and verbal referral to the Chief Psychologist or designee and to the complex Psychiatrist/Psychiatric Mid-Level Provider/Psychiatric Nurse as necessary.

2. **Intake Psychological Evaluation**. An Intake Psychological Evaluation occurs for all inmates arriving at ADX Florence and is documented in BEMR/PDS, as follows.

a. An intake psychological evaluation of each inmate will occur within seven business days of his arrival at the facility.

b. The psychologist completing the clinical interview of the inmate is responsible for reviewing the inmate's completed Psychological Services Intake Questionnaire (PSIQ), all psychological evaluations conducted in connection with the ADX referral process, the inmate's BEMR/PDS records, SENTRY data, and Pre-Sentence Reports (PSR).

c. The psychologist will conduct a clinical interview in a private setting. Based on information gathered through this process, the evaluating psychologist will

validate the accuracy of the inmate's assigned mental health care level.

d. If the care level is CARE2-MH, CARE3-MH, or CARE4-MH, a Diagnostic and Care Level Formulation note will be entered into PDS, and the case will be reviewed with the Chief Psychologist and the ADX psychiatrist or psychiatric services provider to determine if a transfer is indicated. (See transfer procedures noted below).

If the care level is CARE4-MH, the inmate will be immediately evaluated for a transfer to a medical center.

[A2]

e. In addition, Psychology Services staff will promptly notify Health Services staff of any relevant concerns, e.g., a recommendation for psychiatric consultation and/or medication consultation.

f. If the inmate has a current prescription for psychotropic medication, the psychologist will ensure Health Services staff are aware of the current prescription to ensure the inmate receives all such medication until a psychiatric consultation occurs.

B. **Assignment and Change of Mental Health Care Level.** As outlined in the Bureau's current Program Statement regarding the *Treatment and Care of Inmates with Mental Illness*, ADX Psychologists and Psychiatrists can determine and assign a current mental health care level following a review of records and a face-to-face clinical interview.

1. If the inmate does not consent to a face-to-face interview, the clinician may proceed based on observations and a thorough record review.

2. All current mental illness diagnoses, including personality disorders and intellectual disabilities, and any past significant diagnoses will be identified in a Diagnostic and Care Level Formulation note in BEMR/PDS.

3. The cumulative impact of an inmate's diagnosed disorders on current functioning is taken into account when assigning a mental health care level.

4. Mental health care levels are entered into SENTRY by

Psychology Services. If a psychiatrist assigns a current mental health care level, the psychiatrist will promptly notify the Mental Health Treatment Coordinator so it is entered into SENTRY. The Assistant Health Services Administrator (AHSA)/Supervisory Nurse will ensure proper documentation of this determination in BEMR.

5. If a psychologist and/or psychiatrist determine that a reduction in the mental health care level for an inmate is warranted, the determination will be reviewed by the Chief Psychologist or Deputy Chief Psychologist, and the Psychology Services Branch before the reduction is finalized. The Chief Psychologist or Deputy Chief Psychologist will enter a consultation note in BEMR/PDS to document that consultation with the Psychology Services Branch occurred[A3].

C. **ADX Mental Health Rounds.**

1. **Psychology Rounds**

a. A psychologist will make weekly rounds in each of the ADX housing units to identify and address mental health and behavioral concerns as follows.

b. Rounds will routinely be conducted during daytime or evening hours when inmates are most likely to be awake, and attempts will be made to conduct them on a regular schedule.

c. For inmates assigned a CARE2-MH or CARE3-MH levels, inmates who have been referred for mental health services, or inmates who demonstrate changes in functioning, in the absence of unique, documented security concerns, such rounds will consist of face-to-face interaction with the outer cell door opened and a correctional staff member with a baton present, if required.

d. During rounds, the psychologist will look in every cell, speak with all inmates who indicate a desire to talk, and accept requests/referrals for mental health services.

e. A written log will be maintained of all rounds, identifying the provider who conducted the rounds,

when the rounds were completed, and how long the provider spent in the unit and on each range.

2. **Health Services Rounds**. Health Services providers will be sensitive to identifying mental health symptoms and concerns during their daily rounds. Pertinent clinical information will be identified in a clinical care note in BEMR/PDS and shared verbally with psychology and psychiatry, as clinically indicated.

D. **ADX 30-Day Mental Health Reviews.**

1. A psychologist will complete a psychological review for each ADX inmate at 30-day intervals, which will be documented in BEMR/PDS.

2. For inmates assigned CARE2-MH and CARE3-MH levels, inmates who have been referred for mental health services, or inmates who demonstrate changes in functioning, in the absence of unique, documented security concerns, this face-to-face interaction will take place with the outer cell door opened and a correctional staff member with a baton present, if required. If clinically indicated, the inmate will be removed from the cell to be interviewed in a private interview space.

3. The BEMR/PDS entries will be individualized and based on face-to-face interaction with each inmate. The entries will include a description of:

   a. The inmate's functioning since the last review;

   b. Mental health services received since the last review;

   c. The inmate's cell sanitation;

   d. The inmate's personal hygiene;

   e. The inmate's participation in regular recreation and exercise during the last month;

   f. The inmate's medical issues during the last month to the extent they impact mental health;

   g. The inmate's discipline record and participation in programming during the past month; and

   h. Review of the inmate's current mental health care level.

4. For example, if the inmate has been assessed for risk of suicide, has engaged in disruptive behaviors, or has engaged in a hunger strike since the last review, this will be discussed in the 30-day review.

5. The Assistant Health Services Administrator (AHSA)/Supervisory Nurse will ensure proper documentation of medical observations is placed in BEMR by medical staff. The AHSA/Supervisory Nurse will provide updates to the Mental Health Treatment Coordinator on future medical appointments and medical concerns. The pharmacist will provide information regarding medication compliance and any medication concerns.

E. **Extended Restrictive Housing Reviews**. As outlined in Program Statement 5310.16, *Treatment and Care of Inmates with Mental Illness*, inmates will receive regular mental health evaluation when they have been continuously housed:

1. In the SHU at the ADX for 6 months, or

2. In the ADX for 12 months.

Updates will be conducted for subsequent anniversaries. For example: An inmate has been continuously housed in the ADX for 48 months, having arrived at the ADX on 1/1/2001. During those 48 months, he was continuously housed in the SHU at the ADX for 18 months (2/1/2001 – 8/1/2002). The inmate would receive the evaluation associated with him being continuously housed in SHU for 6 months (8/1/2001), with an update at 12 months (2/1/2002) and 18 months (8/1/2002). The inmate would also receive the evaluation associated with him being continuously housed in the ADX for 12 months (1/1/2002), with updates at 24 months (1/1/2003), 36 months (1/1/2004), and 48 months (1/1/2005).

F. **Referrals for Treatment.** Inmates will be encouraged to make self-referrals and referrals on behalf of other inmates to staff, if an inmate believes he or another inmate is in need of mental health services. Referrals may be made verbally or in writing. All inmates will have reasonable access to "Inmate Request to a Staff Member" forms for such requests/referrals, although requests for mental health services will be accepted in any format. However, inmates will be encouraged to make non-emergent requests for mental health services in writing and emergent requests verbally. Any ADX staff member may also make a referral for mental health services for an inmate by communicating the request to Psychology

Services. Referrals may also be made by an inmate's family members, friends or attorneys.[A4]

G. **Procedures for Heightened Review of Requests and Referrals for Mental Health Services.** The following procedures are designed to enhance the review of requests and referrals for mental health services and should be read in conjunction with the paragraphs above and applicable Bureau Program Statements and ADX Institutional Supplements concerning the treatment and care of inmates with mental illness:

1. When any request or referral for mental health services relating to an ADX inmate is received by the Psychology Services Department, the staff in Psychology will evaluate the referral, or request, the day it is received and classify it as emergent, urgent, or routine.

2. Emergent requests will be responded to as soon as possible and no more than 4 hours, unless an operational emergency precludes a timely response. [A5]

3. Urgent requests will be responded to as soon as possible and no more than 24 hours, unless an operational emergency precludes a timely response.

4. Routine requests will ordinarily be processed within 3 business days, but no more than 10 business days, after a request or referral is received by the Psychology Services Department.

5. The Chief Psychologist, Deputy Chief Psychologist, or designee will review the request or referral and assign it to the appropriate Psychologist or another qualified member of the Psychology staff for timely resolution. Once achieved, the result will be documented in PDS/BEMR.

6. Upon receipt, each written request or referral will be date-stamped to reflect the date received by the Psychology Services Department. Requests and referrals received electronically will be printed and handled in the same manner as other requests and referrals.

7. Each request/referral will be scanned into PDS/BEMR under the appropriate tab and identified as needing review by the Chief Psychologist, Deputy Chief Psychologist, or designee.

8. If the request or referral raises medication issues or a medical issue, the correspondence will also be identified as needing review by the Assistant Health Services Administrator, Clinical Director, Psychiatrist, Mid-Level Provider, or Pharmacist.

9. The Psychology Services Department will generate quarterly and annual reports for review by the Warden, Chief Psychologist, Psychiatrist, Mid-Level Provider, and Psychology Services Administrator. The reports will be reviewed at least twice per year to facilitate the quality improvement process.

X. ADX REMOVAL CRITERIA.

A. The Chief Psychologist or ADX psychiatric services provider will promptly contact the Psychology Services Branch and the Bureau's Chief Psychiatrist to discuss:

1. Any inmate who is identified to be in need of transfer from the ADX to a medical referral center ("MRC") as an emergency psychiatric transfer.

2. [A6]Any inmate who, upon arrival to the ADX, is judged by the Chief Psychologist or psychiatric services provider to have serious mental illness or significant cognitive limitations that make placement at the ADX inappropriate.

3. Any inmate who develops onset or re-emergence of symptoms of serious mental illness while at the ADX.

B. The inmate's deterioration may be identified through any routine mental health evaluation described above or may become evident through identification of symptoms of serious mental illness indicating the need for an emergency psychiatric transfer.

C. If an inmate's mental health appears to have deteriorated during placement at the ADX such that the inmate is a CARE4-MH, or the CCARE team determines the inmate needs inpatient hospitalization, the Mental Health Treatment Coordinator will work actively with the CCARE Team, the Psychology Services Branch, and the Bureau's Chief Psychiatrist to identify an alternative, appropriate placement. The BP-A0770 (Medical/Surgical and Psychiatric Referral Request) will be submitted to the Office of Medical Designations and Transfers (OMDT), Health Services Division. If an inmate who is approved for an emergency transfer to a MRC has not been

transferred within 72 hours of the approval, the Warden will be notified to expedite the transfer. If the inmate has not been transferred within 7 days of the approval, the Assistant Director of the Health Services Division and the North Central Regional Director will be notified to take appropriate action.

D. If, while housed at the ADX, an inmate is diagnosed with serious mental illness (as defined above) and it is determined the inmate does not need inpatient hospitalization, the Mental Health Treatment Coordinator will convene a multi-discipline committee to review the inmate to determine whether extraordinary security needs exist that cannot be managed elsewhere, requiring the inmate to remain at the ADX, as follows:

1. The composition of the committee will ordinarily consist of the Warden, Associate Wardens, Captain, Special Investigative Agent, Case Management Coordinator, Unit Manager, Psychology, provider(s) of Psychiatric Services, Assistant Health Services Administrator/Supervisory Nurse, Psychiatric Nurse, and Supervisory Attorney.

2. The determinations will be made on a case-by-case basis.

3. The review by the committee is not a hearing. The inmate is not entitled to notice, to be present, to have counsel, to present evidence, or to call witnesses.

4. The final determination regarding extraordinary security needs is made by the Warden.

5. Notification

a. Each inmate will receive written notification of the decision from the appropriate Associate Warden.

b. If it is determined the inmate has extraordinary security needs that cannot be managed elsewhere, the Associate Warden's written notification will include the following:

i. The reason(s) for the determination, unless it is determined the release of this information could pose a threat to individual safety or institutional security, in which case that limited information may be withheld.

ii. An explanation that the inmate will receive mental health services consistent with his mental health care level, and that his security needs do not impact his diagnosis, mental health care level, or the provision of care-level appropriate services.

iii. Notice that the inmate may appeal the decision through the Federal Bureau of Prisons' Administrative Remedy Program.

c. If it is determined the release of the information could pose a threat to individual safety or institutional security, the determination will be documented in a memorandum placed in the FOI exempt section of the inmate's Central File specifying the Warden's reasons that the inmate cannot, despite his serious mental illness, be removed from the ADX due to extraordinary security needs.

d. If it is determined the inmate has extraordinary security needs that cannot be managed elsewhere, a copy of the notification will be forwarded to the Regional Director, North Central Region, and if the inmate is in the Control Unit, to the Assistant Director, Correctional Programs Division.

e. On an annual basis, the Warden will notify the Regional Director, North Central Region, and if applicable, the Assistant Director, Correctional Programs Division, of the inmates with serious mental illness who continue to be housed at the ADX due to extraordinary security needs that cannot be managed elsewhere.

f. The determination that an inmate has extraordinary security needs that cannot be managed elsewhere does not preclude the Warden from exercising his/her discretion to reach a different conclusion at a future review.

g. The inmate will be reviewed at least every six months to determine if the extraordinary security needs that cannot be managed elsewhere still exist. The Chief Psychologist is responsible for convening the committee to review these determinations.

E. The inmates who are newly identified as suffering from a serious mental illness and who do **not** have extraordinary security needs will be referred to an appropriate treatment program or other setting outside the ADX. The Mental Health Treatment Coordinator will work actively with the CCARE Team, the Psychology Services Branch, and the Bureau's Chief Psychiatrist to identify an alternative, appropriate placement. The Mental Health Treatment Coordinator, in collaboration with the Chief Psychologist or Mid-level Psychiatric Provider, will initiate the following transfer procedures:

1. An ADX transfer is submitted to the Psychology Services Branch and the Designations and Sentence Computation Center.

2. Efforts will be made to transfer the inmate within 30 days of the determination of a need for transfer.

3. The Warden will monitor the transfer process, and if transfer has not been accomplished within 30 days, the Warden will make efforts as to expedite the process, which will include notifying the Assistant Director, Reentry Services Division; Assistant Director Health Services Division; and Regional Director, North Central Region, to take appropriate action.

While awaiting transfer, care that is consistent with the inmate's identified care level and needs will be provided by the ADX staff.

XI. MENTAL HEALTH SERVICES: An inmate's current housing status does not impact his diagnosis, mental health care level, or the provision of care-level appropriate services. Mental health services may include, but is not limited to, any of the following:

A. **Individual Counseling/Therapy.** Individual counseling/therapy is provided in a confidential setting by a qualified mental health provider as clinically indicated or outlined in a treatment plan, as follows.

1. Inmates may submit a request to Psychology Services for individual counseling/therapy, or Psychology Services may recommend individual counseling/therapy to an inmate. Upon mutual agreement to begin individual counseling/therapy, the inmate's treating clinician will schedule the inmate for treatment sessions according to the inmate's treatment plan.

2. Adequate escort staff will be assigned to provide timely and secure escorts for such purposes, and Psychology Services and Health Services will coordinate with Correctional Services regarding the scheduling of escorts.

3. Correctional Services staff will provide escort services within the housing units, upon request, to permit Psychology Services and Health Services staff to meet with the inmate in a confidential setting.

B. **Group Treatment.** Therapeutic groups are preferably evidence-based, and use an established Bureau protocol when available, as follows:

1. They are facilitated by a doctoral-level psychologist or another designated mental health services provider (such an art therapist, recreation therapist, vocational rehabilitation specialist, drug treatment specialist, or health services social worker).

2. To ensure the safety of staff and inmates, group treatment is offered in settings appropriate to the participants' security needs. Recommendations for group treatment will be noted in the inmate's treatment plan.

3. Psychology Services staff will schedule groups in a manner that ensures inmates timely access to group programming that is clinically indicated and in compliance with applicable Program Statements.

4. Examples of groups include, but are not limited to, Criminal Thinking, Emotional Self-Regulation, Seeking Safety, Anger Management, Basic Cognitive Skills, and Non-Residential Drug Abuse Program (NRDAP).

5. Correctional Services will provide escort coverage to allow inmates to participate in group treatment.

6. Psychology Services will notify and coordinate with the Captain of the need for escorts in advance of the group meeting time. Escort staff will be assigned to provide timely escorts to and from group sessions.

7. The Priority Practices for the delivery of group treatment will be in accordance with the Bureau's current Program Statement regarding the *Treatment and Care of Inmates with Mental Illness.*

8. Consistent with the Bureau's current Program Statement regarding the *Treatment and Care of Inmates with Mental Illness*, a minimum of one Priority Practice therapeutic group will be offered each quarter.

9. Priority for the use of the group treatment modules will be given to Psychology Services, Education, and Recreation.

C. **Psychiatric Services.** Inmates at ADX Florence are entitled to the full range of psychiatric services and medications available to inmates at other Bureau facilities and will be provided, if clinically indicated, the following services:

1. Psychiatric consultations will be conducted in a private setting unless extraordinary security issues exist. [A7].

2. All inmate requests for psychiatric services will be handled as requests for other mental health services.

3. Psychiatric assessment, treatment, and consultation generally will be provided by the institution psychiatrist, contract psychiatrist, or psychiatric mid-level provider. Other qualified providers with appropriate privileges/practice agreements (*e.g.*, physicians or mid-level providers) may initiate, monitor, and assist in continuing psychiatric care and medications as appropriate. When a provider prescribes psychiatric medication, the inmate will a copy of the consent form, which will disclose the potential side effects and medical risks associated with the prescribed medication.

4. Psychotropic medication will be available to any inmate for whom medication is prescribed regardless of the inmate's housing assignment or unit (i.e., there will be no exceptions for the Control Unit).

5. At a minimum, inmates receiving psychiatric medications will be seen by a psychiatrist, psychiatric mid-level provider, or other qualified provider every 90 days, or more often as clinically indicated for, at a minimum, the first year. Unstable inmates or inmates who require continued adjustment of their medication regimen will continue to be seen at least every 90 days. Long-term clinically stable inmates (as determined by the psychiatrist), will be reviewed no less than every 6 months, following the initial first year of treatment with psychiatric medication.

6. [A8][A9]Health Services will notify the psychiatrist, psychiatric mid-level provider, or prescribing clinician and Psychology Services of inmates who refuse or consistently miss their prescribed psychotropic medication for:

   a. 3 consecutive doses;

   b. 50% of doses within one week; or

   c. a clinically significant pattern of doses.

7. Health Services staff will ensure that newly prescribed medications are dispensed to the inmate within 48 hours (or as soon as possible the next work day) of entry of the prescription order into BEMR, or more quickly if specified by the prescriber.

8. Emergency medication will be administered consistent with Bureau policy.

9. Where medication should be administered with food, Health Services will arrange to administer medication at mealtime, provide sufficient food with the medication, or ensure the inmate has food in his cell to consume with the medication.

10. Medication may be administered in crushed form consistent with national policy. [A10]

D. **Turning Point Protocol.** The Turning Point Protocol is a pretreatment service offered to all ADX inmates by Psychology Services. Turning Point is designed to: (1) build rapport by creating a context for cooperative interaction between inmates and psychologists; and (2) prepare inmates for Bureau programs before the inmate is returned to an open compound facility. Turning Point handouts offer practical skills that may help the inmate adjust to restrictive housing. When an inmate completes the Turning Point handouts, Psychology Services may award a certificate of completion to the inmate, Release Preparation Program credit, or special incentive items. Special incentive items may include oil pastels, 3-D paint pens, coloring books, Sudoku books, stress balls, origami materials, erasers, craft materials, etc., as approved by the warden. To receive incentives, the inmate must apply the concepts and skills addressed in the handouts and must engage in positive, meaningful interactions with his psychologist and other institution staff. Completion of the Turning Point Protocol is not required before enrollment in other group or individual services.

E. **Adjunctive In-Cell Therapeutic Activities.** Inmates will ordinarily have access to in-cell therapeutic activities, including access to programming through closed-circuit television (e.g., Psychology Services programs), hobby craft provided by Recreational Services or available through a Special Purchase Order, puzzles provided by Recreational Services or Psychology Services, and leisure reading materials. Inmates will also be encouraged to engage in yoga, relaxation techniques, meditation, deep breathing exercises, mindfulness exercises, and grounding techniques. A variety of educational and religious in-cell programming will also be made available to inmates.

F. **Treatment and Care for Inmates with Serious Mental Illness Remaining at the ADX Due to Extraordinary Security Concerns.** An inmate who is diagnosed with serious mental illness and not needing inpatient hospitalization may remain at the ADX if extraordinary security needs are identified that cannot be managed elsewhere. All inmates at the ADX receive mental health services consistent with their diagnosis and mental health care level, as outlined in Program Statement 5310.16, *Treatment and Care of Inmates with Mental Illness*. Mental health services provided for inmates with serious mental illness will include the services identified above, if clinically indicated, provided at the frequency and intensity required by the mental health care level assigned, or more frequently as clinically indicated. In addition, the following procedures will apply to every inmate diagnosed with serious mental illness:

1. Every inmate with serious mental illness will have an individualized treatment plan entered in BEMR/PDS within 30 days of his diagnosis of serious mental illness. The treatment plan will:

    a. Be developed with input from the inmate.

    b. Describe the inmate's problems and goals, and the interventions planned to achieve these goals.

    c. Be reviewed and updated at least once every 12 months for CARE2-MH inmates and every 6 months for CARE3-MH inmates, or more often if clinically indicated.

2. A copy of his treatment plan and any revisions thereto will be offered to the inmate.

3. Every inmate with a serious mental illness will be assigned a treating psychologist.

4. An internal on-call and coverage system will be maintained to ensure continuity of care and emergency response.

5. If there is a change of therapist, the inmate will be clinically teamed by the departing therapist and oncoming therapist and the results of this team will be documented as an administrative note in the inmate's BEMR/PDS record.

6. Unless otherwise clinically indicated or specific security or separation issues preclude group access, every inmate with serious mental illness will be offered both individual and group treatment services.

7. Every inmate with serious mental illness will receive supplemental services to include, but not limited to, additional out-of-cell and in-cell recreational activities, in-cell therapeutic activities, and self-help materials from the psychology self-help library.

8. Special attention will be paid to encouraging involvement in out-of-cell activities, including recreation and structured mental health programming.

9. Seriously mentally ill inmates will be offered out-of-cell recreation as determined by the particular housing unit they are currently assigned.[A11] Additional out-of-cell time will also be offered and may include, but is not limited to, education programming, reentry services programming,delivery of health services, religious services programing, visitation, and therapy in accordance with their individually developed treatment plan.

10. If an inmate with serious mental illness declines treatment consistent with his mental health care level, a treatment plan will be developed and implemented which includes regular assessment of the inmate's mental status, rapport-building activities, and other efforts to encourage engagement in a treatment process. Ordinarily, the treatment plan will include, at a minimum, a weekly attempt to engage the inmate.

11. An inmate with serious mental illness who refuses mental health treatment consistent with his mental health care level

will be considered for involuntary commitment at a Medical Referral Center or other suitable treatment facility.

12. Efforts will be made to address any deterioration of an inmate's mental health that may occur during the time the inmate is housed at the ADX. Examples of these efforts may include, but are not limited to:

    a. Increased observations of the inmate and visits with the inmate by Psychology Services and Unit Staff.

    b. Referral to the At-Risk Recreation Program implemented by the ADX Recreation Department.

    c. Referral to Religious Services for Prison Visitation Support (PVS) visits or other services.

    d. Development and ongoing review of an individualized safety plan with the inmate.

    e. Recommendation that the inmate be offered work activities, such as after-hours orderly work, that could provide him with additional out-of-cell time.

XII. MENTAL HEALTH TRAINING

A. Mental health training is provided to all Bureau employees through Introduction to Correctional Techniques and Annual Training. Annual Training at the ADX will include at least 7 hours of training provided by Psychology Services, which all ADX personnel will be required to attend. The Annual Refresher Training will include identifying and proper reporting of the signs and symptoms of mental illness and the safe and secure management of misconduct, including violence, by inmates with mental illness.

B. Mental Health Specialty Training is also made available at the ADX. At a minimum, this specialty training is offered twice annually. Mental Health Specialty Training will include 4 hours of specialized mental health training, focused on understanding mental illness, cultural diversity and sensitivity, psychiatric medications, behavior management principles, confidentiality, communication skills, de-escalation skills, and building collaborative relationships. This training may be offered to all ADX staff on a voluntary basis. This training is in addition to yearly training on suicide prevention, which includes mock suicide drills, as explained in FLM 5324.08, *Suicide Prevention Program*.

XIII. INMATE DISCIPLINE

A. An inmate's diagnosed mental illness may contribute to inmate code violations that could result in disciplinary sanctions, including SHU placement or the extension of SHU placement. In these cases, it is the responsibility of the Chief Psychologist or his or her designee to consult with the DHO or UDC to ensure the disciplinary process is applied appropriately to inmates with mental illness. Pursuant to Program Statement 5310.16, *Treatment and Care of Inmates with Mental Illness*, the following incident reports will be referred to the Chief Psychologist who will identify an appropriate clinician to provide input as to the inmate's competence to participate in the disciplinary hearing, any impact the inmate's mental illness may have had on his responsibility for his behavior at the time of the charge, or information on any known mitigating factors in regard to his behavior, when clinically indicated:

1. Any incident report received by a CARE3-MH or CARE4-MH inmate.

2. Any incident report received by a CARE2-MH inmate where there appears to be a mental health concern.

3. Any incident report for Code 228 involving self-harm.

4. Any incident report for Code 302, Misuse of Authorized Medication.

B. The Unit Discipline Committee (UDC) and Discipline Hearing Officer (DHO) will consider the input from Psychology Services prior to adjudicating the charges. For the purposes of this review, the standards for evaluation are outlined in Program Statement 5270.09, *Inmate Discipline Program*.

C. The UDC and DHO will consult with the treating clinician as to whether sanctions that limit social support (e.g., SHU placement, loss of visits, or loss of phone calls) may not be appropriate for the inmate with mental illness who uses these supports as a component of his treatment or recovery.

D. Psychotropic medication will not be withheld from any inmate solely for disciplinary reasons. If an inmate has diverted a psychotropic medication, the psychiatric care provider will make the determination as to whether discontinuation of the medication is clinically warranted.

XIV. CALCULATED USE OF FORCE: Mental health clinicians will not participate as a use of force of team member in a calculated use of force situation, but may be utilized as a member of a calculated use of force team for confrontational avoidance. Specifically, the ADX mental health professionals may participate in confrontation avoidance procedures pursuant to Program Statement 5566.06, *Use of Force and Application of Restraints*.

XV. ACHIEVEMENT AWARDS & INCENTIVES

A. Mental Health achievement awards are available to all inmates at ADX Florence. Achievement awards are offered to participants who demonstrate behaviors that reflect sustained efforts toward recovery, progress on treatment goals, and pro-social attitudes and behaviors.

B. When an inmate completes a psychology program, Psychology Services issues certificates and program credit to inmates who complete psychology programming.

C. The ADX may offer incentives such as additional phone calls, extra commissary shopping opportunities, or permission to place a special purchase order.

D. With the Warden's approval, tangible incentives may be given, (e.g., books, t-shirts, notebooks, pencil pouches, mugs with positive affirmations, food and hygiene items not sold in commissary).

XVI. COMMUNICATION AND CONTINUITY OF CARE

A. **Inmates Who are Known to Require Special Precautions.** Consistent with Institutional Supplement FLM 5324.08A, *Suicide Prevention Program*, on a monthly basis, the Mental Health Treatment Coordinator will provide each housing unit a list of known inmates with mental health conditions who should be monitored when placed in the SHU for signs that they may become dangerous, self-destructive, suicidal, or who have a history of suicide attempts. This list will be reviewed by the Mental Health Treatment Coordinator at least quarterly, updated as needed, and distributed via email to Correctional Services, Health Services, and Unit Team staff. This list will be made available to all staff through the BOPWARE Special Housing Unit Application. When an inmate on this list is placed in the SHU, a Correctional Services Supervisor will notify Psychology Services immediately. Staff will continue to observe all inmates in SHU for any change in mental health status and report any observations to Psychology Services.

B. **Behavioral Health Committee Meeting (BHCM)**. The BHCM will be held monthly. Attendees will include the Assistant Health Services Administrator/Supervisory Nurse, psychiatrist, psychiatric mid-level provider, Clinical Director, and the ADX psychologists. This committee will promote coordination of mental health care for all the ADX inmates through discussing treatment goals and engaging in problem-solving for inmates suffering from mental illness. The Committee will also attempt to reconcile any differences in diagnoses between Health Services and Psychology Services. The Committee will ensure the ADX inmates receive appropriate medication and follow-up care. This meeting may be combined or integrated with the CCARE meeting.

C. **Between Bureau Institutions.** To promote continuity of care for inmates with mental illness as they transfer, a Mental Health Transfer Summary must be completed in BEMR/PDS every time an inmate with mental illness (CARE2-MH, CARE3-MH, and CARE4-MH) transfers out of the ADX. The ADX Psychologist assigned to the case is responsible for completion of this summary in collaboration with the Psychiatric Service Provider, Psychiatric Mid-Level Provider, and/or Psychiatric Nurse.

D. **Community Treatment Services (CTS).** Beginning no later than 9 months before an inmate's anticipated release, Psychology and Health Services staff will collaborate with CTS regarding the ADX inmates assigned a CARE2-MH or higher releasing to a residential re-entry center or home detention. When a releasing inmate is appropriate for CTS mental health services, psychology staff will enter a Mental Health Treatment Summary in BEMR/PDS and forward a copy to CTS.

E. **Reentry Planning Services.** A full-time, master's level, licensed clinical social worker, who is a member of the Health Services Department and mentored by the North Central Regional Social Worker, will provide reentry planning services, in conjunction with the treatment team and consistent with best practices, as follows:

1. Reentry services consistent with best practices will be provided to all inmates pending release directly to the community, home detention, or Residential Reentry Center (RRC), listed in order of priority for services:

    a. The ADX inmates and inmates transferred from the ADX to another facility within 3 months of their

release, regardless of medical/mental health classification.

b. Inmates in the SECURE Stages Program at the United States Penitentiary, High Security, Florence, Colorado.

c. Inmates housed in other facilities at FCC Florence, Colorado, who are assigned a CARE3-MH.

d. Inmates housed in other facilities at FCC Florence, Colorado, who are assigned a CARE3-Medical.

e. Inmates housed in other facilities at FCC Florence who are assigned CARE2-MH.

f. Inmates housed in other facilities at FCC Florence who are assigned CARE2-Medical.

2. Beginning at a minimum of 12 months prior to release and continuing up to release, inmates in the targeted population are provided, as appropriate and consistent with best practices: (a) personal interview/counseling; (b) group reentry counseling; and (c) individual tele-social work.

3. Beginning no later than 12 months before the inmate's expected release, the social worker will engage with critical stakeholders involved in the inmate's release planning, including but not limited to, the inmate's correctional case manager, treating clinicians, and drug treatment specialists. The social worker and critical stakeholders assess and evaluate the inmate's: (a) psychosocial issues; (b) individualized treatment plan for mental/medical needs including medications, counseling services, and subspecialty care as indicated; (c) addiction intervention needs; (d) disability identification; (e) financial needs; (f) housing concerns; (g) employment opportunities; (h) life skills; (i) family integration; and (j) child support obligations.

4. Beginning no later than 12 months before the inmate's expected release, the social worker will begin to provide the following services: (a) an individual written release plan approved by the treatment team and documented in the inmate's medical record; (b) assistance with obtaining government-issued personal identification, a social security card, and a birth certificate; (c) linkage to probation/reentry court as appropriate; (d) scheduling appointments for follow-

up medical/mental health and needed psychosocial services in community; (e) ensuring a supply of prescription medications; (f) provision of necessary medical equipment and ancillary health services as warranted; (g) referral to drug treatment program for chronic addiction as appropriate; (h) education and enrollment into Social Security, Disability, Medicare, Medicaid, Veterans Benefits, and Affordable Health Care Act Exchanges as appropriate; (i) assistance with housing arrangements; (j) assistance with integration into Health and Human Services-funded community-based transitions programs for released offenders as available; (k) guidance/support toward securing education, training, and employment opportunities; and (l) guidance/support toward healthy family and community reintegration.

F. **Suicide Prevention.** The ADX staff will comply with Institution Supplement FLM 5324.08, *Suicide Prevention Program*. Without limiting or modifying that Institution Supplement, every observation cell at the ADX used to house inmates for suicide prevention purposes will be cleaned and sanitized before each use and will be maintained at the temperature required by Program Statement 4200.10, *Facilities Operations Manual*. During nighttime hours, to permit the inmate to sleep, the lighting in such cells may be adjusted to the lowest level consistent with the need to maintain the inmate under appropriate observation.

G. **Quality Improvement (QI).** Mental health care (i.e., assessment, referral, and treatment services) will be reviewed under the Bureau's existing protocols, to include the Health Services Improving Organizational Performance Plan (IOP) protocol, perpetual audits of Program Review Guidelines, Health Services and Psychology Services Peer Reviews, Operational Reviews, and Program Reviews. Examples of appropriate QI activities include reviewing promptness and appropriateness of medication renewals, review of suicide attempts and follow-up, review of clinical use of restraints, and determining the adequacy of sick call procedures. As appropriate, Correctional Services will participate in QI activities with Psychology and Health Services staff.

EXHIBIT 4

U.S. Department of Justice
Federal Bureau of Prisons
United States Penitentiary
Florence, Colorado 81226

INSTITUTION SUPPLEMENT

OPI: Psychology Services
NUMBER: 5330.11(__)__
DATE: July __, 2016

SECURE STEPS TOWARD AWARENESS GROWTH AND EMOTIONAL STRENGTH (STAGES) PROGRAM

/s/
Approved: Jack Fox, Complex Warden

I. **Purpose:** To implement local guidelines and procedures for the implementation of the **Secure Steps Toward Awareness Growth and Emotional Strength (STAGES)** Program, a residential psychology treatment program at the United States Penitentiary, Florence, Colorado.

II. **Directives Affected:**

A. **Directives Rescinded:**

Institution Supplement FLP 5330.11(2), Secure Steps Toward Awareness Growth and Emotional Strength (STAGES) Program, dated July 21, 2015.

B. **Directives Referenced:**

PS 5330.11, Psychology Treatment Programs;
PS 5310.12, Psychology Services Manual;
PS 5310.16, Treatment and Care of Inmates with Mental Illness.

III. **Standards Referenced:**

American Correctional Association 4th Edition Standards for Adult Local Detention Facilities: 4-ALDF-4C-13, 4-ALDF-6B-03 and 4-ALDF-6B-02.

IV. **Program Overview:** The Secure STAGES Program is a residential psychology treatment program which targets male inmates from Maximum custody and/or High security Federal Bureau of Prisons (Bureau) institutions with a Personality Disorder diagnosis, who have a chronic history of self-injurious behavior or do not function effectively in a prison setting. The Program employs a comprehensive model that includes an emphasis on a modified therapeutic community, cognitive-behavioral therapy/dialectical behavior therapy, and peer support. The treatment materials used are evidence-based practices. Interventions and skills taught to inmates are based on Dialectical Behavior Therapy theory, Rational Self Analysis, Supported Employment, Seeking Safety, and cognitive-behavioral therapy.

The goals of the Program are to (1) evaluate and diagnose mental health disorders; (2) promote stabilization; (3) rekindle hope through psychotherapeutic methods and rehabilitation; (4) design and implement a multi-dimensional treatment plan grounded in evidence-based interventions; (5) educate inmates about their mental illness, treatment options, and relapse prevention strategies; (6) assist inmates with making a successful transition to less restrictive environments (where such a transition is appropriate given the inmate's security needs, mental health needs, and progress in the Program), or the community, (7) establish pro-social skills and lifestyles; and (8) train staff to support inmates in their recovery process. The primary objective of the Program is to provide psychological treatment that improves quality of life and decreases the risk of suicide for inmates who use self-harm as a means to manage emotional distress, and have displayed poor functioning in prison as a result of characterological problems. Thus, the Program is designed to increase the time between, and diminish the severity of, emotionally disruptive behaviors, foster living skills that support adaption into the General Population or community setting, and increase pro-social skills. The Program prepares inmates for transition to less secure prison settings and for successful reentry into society at the conclusion of their term of incarceration.

The Program's treatment philosophy is based on the biopsychosocial and rehabilitative model. Staff will help the Program participants look at all aspects of their lives: biological, psychological, and social. Staff will emphasize a participant's strengths in these areas, as well as problem behaviors that prevent them from achieving their stated goals. The Secure Program Treatment Team will discuss its recommendations with the participant in regular Treatment Team meetings, and the primary clinician will follow up on Treatment Team recommendations with the participant.

In addition to mental health treatment and peer support interactions, the participants will be encouraged to participate in an array of pro-social, healthy leisure activities. The participants will regularly participate in community-building activities throughout the course of treatment. The ability to structure free time is considered paramount for successful management of mental health treatment needs and decreasing risk of violence against self and others, as well as building skills for successful re-entry into less restrictive environments. These activities, such as regular community meetings and group therapy, are modified as appropriate for the security needs of the participants. As the participants demonstrate the ability to manage symptoms of mental

illness and maintain the safety of self and others, these self-directed activities may take place socially, with other program participants, and in a progressively less restrictive environment or security level. A participant's treatment phase and security level will be used as an indicator of how he may engage in these activities.

All inmates living in the Residential Program Unit, along with the staff affiliated with the Program, work to promote the goals of the Program. The Program, when fully staffed, has a capacity of 18 (10 in the "secured cell area" and 8 in the "unsecured cell area") participants. The participants may be assigned one to two companions who will assist the participant with implementation of dialectical behavior therapy skills. The policies and procedures in the Program may differ from other General Population units and will be designed to influence improved functioning of the Program community members. The Program staff will work closely with other disciplines to enhance programing opportunities and to ensure programing activities do not violate any safety or security regulations.

Program participation will vary in length depending on the treatment needs of the participant. Participants who have successfully completed the Program may be transferred to other facilities. Some participants may be allowed to remain in the Program Unit after completing the Program; if so, they will continue to actively engage in the Program.

V. Program Responsibilities:

A. **Chief Psychologist:** The Chief Psychologist at FCC Florence has primary responsibility for the implementation of the Program. The Chief Psychologist may designate another doctoral-level psychologist as the Secure STAGES Program Coordinator.

B. **Secure STAGES Program Coordinator (Program Coordinator):** The Program Coordinator is a Specialty Treatment Program Coordinator, who, in conjunction with the Chief Psychologist and the Federal Bureau of Prisons (Bureau) Psychology Services Branch, is responsible for assessing the suitability of inmates referred to the Program. The Program Coordinator will ensure that treatment plans are developed by a Secure STAGES Program Psychologist for each participant, and will facilitate and supervise program services, monitor participant progress in the program, recommend discharge, and plan aftercare. The Program Coordinator will complete a "Secure STAGES Monthly Status Report," Attachment A, and assist the Chief Psychologist in ensuring that contacts with participants are documented appropriately. Ordinarily, the Program Coordinator does not carry a caseload.

C. **Secure STAGES Program Psychologist (Psychologist):** The Psychologist is responsible for providing group and individual therapy to the participants in the Secure STAGES Program. The Psychologist completes psychosocial interviews, prepares relevant reports and documentation, develops treatment plans,

participates in clinical team meetings, and reports relevant information to the Program Coordinator. In addition, the Psychologist completes any clinically relevant psychological testing on program participants. The caseload for a Psychologist is a maximum of 6 participants.

D. **Psychiatric Care Provider:** The Psychiatric Care Provider (e.g., a psychiatrist or psychiatric mid-level provider) is responsible for providing psychiatric treatment, assisting with medication compliance, and ensuring that psychiatric contacts with inmates are documented appropriately.

E. **Social Worker:** The Social Worker for the Federal Correctional Complex assists in providing re-entry initiatives and ensuring continuity of care for participants who are either transferring to another institution or being released to the community.

F. **Secure STAGES Program Lieutenant (Lieutenant):** The Lieutenant is responsible for ensuring staff follow the safety and security policies on the Program Housing Unit. The Lieutenant oversees the Unit Officers on the Program Unit, ensuring enough staff are available for programming and recreation moves on the unit. In addition, the Lieutenant works with program unit staff to support the therapeutic environment by monitoring participants' completion of daily activities and communicating regularly with the Treatment Team.

G. **Unit Team Staff:** The Unit Team includes a Unit Manager, Case Manager, and Correctional Counselor, who maintain all housing unit and unit management responsibilities; to include the establishment of measurable goals to coincide with the individualized treatment plan developed by the Treatment Team and the review of a participant's progress during his regularly scheduled reviews. The Unit Manager and Program Coordinator work together to coordinate inmate movement into and out of the Program.

H. **Secure STAGES Program Treatment Team (Treatment Team):** The Treatment Team consists of the Program Coordinator, up to three Psychologists, and the Psychiatric Care Provider. Together, they create a team approach to the treatment and care of participants in the Program. They collaborate with one another in creating/revising treatment plans and clinical interventions. They oversee a participant's treatment and gauge his progress in treatment. The Treatment Team determines when an inmate is moved forward or regressed in treatment. The Treatment Team communicates regularly with the Lieutenant and the Unit Team.

I. **Secure STAGES Program Monthly Briefings:** The Program Coordinator or designee will meet monthly with institution Executive Staff to discuss current participants' security levels, status, and treatment progress; pending referrals; companion concerns or issues; and other relevant issues that affect the Program.

The Chief Psychologist, Deputy Chief Psychologist, Unit Manager, Program Unit Lieutenant, and Attorney Advisor are included.

VI. Conditions of Confinement

A. **Residential Program Unit (Program Unit):** The Program will be housed in Delta-B. Eleven cells ("secured cell area") in Delta-B have been separated from the remaining cells in the housing unit ("unsecured cell area"). A small indoor recreation area and group treatment enclosures have been created in the common area of the unit. Delta-B has a designated outdoor recreation area separate from the recreation areas designated for General Population inmates. The outdoor recreation area consists of two separated recreation enclosures and a larger group recreation area.

B. **Treatment Community:** The Program Unit will have rules and daily procedures designed to maximize treatment success and promote pro-social community involvement. The following procedures will apply to the Program Unit:

1. Only inmates affiliated with the Program will be allowed to live in the Program Unit. Listed below are the SENTRY assignments for those inmates who are suitable for living in the Program Unit. These assignments will be reflected in SENTRY and updated as indicated:

   a. STAGES SECURE PROG WAITING (STA WAIT S)
   b. STAGES SECURE PROG PARTICIPANT (STA PART S)
   c. STAGES SECURE PROG CADRE (STA CADRES)
   d. STAGES SECURE PROG COMPLETED (STA COMP S)

2. Community meetings will occur every work day to discuss activities of the day, report news and upcoming events, recognize the achievements of participants, and to discuss relevant STAGES community issues. Participants and companions who are in the unit at the time of the meeting will be required to attend and participate. Participant attendance will be consistent with the identified security level for each participant.

C. **Admission and Orientation:** Companions and participants will receive a USP Florence A&O Handbook, as well as a Secure STAGES Participant Handbook, which will serve as a guide to the expectations, procedures, and rules and regulations of the Program Unit. All companions and participants will participate in an Institution and Program Unit A&O Program as outlined by Program Statement 5290.14, Admission and Orientation Program, instructed by all applicable staff members. Instructions for participating in the Institution A&O Program are provided to companions and participants at intake screening and during Program Unit A&O.

D. **Environment/Sanitation**: All participants and companions will be accountable for maintaining acceptable levels of sanitation in common living areas, treatment areas, and cells of the Program Unit. Environment and sanitation standards are outlined in applicable Institution Supplements, A&O Handbook, and Secure STAGES Participant Handbook. Unit sanitation will be monitored by Treatment Team, Unit Team, and the Program Unit Officers on a regular basis. The participants and companions are expected to work together to keep the housing unit and treatment area clean.

E. **Cell Assignments:** All participants will be celled as outlined in the Security Levels section, below. Participants in secure cell assignments will be rotated every 90 days. Participants and companions in the unsecured cells will rotate in accordance with the institution cell rotation plan.

F. **Bedding/Clothing**: All participants and companions will be issued a laundry bag with an adequate supply of clothing, towels, and linens. A list of institution-issued clothing, towels, and linens can be found in applicable Institution Supplements, A&O Handbook, and Secure STAGES Participant Handbook. Specific procedures for linen exchange and laundry are also outlined in applicable Institution Supplements, A&O Handbook, and Secure STAGES Participant Handbook. Participants and companions who alter or damage institution-issued items will be subject to disciplinary action.

G. **Personal Hygiene**: All participants and companions have access to a wash basin and toilet in their cell. Participants in Security Levels 1 and 2 will be provided with a minimum of three showers per week. All other participants and the companions will have access to showers when they are out of their cell. Hygiene items will be issued to participants and companions on a regular basis, and additional items may be purchased through commissary. Procedures for the issuance of hygiene items are outlined in applicable Institution Supplements, A&O Handbook, and Secure STAGES Participant Handbook.

H. **Meals:** All participants and companions will receive three meals per day, either through satellite feeding in their cell or on the Program Unit, or by attending mainline. Feeding procedures are outlined in the applicable Institution Supplements, A&O Handbook, and Secure STAGES Participant Handbook.

I. **Work Assignments:** Companions will be assigned a “Secure STAGES Companion” work assignment. Participants will have work assignments commensurate with their treatment phase and security level, such as unit or recreation orderlies. Unit Team will be responsible for work assignments and will collaborate with the Treatment Team, Lieutenant, and Program Unit Officers with regard to appropriate work assignments for participants and companions.

J. **Education:** Participants and companions will have access to the Education department and library services on the Program Unit. Security Level 4

participants and companions will also have access to the Education department and library services in General Population. Information regarding access to the Education department is available in applicable Institution Supplements, A&O Handbook, and Secure STAGES Participant Handbook.

K. **Recreation:** All participants will be offered a minimum of 13 hours of unstructured out-of-cell recreation per week, including a minimum of 5 hours of recreation occurring outdoors. Access to recreation will be determined by the participant's security level. Security Level 4 participants and the companions will have access to the Program Unit recreation area, as well as the recreation areas designated for General Population inmates. Additional programming opportunities may be offered by the Recreation department. Information regarding recreation procedures is available in applicable Institution Supplements, A&O Handbook, and Secure STAGES Participant Handbook.

L. **Personal Property:** Provided there are no property restrictions in place, participants will be allowed personal property based on their individual security level. To the extent consistent with the treatment goals of the Program, companions will ordinarily be allowed the same personal property afforded to General Population inmates. Information regarding authorized personal property is outlined in applicable Institution Supplements, A&O Handbook, and Secure STAGES Participant Handbook.

M. **Commissary:** Provided there are no commissary restrictions in place, participants will be allowed commissary based on their individual security level. To the extent consistent with the treatment goals of the Program, companions will ordinarily be allowed the same commissary afforded to General Population inmates. Information regarding approved commissary lists is outlined in applicable Institution Supplements, A&O Handbook, and Secure STAGES Participant Handbook.

N. **Visits:** Provided there are no visiting restrictions, all inmates may receive social visits. Ordinarily, companions and Security Level 4 participants will receive contact social visits; all other inmates will receive non-contact social visits. The Warden may permit Security Level 3 participants a contact social visit if, following consultation with the Treatment Team, it is appropriate given the goals of the Program and the participant's treatment plan, treatment phase, and level of functioning, Such a determination will be made on an individual, case-by-case basis. Information regarding visiting procedures is available in applicable Institution Supplements, A&O Handbook, and Secure STAGES Participant Handbook.

O. **Correspondence, Telephone Use, and TRULINCS Access:** Social correspondence will be permitted, subject to any correspondence restrictions. Ordinarily, if a participant is not on telephone restrictions, regardless of Security Level, he will be allowed 300 minutes per month. Ordinarily, companions will

also be allowed 300 minutes per month. Provided there are no TRULINCS restrictions in place, participants and companions will have access to TRULINCS. Procedures for correspondence and use of the Inmate Telephone System and TRULINCS are provided in applicable Institution Supplements, A&O Handbook, and Secure STAGES Participant Handbook.

P. **Legal Activities:** Participants and companions will be provided legal telephone calls and visitation in accordance with national policy. Participants and companions will also have access to the Electronic Law Library in the housing unit and will be allowed to assist one another as permitted by national policy. Participants and companions will be permitted to maintain one cubic foot of legal materials in their cells. In limited circumstances, Security Level 1, 2, and 3 participants may request that copies be made of legal documents; Security Level 4 participants and companions will have access to a photocopier in Education. Specific information regarding inmate legal activities is located in applicable Institution Supplements, A&O Handbook, and Secure STAGES Participant Handbook.

Q. **Religious Activities:** All participants and companions may pursue religious beliefs and practice in accordance with national policy. Specific information regarding inmate religious practices is available in applicable Institution Supplements, A&O Handbook, and Secure STAGES Participant Handbook.

R. **Library Services:** Library services will be available to participants and companions. Specific information regarding access to library services is available in applicable Institution Supplements, A&O Handbook, and Secure STAGES Participant Handbook.

S. **Medical Care:** Security Level 4 participants and companions will access medical services in accordance with General Population procedures. A health care provider will make daily rounds to conduct sick call and pill line for Security Level 1, 2, and 3 participants. More specific information regarding medical services is outlined in applicable Institution Supplements, A&O Handbook, and Secure STAGES Participant Handbook.

T. **Mental Health Care**: Participants in the Program will have access to Psychology Services through the Program. Additional optional Psychology services may be available. Participants will be offered a minimum of 5 hours of out-of-cell structured therapeutic programming per week, which may include group therapy, individual therapy, community meetings, art therapy, recreational therapy, or other structured recreational time. Emergency mental health care will be available via the on-call psychologist.

VII. Program Referrals:

A. Male inmates from high and maximum custody Bureau facilities will be considered for the Program.

B. A prospective participant must consent to enter the Program and be no less than 18 months from release, to allow sufficient time to compete the Program. In general, referrals to the Program will be submitted to the designated Mental Health Treatment Coordinator in the Psychology Services Branch of Central Office by the referring institution's treating psychologist or psychiatric care provider. Once the Mental Health Treatment Coordinator reviews the case, he/she will submit the referral to the Program Coordinator for review. The Program Coordinator reviews the case in consultation with institution Executive Staff and Psychologists. If the prospective participant is determined to be an appropriate referral, the referring psychologist is notified and encouraged to begin Pre-STAGES Treatment. At this time, the referring psychologist will also ensure an updated Diagnostic and Care Level formulation has been entered into PDS/BEMR. As bed space becomes available, an interview will be scheduled by the Program Coordinator with the prospective participant. The Program Coordinator is responsible for documenting the interview in PDS/BEMR. Although an inmate may be appropriate to participate in the Program, he may be placed on the waitlist pending bed space and/or resolution of safety and security issues.

C. Documentation will be sent to the referring psychologist or psychiatric care provider regarding acceptance or denial into the Program. Once inmates from other Bureau facilities are accepted into the Program, the referring psychologist will coordinate the inmate's designation with the inmate's Unit Team.

D. The referring psychologist or psychiatric care provider is responsible for obtaining the prospective participant's consent to participate in the Program (form BP-A094), uploading the consent to PDS/BEMR, and submitting it to the Program Coordinator. If an inmate who is recommended for the Program does not consent to participate in the Program, staff will utilize motivational interviewing strategies on an ongoing basis in attempt to obtain the prospective participant's consent. In addition, care consistent with the prospective participant's mental health care level will be offered to the prospective participant in his current setting, to include dialectical behavior therapy interventions, if the prospective participant is amenable. Psychology Services Branch staff will also explore involuntary treatment options, which may be available to the inmate at an alternate facility.

VIII. Treatment Assessment Procedures: Upon arrival to the Program, the Psychologist will conduct a comprehensive psychosocial assessment (including a thorough records review), contact previous treatment providers, and complete a thorough diagnostic and care level formulation in PDS/BEMR of each new participant. The Psychiatric Care

Provider will also assess the participant and review any psychotropic medications. These evaluations will assist in formulating an individualized treatment plan for each participant.

Once in the Program, each participant will receive 60-day progress reviews by the Psychologist, which will serve as a way to assess the participant's progress. The 60-day progress review will be reviewed with the participant and will outline treatment plan accomplishments, areas of improvement, areas of difficulty, recommendations for continued improvement, etc.

IX. **Treatment Phases:** The Program does not use a cohort model; rather, participants are admitted to the Program as space becomes available and will advance through the Program according to their observed behavioral mastery of the skills. When the Treatment Team determines that a participant is ready to advance to the next treatment phase, a transition ceremony will be held within the community to recognize the participant's accomplishments. If a participant displays a pattern of behavior inconsistent with the treatment phase to which he was advanced, he may be returned to an earlier treatment phase in order to ensure mastery of more basic skills. The Program is comprised of three treatment phases, which follow a Pre-STAGES component. All participants will be in an identified treatment stage. The treatment phases determine the attributes of the participant's treatment environment that best match the participant's current functioning with regard to the participant's ability to keep himself and others safe, engage in appropriate social contact, follow institutional and program rules, manage emotional expression, and manage activities of daily living. A description of the Pre-STAGES component, each of the treatment phases, and the participants' movement through the treatment phases is as follows:

A. **Pre-STAGES Component:** Inmates identified as meeting diagnostic criteria for the Program will participate in Pre-STAGES programming prior to entering the Program. The goal during Pre-STAGES is to assess a prospective participant's readiness and commitment to the Program and to provide psychoeducation and clinical interventions to prepare the inmate to transfer to the Program. The Pre-STAGES programming will occur at the referral institution. During this period, the prospective participant will be provided with the Secure STAGES Participant Handbook, and his treating psychologist will review and discuss the Program's expectations with him. A written individualized treatment plan will also be developed by the treating psychologist with the treatment goals that the prospective participant must work toward prior to his transfer to the Program. The prospective participant will be assessed by the treating psychiatrist or psychiatric mid-level provider to determine any medication needs or adjustments. The prospective participant may be required to participate in additional psychological testing to aid in assessing appropriateness. Areas of assessment may include the prospective participant's current ability and willingness to address his mental health treatment needs, risk for violence, social skills, independent living skills, and any other skills needed for transition to the Program. Evidence-based treatment interventions that may be provided during

this phase include Dialectical Behavior Therapy, social skills trainings, and examining criminal thinking errors. When the Program Coordinator determines the prospective participant has made satisfactory progress on his individualized treatment plan, he will be interviewed by the Program Coordinator to further discuss the Program and assess the prospective participant's readiness to begin the Program.

B. **Treatment Phases**

1. **Phase 1 - Orientation Phase:** Upon arrival to the Program Unit, the participant will be placed in Treatment Phase 1 - Orientation Phase. The goals of this phase include building rapport with staff and motivating the participant to engage in treatment in a modified treatment community. The primary focus is on stabilizing and orientating the participant and assisting him in achieving behavioral control.

   During the Orientation Phase, the participant will participate in a Psychosocial Interview and an evaluation by a psychiatrist or mid-level psychiatric provider. The Treatment Team will develop a treatment plan in collaboration with the participant within the first 30 days of the participant's arrival to the Program. The participant is expected to demonstrate willingness to conform to the norms of the Program, participate fully in treatment sessions, demonstrate a positive attitude, complete a statement that outlines his readiness for treatment, and learn to accept feedback from staff, companions, and peers. The participant will be encouraged to participate in community meetings and group treatment on the unit, but may begin with in-cell treatment assignments if clinically necessary (i.e., participant is still acclimating to the treatment environment). The participant will also engage in individual therapy sessions; become familiar with staff, companions, and peers; begin adjusting to the unit; identify personal goals; and learn and practice adherence to program rules.

   The behavioral targets in the Orientation Phase include: decreasing life-threatening behaviors (e.g., self-harm acts, including suicide attempts, high risk suicidal ideation, plans, and threats), decreasing therapy-interfering behaviors (e.g., missing sessions, physical disruption of sessions, encouraging negative interactions), decreasing quality-of-life interfering behaviors, reducing behavioral patterns serious enough to substantially interfere with any chance of a reasonable quality of life (e.g., depression, anxiety, time in the Special Housing Unit), and increasing behavioral skills (e.g., skills in emotional regulation, interpersonal effectiveness, distress tolerance, mindfulness, and self-management). The participant's willingness and capability to interact with staff, companions, and peers in a safe and cooperative manner will also be assessed.

During the Orientation Phase, the participant participates in weekly individual sessions with a Psychologist, which may occasionally include his companion(s). All interactions will be conducted in a therapeutic setting appropriate for the participant's security level, including secure treatment enclosures in the common area of the unit or a private, secure treatment room. The participants progressing through Orientation Phase will have the ability to attend and participate in group. The Orientation Phase will last ***a minimum*** of three months.

2. **Phase 2 - Core Treatment Phase:** Once a participant emotionally and behaviorally adjusts to the treatment environment, displays appropriate behavior in individual and group treatment, and begins to grasp treatment concepts, he is moved into Treatment Phase 2 - Core Treatment Phase. During this phase, he will be ***required*** to participate in community meetings and group treatment on the unit.

   The participant will develop knowledge related to the four core Dialectical Behavior Therapy (DBT) skills (Core Mindfulness, Emotional Regulation, Interpersonal Effectiveness, and Distress Tolerance) through repeated exposure in Skills Group. The participant is expected to begin building positive relationships in group, on the treatment unit, with institution staff, and with community friends and family. The participant is also expected to develop thought processes and pro-social coping skills required to improve his quality of life in both prison and the community. In addition, the participant is expected to appropriately accept feedback from peers, companions, and staff, while continuing to identify strengths and work on weaknesses. Furthermore, the participant is expected to routinely display alternative coping skills and refrain from engaging in self-harm as a means to cope with negative emotions or control his environment. The participant will begin to develop realistic expectations for exiting the Program. The Core Treatment phase will last ***a minimum*** of six months.

3. **Phase 3 - Transition Phase:** The primary focus of Treatment Phase 3 - Transition Phase is on improving the quality of life of the participant within the treatment setting, as well as in the General Population outside of the Program Unit, with the ultimate goal being successful transition to the community. This is accomplished by the participant achieving mastery related to DBT Skills with decreased need for therapeutic and coaching interventions. The participant will continue to participate in group therapy and community meetings and will take a more active leadership role. The participant will practice the skills acquired both during treatment programming and during his daily interactions with peers and staff within the prison setting.

   Participants in the Transition Phase are expected to be helpful to, and serve as positive role models for, newer participants. Also, participants

will be able to teach the skills acquired during treatment to individuals in the Program. The primary focus is on reinforcing independent practice of DBT skills. In addition, the participant will work with the Social Worker to solidify an appropriate release or transfer plan to ensure support is available after the Program. Transition phase will last ***a minimum*** of three months.

C. **Movement through the Treatment Phases:** The Treatment Team determines changes in a participant's treatment phases.

1. During daily interactions with Program Unit Officers, Unit Team, and other appropriate staff, and regular Treatment Team meetings, a participant's program treatment phase will be evaluated to ensure the participant is in the appropriate treatment phase.

2. The Secure STAGES Participant Handbook provides participants with an outline that clearly links treatment phases to behavioral benchmarks, including benchmarks to progress to and remain in a treatment phase.

3. When the Treatment Team observes a participant's consistent increase in functioning, the participant may progress to the next treatment phase. Increase in functioning is typically evidenced by the participant's ability to keep himself and others safe, engage in appropriate social contact, follow institutional and program rules, manage emotional expression, and to independently coordinate activities of daily living.

4. When the Treatment Team observes a participant's consistent decrease in functioning, he may be returned to a previous treatment phase. Decrease in functioning is typically evidenced by a participant's inability to keep himself and others safe, lack of appropriate social contact, not following institutional and Program rules, inability to manage emotional expression, and inability to independently coordinate activities of daily living.

5. When a participant's treatment phase is changed, the Treatment Team will document the reason for the change in treatment phase within the inmate's PDS/BEMR record, and verbally notify the participant of his change in treatment phase.

X. **Security Levels:** The security levels are used for participants to ensure the safety and security of the participant, peers, companions, staff, and the institution. The security levels allow for a participant to step-down to less restrictive housing and acclimate to a less restrictive setting. Prior to arrival to the Program, a participant's security needs will be assessed during the Secure STAGES Committee meeting, and he will be assigned a Program security level. It is anticipated that as the participant progresses through the treatment phases, the need for enhanced security measures will diminish. All participants will have an institution work assignment commensurate with his security level.

A. **Levels**: The security levels range from Security Level 1 (most restrictive) to Security Level 4 (least restrictive). A description of each of the levels is as follows:

1. **Security Level 1:**

a. As a Security Level 1, the participant will reside in a single cell on the secured-cell range of the Program Unit.

b. The participant will have single occupancy recreation through the use of a recreation enclosure.

c. He will participate in both group and individual treatment through the use of treatment enclosures or other appropriate non-contact measures.

d. All other services, such as meals and telephone calls, will be provided in-cell or at cell-front.

e. Security Level 1 participants may have a television in their cell.

f. While being escorted within the Program Unit and its designated recreation area, the participant's hands will be restrained behind his back, using appropriate, double-locked hand restraints. If a participant is escorted outside of the Program Unit, he will be restrained in the front with a martin chain and appropriate, double-locked hand restraints.

g. Anytime a Security Level 1 participant is removed from his cell, he is expected to back out of his cell and to be pat-searched. A minimum of two staff will conduct all escorts. A rapid rotation baton is required when escorting a Security Level 1 participant.

2. **Security Level 2:**

a. As a Security Level 2, the participant will reside in a single cell on the secured-cell range of the Program Unit.

b. At the discretion of the participant and Program Unit Officers, the participant ***may*** engage in double occupancy recreation with one other Security Level 2 participant.

c. He will engage in individual and group treatment through the use of treatment enclosures or other appropriate non-contact security measures.

d. All other services, such as meals and telephone calls, will be provided in-cell or at cell-front.

e. Participants may have a television in their cell.

f. Security Level 2 participants are offered up to 2 hours per day of out-of-cell "leisure time" in a treatment enclosure, while other inmates are in the common area of the unit. During this time, a participant can watch television, play games, socialize, or engage in other pro-social activities with other Security Level 2 participants and their assigned companions.

g. While being escorted within the Program Unit and its designated recreation area, the Security Level 2 participant's hands will be restrained behind his back, using appropriate, double locked hand restraints. If a Security Level 2 participant is escorted outside of the Program Unit, he will be restrained in the front with a martin chain and appropriate, double-locked hand restraints. Anytime a Security Level 2 participant is removed from his cell, he is expected to back out of his cell and to be pat-searched. A minimum of two staff will conduct all escorts.

3. **Security Level 2.5:**

a. In an effort to ease a participant into a less restrictive environment, he ***may*** be placed on a Security Level 2.5. This level is an intermediate step within Security Level 2, allowing for ***some*** treatment to take place without the use of treatment enclosures. The Program Coordinator or designee, in consultation with the Lieutenant, determines when a Security Level 2.5 participant can participate in treatment on the unsecured cell area of the unit or without the use of restraints.

b. A Security Level 2.5 participant continues to reside in a single cell on the secured cell area, however, he may participate in recreation with other Security Level 2.5 participants and their assigned companion(s) in the group area of Delta-B recreation.

c. All other services, such as meals and telephone calls, will be provided in-cell or at cell-front.

d. Participants may have a television in their cell.

e. Security Level 2.5 participants continue to be offered up to 2 hours of "leisure time" in a treatment enclosure, while other inmates are in the common area of the unit. During this time, a participant can watch television, play games, socialize, or engage in other pro-social activities with other Security Level 2.5 participants and their assigned companions.

f. While being escorted on the secured-cell range of Program Unit, the participant's hands will be restrained behind his back, using appropriate hand restraints. A Security Level 2.5 participant may enter the Program Unit's recreation area and unsecured cell area without restraints. If a participant is escorted outside of the Program Unit, he will be restrained in the front with a martin chain and appropriate, double-locked hand restraints.

g. Anytime a Security Level 2.5 participant is removed from his cell, he is expected to back out of his cell and to be pat-searched. A minimum of two staff will conduct all escorts.

4. **Security Level 3**:

a. As a Security Level 3, the participant will reside on the unsecured cell area of the Program Unit.

b. The participant ***may*** have a cellmate if the Treatment Team determines it is appropriate based on his treatment needs.

c. The participant will participate in recreation with other Security Level 3 and Secure STAGES Companions in the group area of Delta-B recreation.

d. The participant will participate in individual and group treatment without the use of treatment enclosures or restraints.

e. The participant will be provided services, such as meals and phone calls, within the common area of the housing unit.

f. A Security Level 3 participant will not have a television in his cell.

g. Movement throughout the housing unit or institution will not require the use of restraints; however, movement throughout the institution requires a staff escort.

5. **Security Level 4:**

a. As a Security Level 4, the participant will reside on the unsecured cell area of the Program Unit Program Unit.

b. Typically, the participant will be celled with one of his assigned companions, in preparation for transition to a regular mainline institution.

c. The participant is expected to attend recreation with General Population inmates; although he may also attend recreation in the group area of Delta-B recreation.

d. The participant will participate in all components of the Secure STAGES Program without the use of restraints or treatment enclosures.

e. The participant will access institution services in the same manner as companions, including attending mainline for meals.

f. The participant will not have a television in his cell.

g. Security procedures will be consistent with General Population inmates at the institution.

B. **Referral & Eligibility for Security Level Advancement:** The Program Coordinator will review each participant to determine eligibility for consideration for advancement to a less-restrictive security level in the Program. A participant may present issues concerning his security level during his 60-day treatment reviews with STAGES Psychology staff. A participant may also present issues concerning his security level during his 6-month Program Reviews with his Unit Team. Each of these reviews gives staff and inmates the opportunity to discuss issues in an open forum. Ordinarily, a participant must actively participate in and complete all programs recommended by the Treatment Team to be eligible for consideration for advancement to a less-restrictive security level in the Program. The participants who the Program Coordinator determines are eligible for consideration for advancement for a less-restrictive security level will be referred to the Committee for consideration.

C. **Review Procedure:**

1. A multi-disciplinary Secure STAGES Committee (Committee) will review each participant, at a minimum, every 90 days to determine whether the participant can safely function in a less-restrictive security level without posing a risk to institutional security and good order; posing a risk to the safety and security of staff, inmates, or others, including the participant

himself; and/or posing a risk to public safety (see Attachment B, "Secure STAGES Security Level Evaluation Form").

2. The Committee will, at a minimum, consist of the Warden, Associate Warden (Programs), Captain, Deputy Chief Psychologist, Program Coordinator, Unit Manager, Lieutenant, and Attorney Advisor.

3. Consideration for a different security level by the Committee is not a hearing, and the participant is not entitled to be present, to have counsel, to call witnesses, or to present evidence.

4. The determinations made by the Committee are made on a case-by-case basis.

5. Eligibility for consideration does not equate to appropriateness for advancement to a less-restrictive security level.

6. The factors the Committee may consider include, but are not limited to:

   a. The participant's conduct while housed at his previous institution and his current institution;
   b. The participant's behavior and conduct towards, and interaction with, staff and other inmates while at the previous institution and while in the Program;
   c. The reason(s) the participant was designated to the prior institution;
   d. The participant's criminal history;
   e. The participant's involvement with criminal organizations, if any, and the potential safety and security threat implicated by such involvement;
   f. The participant's overall adjustment during his history of confinement;
   g. The institution's safety and security needs, including the safety and security of staff;
   h. The safety and security needs of the participant;
   i. The safety and security needs of other participants and companions;
   j. The safety and security needs of the public;
   k. Progress toward treatment goals;
   l. Demonstration of skills learned in the Program;
   m. Responsiveness to treatment; and
   n. Any other relevant factor(s).

7. During the review, the Committee will ordinarily place an emphasis on a participant's most recent conduct.

8. The final decision regarding a participant's security level advancement is

made by the Warden.

9. When the Committee decides whether to recommend that a participant's security level change, written documentation will be completed outlining the rationale for that decision and will be placed in the participant's treatment file. Each participant will receive verbal and written notification of the decision from the Program Coordinator (or designee). If the participant is denied advancement to a less restrictive security level, the written notification will include the following:

   a. The reason(s) for denial, unless it is determined the release of this information could pose a threat to individual safety or institutional security, in which case that limited information will be withheld.

   b. A notification that the inmate may appeal the decision through the Bureau's Administrative Remedy Program.

10. The Program Coordinator (or designee) will also document the decision and discussion within the participant's electronic PDS/BEMR record.

11. The Program Coordinator (or designee) will document the decision and discussion within the inmate's electronic PDS/BEMR record and verbally notify the inmate of the Committee's decision.

12. The denial of an inmate for security level advancement does not preclude the Committee for exercising their discretion to reach a different conclusion at a future review.

13. Provided the participant who was denied advancement continues to meet the eligibility requirements for security level advancement, the participant will continue to be reviewed at a minimum every 90 days.

D. **Security Level Regression:**

1. Participants may be moved to a more restrictive security level for the following reasons:

   a. If the participant displays a pattern of behavior inconsistent with his security level demonstrating can no longer safely function in a less-restrictive security level without posing a risk to institutional security and good order; posing a risk to the safety and security of staff, inmates or others, including the inmate himself; and/or posing a risk to public safety.

   b. If the participant is found guilty of committing prohibited act(s) by the UDC or DHO.

2. The circumstances warranting consideration for regression may require the inmate to be immediately moved to a more restrictive security level.

3. The final decision regarding the regression of a participant to a more restrictive security level is made by the Associate Warden (Programs) in consultation with the Program Coordinator.

4. If a participant's security level is regressed, a recommendation will be made to the Associate Warden (Programs) by the Program Coordinator, in consultation with Program Unit Lieutenant, as to which security level the participant will be regressed. The determination will be made on a case-by-case basis.

5. When the Associate Warden (Programs) decides a participant's security level will be regressed, written documentation will be completed outlining the rationale for that decision and will be placed in the participant's treatment file.

6. The inmate will receive verbal and written notice from the Program Coordinator (or designee). The written notice will include the reason(s) for the regression, unless it is determined the release of this information could pose a threat to individual safety or institutional security, in which case that limited information may be withheld. The notice will also notify the participant that he may appeal the decision through the Bureau's Administrative Remedy Program.

7. The Program Coordinator (or designee) will document the decision and discussion within the inmate's electronic PDS/BEMR record and verbally notify the inmate of his change of security level.

XI. Psychology Treatment Program Achievement Awards:

A. In accordance with Program Statement 5310.16, Treatment and Care of Inmates with Mental Illness, the Program employs a token economy system. Program participants earn points by participating in mental health treatment, participating in recreation, completing activities of daily living, maintaining safety of self and others, encouraging others in a prosocial manner, etc. The Treatment Team, Unit Team, Lieutenant, and other Program Unit staff work together to award points on a daily tracking sheet posted on each participant's door. If the participant engages in rule-breaking behavior, refuses to program, or otherwise becomes disruptive to the Program, the participant's point sheet may be removed for the day at staff's discretion and no points will be awarded for that day. Points are tallied each day and the participant is notified each week of how many points

he has earned. Typically, the participants have an opportunity to spend points to purchase incentive award items weekly (e.g., additional food items, hygiene items, art supplies, games, etc). The Secure STAGES Participant Handbook provides a detailed description of how to earn incentive points, incentives available for purchase, and the cost of each incentive item.

B. The Privilege Incentive Program (PIP) is offered to all the participants who have commissary, phone, and/or visitation restrictions, provides incentives for inmates who are on prolonged disciplinary restrictions to participate in available programs and maintain clear conduct, furthering the mission of the Program. As inmates participate in the PIP, it is possible for inmates to earn some privileges that were suspended through the discipline process, although privileges cannot be restored completely. A goal of the PIP is to assist inmates by enhancing and promoting the Bureau's reentry initiative which encourages them to build better community ties. The specifics of the PIP is as follows:

1. The PIP is four steps. All inmates start at Step 1. The types of available incentives are determined by the step.

2. Every participant enrolled in the Program who is on prolonged disciplinary telephone, visiting, and/or commissary restriction has the opportunity to demonstrate he may be afforded these privileges.

3. Participants demonstrating positive programming may be awarded the following incentives:

Step	Time Period	Incentive
1	30 days meeting requirements Incentives are for the next 30 days, or expiration of sanctions	One (1) 15-minute phone call per month **or** $40 commissary purchase per month **or** One (1) social visit per month
2	60 days meeting requirements Incentives are for the next 60 days, or expiration of sanctions	Two (2) 15-minute phone calls per month **or** $80 commissary purchase per month **or** Two (2) social visits per month
3	90 days meeting requirements Incentives are for the next 90 days, or expiration of sanctions	Three (3) 15-minute phone calls per month **or** $120 commissary purchase per month **or** Three (3) social visits per month

4	120 days meeting requirements Incentives continue as long as inmate meets eligibility criteria, or expiration of sanctions	Four (4) 15-minute phone calls per month **or** $160 commissary purchase per month **or** Four (4) social visits per month

4. Participants must demonstrate positive programming by meeting the following requirements:

   a. Paying disciplinary fines;
   b. Maintaining clear disciplinary conduct;
   c. Participating in the Inmate Financial Responsibility Program, and/or Encumbrance (50/50) Program;
   d. Maintaining a job with satisfactory work performance, if applicable;
   e. Active participation in and satisfactory completion of all programs recommended by Unit Team and the Treatment Team;
   f. Completion of all ABE/GED, or satisfactory progress towards obtaining a GED as determined by Education staff, or be exempt from the Literacy Program;
   g. Positive overall institution adjustment to include, but not limited to, personal hygiene, cell sanitation with established standards;
   h. Positive behavior and respectful conduct towards staff and other inmates;
   i. Attendance at all Treatment Teams;
   j. Active participation in group and individual treatment, as well as good progress towards treatment goals.

5. Participants will be reviewed by Secure STAGES Program staff and Unit Team every 30 days to determine their appropriateness to receive an incentive; with final approval being made by the Warden.

6. Participants who fail to meet the eligibility criteria at the review will return to Step 1. An inmate's failure to maintain clear conduct between 30 day reviews will result in the inmate returning to, or remaining at, Step 1.

7. Participants demonstrating positive programming, prosocial behavior, and no misconduct for 30 consecutive days may also be considered for an exception to their disciplinary sanction(s).

C. Pursuant to Program Statement 5330.11, Psychology Treatment Programs, the Warden or designee may approve other certain tangible incentives. The other individual and community incentives may be offered to recognize, reward, and encourage individual progress and to encourage a high morale for the larger treatment community. Additional program incentives may include, but are not limited to, any of the following:

1. Monetary Achievement Award

2. Structured Program Activities
3. STAGES Resource Library
4. Tangible Incentives (e.g., books, notebooks, pencil pouches, mugs with program logo, food and hygiene items that are not sold in commissary ***as approved by the Warden***)
5. Recommendation for transfer to an institution closer to permanent residence (upon successful completion of the program) or an institution that provides an additional beneficial treatment program.

XII. Program Completion:

A. The completion of all three treatment phases is required before a participant will be considered for Program completion. The minimum time period to complete the Program is 12 months. However, there is no maximum time period for completion of the Program. Each participant's individual needs determine the length of time, beyond the 12-month minimum, that he will remain in the Program.

B. Upon completion of the Program, the participants will be considered for an appropriate placement option where the individual can continue to practice skills and techniques learned throughout the Program and the setting from which they would most benefit. This placement could include, but is not limited to: transfer to a lower security STAGES Program; transfer to another appropriate institution, transfer to General Population at the current institution; or remaining on the Program Unit and becoming a Mental Health Companion. The consideration for transfer to another appropriate institution will be based on the specific treatment and security needs of the participant. While the ultimate objective of the Program is for the participant to complete the Program and transition to another institution, or release to a Residential Re-entry Center (RRC), there are some cases that may require continued placement in the Program Unit upon completion of the Program. For example, if it is determined that removal from the therapeutic environment may affect the participant adversely, the participant may continue to live in the Program Unit after completion.

C. If the participant is determined to be eligible for program completion and/or institutional transfer, the participant's primary Psychologist prepares a Treatment Summary indicating the participant's course of treatment, his therapeutic gains, conditions that increase his likelihood for success, and recommendations for future mental health providers, probation officers, and/or community resources, as applicable.

D. If the participant is determined to be ineligible for completion of the Program and there is time remaining on his sentence, he and his primary Psychologist will revise his treatment plan to address barriers to the completion of the Program. The participant will be encouraged to complete treatment activities that target these barriers. If the participant acquires skills to address these barriers, he will

again be reviewed for completion of the Program and/or institutional transfer eligibility.

E. In the event a participant releases directly from the Program to an RRC, special accommodations for an escorted furlough may be warranted. Considerations for such accommodations will be reviewed on a case-by-case basis and are subject to the approval of the Unit Team and Executive Staff.

XIII. **Program Withdrawals:** A participant may withdraw voluntarily from the Program and receive a SENTRY code reflecting his withdrawal status.

A. The participant must submit a written request to the Program Coordinator to withdraw from the Program.

B. In response to a request to withdraw, the following will occur:

1. The Program Coordinator will provide a clinical intervention by meeting individually with the participant to discuss his concerns and the implications for withdrawal.

2. The Treatment Team will then meet to discuss the withdrawal request and assign two additional clinical interventions over a 7-day period to assist in motivating the inmate for treatment

3. The Treatment Team will properly document the meetings and assigned treatment interventions in PDS/BEMR.

C. If the participant maintains his withdrawal request, a memorandum will be forwarded to the Warden, with a copy sent to Unit Team (see Attachment D, “Change in Secure STAGES Program Status Memo”).

D. The Consolidated Legal Center for the Federal Correctional Complex and the Bureau’s Psychology Services Branch will be notified.

E. Upon completing the process of withdrawing from the Program, the inmate may be removed from the Program Unit.

F. Participants who were transferred from other institutions, and are unwilling to complete the Program, may be returned to the referring institution.

G. The inmate may reapply and receive reconsideration, based on clinical rationale, to return to the Program. The inmate may be placed on a wait list based on his clinical needs and availability of bed space in the Program.

XIV. **Program Incompletes:** A participant may be moved to Incomplete status for various reasons. Examples include, but are not limited to:

A. Placement in Special Housing Unit (SHU)
B. Removed from the institution on a WRIT
C. Unforeseen redesignation

The reason for the incomplete will be documented in PDS/BEMR and does not mean the participant is a program failure.

XV. **Program Expulsion:** Participants may be removed from the Program by the Program Coordinator because of behavior disruptive to the degree that treatment is no longer possible, such as assaulting staff or engaging in behavior that severely compromises the treatment environment.

A. In response to such behavior, treatment staff will:

1. Meet with the participant to discuss his behavior or lack of progress.
2. Assign a clinical intervention, chosen to reduce or eliminate the behavior, or to improve progress.
3. Inform the participant of the consequences of failure to alter his behavior
4. Properly document the meeting and assigned clinical interventions in PDS/BEMR.
5. If clinically necessary, update the participant's treatment plan to include the new treatment intervention(s).
6. When appropriate, require the participant to discuss his targeted behavior in the community.

B. Ordinarily, a minimum of three clinical interventions are employed to reduce or eliminate the treatment/community interfering behavior. If the disruptive behavior(s) or lack of progress continue, the Treatment Team, in collaboration with the Chief Psychologist, will decide if the participant may continue in the Program. If a participant cannot continue in the Program, the Program Coordinator will consult with the Bureau's Psychology Services Branch regarding alternative treatment settings that can meet the needs of the participant. The Program Coordinator will also complete a Treatment Summary and make recommendations for a setting that can address the participant's mental health needs.

C. If a participant disagrees with the decision to remove him from the Program, he has the right to appeal the decision through the Bureau's Administrative Remedy Program.

D. The expulsion from the Program will not result in an automatic reduction of the inmate's mental health care level.

E. An inmate may request Psychology Services at any time in the future, even if he has been expelled or voluntarily withdrew from treatment.

XVI. **Secure STAGES Companions:** A select group of high security inmates will be offered an opportunity to reside in the unit and serve as Mental Health Companions (companions) to the participants, as follows:

A. The primary objective of a companion is to enhance the "Community as Method" concept by providing supportive encouragement to participants and by demonstrating basic life skills in their own lives.

B. Ordinarily, one or two companions will be assigned to work with one participant. The decision on whether to assign a companion to work with a participant will be made on a case-by-case basis by the Treatment Team. The assignment of a companion will be based on the individual clinical need of the participant.

C. While the Program Coordinator is responsible for the selection, training, assignment, and removal of individual companions, the Program Coordinator will consult with the Deputy Chief Psychologist, Unit Team, Special Investigative Services, and institution Executive Staff.

D. The responsibilities of a companion are to:

1. Offer informal guidance and support the participants.
2. Provide basic assistance with Dialectical Behavior, social skills assignments, criminal thinking errors, etc.
3. Demonstrate sound decision-making in their daily lives.
4. Interact with other inmates and staff in a pro-social manner.
5. Serve as a positive role model for participants.

E. The companions will be selected and trained consistent with Program Statement 5310.16, Treatment and Care of Inmates with Mental Illness, by the Program Coordinator. Inmates who demonstrate personal maturity and have made good institutional adjustment will be considered for this role. It is essential that companions have good communication, demonstrate good decision-making skills, and live within the rules of the program and the institution. The companions must demonstrate a positive attitude, be willing to assist program staff, and engage in productive activities in their own lives. The companions are not to demonstrate attitudes typical in the "prison culture" or engage in any behavior that undermines program objectives or participant progress. The role of the companion is supportive and not authoritarian or power oriented. The exploitation of any participant by a companion will not be tolerated.

F. The companions will receive weekly training and supervision from the Treatment Team on their role in the Program. Furthermore, companions may attend community meetings and other programming with their assigned participant to learn the appropriate skills with which to assist their participant as needed.

G. The companions will be housed in the unsecured cell area of the Program Unit.

The companions will primarily be single-celled, but will be expected to cell with their assigned participant when the participant reaches Security Level 4. When on-duty as a companion, he will be expected to primarily attend recreation in the group area of the Program Unit recreation yard and interact with his participant in a manner consistent with the participant's Security Level (i.e., through cell door, treatment enclosures, or in the common area of the housing unit). The companions access institution services in the same manner as General Population inmates.

H. Consistent with Program Statement 5310.16, the Program Coordinator may remove any companion from their role at the Program Coordinator's discretion. The companions will be removed from their role and the Program Unit for failure to comply with Program rules. Companions will be considered for immediate removal when they have committed a prohibited act or violated confidentiality, but may also be removed from the role of a companion when the Program Coordinator determines that their continued placement in the Program Unit is counterproductive to the treatment community. If the companion disagrees with a decision to remove him, he has the right to appeal through the BOP's Administrative Remedy Program.

XVII. **Program SENTRY Codes:** The following Psychology Treatment Program (PTP) SENTRY Codes will be used to document participation in the Program:

CAT	AUTH	ASN	DISP	DESC
PTP	BOP	STA WAIT S	UWS	STAGES SECURE PROG WAITING
PTP	BOP	STA PART S	UPS	STAGES SECURE PROG PARTICIPANT
PTP	BOP	STA COMP S	UCS	STAGES SECURE PROG COMPLETED
PTP	BOP	STA INCP S	UIS	STAGES SECURE PROG INCOMPLETE
PTP	BOP	STA FAILWS	UFS	STAGES SECURE PROG FAIL-WITHDR
PTP	BOP	STA FAILES	UFS	STAGES SECURE PROG FAIL-EXPELL
PTP	BOP	STA CADRES	U1S	STAGES SECURE PROG CADRE
PTP	BOP	STA UNQU S	UUS	STAGES SECURE PROG UNQUALIFIED

XVIII. **Discipline Procedures:** Generally, inmate disciplinary action will be performed in accordance with the Program Statement 5270.09, Inmate Discipline Program, and Program Statement 5310.16, Treatment and Care of Inmates with Mental Illness.

A. Ordinarily, if a participant receives a 100- or 200- series incident report, the following may occur:

1. Participant will be placed in Administrative Detention status.
2. Participant ***may*** be regressed back to a Security Level 1.
3. Property allowance ***may*** be consistent with Administrative Detention property restrictions for Special Housing Unit inmates.
4. Participant's television ***may*** be removed until the DHO adjudicates the incident report or until the television restriction sanction is removed.

5. Participant ***may*** be placed on in-cell treatment if deemed necessary by the Treatment Team.
6. Participant may continue earning incentive points for appropriate behavior, but participation in the incentive award purchasing is at the discretion of the Program Coordinator.

If a participant is sanctioned to Disciplinary Segregation time, the Treatment Team will determine whether the participant's involvement in out-of-cell programming should be modified. The participant ordinarily will ***not*** earn incentive points, participate in incentive award purchasing, or earn programming pay until the sanction is complete. When a participant is serving Disciplinary Segregation time, whether in SHU or in the Program Unit, he will continue to receive mental health care in accordance with his Mental Health Care Level.

XIX. **Program Participant Appeal Rights:** An inmate may appeal any aspect of his confinement or programming in the Program through the Bureau's Administrative Remedy Program as outlined in Title 28, C.F.R. Part 542 and Program Statement 1330.18, Administrative Remedy Program.

XX. **Staff Training:** The Captain and Program Coordinator, or their designees, will provide at least four hours of quarterly training to correctional and non-correctional staff assigned to the Program Unit. Training will be based on a standardized curriculum developed through the Psychology Services Branch.

XXI. **Inmate Monitoring Form:** All participants' activities, meals, and showers will be recorded by the Officer In Charge (OIC) using the "Inmate Monitoring Form," Attachment C, as follows.

A. This form will be recorded every shift, of every day, from Sunday until Saturday. On Sundays, the OIC will print new forms for the upcoming week. The completed form will be forwarded to the Lieutenant, who will copy the Program Coordinator and the Unit Team for filing.

B. The following information will be filled out:

1. Date
2. Shift
3. Meals consumed (Breakfast, Dinner, Supper)
4. Showers (A minimum of 3 times per week)
5. Exercise (All exercise Inside (I) or Outside (O) will be documented, to include the time frames (ex. 9:00 a.m. – 10:00 a.m. (O).)
6. Treatment/Group Time (All Treatment and Group Times will be documented, to include the timeframes.)
7. Other hours out of cell time (ELL, Education, etc.)
8. Total hours out of cell time (This will consist of the total hours the STAGES participants spent out of their cells.)

9. Officer In Charge (OIC) Signature
10. Additional Comments, if applicable.

DISTRIBUTION:

FLX Supplements Directory
Sallyport

SECURE STAGES MONTHLY STATUS REPORT

DATE:

Current Participants:	Current Mentors:
Accepted (waiting for interview):	Unassigned Mentors:
Interviewed (waiting for transfer):	
Failed:	
Completed:	

CURRENT PARTICIPANTS and COMPANIONS

Participant/ Reg. No. (Companion)	Entered STAGES/PRD	Comments

STAGES COMPLETE UPDATES

Inmate Name/Reg. No.	Completion Date/Location	Comments

UNASSIGNED MENTORS

Mentor Name/Reg. No.	Last Day as Active Mentor	Comments

INMATES RECENTLY REMOVED FROM THE PROGRAM

Inmate Name/Reg. No.	Removal Date/Reason	Comments

INMATES APPROVED FOR SECURE STAGES PROGRAM

Inmate Name/Reg. No.	Status/Location	Comments

PRE-STAGES INMATES PENDING INTERVIEW

Inmate Name/Reg. No.	Status/Location	Comments

INMATES INTERVIEWED AND NOT ACCEPTED

Inmate Name/Reg. No.	Status/Location	Comments

FINAL CLIENT REVIEW DRAFT - 8/3/2016

SECURE STAGES SECURITY LEVEL EVALUATION FORM

Inmate Name _____ Register Number _____

Current Security Level: 1 2 3 4 New Admission

Factors considered:

Conduct at Previous Institution and Current Institution	
Reason Designated to Prior Institution	
Criminal History	
Involvement With Crime Organizations and Current Safety/Security Threat	
Overall Adjustment During History of Confinement	
Institutions Safety/Security Needs	
Safety/Security Needs of Inmates	
Safety/Security Needs of Other Inmates	
Safety and Security of the Public	
Progress Toward Treatment Goals	
Demonstration of Skills Learned in STAGES Program	
Responsiveness to Treatment	
Other Relevant Factors	
Security Level Decision	Level 1 2 3 4

STAGES Coordinator_____ Date _____

Captain _____ Date _____

Warden _____ Date _____

FCC FLORENCE
USP Florence, Colorado

Inmate Monitoring Form
SECURE STAGES

INMATE NAME: REG. NO.:

TEAM/CASEWORKER: UNIT: CELL:

DATE REC'D: TIME REC'D:

DATE REL: TIME REL:

DATE	SHIFT	MEALS B	MEALS D	MEALS S	SHOWER	EXERCISE IN/OUT	TREATMENT-GROUP TIME	OTHER HOURS OUT OF CELL	"TOTAL" HOURS OUT OF CELL	OIC SIGNATURE
SUNDAY mm-dd-2014	MORNING									
	DAY									
	EVENING									
MONDAY mm-dd-2014	MORNING									
	DAY									
	EVENING									
TUESDAY mm-dd-2014	MORNING									
	DAY									
	EVENING									
WEDNESDAY mm-dd-2014	MORNING									
	DAY									
	EVENING									
THURSDAY mm-dd-2014	MORNING									
	DAY									
	EVENING									
FRIDAY mm-dd-2014	MORNING									
	DAY									
	EVENING									
SATURDAY mm-dd-2014	MORNING									
	DAY									
	EVENING									

EXPLANATORY NOTES:

Meals - Yes (Y); No (N); Refused (R)
Ex: Exercise: Enter actual time period and inside or outside (i.e., 9:30/10:00 IN) (2:00/2:30 OUT)
Treatment/Group Time: Enter actual time period in Group/Treatment (i.e., 8:00 to 11:00 GROUP)
Other hours out of cell (ELL, Education, etc.)
Document comments: i.e., Conduct, attitude, etc. Additional comments on reverse side must include date, signature, and title.
OIC Signature: OIC must sign all record sheets each shift. (OIC - Unit Officer)

FCC FLORENCE
USP Florence, Colorado

Inmate Monitoring Form
SECURE STAGES

INMATE NAME: REG. NO.:

TEAM/CASEWORKER: UNIT: CELL:

DATE REC'D: TIME REC'D:

DATE REL: TIME REL:

ADDITIONAL COMMENTS	DATE	SIGNATURE	TITLE

U.S. Department of Justice
Federal Bureau of Prisons

Federal Correctional Complex
☐ *Administrative Maximum Security Institution*
☑ *High Security Institution*
☐ *Medium Security Institution*
☐ *Minimum Security Institution*

Florence, CO 81226

Date

MEMORANDUM FOR: WARDEN

THRU: Associate Warden (Programs)

FROM: Secure STAGES Coordinator

SUBJECT: **Change in Secure STAGES Program Status**

Inmate **NAME**, Reg. No. **12345-678** arrived at USP Florence on **Month Day, Year**, for the purpose of voluntarily participating in the Secure STAGES Program. He had previously signed the BP-A0940 Agreement to Participate in Psychology Treatment Programs form on **Month Day, Year**. He also signed the Secure STAGES Participant Handbook on **Month Day Year,** acknowledging he understood his responsibilities as a program participant and committing to abide by the rules and procedures of the Secure STAGES Program as set forth in the Handbook.

On **Month Day, Year,** inmate **NAME**'s program status was changed to:

____ WITHDRAW

Reason:

_____ Inmate submitted a written request to withdraw from the Secure STAGES Program and, despite at least three clinical interventions by the mental health treatment team, refused to engage in treatment and continued to want to withdraw from the program.

_____ Other:

____ UNQUALIFIED

Reason:

_____ Inmate does not meet criteria for the program. Specify:

____ EXPELLED

Reason:

_____ Inmate has committed an egregious institutional rule violation. Specify:

_____ The inmate's presence is not conducive to the treatment community and/or repeatedly disrupts programming for other program participants. He has received at least three interventions from the mental health treatment team members to curb this type of behavior to no avail.

I have discussed this with the inmate and have made appropriate SENTRY changes. The inmate has been notified that if he has withdrawn or been expelled, he may apply for readmission and be reviewed for readmission, based on clinical rationale. He may be placed on a wait list based on his clinical needs and availability to bed space in the Program.

_____	_____
Inmate Name (Printed)/Signature	STAGES Staff Member Name (Printed)/Signature
_____	_____
Inmate Register Number	STAGES Staff Member Title
_____	_____
Date	Date

☐ Check here if inmate refuses to sign.

For Staff Member Attempting to Have Inmate Sign:	*For Staff Witness:*
_____	_____
STAGES Staff Member (Print/Sign)	Staff Member Witness (Print/Sign)
_____	_____
STAGES Staff Member Title	Staff Member Title
_____	_____
Date	Date

EXHIBIT 5

U.S. Department of Justice
Federal Bureau of Prisons

Program Statement

OPI: CPD/PSB
NUMBER: P5324.08
DATE: 4/5/2007
SUBJECT: Suicide Prevention Program

RULES EFFECTIVE: 3/15/2007

1. **PURPOSE AND SCOPE.** The Bureau of Prisons (Bureau) operates a suicide prevention program to assist staff in identifying and managing potentially suicidal inmates. Each Warden will ensure that a suicide prevention program is implemented consistent with this policy. In addition, Wardens will facilitate a discussion regarding the issue of suicide at department head meetings, staff recalls, lieutenants' meetings, etc., to heighten staff awareness about the need to detect and report any changes in inmate behavior that might suggest suicidal intent.

2. **SUMMARY OF CHANGES.** This re-issuance adds the following new procedures for preventing inmate suicides:

a. Suicide prevention training will include three mock suicide emergencies per year, one on each shift. One of these exercises must be conducted in the Special Housing Unit (SHU) during the morning or evening watch.

b. Specific minimum criteria that must be included in a Suicide Risk Assessment and a Post-Watch Report are delineated.

c. Designation of a room for suicide watch outside of the Health Services area requires written approval of the Regional Director.

d. Specific criteria that exclude an inmate from consideration for an inmate companion position are delineated.

e. Correctional Services will notify Psychology Services when an inmate requests protective custody (PC). Psychology Services will no longer be required to monitor SENTRY for entry of a PC code.

3. **PROGRAM OBJECTIVES.** The expected results of this program are:

a. All institution staff will be trained to recognize signs and information that may indicate a potential suicide.

b. Staff will act to prevent suicides with appropriate sensitivity, supervision, and referrals.

c. Any inmate clinically found to be suicidal will receive appropriate preventive supervision, counseling, and other treatment.

4. **DIRECTIVES AFFECTED**

a. **Directive Rescinded**

P5324.05 Suicide Prevention Program (3/1/04)

b. **Directives Referenced**

P5270.07 Inmate Discipline and Special Housing Units (12/29/87)
P5290.14 Admission and Orientation Program (4/3/03)
P5310.12 Psychology Services Manual (8/13/93)
P5566.06 Use of Force and Application of Restraints (11/30/05)
P6031.01 Patient Care (1/15/05)
P6340.04 Psychiatric Services (1/15/05)

c. Rules cited in this Program Statement are contained in 28 CFR 552.40 through 552.41.

5. **STANDARDS REFERENCED**

a. American Correctional Association Standards for Adult Correctional Institutions, 4th Edition: 4-4084,4-4084-1,4-4370M,4-4371M,and 4-4373M.

b. American Correctional Association Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-7B-08,4-ALDF-7B-10,4-ALDF-7B-10-1,4-ALDF-4C-29M,4-ALDF-4C-30M,and 4-ALDF-4C-32M.

6. **INSTITUTION SUPPLEMENT.** See Section 7a.

7. **POLICY.** Each Bureau institution, other than Medical Referral Centers (MRCs), will implement a suicide prevention program that conforms to the procedures outlined in this policy. Each Bureau medical center is to develop specific written procedures consistent with the specialized nature of the institution and the intent of this policy.

a. **Medical Referral Centers.** MRCs serve a unique evaluation/treatment function addressing the needs of a wide range of inmates, while meeting community standards of care. Psychology Services is responsible for developing an Institution Supplement that describes local procedures for managing the

Suicide Prevention Program's components.

MRC psychologists are to document significant treatment information in the Psychological Data System (PDS) so that the information is readily available for post-discharge treatment.

b. **Residential Reentry Center Contract Facilities.** When contracts for outside facilities (including Residential Reentry Centers (RRCs)) are used, the Statement of Work will include a suicide prevention plan or program that meets accepted Bureau standards.

Community Corrections Managers (CCMs) will monitor contract facilities regularly to determine their capability to manage at-risk populations effectively. The CCM will consult the Regional Psychology Services Administrator if questions arise about the adequacy of a contract facility's Suicide Prevention Program or about the need to transfer a suicidal inmate to a different facility. The CCM will contact Central Office Psychology Services when there is system-wide or interagency issues.

In the event of a suicide, all possible evidence and documentation will be preserved to provide data and support for subsequent investigators doing a psychological reconstruction. Ordinarily, the Regional Director will authorize an after-action review of a suicide at a RRC, to be conducted by the Regional Psychology Administrator. The findings will be documented as a Psychological Reconstruction Report as outlined in Attachment A.

c. **Privately-Managed Contract Prisons.** Private security contract facilities maintain a suicide prevention and intervention program in compliance with American Correctional Association (ACA) standards. Ordinarily, the Assistant Director, Correctional Programs Division, will authorize an after-action review of a suicide at a contract private prison, to be conducted under the direction of the Central Office Psychology Services Administrator. The findings will be documented as a Psychological Reconstruction Report as outlined in Attachment A.

8. **PROGRAM ADMINISTRATION.**

a. **Program Coordinator.** Each institution must have a Program Coordinator for the institution's suicide prevention program. The Program Coordinator shall be responsible for managing the treatment of suicidal inmates and for ensuring that the institution's suicide prevention program conforms to the guidelines for training, identification, referral, assessment, and intervention outlined in this policy.

Ordinarily, the Chief Psychologist will be the Program Coordinator. The Program Coordinator's responsibilities will not be delegated to staff other than a doctoral-level psychologist.

The Program Coordinator, in conjunction with institution executive staff, must ensure that adequate coverage is available when he or she is absent from the institution for training, annual leave, etc.

b. **Training.** While the initial period of incarceration is often a critical time for detecting potential suicides, serious suicidal crises may arise at any time. Line staff are often the first to identify signs of potential suicidal behavior based on their frequent interactions with inmates.

The Program Coordinator is responsible for ensuring that appropriate training is available to staff. The Program Coordinator will ensure that all staff will be trained (ordinarily by psychology services personnel) to recognize signs indicative of a potential suicide, the appropriate referral process, and suicide prevention techniques.

Wardens will include discussions of suicide prevention at department head meetings, staff recalls, etc., to remind staff of the need to observe inmates constantly for signs of suicidal behavior.

1) **Training for All Staff.** Suicide prevention training will be included in the Introduction to Correctional Techniques curriculum. Training in local suicide prevention procedures will be provided during Institution Familiarization Training and Annual Training (AT) at all institutions.

Training for staff will focus on:

- identifying suicide risk factors;
- typical inmate profiles of completed suicides;
- recognition of potentially suicidal behavior;
- appropriate information associated with identifying and referring suicidal inmates;
- responding to a suicide emergency (e.g., a suicide in progress), including location and proper use of suicide cut-down tool; and
- name of Program Coordinator, location of suicide watch room, etc.

2) **Supplemental Speciality Training.** The Program Coordinator will offer supplemental training to staff having frequent inmate contacts. Ordinarily, supplemental specialty training for health services staff (i.e., Physician's Assistants, Nurse Practitioners, Emergency Medical Technicians, Registered

Nurses), lieutenants, and correctional counselors is offered approximately six months after the conclusion of institution AT. It is encouraged that this training be provided during regularly scheduled meetings when possible.

3) **Supplemental Training for Special Housing Unit (SHU) Staff.** Information about recognizing potentially suicidal inmates and procedures to follow will be included in the SHU post orders. Attachment B is an example of post orders for suicide prevention in a SHU.

4) **Emergency Response Training.** At a minimum, the Captain and Chief Psychologist will jointly conduct three mock suicide emergencies yearly, one on each shift, approximately four months apart. Complexes will complete the exercises separately at each institution within the complex.

- Within the calendar year, at least one of these exercises will be conducted in the SHU during the evening or morning watch. (Institutions that do not have a SHU [e.g., Camps] are exempted from this requirement, but are still required to conduct three mock suicide emergencies yearly).
- Confirmation of mock suicide emergency training will occur in writing to the Associate Warden over Psychology Services with a copy to the Suicide Prevention Program Coordinator for placement in a training documentation file. See sample memorandum format in Attachment C.
- This training is in addition to the supplemental speciality training for lieutenants, health services staff, and correctional counselors.

9. **IDENTIFICATION OF AT-RISK INMATES.**

a. **Medical Staff Screening.** Medical staff are to screen a newly admitted inmate for signs that the inmate is at risk for suicide. Ordinarily, this screening is to take place within twenty-four hours of the inmate's admission to the institution.

- The Physician's Assistant/Nurse Practitioner (PA/NP) will refer suicidal or emotionally disturbed inmates on an emergency basis to the Program Coordinator or designee.

b. **Psychological Intake.**

1) **Pre-Trial Detainees, Pre-Sentence Detainees, and Holdovers in MCCs, MDCs, FDCs, FTCs, or Jails.** Because of the high rate of admissions and short length of stay in MCCs, MDCs,

FDCs, FTCs and Detention units, the comprehensive psychological intake conducted by Psychology Services ordinarily will be performed only on inmates who are suspected of being suicidal or appear psychologically unstable (e.g., mental illness or significant substance abuse withdrawal), or who request services via the Psychology Services Inmate Questionnaire.

2) **Newly Assigned or Writ-Return Inmates.** For newly assigned designated inmates or writ-return inmates, a psychologist will conduct a comprehensive psychological intake within 14 days of the inmate's admission to the institution.

3) **Transferred Inmates.** For transferred inmates, a psychologist will conduct a comprehensive psychological intake within 30 days of the inmate's admission to the institution if the psychologist determines it is clinically warranted based upon the PSIQ and other available inmate records.

c. **Inmates in SHUs.** Inmates in Administrative Detention or Disciplinary Segregation status often may be at higher risk for suicidal behavior. Inmates being transferred into the SHU will be monitored for signs of potential suicide risk (e.g., crying, emotionally distraught, threats of self-harm, or engaging in misconduct to purposefully effect removal from the general population). Inmates exhibiting such behavior will be referred to the Shift Lieutenant.

1) **Protective Custody (PC) Inmates.** Inmates requesting protective custody or demanding to be housed alone may actually be contemplating suicide. When an inmate requests protective custody or demands to be celled alone, Correctional Services staff will immediately:

- notify the Program Coordinator or designee in Psychology Services during normal business hours, or
- during non-routine working hours notify the on-call psychologist.

The PC inmate should be screened for suicidal ideation **within 72 hours** of being placed into SHU. When clinically indicated by this screening, a formal Suicide Risk Assessment will be conducted.

The Program Coordinator will work closely with custody staff to monitor each PC inmate’s mental status for behavior (e.g., hopelessness, anxiety, increasing agitation, depression, psychoses) that suggests a need for an increased level of services.

2) **Inmates Requiring Special Precautions.** The Program Coordinator will provide SHU staff with a list (“hot list”) of

inmates with mental health conditions who may become dangerous, self-destructive, or suicidal when placed into the SHU.

- This list will be updated as needed and distributed to Correctional Services, Health Services, and Unit Team staff. This list will be made available to all staff.

- When an inmate on this "hot list" is placed into the SHU, a Correctional Services Supervisor will notify Psychology Services immediately.

3) **SHU Custodial Issues.**

A) **Program Coordinator Involvement.** At a minimum, the Program Coordinator or designee will make weekly rounds of SHUs and consult with staff in those areas concerning any inmates needing special attention.

B) **Review of Lieutenant's Log.** The Program Coordinator will review the Lieutenant's log each working day to determine if an inmate with mental health problems has been placed in the SHU. A psychologist will see the inmate as soon as possible to assess the inmate's mental status and alert SHU staff.

C) **Health Services.** Health Services policy contains procedures to ensure inmates placed in SHU continue to received needed medications.

- Psychology Services will be notified whenever an inmate refuses or misses his/her medication. If the inmate has the potential to become violent, self-destructive, or suicidal without the medication, psychologists will notify SHU staff of this.

D) **Suicide Rescue Tool.** Every SHU will be equipped with a suicide rescue tool(s) that is sharp, stored in a secure location, and readily available. All SHU staff will be trained to use the tool and in the procedures for responding to a suicide emergency.

E) **Inmate Removal from the SHU.** The Program Coordinator will arrange to have an inmate exhibiting significant potential for suicide removed from the SHU and placed on suicide watch. Ordinarily, once the crisis is over, the inmate will be returned to the SHU to satisfy any sanction that was imposed.

d. **Staff Referral. Any staff** may identify an inmate as potentially suicidal **at any time** based upon the inmate's observed behavior.

STAFF MUST NEVER TAKE LIGHTLY ANY INMATE SUICIDE THREATS OR ATTEMPTS OR ANY INFORMATION OR HINTS FROM OTHER INMATES ABOUT AN INMATE BEING POTENTIALLY SUICIDAL.

Any staff member who has reason to believe an inmate may be suicidal should:

- ordinarily maintain the inmate under direct, continuous observation,
- contact the Shift Lieutenant for assistance, and
- during regular working hours, contact the Program Coordinator or designee (i.e., any other available psychologist).
- During non-routine working hours, the Shift Lieutenant will contact the on-call psychologist and continue direct, continuous observation, or immediately place the inmate on suicide watch.

In emergency situations, the Shift Lieutenant will immediately place the inmate on suicide watch. It should be noted that in emergency situations **any staff** member may place an inmate on suicide watch. Special procedures may apply to MRCs where the initiation of suicide watch may be limited to specific clinical staff.

e. **Inmate Referral.** In addition to staff, inmates can play a vital role in helping to prevent inmate suicides. To facilitate this process each institution will encourage inmate referrals by:

- including a statement in the institution inmate handbook/orientation materials encouraging inmates to notify staff of any behavior or situation that may suggest an inmate is upset and potentially suicidal,
- incorporating the topic of inmate referrals into the Admissions and Orientation lesson plan for Psychology Services,
- placing posters in each housing unit addressing the topic, and
- ensuring that the information is made available to inmates in multiple languages as appropriate, particularly Spanish.

10. **SUICIDE RISK ASSESSMENT OF IDENTIFIED INMATES.** During regular working hours inmates referred for assessment of suicide potential will be seen on a priority basis. During non-regular hours, the Program Coordinator or designee should consult with institution staff and may choose to see the inmate immediately or have the inmate placed on suicide watch. In either case, the inmate will receive an individual assessment within 24 hours of referral.

A Suicide Risk Assessment will be completed when:

- staff refer an inmate to Psychology Services because the inmate may be at risk for suicide (e.g., the inmate refuses his or her property, talks about ending his or her life),
- an inmate's written or verbal behavior is suggestive of suicide,
- an inmate exhibits behavior suggestive of self-harm, or
- any other condition is present that would lead the clinician to believe an assessment is warranted.

Ordinarily, the Suicide Risk Assessment will be completed in PDS within 24 hours of the incidents outlined above. At a minimum, the Suicide Risk Assessment will include:

- reason for / source of referral,
- risk factors assessed,
- risk assessment findings,
- diagnosis, and
- follow-up recommendations.

When a staff member has made a referral based on observed behavior, the psychologist who interviews the inmate will also make every effort to interview the staff member who observed the behavior. The staff member's comments will be included in the report/clinical notes.

11. **INTERVENTION.** Upon completion of the suicide risk assessment, the Program Coordinator or designee will determine the appropriate intervention that best meets the needs of the inmate. Because deliberate self-injurious behavior does not necessarily reflect suicidal intent, a variety of interventions other than placing an inmate on suicide watch may be deemed appropriate by the Program Coordinator, such as heightened staff or inmate interaction, a room/cell change, greater observation,

placement in restraints, or referral for psychotropic medication. In any case, the Program Coordinator or designee will assume responsibility for the recommended intervention and clearly document the rationale.

a. **Non-suicidal Inmates.** If the Program Coordinator determines that the inmate does not appear imminently suicidal, he/she shall document in writing the basis for this conclusion and any treatment recommendations made. This documentation will be placed in the inmate's medical, psychology, and central file.

b. **Suicidal Inmates.** If the Program Coordinator determines the individual to have an imminent potential for suicide, the inmate will be placed on suicide watch in the institution's designated suicide prevention room. The actions and findings of the Program Coordinator will be documented, with copies going to the central file, medical record, psychology file, and the Warden.

12. SUICIDE WATCH.

a. **Housing.** Each institution must have one or more rooms designated specifically for housing an inmate on suicide watch. The designated room must allow staff to maintain adequate control of the inmate without compromising the ability to observe and protect the inmate.

- The primary concern in designating a room for suicide watch must be the ability to observe, protect, and maintain adequate control of the inmate.
- The room must permit easy access, privacy, and unobstructed vision of the inmate at all times.
- The suicide prevention room may not have fixtures or architectural features that would easily allow self-injury.

Inmates on watch will be placed in the institution's designated suicide prevention room, a non-administrative detention/segregation cell ordinarily located in the health services area. Despite the cell's location, the inmate will not be admitted as an in-patient unless there are medical indications that would necessitate immediate hospitalization.

Placement of a suicide watch room in a different area may be warranted given the unique features of some institutions.

- However, designating a room for suicide watch outside of the Health Services area requires written approval of the Regional Director. Such rooms must meet all of the requirements identified above.

- Administrative detention and disciplinary segregation cells will not be designated or approved as suicide watch cells.

- Under emergency conditions a suicidal inmate may be placed temporarily on suicide watch in a cell other than the institution's designated watch room. The inmate must be moved to a designated suicide watch room as soon as one becomes available.

b. **Conditions of Confinement.** While on suicide watch, the inmate's conditions of confinement will be the least restrictive available to ensure control and safety.
The inmate on watch will ordinarily be seen by the Program Coordinator on at least a daily basis. Unit staff will have frequent contact with the inmate while he/she is on watch. Ordinarily, the Program Coordinator or designee will interview or monitor each inmate on suicide watch at least daily and record clinical notes following each visit.

The Program Coordinator or designee will specify the type of personal property, bedding, clothing, magazines, that may be allowed.

- If approved by the Warden, restraints may be applied if necessary to obtain greater control, but their use must be clearly documented and supported.

- Any deviations from prescribed suicide watch conditions may be made only with the Program Coordinator's concurrence.

- The Program Coordinator will develop local procedures to ensure timely notification to the inmate's Unit Manager when a suicide watch is initiated and terminated. Correctional Services staff, in consultation with the Program Coordinator or designee, will be responsible for the inmate's daily custodial care, cell, and routine activities.

- Unit Management staff in consultation with the Program Coordinator will continue to be responsive to routine needs while the inmate is on suicide watch.

c. **Observation.** For **all** suicide watches:

- Any visual observation techniques used to monitor the suicide companion program will focus on the inmate companion and/or the inmate on suicide watch only.

- The observer and the suicidal inmate will not be in the same room/cell and will have a locked door between them.
- The person performing the suicide watch must have a means to summon help immediately (e.g., phone, radio)

if the inmate displays any suicidal or unusual behavior.

- The Program Coordinator will establish procedures for documenting observations of the inmate's behavior in a Suicide Watch log book, which will be maintained as a secure document. Staff and inmate observers will document in separate log books. Post Orders will provide direction to staff on requirements for documentation.

1) **Staff Observers.** The suicide watch may be conducted using staff observers. Staff assigned to a suicide watch must have received training (Introduction to Correctional Techniques or in AT) and must review and sign the Post Orders before starting the watch. The Program Coordinator will review the Post Orders annually to ensure their accuracy.

2) **Inmate Observers.** Only the Warden may authorize the use of inmate observers (inmate companion program). The authorization for the use of inmate companions is to be made by the Warden on a case-by-case basis. If the Warden authorizes a companion program, the Program Coordinator will be responsible for the selection, training, assignment, and removal of individual companions. Inmates selected as companions are considered to be on an institution work assignment when they are on their scheduled shift and shall receive performance pay for time spent monitoring a potentially suicidal inmate.

d. **Watch Termination and Post-Watch Report.** Based upon clinical findings, the Program Coordinator or designee will:

1) Remove the inmate from suicide watch when the inmate is no longer at imminent risk for suicide, or

2) Arrange for the inmate's transfer to a medical referral center or contract health care facility.

Once an inmate has been placed on watch, the watch may not be terminated, **under any circumstance**, without the Program Coordinator or designee performing a face-to-face evaluation. Only the Program Coordinator will have the authority to remove an inmate from suicide watch. Generally, the post-watch report should be completed in PDS prior to terminating the watch, or as soon as possible following watch termination, to ensure appropriate continuity of care. Copies of the report will be forwarded to the central file, medical record, psychology file, and the Warden. There should be a clear description of the resolution of the crisis and guidelines for follow-up care.

At a minimum, the post-watch report will include:

- risk factors assessed,
- changes in risk factors since the onset of watch,
- reasons for removal from watch, and
- follow-up recommendations.

13. **INMATE OBSERVERS - INMATE COMPANION PROGRAM.**

a. **Selection of Inmate Observers.** Because of the very sensitive nature of such assignments, the selection of inmate observers requires considerable care. To provide round-the-clock observation of potentially suicidal inmates, a sufficient number of observers should be trained, and alternate candidates should be available.
Observers will be selected based upon their ability to perform the specific task but also for their reputation within the institution. In the Program Coordinator's judgement, they must be mature, reliable individuals who have credibility with both staff and inmates. They must be able, in the Program Coordinator's judgement, to protect the suicidal inmate's privacy from other inmates, while being accepted in the role by staff. Finally, in the Program Coordinator's judgement, they must be able to perform their duties with minimal need for direct supervision.

In addition, any inmate who is selected as a companion **must not:**

- Be in pre-trial status or a contractual boarder;
- Have been found to have committed a 100-level prohibited act within the last three years; or
- Be in FRP, GED, or Drug Ed Refuse status.

b. **Inmate Observer Shifts.** Observers ordinarily will work a four-hour shift. Except under unusual circumstances, observers will not work longer than one five-hour shift in any 24-hour period. Inmate observers will receive performance pay for time on watch.

c. **Training Inmate Observers.** Each observer will receive at least four hours of initial training before being assigned to a suicide watch observer shift. Each observer will also receive at least four hours of training semiannually. Each training session will review policy requirements and instruct the inmates on their duties and responsibilities during a suicide watch, including:

- the location of suicide watch areas;
- summoning staff during all shifts;

- recognizing behavioral signs of stress or agitation; and
- recording observations in the suicide watch log.

d. **Meetings with Program Coordinator.** Observers will meet at least quarterly with the Program Coordinator or designee to review procedures, discuss issues, and supplement training. After inmates have served as observers, the Program Coordinator or designee will debrief them, individually or in groups, to discuss their experiences and make program changes, if necessary.

e. **Records.** The Program Coordinator will maintain a file containing:

- An agreement of understanding and expectations signed by each inmate observer;
- Documentation of attendance and topics discussed at training meetings;
- Lists of inmates available to serve as observers, which will be available to Correctional Services personnel during non-regular working hours; and
- Verification of pay for those who have performed watches.

f. **Supervision of Inmate Observer During a Suicide Watch.** Although observers will be selected on the basis of their emotional stability, maturity, and responsibility, they still require some level of staff supervision while performing a suicide watch.

- This supervision will be provided by staff who are in the immediate area of the suicide watch room or who have continuous video observation of the inmate observer.
- In all cases, when an inmate observer alerts staff to an emergency situation, staff must immediately respond to the suicide watch room and take necessary action to prevent the inmate on watch from incurring debilitating injury or death. In no case will an inmate observer be assigned to a watch without adequate provisions for staff supervision or without the ability to obtain immediate staff assistance.

  THE DECISION TO USE INMATE OBSERVERS MUST BE PREDICATED ON THE FACT THAT IT TAKES ONLY THREE TO FOUR MINUTES FOR MANY SUICIDE DEATHS TO OCCUR.

- Supervision must consist of at least 60-minute checks conducted in-person. Staff will initial the chronological log upon conducting checks.

g. **Removal.** The Program Coordinator or designee may remove any observer from the program at his/her discretion. Removal of an inmate observer should be documented in the records kept by the Program Coordinator.

14. **TRANSFER OF INMATES TO OTHER INSTITUTIONS.** The Program Coordinator will be responsible for making emergency referrals of suicidal inmates to the appropriate medical center. No inmate who is determined to be imminently suicidal will be transferred to another institution, except to a medical center on an emergency basis.

a. **Medical Center Referral.** Inmates who do not respond to treatment interventions and remain imminently suicidal require emergency hospitalization. Although a psychiatric referral may be indicated at any time, ordinarily the inmate shall be referred to a MRC after he or she has been on continuous watch for 72 hours. If the watch exceeds 72 continuous hours, the Program Coordinator must:

- Contact the Regional Psychology Administrator to discuss the case and determine if an emergency transfer is appropriate.

- If the decision is not to transfer the inmate to a MRC, the rationale for **not** initiating a request for emergency transfer must be documented in the PDS.

b. **Psychology Services at MRCs.** Psychology Services at each MRC will provide an appropriate intervention program for inmates who have been admitted for suicidal behavior. The program will include:

- assessment,
- therapeutic interventions, and
- discharge planning.

The discharge planning may include a request to designate an institution for the inmate that can provide the custody and level of psychological service needed to prevent re-hospitalization.

c. **Consultations.** As part of the referral consideration process, it may be beneficial to consult with other mental health resources, MRC staff, or the Regional Psychology Services Administrator.

- To ensure maximum communication and tracking of suicidal inmates, the Program Coordinator will notify

his or her Regional Psychology Administrator when a suicide watch is begun or terminated and when a suicide watch exceeds 72 hours.

- The Program Coordinator or designee will document the referral considerations and all actions taken in the inmate's PDS record.

d. **SENTRY "Psych Alert" Assignments.** It is critically important that other institutions are notified when they are to receive inmates with recent suicidal indications and are at risk for self-harm.

- The Program Coordinator must ensure that a suicidal inmate being transferred to a MRC is given the SENTRY "Psych Alert" assignment to signal all staff that serious psychological management problems and "continuity of care" issues are present.

15. **ANALYSIS OF SUICIDES.** If an inmate suicide does occur, the Program Coordinator will immediately notify the Regional Administrator, Psychology Services.

The suicide scene will be treated in a manner consistent with an inmate death investigation. All measures necessary to preserve and document the evidence needed to support subsequent investigations will be maintained or otherwise recorded adequately.

- In the event of a suicide, institution staff, particularly Correctional Services staff, and other law enforcement personnel, will handle the site with the same level of protection as any crime scene in which a death has occurred.

- All possible evidence and documentation will be preserved to provide data and support for subsequent investigators doing a psychological reconstruction.

Ordinarily, the Regional Director will authorize an after-action review of the suicide to be completed by a psychologist from another institution or administrative office. Psychologists who have previously been involved in treatment of the inmate or in peer consultation in the case shall not participate in the suicide reconstruction. The report will address all the areas listed in the "Guide for the Psychological Reconstruction of an Inmate Suicide" (Attachment A).

The Regional Psychology Administrator will also review the Mortality Review Report prepared by Health Services for additional information and to explain any discrepancies with the Psychological Reconstruction Report.

a. **Central Office Review.** The Regional Director will forward copies of the Psychological Reconstruction Report to:

- the Assistant Director, Correctional Programs Division;
- the Assistant Director, Health Services Division; and
- the Senior Deputy Assistant Director, Program Review Division.

b. **Special Review Committee.** The PRD Senior Deputy Assistant Director will submit the report to the Special Review Committee. The Special Review Committee will review the report and assess whether recommendations for corrective action will be addressed at the national or local institution level.

- The PRD Senior Deputy Assistant Director will be responsible for tracking corrective actions and verifying the corrective action is accomplished.

16. **CODE OF FEDERAL REGULATIONS.** Federal Regulations appear in bracketed bold text, as reproduced from volume 28 of the Code of Federal Regulations, Chapter 5. The federal regulations that bind Bureau staff to specific program practices are primarily intended to describe Bureau programs and inmate rights, privileges, or responsibilities to inmates and members of the public.

[§ 552.40 Purpose and scope.

The Bureau of Prisons (Bureau) operates a suicide prevention program to assist staff in identifying and managing potentially suicidal inmates. When staff identify an inmate as being at risk for suicide, staff will place the inmate on suicide watch. Based upon clinical findings, staff will either terminate the suicide watch when the inmate is no longer at imminent risk for suicide or arrange for the inmate's transfer to a medical referral center or contract health care facility.

§ 552.41 Program procedures.

(a) Program Coordinator. Each institution must have a Program Coordinator for the institution's suicide prevention program.

(b) Training. The Program Coordinator is responsible for ensuring that appropriate training is available to staff and to inmates selected as inmate observers.

(c) Identification of at risk inmates.

(1) Medical staff are to screen a newly admitted inmate for signs that the inmate is at risk for suicide. Ordinarily, this screening is to take place within twenty-four hours of the inmate's admission to the institution.

(2) Staff (whether medical or non-medical) may make an identification at any time based upon the inmate's observed behavior.

(d) Referral. Staff who identify an inmate to be at risk for suicide will have the inmate placed on suicide watch.

(e) Assessment. A psychologist will clinically assess each inmate placed on suicide watch.

(f) Intervention. Upon completion of the clinical assessment, the Program Coordinator or designee will determine the appropriate intervention that best meets the needs of the inmate.

§ 552.42 Suicide watch conditions.

(a) Housing. Each institution must have one or more rooms designated specifically for housing an inmate on suicide watch. The designated room must allow staff to maintain adequate control of the inmate without compromising the ability to observe and protect the inmate.

(b) Observation.

(1) Staff or trained inmate observers operating in scheduled shifts are responsible for keeping the inmate under constant observation.

(2) Only the Warden may authorize the use of inmate observers.

(3) Inmate observers are considered to be on an institution work assignment when they are on their scheduled shift.

(c) Suicide watch log. Observers are to document significant observed behavior in a log book.

(d) Termination. Based upon clinical findings, the Program Coordinator or designee will:

(1) Remove the inmate from suicide watch when the inmate is no longer at imminent risk for suicide, or

(2) Arrange for the inmate's transfer to a medical referral center or contract health care facility.]

/s/
Harley G. Lappin
Director

GUIDE FOR THE PSYCHOLOGICAL RECONSTRUCTION OF AN INMATE SUICIDE

Name:_____ Prepared by:_____

Reg. No:_____ Date:_____

Date of Birth:_____ Date of Death:_____

I. Background Information

Education
Marital/Family Status
Religious Preference/Involvement
Race/Ethnic Background
Offense
Sentence/Time Served
Occupational/Military History
Release Plans

II. Health Care and Personality Description

Physical Status-Functioning
  Previous/Current
Social Status-Functioning
  Previous/Current
Psychological Status-Functioning
  Previous/Current
Suicidal History
Medication History
Mental Health History
  Diagnosis/Treatment
Abuse History
  Drug/Alcohol
Assaultive History
Institutional Infractions

III. Antecedent Circumstances

Identifiable Stressors
Staff Opinions
Inmate Opinions
Last Person to Have Contact
Last Staff Contact

IV. **Full Description of Suicide Act and Scene (to include diagrams were appropriate)**

Date/Time of incident
Location
Method
Predictors of Suicidal Actions
Suicide Note
Other Relevant Information

V. **Conclusions/Recommendations**

VI. **List of Documents Examined**

VII. **List of Staff and Inmates Interviewed**

"SAMPLE"
SUICIDE PREVENTION INFORMATION
SPECIAL HOUSING UNIT ADDENDUM TO POST ORDERS

BOP HIGH RISK GROUPS

- **New Inmates** - The first few hours and days after admission can be critical. Newly incarcerated inmates may experience feelings such as shame, guilt, fear, sadness, anger, agitation, depression, relationship problems, legal concerns, hopelessness, and helplessness, which can contribute to increased suicide risk.

- **Protective Custody** - Inmates who volunteer to enter protective custody are at high risk for suicide, especially during the first 72 hours in SHU. These inmates should be referred to psychology services immediately.

- **Long-term Protective Custody Inmates** - These inmates are particularly vulnerable to depression that can lead to a suicide attempt, and should be monitored closely while they are in SHU.

- **Inmates Taking Medication for Mental Health Reasons** - These inmates are vulnerable to developing suicidal thoughts and attempting suicide by overdosing on their medication. Inmates on medication should be monitored to make sure they are not hoarding medication. Any signs of distress, deterioration in hygiene, or sudden changes in behavior should be reported to psychology.

FACTORS THAT CAN INCREASE THE PROBABILITY THAT AN INMATE MAY BECOME SUICIDAL:

- **Mental Health Factors**

  History of mental illness
  1. Is the inmate depressed, actively psychotic?
  2. Has the inmate been compliant with psychotropic medication?
  3. Have there been changes in eating, sleeping, hygiene, weight, recreation, activity level?

  Prior suicide attempt
  1. How lethal was the attempt?
  2. How many attempts have been made?

Inmate's current mood, affect, and behavior

1. Is the inmate emotionally upset, angry, easily agitated?
2. Are the inmate's thoughts clear and goal directed (vs. delusional or psychotic in nature)?
3. Is the inmate depressed, has there been a recent loss?
4. Has hopelessness persisted even after the depression has lifted?
5. Has the inmate given away property, revised a will, requested a phone call to say his goodbyes?

- **Medical Condition(s)/Chronic Pain**
  1. Does the inmate have a chronic life threatening medical illness?
  2. Has the inmate's overall health diminished recently?
  3. Is the inmate experiencing pain or other negative symptoms?

- **Relationship Difficulties**
  1. Has the inmate received a Dear John letter?
  2. Have communications and or visits decreased?
  3. Has there been a change in the relationship?

- **Situational Factors**
  1. Legal issues - pending indictment; loss of appeal to reduce sentence.
  2. Difficulties with staff or other inmates.
  3. Gambling debts, drugs.
  4. Ending of a close relationship with another inmate.
  5. Possible victim of a sexual assault.

REPORTING AND DOCUMENTING INMATE BEHAVIOR

- **Report Your Concerns** - Any inmate behavior(s) that is questionable and may reflect a change in mental health status should be reported to the Shift Lieutenant immediately.

- **During non-working hours** - Inform the Shift Lieutenant of any questionable inmate behavior. He/she will determine if the on-call psychologist needs to be contacted.

- **Segregation Log Book** - Any changes in inmate behaviors should be noted in the log book. A detailed note regarding the observed behavior is advisable. Documenting in the log book serves two purposes. First, the entry serves as a means of communication for other staff members. Second, it provides an accurate account of activity during your shift. Documentation should be neat, legible, and professional.

RESPONDING TO A SUICIDE EMERGENCY

- A Segregation Officer observing an inmate in the act of committing suicide, causing other self-injurious behavior, or who appears to have committed suicide will call for back-up before entering the cell. The officer will notify the Control Center and the Lieutenant's Office by radio of the situation and request immediate back-up. BACK-UP MUST BE PRESENT IN ORDER TO ENTER A CELL.

- The "cut-down" tool is located in the storage closet on a shadow board. It is the #1 officer's responsibility to locate this item at the start of the shift. This tool is only authorized to be used in emergency situations. Miscellaneous use of this tool is not permitted and will result in dulling the blade of the tool.

- In the event an inmate commits suicide, the scene of the suicide will be treated in a manner consistent with the investigation of an inmate death. All measures necessary to preserve and document the evidence needed to support subsequent investigations will be maintained or otherwise adequately recorded.

"SAMPLE"
MEMORANDUM DOCUMENTING MOCK SUICIDE EMERGENCY TRAINING

DATE: 4/5/2007

TO: Name, Associate Warden

FROM: Name, Operations Lieutenant

Subject: Mock Suicide Emergency Training

This memorandum documents a mock suicide emergency training exercise. This training exercise occurred in the Special Housing Unit on Morning Watch on today's date at 5:30 a.m.

Staff present were:
Name, Psychologist
Name, Operations Lieutenant
Name, Correctional Officer
Name, Correctional Officer
Name, Correctional Officer

The mock suicide emergency involved a hanging in a SHU cell. Staff responded quickly in notifying the Operations Lieutenant and Control. The Cut Down tool, AED, appropriate keys to allow access to the cell, and sufficient staff to open the cell door were assembled quickly (within XX minutes).

Staff discussed the exercise and response for training purposes.

(IN CASES WHERE RECOMMENDATIONS ARE MADE, TEXT CAN BE ADDED TO DESCRIBE THE RECOMMENDATION AND CORRECTIVE ACTION TAKEN, e.g.)
Staff suggested the key to the security cage housing the Cut Down tool be placed on the Operations Lieutenant's and Compound Officer's key rings. A security work order has been initiated to do this.

cc: Psychology Services, Suicide Prevention Training File

EXHIBIT 6

U. S. Department of Justice
Federal Bureau of Prisons
United States Penitentiary –
Administrative Maximum
Florence, Colorado 81226

INSTITUTION SUPPLEMENT

OPI: Psychology Services
NUMBER: FLM 5324.08A
DATE: October 31, 2014

Suicide Prevention Program

/s/
Approved: *J. Oliver, Warden*
ADX Florence

I. **PURPOSE & SCOPE:** This institution supplement provides guidelines to assist staff in monitoring the health and welfare of inmates and to ensure procedures are followed which enhance mental health and preserve life. Its goal is identification, management, and treatment of suicidal and self-injurious inmates.

II. **DIRECTIVES AFFECTED:**

A. Directives Referenced

Program Statement 5324.08, Suicide Prevention Program, dated April 5, 2007;
Program Statement 5310.16, Treatment and Care of Inmates with Mental Illness, dated May 1, 2014;
Program Statement 5290.15, Intake Screening, dated March 30, 2009;
Program Statement 5310.12, Psychology Services Manual, dated March 7, 1995;
Program Statement 5566.06, Use of Force and Application of Restraints, dated November 30, 2005;
Program Statement 5100.08, Inmate Security Designation and Custody Classification, dated September 12, 2006;
Program Statement 6031.03, Patient Care, dated August 23, 2012;
Program Statement 6270.01, Medical Designations and Referral Services for Federal Prisoners, dated January 15, 2005;
Program Statement 6340.04, Psychiatric Services, dated January 15, 2005.

III. **STANDARDS REFERENCED:** American Correctional Association Standards for

Adult Correctional Institutions, 4th Edition: 4-4084, 4-4084-1, 4-4370M, 4-4371M, and 4-4373M.

IV. **DELEGATION OF AUTHORITY:** The Warden designates the Chief Psychologist as Program Coordinator for the Suicide Prevention Program. The primary function of the Program Coordinator is to manage the treatment of suicidal and self-injurious inmates and ensure the institution's Suicide Prevention Program conforms to the guidelines for training, identification, referral, and assessment/intervention outlined in Program Statement 5324.08, Suicide Prevention Program, and in this institution supplement. Responsibilities of the ADX Suicide Prevention Program may be delegated to a doctoral level psychologist who serves as an Alternate Program Coordinator for the Suicide Prevention Program. All doctoral level psychologists are expected to clinically and administratively manage and treat cases in which a suicide risk assessment ("SRA") and/or intervention is indicated. A psychiatric care provider (e.g., a psychiatrist or psychiatric mid-level provider) or a physician (the Clinical Director or staff physician) will evaluate for treatment with psychotropic medications or make adjustments as indicated if they are currently prescribed psychotropic medications. The Clinical Director will consult with a BOP psychiatrist or psychiatric mid-level provider, if indicated, as soon as one is available.

The Program Coordinator's responsibilities include, but are not limited to, the following:

A. Design and implementation of screening procedures maximizing identification of suicidal and self-injurious inmates;
B. The training of new staff in suicide prevention during Institutional Familiarization;
C. The design and implementation of a training program for all staff and inmates in suicide prevention (this includes local adaptation of national lesson plans for suicide prevention that will be used during Annual Training, and supplemental training for Health Services staff, lieutenants, and counselors);
D. Educating inmates during Admission and Orientation (A&O);
E. Designing and conducting mock suicide attempt response drills in cooperation with Correctional Services staff on each shift; and
F. Consulting with Psychology Services Branch staff to ensure adherence to policy and review of high risk cases.

V. **PROCEDURES:**

A. Screening Procedures

1. Health Services

a. Health Services clinical staff will conduct an assessment of each new inmate upon his arrival at an institution. This screening is to determine, among other things, urgent mental health care needs (i.e., psychosis, suicidality, self-injury, mood disturbance) and signs

of acute drug or alcohol intoxication or symptoms of withdrawal. Inmates with immediate mental health needs will be referred to the appropriate health care staff for further evaluation and management. Documentation of this assessment will be made in the medical record (i.e., BEMR). Health Services staff will complete a written and verbal referral to the institution Chief Psychologist or designee on a priority basis. If the inmate has an urgent mental health need, he will be seen by a psychologist or psychiatric care provider on the day of arrival.

b. Inmates showing signs of acute drug/alcohol intoxication or withdrawal symptoms will be managed in accordance with the institution's local procedure for detoxification of chemically dependent inmates. Staff will obtain a detailed history of substance use and conduct an examination. Health Services staff will complete a written referral to the institution Chief Psychologist and Clinical Director for any inmate showing evidence of substance use disorder.

2. Psychology Services

a. All inmates will complete the Psychology Services Inmate Questionnaire at the time of admission. All inmates will be have an Intake or Transfer Intake completed within their first 7 business days at the facility and will be interviewed by a psychologist. Psychological testing will be completed if determined to be necessary or useful by a psychologist.

b. Inmates with a recent (within the last three years) known history of suicide attempts or of serious self-harm will be screened by Psychology Services in R&D, upon arrival at the institution during normal business hours. An SRA will be completed if indicated based upon a face to face interview and review of records.

B. Identification of Potentially Suicidal Inmates

1. Referrals

a. All staff are responsible for detecting signs that suggest an inmate has a mental health disorder and/or is at risk for suicide or self-injury. Any staff may identify an inmate as potentially suicidal at any time based upon the inmate's observed behavior. If a staff member suspects that an inmate is suicidal or self-injurious, he/she will maintain the inmate under direct, continuous observation or assure that this is done. The Program Coordinator or designee or a Correctional Services Supervisor will be contacted for assistance.

b. Inmates play a vital role in helping to prevent inmate suicides and it is important to facilitate this process. Via in-cell education, awareness

video programming and/or printed materials, ADX inmates will be encouraged to learn risk factors and warning signs of suicide and make referrals to staff. A record will be maintained in Psychology Services of these efforts to educate inmates.

2. Documentation

   a. A psychologist will document a Suicide Risk Assessment in the Psychology Data System (PDS - BEMR) within 24 hours of completing the assessment.

C. Suicide Watch and Procedures

1. Placement on Suicide Watch

   a. Ordinarily, the Chief Psychologist, designee (a doctoral level psychologist), or a psychiatrist, will determine the appropriateness of placement on suicide watch following a comprehensive suicide risk assessment.

   b. In emergency situations, any staff member who has reason to believe an inmate may be suicidal may place an inmate on suicide watch pending an evaluation by the Program Coordinator or designee at the earliest opportunity.

   c. During non-routine working hours, the Shift Lieutenant will contact the on-call psychologist and continue direct, continuous observation, or place the inmate on suicide watch. Following the initiation of a formal suicide watch, the Program Coordinator or designee will conduct an in-person evaluation at the earliest opportunity.

2. Notifications

   a. The Program Coordinator or designee will notify the following individuals when a suicide watch is initiated and terminated: (1) Warden; (2) Associate Warden (Programs); (3) Captain; (4) Operations Lieutenants; (5) ADX psychologists; (6) the FCC psychiatric care provider; (7) Unit Manager; and (8) Clinical Director.

   b. The Program Coordinator or designee will notify the National Suicide Prevention Coordinator when a suicide watch is initiated, terminated, or exceeds 72 hours.

3. Housing

   a. An inmate who is determined to need placement on suicide watch will be removed from his cell and placed in designated and approved suicide watch cells. Approved suicide watch areas at the ADX are as follows: (1) Health Services Medical Observation Cells 1 & 2 (which are the preferred cells to use); (2) both holding cells in Golf Unit; (3) holding cell in Charlie Unit; and (4) observation cell in the Special Security Unit.

   b. Under emergency conditions, a suicidal inmate may be placed temporarily on suicide watch in a cell other than the designated watch room (e.g., R&D). If an inmate is placed on suicide watch in a cell other than the designated suicide watch cell, the conditions of a suicide watch must be maintained, e.g., constant observation, one tear resistant mattress, one tear resistant safety blanket, one tear resistant safety smock, and other items as approved by the Program Coordinator or designee. The inmate must be moved to a designated suicide watch room as soon as one becomes available.

4. Observation

   a. The suicide watch will be conducted using staff observers who will maintain constant visual and audio supervision of the inmate on suicide watch. Staff assigned to a suicide watch duty must have received training in accordance with national policy and must review and sign the Post Orders before starting the watch.

   b. Inmate companions are not authorized for ADX suicide watches.

   c. Documentation of the inmate's behavior in an approved suicide watch log book will occur at a minimum of fifteen minute intervals. The log books will be maintained after the suicide watch by the Program Coordinator or designee. Details of behavioral observation guidelines will be located in the Post Orders. The Program Coordinator or designee will review the Post Orders annually to ensure compliance with national and institution policies.

   d. When the observing staff member identifies any problematic behavior, particularly behavior indicative of efforts of self-harm or of an onset of new or increase in existing symptoms, Psychology Services (or on-call Psychologist during non-business hours) will be notified immediately.

5. Treatment

   a. When an inmate is placed on suicide watch, the psychologist will ordinarily make recommendations for psychosocial interventions while on watch (i.e., Reasons for Living Card, mindfulness exercises,

behavioral activation). Additional recommendations for psychosocial interventions are ordinarily made upon completion of watch in the form of a treatment plan, safety plan, or suicide risk management plan. These interventions are individualized to the inmate's needs and focus on reducing suicide risk. They are documented in PDS-BEMR.

b. A treatment plan or suicide risk management plan may direct interventions that involve removing inmates on suicide watch from the suicide watch cell for therapeutic activities such as counseling sessions, exercise, etc. This will be done in consultation and agreement with Executive Staff at the institution. All movement will be supervised consistent with current policy and procedures.

c. Psychiatric consultation with the institutional attending psychiatric provider will be sought in determining the treatment plan.

d. Medication, including emergency medication, will be prescribed and managed by the attending psychiatrist, psychiatric MLP, Clinical Director, or staff physician.

e. Consultation regarding policy, procedure, and practical issues is encouraged with the Psychology Services Branch and Chief Psychiatrist.

6. Contacts

a. The Program Coordinator or designee will evaluate the inmate on suicide watch on a daily basis.

b. A Psychologist will re-assess any inmate on suicide watch to determine the need for a continued formal suicide watch. This re-assessment will occur every 24 hours and will be conducted in person.

c. Unit Team staff, in consultation with the Program Coordinator, will continue to be responsive to routine needs while the inmate is on suicide watch.

d. Correctional Services staff will be responsible for the inmate's daily custodial care, cell, and routine activities.

e. Staff from other departments will meet with the inmate as needed to address concerns and effectuate problem solving.

f. When a suicide watch exceeds 72 hours, the Central Office Psychology Services Point of Contact will be notified. Consultation with the Mental Health Team is indicated if a clear plan for removal from watch is not in place at this time.

7. Conditions of Watch

   a. The Program Coordinator or designee is responsible for deciding the specific suicide watch conditions (bedding, property, etc.). The minimum standard conditions are as follows: one tear resistant mattress, one tear resistant safety blanket, and one tear resistant safety smock. The Program Coordinator or designee has discretion to alter the standard conditions when warranted.

   b. Restraints may be used during suicide watch as provided in Program Statements 5324.08 and 5566.06. The use of restraints must be clearly documented and supported. Staff may immediately use force and/or apply restraints as outlined in 28 C.F.R. § 552.21(a) and Program Statement 5566.06, Use of Force and Application of Restraints.

   c. Ordinarily, the least restrictive method for serving meals will be used. If it becomes necessary to limit materials introduced into the cell for safety reasons, bagged meals or other appropriate limitations (such as alternative trays or utensils) may be utilized with the approval of the Warden, in consultation with Program Coordinator or designee.

   d. Health Services staff will be consulted regarding special medical considerations during a suicide watch including the inmate's direct access to medical services and equipment.

8. Removal From Suicide Watch

   a. Once an inmate has been placed on watch, the watch may not be terminated, under any circumstance, without the Program Coordinator or designee performing a face-to-face evaluation. Only the Program Coordinator or designee will have the authority to remove an inmate from suicide watch.

   b. The psychologist terminating the suicide watch will be responsible for completing a Post Suicide Watch Report, which will be entered into PDS – BEMR. This report will have a clear description of the resolution of the crisis and plan for follow up care. This will include diagnostic considerations and Mental Health Care Level adjustments.

D. Preventative Measures

1. On a monthly basis, Psychology Services will provide each housing unit a list of known inmates who are considered or known to be dangerous, self-destructive, or suicidal, or who have a history of suicide attempts. This list is not to be considered an exhaustive list, but is provided to enhance safety and planning on the unit. A Psychologist will make weekly rounds of

the housing units in an attempt to identify and address mental health and behavioral concerns.

2. Health Services will notify Psychology Services whenever an inmate refuses or demonstrates a pattern of poor compliance with his psychotropic medication and will document this notification in BEMR. Health Services staff will ensure psychotropic medications are prescribed and/or dispensed in a manner to prevent diversion or hoarding.

3. Every housing unit will be equipped with a suicide rescue tool that is sharp, stored in a secure location, and readily available.

4. All episodes of serious self-injury will be followed by a Suicide/Self-harm Risk. This review includes an analysis of the incident by Psychology Services, Health Services, and Correctional Services staff, which is reviewed and discussed in a meeting facilitated by the Associate Warden. If any concerns are identified during this review, a corrective action plan is developed and implemented. . The National Suicide Prevention Coordinator may be consulted during this process. The Suicide/Self-Harm Risk Review form is available on the Psychology Services Branch Sallyport Webpage.

E. Additional Notifications

1. Information regarding the inmate's risk of suicide and plan for intervention will be shared with the Operations Lieutenant, Unit Team, Health Services, Associate Wardens, and the Warden.

2. When a formal suicide watch is discontinued, a Post Suicide Watch Report will also be completed by the Psychologist and distributed to the same parties as the suicide risk assessment.

F. Transfers

1. In consultation with Executive and Health Services staff, an inmate may be referred for a transfer to a Medical Referral Center (MRC) in accordance with Program Statement 5100.08, Inmate Security Designation and Custody Classification, and Program Statement 6270.01, Medical Designations and Referral Services for Federal Prisoners, and Program Statement 6340.04, Psychiatric Services.

2. If an inmate who is approved for an emergency transfer to a MRC has not been transferred within 72 hours of the approval, the Warden will be notified to expedite the transfer. If the inmate has not been transferred within 7 days of the approval, the Assistant Director of the Health Services Division and the Regional Director will be notified to take appropriate action.

G. Procedures in the Event of a Suicide

1. In the event of an inmate suicide, the procedures outlined in Program Statement 5324.08, Suicide Prevention Program, will be followed to include appropriate notifications to administrative and law enforcement personnel.

H. Training

1. All staff will be provided training annually on suicide prevention. This training will include recognition of suicide risk and protective factors, recognizing signs of suicidal ideation, and responding to a suicide attempt in progress. This training will include specific information on ADX inmates on the monthly lists provided to each housing unit, lessons learned from near fatal or fatal suicide attempts at ADX, and lessons learned from mock drills at ADX.

2. Supplemental Specialty Training will be offered approximately six months after Annual Refresher Training for Health Services Staff, Lieutenants, Correctional Counselors and Chaplains.

3. Each year, three realistic mock exercises simulating a suicide emergency will be conducted. These will be coordinated between the Program Coordinator, the Emergency Preparedness Coordinator, and the Captain. At least one suicide emergency mock exercise will be embedded in a larger complex mock exercise, and will be located at the ADX. A mock exercise must occur during each shift annually.

6. **OFFICE OF PRIMARY INTEREST:** Psychology Services Department

7. EFFECTIVE DATE: This supplement becomes effective upon issuance.

EXHIBIT 7

U.S. Department of Justice
Federal Bureau of Prisons

Program Statement

OPI: HSD/PSY
NUMBER: P6340.04
DATE: 1/15/2005
SUBJECT: Psychiatric Services

1. **PURPOSE AND SCOPE.** To provide Psychiatric Services which address the physical, medical, psychological, social, vocational and rehabilitative needs of inmates in the Bureau's custody who suffer from mental illnesses and disorders. The Bureau provides essential, cost-effective, high-quality, and humane diagnostic and treatment services throughout the inmates' incarceration.

By doing so, we strive to improve the inmates' condition, enhance the process of ongoing recovery and reduce the chances of relapsing and/or re-offending. Psychiatric services provided to inmates improves the safety and security of institutions and communities.

- All psychiatric services within the Bureau will be provided in accordance with the Bureau's overall mission, goals, and policies, and specifically, as they are outlined in other Program Statements on the provision of health care.

- This Program Statement does not cover forensic services which are covered under the Program Statement on Institution Management of Mentally Ill Inmates.

2. **PROGRAM OBJECTIVES.** The expected results of this program are:

a. Inmates in need of psychiatric services will be identified.

b. Essential psychiatric diagnostic and treatment services will be available for all Bureau inmates.

c. High-quality and cost-effective psychiatric services will be provided at all institutions where such services are rendered.

d. Continuity of psychiatric care during incarceration and upon release will be enhanced.

3. **DIRECTIVES REFERENCED**

P5050.46	Compassionate Release, Procedures for Implementation of 18 U.S.C. §§ 3582/4205 (5/19/98)
P5070.11	Study and Observation Report (12/31/97)
P5212.07	Control Unit Programs (2/20/01)
P5270.07	Inmate Discipline and Special Housing Units (12/29/87)
P5310.12	Psychology Services Manual (8/13/93)
P5310.13	Mentally Ill Inmates, Institution Management of (3/31/95)
P5324.05	Suicide Prevention Program (3/1/04)
P5566.05	Use of Force and Application of Restraints (7/25/96)
P6010.01	Psychiatric Treatment and Medication, Administrative Safeguards for (9/21/95)
P6027.01	Health Care Provider Credential Verifications, Privileges and Practice Agreement Program (1/15/05)
P6090.01	Health Information Management (1/15/05)
P6270.01	Medical Designations and Referral Services for Federal Prisoners (1/15/05)
P6360.01	Pharmacy Services (1/15/05)
P7331.04	Pretrial Inmates (1/31/03)

4. **STANDARDS REFERENCED**

a. American Correctional Association 4th Standards for Adult Correctional Institutions: 4-4347, 4-4368, 4-4369, 4-4370, 4-4371, 4-4372, 4-4374, 4-4376, 4-4381, 4-4382, 4-4384, 4-4392, 4-4397, 4-4399, 4-4400, 4-4401, 4-4404, 4-4405, and 4-4411

b. American Correctional Association Standards for Adult Local Detention Facilities, 3rd Edition: 3-ALDF-4E-11, 3-ALDF-4E-12, 3-ALDF-4E-18, 3-ALDF-4E-32, 3-ALDF-4E-37, and 3-ALDF-4E-38

5. **DEFINITIONS**

a. **Behavior Therapy.** A form of psychological treatment aimed at modifying behavior in a direction that improves a patient's mental health condition. It includes specific methodology and technology used to bring about the behavior change.

b. **Competence to Give Informed Consent.** The inmate has an understanding of his/her diagnosis or condition, the treatment being offered, the potential risks, benefits and side-effects of treatment, especially serious ones, what to do in the event of such effects, the alternatives to the treatment being offered (including no treatment), and risks associated with the alternatives.

c. **Least Restrictive Clinical Interventions.** The minimum intervention necessary to control the situation including the use of non-physical interventions, as well as voluntary medication, voluntary special housing, seclusion, involuntary medications, and restraints.

d. **Mental Health Emergency.** For the purposes of the potential use of mental health seclusion or restraint, a mental health emergency is defined as a situation in which an inmate is suffering from a mental illness which creates an immediate threat of:

- Bodily harm toward self;
- Bodily harm toward others;
- Serious destruction of property which would immediately endanger self or others; or
- Serious disruption of the therapeutic milieu that places the inmate at risk of harm by others.

For the purposes of emergency medication, a mental health emergency includes all of the above situations, as well as a situation in which there is an immediate risk of extreme deterioration of functioning secondary to a psychiatric illness.

e. **Mental Health Restraint.** The direct application of physical force or device(s) to an inmate without his/her permission, to restrict his/her freedom of movement when a mental health emergency exists.

f. **Mental Health Unit.** The designated part of an institution which houses inmates with a mental health designation. This may include units providing the following kinds of services, as defined at the individual institution: inpatient, outpatient, forensic, diagnostic and observation, seclusion, administrative detention, disciplinary segregation, and other housing statuses as defined in the institution's policies and procedures.

g. **Psychiatric Medication.** Medication prescribed for the treatment of signs or symptoms of mental disorders or illnesses.

h. **Psychiatric Referral Center (PRC).** An institution (usually a Medical Referral Center (MRC)) which has as part of its mission the provision of inpatient psychiatric services.

i. **Seclusion.** Involuntary confinement of an inmate in a locked room when a mental health emergency exists.

6. **PSYCHIATRIC SERVICES AND ORGANIZATION.** Bureau Psychiatric Services are under the direction of the BOP Chief Psychiatrist. The Medical Director gives privileges to and supervises the BOP Chief Psychiatrist.

Psychiatric services are delivered at PRCs and non-PRC institutions through the services of staff and contract/consultant psychiatrists, other mental health care providers and allied health professionals.

a. **PRCs.** The Medical Director will designate the PRC's mission. PRCs provide a full range of psychiatric diagnostic and treatment services consistent with their missions.

- Psychiatric services at PRCs will be under the direction of the institution Chief of Psychiatry. Each Chief of Psychiatry will have a documented external peer review at least every two years.

- PRCs will seek and maintain accreditation by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) under the appropriate behavioral health standards.

- PRCs will maintain accreditation by the American Correctional Association (ACA) in accordance with the missions the Medical Director assigned.

- Each PRC will establish an organizational plan designed to meet the needs of both the institution and the Bureau. The plan is subject to the Medical Director's approval.

b. **Other Institutions.** Ordinarily, psychiatric services at institutions other than PRCs will be under the Clinical Director's direction. When such institutions have more than one psychiatrist on staff, the Warden may select a Chief of Psychiatry with the Medical Director's approval.

- It is recommended that each institution not having a full-time psychiatrist or regular access to tele-psychiatry, contract for psychiatric services.

- Inmates with severe mental illness or who are severely developmentally disabled, will receive a mental health evaluation and, where appropriate, will be referred for placement in a facility or unit specifically designated for managing this type of individual.

7. **STAFFING.** PRCs will have an organized medical staff subject to medical bylaws consistent with JCAHO standards. Medical bylaws are subject to negotiation in accordance with the Master Agreement. Psychiatrists and licensed psychologists are eligible for membership on the medical staff and for all privileges within the scope of their licenses, including admitting and discharging privileges.

- All privileges are subject to the provisions outlined in the Program Statement on Health Care Provider Credential Verification, Privileges, and Practice Agreement Program.

The roles of other staff in the psychiatric program, such as social workers, mid-level practitioners, activity therapists, etc., will be determined by the institution organizational plan and approved by the Medical Director.

a. **Chief Psychiatrist.** The Warden will select the Chief Psychiatrist with the Medical Director's approval. The Medical Director will be the privileging authority for all Chiefs of Psychiatry. Privileging authority may be delegated to the BOP Chief Psychiatrist.

The Chief Psychiatrist has overall responsibility for the supervision and implementation of the psychiatric program. This responsibility includes:

- Supervising staff;
- Overseeing contract psychiatrists;
- Providing other supervisory duties as determined by the institution's organizational plan;
- Serving as a member of the institution Pharmacy and Therapeutics Committee, the Quality Improvement Program Committee, and other committees as determined by the needs of the institution and the Bureau; and
- Coordinating the in-house Continuing Professional Education (CPE) program for the psychiatrists and any other clinical staff he/she directly supervises.

The Chief Psychiatrist works closely with Social Work Services, Nursing Services, Psychology, and Correctional Services to address issues surrounding care and treatment of inmates with mental illnesses and disorders. He/she will be actively involved in the education of staff in the:

- Recognition of signs and symptoms of mental illness;
- Management of the mentally ill inmate; and
- Risk management issues pertaining to working with the mentally ill.

b. **Staff Psychiatrist.** Mental health care will be provided by individual professionals and/or by a multi-disciplinary team. As a team member, the psychiatrist responsible for the psychiatric care being provided to the inmate will provide diagnostic and treatment services consistent with the field of psychiatry and Bureau policy and guidelines.

- The psychiatrist will manage those inmates with complex psychiatric conditions directly. Complex conditions include, but are not limited to, those requiring multiple psychiatric medications, psychiatric illnesses complicated by medical conditions, psychiatric symptoms not responding to usual treatments, etc.

- The psychiatrist will consult with, provide training to, and mentor other team members and staff involved in the medical care, mental health care, or supervision of mentally ill inmates.

Psychiatrists who perform clinical services on an inpatient psychiatric unit have responsibility for coordinating the inmate's psychiatric and medical care while the inmate is an inpatient.

- Members of the Health Services Unit may provide medical care; however, responsibility for coordination and continuity of medical care lies with the psychiatrist assigned to the inmate.

8. **SERVICES.** The exact nature of psychiatric services available at institutions will be based on the institution's mission as well as the staff and community psychiatric resources available at the institution (including tele-psychiatry).

- PRCs specified as forensic sites will provide forensic evaluations pursuant to 18 U.S.C. §§ 4241 - 4247.

All institutions will provide the following services either through medical and mental health care staff at the institution or through consultation with community resources (the services may be delivered by clinicians and staff other than psychiatrists):

- Crisis intervention;
- Emergency services;
- Risk assessment for acts of self-harm or harm towards others;
- Mental health screening of inmates suffering from symptoms or behavioral disturbances indicative of possible mental illnesses or disorders;
- Detoxification from alcohol, benzodiazepines, and barbiturates;
- Diagnosis and treatment of mild to moderate mental illnesses such as non-psychotic major depression, anxiety disorders, or sleep disorders;
- Continuation of psychiatric treatment initiated at other institutions or prior to incarceration; and
- Monitoring of inmates on psychiatric medications for side-effects and drug interactions.

PRCs provide all services necessary to meet their mission either on-site or through community resources. At a minimum, this includes:

- Complete diagnostic services; and
- Inpatient and outpatient psychiatric treatment services for the severely mentally ill.

9. **EVALUATIONS.** The Medical Director will provide guidance for standards and formats for psychiatric evaluations.

a. **Intake Screening.** Staff performing intake screening will assess and make appropriate referrals to a mental health professional when an inmate:

- Has a mental health designation;
- Exhibits signs or symptoms consistent with a possible mental disorder; or
- Is on medication for treatment of a mental illness or disorder.

Screening will be of sufficient detail to determine appropriate housing for the inmate until a thorough mental health evaluation can be completed.

b. **Outpatient Evaluations.** Institutions will have a system in place by which inmates can be referred to a psychiatrist for a psychiatric evaluation. At non-PRCs this will generally be through Health Services or Psychology Services.

Inmates referred for psychiatric evaluation who have not received a psychological/mental health evaluation within the previous 30 days, will be seen within 14 days from the date of referral. Inmates who have received a psychological/mental health evaluation within the previous 30 days, will be seen in a timely manner consistent with the inmate's clinical needs.

- The evaluation will be consistent with ACA standards on mental health evaluations. Further guidance for the content and format for psychiatric evaluations will be provided by the Medical Director.

Inmates with a Mental Health designation who do not need inpatient treatment or refuse admission to an inpatient unit, will undergo a complete psychiatric evaluation by either a psychiatrist or a licensed psychologist.

- The psychiatric evaluation will occur within a clinically appropriate time frame, not to exceed 14 days from arrival.

- The evaluation will be consistent with ACA standards on mental health evaluations. Further guidance for the content and format for psychiatric evaluations will be provided by the Medical Director.

Some PRCs may designate an area of the Mental Health Unit as a "Diagnostic and Observation (D and O) Unit." The D and O unit is an outpatient unit with clearly established admission, transfer and discharge criteria, reasonable time frames for completion of psychiatric evaluations, and length of stays.

- These criteria are subject to the Medical Director's approval.

- All psychiatric treatment provided on the D and O Unit, other than emergency treatment, will be voluntary and with the inmate's informed consent.

c. **Inpatient Admissions.** Inmates will only be admitted to an inpatient unit after giving informed consent for admission or under an appropriate court order (see the Program Statements on Administrative Safeguards for Psychiatric Treatment and

Medication and Institution Management of Mentally Ill Inmates). PRCs will develop and implement admission and discharge criteria approved by the Medical Director.

(1) **Voluntary Admissions**

- The inmate will be informed of his/her rights through the use of the Consent to Admission for Mental Health Treatment (BP-S801) form.
- The informed consent for admission will be in a language understood by the inmate.
- The completed form will be placed in the inmate's health record.

Inmates admitted to an inpatient unit will undergo a psychiatric evaluation within 24 hours of admission. Either a psychiatrist or licensed psychologist with admitting privileges may perform this evaluation. A medical history and physical will be performed in accordance with local policy.

(2) **Involuntary Admissions**

- Involuntary inpatient admission or treatment can occur only with a court order under 18 U.S.C. §§ 4241 - 4247.
- 18 U.S.C. §§ 4241 - 4247 does not apply to un-sentenced Bureau of Immigration and Customs Enforcement (BICE), formerly the Immigration and Naturalization Service, detainees, un-sentenced prisoners in Bureau custody as a result of a court order, and state or territorial prisoners.
- For those persons not covered by 18 U.S.C. §§ 4241 - 4247, the decision to admit or treat the person involuntarily must be made through an administrative hearing in accordance with Vitek v. Jones, 445 U.S. 480 (1980).

Pursuant to 10 U.S.C. § 876(b), military prisoners who are incompetent to stand trial or who have been found not guilty by reason of lack of mental responsibility may be committed to the custody of the Attorney General and are subject to the procedures authorized under 18 U.S.C. §§ 4241, 4243, and 4246. Similarly, under 18 U.S.C. § 4247(j), District of Columbia Code offenders are subject to commitment procedures specified under §§ 4245 and 4246.

d. **Psychiatric Evaluation for Correctional Purposes.** Inmates receiving an incident report and who are psychiatric inpatients, or whose mental status is questionable, will be referred to a psychiatrist or psychologist for an assessment regarding competency and responsibility. The mental health clinician will use the same standards that apply in establishing competency and responsibility pursuant to 28 CFR 541.10(b)(6) (contained in the Program Statement on Inmate Discipline and Special Housing Units).

- It is strongly recommended that PRCs establish separate Special Housing Units (SHU) for inmates with mental illnesses or disorders that are physically distinct from the SHUs used to house general population inmates.

- Non-PRCs are encouraged to identify a specific area in SHU where inmates suffering from active symptoms of a mental illness and who require SHU placement can be housed. These inmates are at increased risk of behaviors of self-harm or harm towards others. The area chosen should facilitate frequent observation by and contact with staff.

- Whenever any inmate is transferred into a SHU, health care staff will be informed immediately and will provide assessment and review as indicated by local protocols established by the local health authority.

- A mental health professional must evaluate inmates being referred to a control unit. Refer to the Program Statement on Control Unit Programs for requirements and the format of the evaluation.

10. **TREATMENT.** Psychiatric treatment, except in an emergency, will begin only after a psychiatric evaluation and plan have been completed. Inmates who have received psychiatric evaluation and treatment services at another Bureau institution will have that treatment continued at the new institution pending further evaluation.

- Further guidance on psychiatric treatment will be provided by the Medical Director.

The timing and extent of the evaluation undertaken at the receiving institution will depend on several factors, including:

- Time elapsed since the last complete psychiatric evaluation;

- The comprehensiveness of the last complete psychiatric evaluation; and
- The inmate's clinical presentation.

Psychiatric treatment, regardless of the unit in which the inmate resides, will be voluntary except when:

- Treatment has been ordered by the court; or
- A mental health emergency exists.

Pretrial inmates and inmates committed by the court can be treated only under certain conditions and usually only after following procedures outlined in the Program Statements on Institution Management of Mentally Ill Inmates and Administrative Safeguards for Psychiatric Treatment and Medication.

a. **Psychiatric Medication**. Except in an emergency, informed consent will be obtained and documented prior to administering medication for psychiatric symptoms or conditions (refer to the Program Statement on Pharmacy Services). Ordinarily, the prescribing physician will be responsible for obtaining the informed consent.

Patient education for obtaining informed consent includes the following information:

- Symptoms of the illness;
- Potential benefits of treatment;
- Potential risks and side-effects (especially serious ones);
- Appropriate use of the medication;
- When to notify staff of problems;
- Consequences of noncompliance; and
- Alternative treatments, including no treatment, and associated risks.

The inmate's competency to give informed consent will be assessed and documented on the corresponding "Consent to Use (name of medication)" form. An informed consent form will be obtained when:

- A psychiatric medication is prescribed for which an informed consent has not previously been obtained;
- An inmate has previously given informed consent, but has been off the medication for at least a year;
- Clinical judgment deems that a new informed consent is appropriate because of a significant change in the inmate's clinical status; or

- An inmate on psychiatric medication is newly committed to the Bureau and does not have informed consent documented on any of the standard forms noted above.

Inmates on psychiatric medication will be monitored regularly in Chronic Care Clinics. Noncompliance should not be the determining factor for exclusion from the Mental Health Chronic Care Clinic. Inmates with mental illness present potentially important risk management issues.

- Inclusion in the Chronic Care Clinic should continue as long as the inmate has active symptoms of mental illness or is on psychiatric medication.

All institutions will have a system(s) in place for assuring continuity of care for all inmates receiving psychiatric treatment even if such treatment was started before incarceration at the current institution.

- Continuity of care is required from admission to transfer or discharge from the Bureau, including referral to community-based providers, when indicated.

- Such a system will include monitoring compliance with psychiatric medications and maintaining documented informed consent in the health record.

- At non-PRCs, timely notification of noncompliance will be made to the Clinical Director and other relevant mental health staff, such as the Chief of Psychology, staff psychiatrist, or contract psychiatrist.

- At PRCs, the treating psychiatrist and Chief Psychiatrist will be informed of any noncompliance issues.

b. **Electroconvulsive Therapy.** Electroconvulsive therapy (ECT) will only be considered for inmates at PRCs, except in an extreme emergency. Prior to administering any ECT, the Medical Director must approve the procedure in writing.

- Once it has been determined that ECT is an appropriate treatment for the inmate and the treatment has been approved, ECT will be performed in the community by a qualified consultant psychiatrist privileged to administer the treatment.

c. **Behavior Therapy.** Behavior therapy may be an appropriate treatment for certain conditions and inmates. When this treatment modality is used, the institution will be in compliance with JCAHO Behavioral Health Care Standards.

- Painful stimuli will not be used as a mental health intervention.

d. **Mental Retardation.** Inmates who are considered mentally retarded will be thoroughly evaluated for their potential psychiatric needs. Not all inmates with mental retardation require intensive psychiatric services.

- Placement at PRCs will be consistent with their clinical needs.

e. **Dementia.** Inmates with possible dementia will undergo a complete psychiatric and medical evaluation. Those with moderately severe or severe dementia should be considered for a reduction in sentence/compassionate release. (Refer to the Program Statement on Compassionate Release.)

- Not all inmates with dementia will require placement at a PRC. Designation and treatment will be consistent with their medical and psychiatric needs.

11. **EMERGENCY TREATMENT.** Interventions during a mental health emergency may include nonphysical interventions, voluntary medication, seclusion, involuntary medication, and/or restraint.

- The **least restrictive method** for controlling the situation will be employed and documented in the inmate health record.

a. **Emergency Medication.** Psychiatric medication may be administered in a mental health emergency only by order of the physician, and if the inmate is at immediate risk of:

- Bodily harm toward self;
- Bodily harm toward others;
- Serious destruction of property which would immediately endanger self or others;
- Serious disruption of the therapeutic milieu that places the inmate at risk of harm from others; or
- Extreme deterioration of functioning secondary to a psychiatric illness.

Documentation of emergency medication administration will include the following:

- Type of emergency;
- Interventions attempted and the result(s);
- Reason that less restrictive interventions were not used or were ineffective;
- When, where and how the medication is to be administered; and
- Assessment and monitoring of the inmate for adverse reactions and side-effects.

The inmate's treatment plan will be reviewed, and, if necessary, revised, as soon as possible.

At non-PRCs, the Clinical Director will consult with the office of the Medical Director within 24 hours of administering emergency medication (excluding weekends and holidays). The Medical Director will provide guidance on further evaluation, treatment, referral to a PRC, or other appropriate clinical interventions.

Ordinarily, emergency treatment with psychiatric medications at non-PRCs will not be continued for more than 72 hours without the Medical Director's approval.

- Ordinarily, long-acting psychiatric medications such as Haldol Decanoate and Prolixin Decanoate will not be used in emergencies except at PRCs.

For guidance on emergency treatment of pretrial, pre-sentence, and other forensic inmates, refer to the Program Statements on Institution Management of Mentally Ill Inmates and Administrative Safeguards for Psychiatric Treatment and Medication.

b. **Seclusion.** Seclusion may be an appropriate clinical intervention during a mental health emergency. All institutions using mental health seclusion must have an Institution Supplement consistent with JCAHO Behavioral Health Standards.

- The Institution Supplement will be negotiated in accordance with the Master Agreement after approval by the Medical Director. (Refer to the Program Statement on Mental Health Seclusion and Restraints).

c. **Restraints.** Restraints may be an appropriate clinical intervention during a mental health emergency. In many cases, the use of restraints during a mental health emergency may be more restrictive than the use of emergency medication. All

institutions using restraints will have an Institution Supplement consistent with JCAHO Behavioral Health Standards and ACA standards on the use of restraints.

- The Institution Supplement will be negotiated in accordance with the Master Agreement after approval by the Medical Director (see the Program Statement on Mental Health Seclusion and Restraints).

12. **DOCUMENTATION.** All documentation related to psychiatric evaluations and treatment (inpatient, outpatient, and forensic) will be available in the inmate's health record and the requirements noted in the Program Statements on Patient Care and Health Information Management will be adhered to.

- All psychiatric diagnoses will adhere to the nomenclature set forth in the most recent Diagnostic and Statistical Manual of Mental Disorders.

- All five Axes will be noted in the diagnosis section of the evaluation.

- The clinician performing the mental health evaluation will be responsible for documenting Axes I, II and V on the problem list of the inmate's health record. When the evaluation is completed via tele-psychiatry, or performed by a contract psychiatrist, the physician on the inmate's primary care provider team will be responsible for noting the diagnoses on the problem list.

Documentation of emergency interventions will include the following:

- Type of emergency;
- Intervention(s) attempted and their result(s); and
- Reason that less restrictive interventions were not used or were ineffective.

If the emergency intervention includes medication, refer to Section 11.a. If the intervention includes seclusion or restraints, documentation will meet the requirements set forth in the Program Statement on Mental Health Seclusion and Restraints.

- The Medical Director will provide additional guidance regarding documentation for psychiatric evaluation and treatment.

13. **EDUCATION.** The Bureau will provide regular professional training opportunities for mental health care staff consistent with their clinical duties and responsibilities.

PRCs are encouraged to provide training for medical and allied health care professionals, including students. They are also encouraged to provide post-graduate training to residents and fellows.

- Residency programs and fellowships may be established with the Medical Director's approval.

/s/
Harley G. Lappin
Director

EXHIBIT 8

U.S. Department of Justice
Federal Bureau of Prisons

P R O G R A M S T A T E M E N T

OPI:	HSD/PSB
NUMBER:	6010.03
DATE:	July 13, 2011
EFFECTIVE DATE:	August 12, 2011

Psychiatric Evaluation and Treatment

/s/
Approved: Thomas R. Kane
Acting Director, Federal Bureau of Prisons

1. **PURPOSE AND SCOPE**

§ 549.40 Purpose and scope.

(a) This subpart describes procedures for voluntary and involuntary psychiatric evaluation, hospitalization, care, and treatment, in a suitable facility, for persons in Bureau of Prisons (Bureau) custody. These procedures are authorized by 18 U.S.C. Chapter 313 and 18 U.S.C. § 4042.

(b) This subpart applies to inmates in Bureau custody, as defined in 28 CFR part 500.

Inmates are defined as all persons in the custody of the Federal Bureau of Prisons or Bureau contract facilities, including persons charged with or convicted of offenses against the United States; D.C. Code felony offenders; and persons held as witnesses, detainees, or otherwise.

(c) **Summary of Changes**

Directive Rescinded:
P6010.01 Psychiatric Treatment and Medication, Administrative Safeguards for (9/21/95)

Federal Regulations from 28 CFR are shown in this type.
Implementing instructions are shown in this type.

- Inmates may be hospitalized at any institution that capably meets their psychiatric needs.
- The practice of transferring an inmate to a suitable facility for examination to determine if hospitalization is necessary without providing the procedural safeguards that accompany hospitalization has been specifically codified in regulation as permissible and in compliance with applicable law, as indicated in § 549.43 of this part.
- Involuntary hospitalization procedures differ in accordance with the legal basis under which the inmate is held in Bureau custody, as indicated in § 549.45 of this part.
- Involuntary administration of medication for the sole purpose of restoring competency to stand trial can only be administered pursuant to an order by a court of competent jurisdiction.

d. **Program Objectives**. The expected results of this program are:

- Psychiatric medications will be administered only when there is a diagnosable psychiatric disorder or symptomatic behavior for which such medication is accepted treatment.
- Inmates who voluntarily submit to psychiatric care or treatment or voluntarily take psychiatric medication will be properly informed of their rights, and their competence to give consent will be properly documented.
- Persons covered by Title 18 U.S.C., Chapter 313, may only be involuntarily hospitalized pursuant to a court order.
- Any decision to involuntarily hospitalize any person not covered by Title 18 U.S.C., Chapter 313, for psychiatric care or treatment will be made at an administrative hearing that complies with proper due process procedures.
- Except for psychiatric emergencies, proper due process procedures will be provided to every inmate before psychiatric medication is involuntarily administered.
- During a psychiatric emergency, appropriate psychiatric medication will be administered only when alternatives are not available, not indicated, or would not be effective. When clinically possible, long-acting psychiatric medications will be avoided.
- When staff are confronted with a situation which requires the authorized use of force to gain control of an inmate who is undergoing psychiatric evaluation, care or treatment, staff shall follow the procedures indicated in the Program Statement **Use of Force and Application of Restraints**.

e. **Pretrial/Holdover Procedures**. Procedures required in this Program Statement apply to pretrial and holdover inmates. However, deciding whether particular procedures apply to individual inmates requires an analysis of the legal basis under which the inmate is held in Bureau custody. Staff are encouraged to contact legal staff for assistance.

2. **HOSPITALIZATION IN A SUITABLE FACILITY**

§ 549.41 Hospitalization in a suitable facility.

As used in 18 U.S.C. Chapter 313 and this subpart, "hospitalization in a suitable facility" includes the Bureau's designation of inmates to medical referral centers or correctional institutions that provide the required care or treatment.

"Hospitalization in a suitable facility" does not require the inmate to be placed in a Medical Referral Center (MRC). Inmates who are medically compliant may not require housing at a MRC if an institution can capably meet their psychiatric needs.

"Hospitalization" refers only to the designation of an inmate for psychiatric care or treatment. Psychiatric care or treatment does not refer to either the voluntary or involuntary use of psychiatric medication.

3. **USE OF PSYCHIATRIC MEDICATIONS**

§ 549.42 Use of psychiatric medications.

Psychiatric medications will be used only for treatment of diagnosable mental illnesses and disorders, and their symptoms, for which such medication is accepted treatment. Psychiatric medication will be administered only after following the applicable procedures in this subpart.

Psychiatric medication is generally not designed for, and must not be used as, a method of chemical control for behaviors unrelated to mental illness. Psychiatric medication may be administered on a voluntary basis for a medical purpose other than treatment of a psychiatric disorder; e.g., disease for which appropriate treatment includes drugs classified as psychiatric. Psychiatric medication is prescribed by a physician specifically for mood-altering, mind-altering, or impulse control purposes. It does not include sleeping medication or minor tranquilizers.

4. **TRANSFER FOR PSYCHIATRIC OR PSYCHOLOGICAL EXAMINATION**

§ 549.43 Transfer for psychiatric or psychological examination.

The Bureau may transfer an inmate to a suitable facility for psychiatric or psychological examination to determine whether hospitalization in a suitable facility for psychiatric care or treatment is needed.

The transfer of an inmate to a suitable facility for the purposes of psychiatric or psychological examination does not encompass hospitalization as defined in Section 2, nor does the transfer alone require staff to comply with procedural protections in Sections 6 or 7.

5. **VOLUNTARY HOSPITALIZATION IN A SUITABLE FACILITY FOR PSYCHIATRIC CARE OR TREATMENT, AND VOLUNTARY ADMINISTRATION OF PSYCHIATRIC MEDICATION**

§ 549.44 Voluntary hospitalization in a suitable facility for psychiatric care or treatment, and voluntary administration of psychiatric medication.

(a) Hospitalization. An inmate may be hospitalized in a suitable facility for psychiatric care or treatment after providing informed and voluntary consent when, in the professional medical judgment of qualified health services staff, such care or treatment is required and prescribed.

(b) Psychiatric medication. An inmate may also provide informed and voluntary consent to the administration of psychiatric medication that complies with the requirements of § 549.42 of this subpart.

(c) Voluntary consent. An inmate's ability to provide informed and voluntary consent for both hospitalization in a suitable facility for psychiatric care or treatment, and administration of psychiatric medications, will be assessed by qualified health services staff and documented in the inmate's medical record. Additionally, the inmate must sign a consent form to accept hospitalization in a suitable facility for psychiatric care or treatment and the administration of psychiatric medications. These forms will be maintained in the inmate's medical record.

Informed consent requires educating the inmate on the symptoms of the illness, potential benefits of treatment, potential risks and side effects, appropriate use of medication, when to notify staff of problems, consequences of noncompliance, and alternative treatments (including no treatment) and associated risks.

To assess an inmate's ability to provide informed consent, staff must determine whether he/she understands the reasons for admission, the recommended treatment, his/her right to object to treatment at any time, and the means by which he/she may object.

The inmate's medical record must include documentation that, before giving written consent, he/she was informed and found competent to consent. Staff document an inmate's medical record using form BP-A0801, "Consent to Admission for Mental Health Treatment," to show an inmate's consent to hospitalization. Staff document an inmate's voluntary administration of psychiatric medication through a consent form to use psychiatric medication (form varies per medication).

6. **INVOLUNTARY HOSPITALIZATION IN A SUITABLE FACILITY FOR PSYCHIATRIC CARE OR TREATMENT**

§ 549.45 Involuntary hospitalization in a suitable facility for psychiatric care or treatment.

(a) Hospitalization of inmates pursuant to 18 U.S.C. Chapter 313. A court determination is necessary for involuntary hospitalization or commitment of inmates pursuant to 18 U.S.C. Chapter 313, who are in need of psychiatric care or treatment, but are unwilling or unable to voluntarily consent.

Inmates covered by this subsection include:

- Individuals found to be suffering from a mental disease or defect that renders them mentally incompetent to stand trial (18 U.S.C. § 4241(d)).
- Individuals committed for evaluation under 18 U.S.C. § 4241(b) or § 4242(a).
- Individuals found not guilty only by reason of insanity (18 U.S.C. § 4243).
- Convicted individuals suffering from a mental disease or defect, committed to a suitable facility for care or treatment in lieu of being sentenced to imprisonment (18 U.S.C. § 4244).
- Persons serving a sentence of imprisonment suffering from a mental disease or defect (18 U.S.C. § 4245).
- Individuals due for release but suffering from a mental disease or defect (18 U.S.C. § 4246).
- Sexually dangerous persons civilly committed to the custody of the Attorney General (18 U.S.C. § 4248).

Involuntary hospitalization of these inmates requires a court determination that the person may be suffering from a mental disease or defect for the treatment of which he/she needs custody in a suitable facility.

After hospitalization, psychiatric medication may only be involuntarily administered after an administrative hearing has been held complying with the procedural safeguards in Section 7.

Any use of force under this provision must comply with procedures in the Program Statement **Use of Force and Application of Restraints**.

(b) Hospitalization of inmates not subject to hospitalization pursuant to 18 U.S.C. Chapter 313. Pursuant to 18 U.S.C. § 4042, the Bureau is authorized to provide for the safekeeping, care, and subsistence, of all persons charged with offenses against the United States, or held as witnesses or otherwise. Accordingly, if an examiner determines pursuant to § 549.43 of this subpart that an inmate not subject to hospitalization pursuant to 18 U.S.C. Chapter 313 should be hospitalized for psychiatric care or treatment, and the inmate is unwilling or unable to consent, the Bureau will provide the inmate with an administrative hearing to determine whether hospitalization for psychiatric care or treatment is warranted. The hearing will provide the following procedural safeguards:

A number of inmates in Bureau custody are not serving a sentence of imprisonment or otherwise fall under the auspices of 18 U.S.C. Chapter 313, and therefore cannot be hospitalized pursuant to an 18 U.S.C. § 4245 court order. Examples include alien detainees subject to an order of deportation, exclusion, or removal; material witnesses; contempt of court commitments; or other unsentenced inmates in Bureau custody. When unsure of the legal status of an inmate's confinement, contact legal staff for assistance before determining whether an inmate is subject to hospitalization pursuant to 18 U.S.C. Chapter 313, requiring a court proceeding and order.

When an inmate not subject to hospitalization per 18 U.S.C. Chapter 313 should be hospitalized for psychiatric care or treatment and he/she is unwilling or unable to consent, staff must provide him/her with an administrative hearing following the procedures below.

Any use of force under this provision must comply with the procedures in the Program Statement **Use of Force and Application of Restraints**.

(1) The inmate will not be involuntarily administered psychiatric medication before the hearing except in the case of psychiatric emergencies, as defined in § 549.46(b)(1).

(2) The inmate must be provided 24-hours advance written notice of the date, time, place, and purpose, of the hearing, including an explanation of the reasons for the proposal to hospitalize the inmate for psychiatric care or treatment.

Use form BP-A0959, "Notice of Hearing and Advisement of Rights for Involuntary Hospitalization or Medication for Psychiatric Care or Treatment" to provide notice to the inmate. This form is filled out only by the referring psychiatrist currently involved in the diagnosis or treatment of the inmate. Any staff member may deliver a copy of the notice to the inmate.

(3) The inmate must be informed of the right to appear at the hearing, to present evidence, to have a staff representative, to request witnesses, and to request that witnesses be questioned by the staff representative or by the person conducting the hearing. If the inmate does not request a staff representative, or requests a staff representative with insufficient experience or education, or one who is not reasonably available, the institution mental health division administrator must appoint a qualified staff representative.

The BP-A0959 form used to provide notice to the inmate also advises the inmate of his/her rights regarding evidence, witnesses, and staff representatives.

Inmates are entitled to appear at the hearing; however, at the discretion of the hearing psychiatrist, the appearance requirement may be met by videoconference. Teleconference is not permissible, as it does not allow the hearing psychiatrist to visually evaluate the inmate.

The assisting staff member's responsibility is limited to helping the inmate obtain copies of documents needed, for example, from his/her central file or other reasonably available source(s), or a written statement(s) from reasonably available inmates or staff. The staff representative also helps the inmate prepare and submit an appeal if he/she requests assistance, or wishes to appeal but is unable to prepare and submit the appeal (see subsection b(9)).

(4) The hearing is to be conducted by a psychiatrist other than the attending psychiatrist, and who is not currently involved in the diagnosis or treatment of the inmate.

The hearing may be conducted via videoconference by a psychiatrist who is not physically located at the institution that currently houses the inmate. When the hearing is conducted via videoconference, the hearing is considered to be held at the location of the inmate, not the location of the hearing psychiatrist.

(5) Witnesses should be called if they are reasonably available and have information relevant to the inmate's mental condition or need for hospitalization. Witnesses who will provide only repetitive information need not be called.

Witnesses are not required to appear at the hearing in person. If reasonably available, witnesses may appear via video- or teleconference, or may submit a written statement.

(6) A treating/evaluating psychiatrist/clinician, who has reviewed the case, must be present at the hearing and must present clinical data and background information relative to the inmate's need for hospitalization. Members of the treating/evaluating team may also be called as witnesses at the hearing to provide relevant information.

The treating/evaluating psychiatrist/clinician may present clinical data and background information relative to the inmate's need for hospitalization via video- or teleconference, or in person.

(7) The psychiatrist conducting the hearing must determine whether involuntary hospitalization is necessary because the inmate is presently suffering from a mental disease or defect for the treatment of which he is in need of custody for care or treatment in a suitable facility.

(8) The psychiatrist must prepare a written report regarding the initial decision. The inmate must be promptly provided a copy of the initial decision report, and informed that he/she may appeal it to the institution's mental health division administrator. The inmate's appeal, which may be handwritten, must be submitted within 24 hours after receipt of the hearing officer's report. Upon request of the inmate, the staff representative will assist the inmate in preparing and submitting the appeal.

The psychiatrist conducting the hearing uses form BP-A0960, "Hearing Report: Involuntary Hospitalization for Psychiatric Care or Treatment," to prepare the written report regarding the initial hospitalization decision.

The hearing psychiatrist must indicate the manner in which the hearing was held (in person or videoconference) on the appropriate section of the hearing report form. At the end of the hearing the hearing psychiatrist advises the inmate of his/her appeal rights and informs the inmate of the specific evidence relied upon in making the determination, the findings, and their justification. The inmate is also advised of the right to appeal the decision to the institution mental health

administrator within 24 hours of receipt of the hearing report. Any staff member may deliver a copy of the hearing report to the inmate.

(9) If the inmate appeals the initial decision, hospitalization must not occur before the administrator issues a decision on the appeal. The inmate's appeal will ordinarily be reviewed by the administrator or his designee within 24 hours of its submission. The administrator will review the initial decision and ensure that the inmate received all necessary procedural protections, and that the justification for hospitalization is appropriate.

The form used for appeals is BP-A0962, "Appeal of Involuntary Hospitalization or Medication Decisions for Psychiatric Care or Treatment." The staff representative who participated in the involuntary hospitalization hearing assists the inmate in filing an appeal, if necessary.

(c) Psychiatric medication. Following an inmate's involuntary hospitalization for psychiatric care or treatment as provided in this section, psychiatric medication may be involuntarily administered only after following the administrative procedures provided in § 549.46 of this subpart.

Following the involuntary hospitalization of inmates for psychiatric care or treatment, whether pursuant to (a) or (b) of this Section, the involuntary administration of psychiatric medication must be preceded by an administrative hearing complying with procedures in Section 7. This hearing is in addition to a court order as explained in subsection (a), or any hearing held pursuant to the involuntary hospitalization of an inmate under subsection (b). Administrative hearings for involuntary hospitalization and medication cannot be combined into a single hearing. If a particular inmate needs both involuntary hospitalization and medication, two separate hearings are conducted.

Any use of force under this provision must comply with the procedures in the Program Statement **Use of Force and Application of Restraints**.

7. **PROCEDURES FOR INVOLUNTARY ADMINISTRATION OF PSYCHIATRIC MEDICATION**

§ 549.46 Procedures for involuntary administration of psychiatric medication.

Except as provided in paragraph (b) of this section, the Bureau will follow the administrative procedures of paragraph (a) of this section before involuntarily administering psychiatric medication to any inmate.

Any use of force under this provision must comply with the procedures in the Program Statement **Use of Force and Application of Restraints**.

(a) Procedures. When an inmate is unwilling or unable to provide voluntary written informed consent for recommended psychiatric medication, the inmate will be scheduled for an administrative hearing. The hearing will provide the following procedural safeguards:

(1) Unless an exception exists as provided in paragraph (b) of this section, the inmate will not be involuntarily administered psychiatric medication before the hearing.

(2) The inmate must be provided 24-hours advance written notice of the date, time, place, and purpose of the hearing, including an explanation of the reasons for the psychiatric medication proposal.

Use form BP-A0959, "Notice of Hearing and Advisement of Rights for Involuntary Hospitalization or Medication for Psychiatric Care or Treatment," to provide notice to the inmate. This form is filled out only by the referring psychiatrist currently involved in the diagnosis or treatment of the inmate. Any staff member may deliver a copy of the notice to the inmate.

(3) The inmate must be informed of the right to appear at the hearing, to present evidence, to have a staff representative, to request witnesses, and to request that witnesses be questioned by the staff representative or by the person conducting the hearing. If the inmate does not request a staff representative, or requests a staff representative with insufficient experience or education, or one who is not reasonably available, the institution mental health division administrator must appoint a qualified staff representative.

The BP-A0959 form used to provide notice to the inmate also advises the inmate of his/her rights regarding evidence, witnesses, and staff representatives.

Inmates are entitled to appear at the hearing; however, at the discretion of the hearing psychiatrist, the appearance requirement may be met by videoconference. Teleconference is not permissible, as it does not allow the hearing psychiatrist to visually evaluate the inmate.

The assisting staff member's responsibility is limited to helping the inmate obtain copies of documents needed, for example, from his/her central file or other reasonably available source(s), or a written statement(s) from reasonably available inmates or staff. The staff representative also helps the inmate prepare and submit an appeal if he/she requests assistance, or wishes to appeal but is unable to prepare and submit the appeal (see subsection b(9)).

(4) The hearing is to be conducted by a psychiatrist other than the attending psychiatrist, and who is not currently involved in the diagnosis or treatment of the inmate.

The hearing may be conducted via videoconference by a psychiatrist who is not physically located at the institution that currently houses the inmate. When the hearing is conducted via videoconference, the hearing is considered to be held at the location of the inmate, not the location of the hearing psychiatrist.

(5) Witnesses should be called if they are reasonably available and have information relevant to the inmate's mental condition or need for psychiatric medication. Witnesses who will provide only repetitive information need not be called.

Witnesses are not required to appear at the hearing in person. If reasonably available, witnesses may appear via video- or teleconference, or may submit a written statement.

(6) A treating/evaluating psychiatrist/clinician, who has reviewed the case, must be present at the hearing and must present clinical data and background information relative to the inmate's need for psychiatric medication. Members of the treating/evaluating team may also be called as witnesses at the hearing to provide relevant information.

The treating/evaluating psychiatrist/clinician may present clinical data and background information relative to the inmate's need for psychiatric medication via video- or teleconference, or in person.

(7) The psychiatrist conducting the hearing must determine whether involuntary administration of psychiatric medication is necessary because, as a result of the mental illness or disorder, the inmate is dangerous to self or others, poses a serious threat of damage to property affecting the security or orderly running of the institution, or is gravely disabled (manifested by extreme deterioration in personal functioning).

(8) The psychiatrist must prepare a written report regarding the initial decision. The inmate must be promptly provided a copy of the initial decision report, and informed that he/she may appeal it to the institution's mental health division administrator. The inmate's appeal, which may be handwritten, must be submitted within 24 hours after receipt of the hearing officer's report. Upon request of the inmate, the staff representative will assist the inmate in preparing and submitting the appeal.

The psychiatrist conducting the hearing uses form BP-A0961, "Hearing Report: Involuntary Medication for Psychiatric Care or Treatment," to prepare the written report regarding the initial medication decision.

The hearing psychiatrist must indicate the manner in which the hearing was held (in person or videoconference) on the appropriate section of the hearing report form. At the end of the hearing

the hearing psychiatrist advises the inmate of his/her appeal rights and informs the inmate of the specific evidence relied upon in making the determination, the findings, and their justification. The inmate is also advised of the right to appeal the decision to the institution mental health division administrator within 24 hours of receipt of the hearing report. Any staff member may deliver a copy of the hearing report to the inmate.

(9) If the inmate appeals the initial decision, psychiatric medication must not be administered before the administrator issues a decision on the appeal, unless an exception exists as provided in paragraph (b) of this section. The inmate's appeal will ordinarily be reviewed by the administrator or his designee within 24 hours of its submission. The administrator will review the initial decision and ensure that the inmate received all necessary procedural protections, and that the justification for administering psychiatric medication is appropriate.

The form used for appeals is BP-A0962, "Appeal of Involuntary Hospitalization or Medication Decisions for Psychiatric Care or Treatment." The staff representative who participated in the involuntary medication hearing assists the inmate in filing an appeal, if necessary.

(10) If an inmate was afforded an administrative hearing which resulted in the involuntary administration of psychiatric medication, and the inmate subsequently consented to the administration of such medication, and then later revokes his consent, a follow-up hearing will be held before resuming the involuntary administration of psychiatric medication. All such follow-up hearings will fully comply with the procedures outlined in paragraphs (a)(1) through (10) of this section.

(b) Exceptions. The Bureau may involuntarily administer psychiatric medication to inmates in the following circumstances without following the procedures outlined in paragraph (a) of this section:

Any use of force under this provision must comply with the procedures in the Program Statement **Use of Force and Application of Restraints**.

(1) Psychiatric emergencies.

(i) During a psychiatric emergency, psychiatric medication may be administered only when the medication constitutes an appropriate treatment for the mental illness or disorder and its symptoms, and alternatives (e.g., seclusion or physical restraint) are not available or indicated, or would not be effective. If psychiatric medication is still recommended after the psychiatric emergency, and the emergency criteria no longer exist, it may only be administered after following the procedures in §§ 549.44 or 549.46 of this subpart.

(ii) For purposes of this subpart, a psychiatric emergency exists when a person suffering from a mental illness or disorder creates an immediate threat of:

(A) Bodily harm to self or others;
(B) Serious destruction of property affecting the security or orderly running of the institution; or
(C) Extreme deterioration in personal functioning secondary to the mental illness or disorder.

(2) Court orders for the purpose of restoring competency to stand trial.

Absent a psychiatric emergency as defined above, § 549.46(a) of this subpart does not apply to the involuntary administration of psychiatric medication for the sole purpose of restoring a person's competency to stand trial. Only a federal court of competent jurisdiction may order the involuntary administration of psychiatric medication for the sole purpose of restoring a person's competency to stand trial.

(i) **Retention of Court Orders and Documentation**. All court orders requiring the involuntary administration of medication for the sole purpose of restoring competency must be retained in the inmate health record. Staff at examining facilities are encouraged to keep a log of time, date, and type of contact for all communication and correspondence related to the order, such as calls to attorneys, and letters to or from the court. This log will help ensure that Bureau staff maintain compliance with court orders originating in the jurisdiction of the court action.

(ii) **Compliance with Court Orders**. Bureau staff must continue to comply with a court order requiring the involuntary administration of medication. If an inmate's medical condition changes, the treating physician should promptly consult with the Regional Medical Director, as well as Regional Counsel and staff at the Consolidated Legal Center, for legal assistance and possible consultation with the prosecuting United States Attorney's Office.

REFERENCES

Program Statements

P5212.07	Control Unit Programs (2/20/01)
P5310.12	Psychology Services Manual (03/07/95)
P5310.13	Mentally Ill Inmates, Institution Management of (03/31/95)
P5566.06	Use of Force and Application of Restraints (11/30/2005)
P6010.02	Health Services Administration (01/15/05)
P6340.04	Psychiatric Services (01/15/05)

Federal Regulations

Rules cited in this Program Statement: 28 CFR §§ 549.40 through 549.46.

ACA Standards

- Standards for Adult Correctional Institutions, 4th Edition: 4-4348, 4-4372, 4-4374, 4-4397M, 4-4399, 4-4401M, 4-4404
- Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-4C-05, 4-ALDF-4C-31, 4-ALDF-4C-34, 4-ALDF-4D15M, 4-ALDF-4C-40, 4-ALDF-4D-17M, 4-ALDF-4D-20

BOP Forms

Various	Consent to Use *(name of psychiatric medication)*
BP-A0801	Consent to Admission for Mental Health Treatment
BP-A0959	Notice of Hearing and Advisement of Rights for Involuntary Hospitalization or Medication for Psychiatric Care or Treatment
BP-A0960	Hearing Report: Involuntary Hospitalization for Psychiatric Care or Treatment
BP-A0961	Hearing Report: Involuntary Medication for Psychiatric Care or Treatment
BP-A0962	Appeal of Involuntary Hospitalization or Medication Decisions for Psychiatric Care or Treatment

Records Retention Requirements

Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) on Sallyport.

EXHIBIT 9

AGREEMENT

This agreement is between Scott Fountain ("Fountain"), Harold Cunningham ("Cunningham"), Charles Hipps ("Hipps"), and Marcellus Washington ("Washington"), (collectively "Transferred Plaintiffs"), and the Federal Bureau of Prisons ("the "Bureau").

Recitals

1. The Transferred Plaintiffs are inmates in the custody of the Bureau who were formerly housed at the United States Penitentiary, Administrative Maximum, located in Florence, Colorado ("ADX"). The Transferred Plaintiffs are among the Plaintiffs in Civil Action No. 12-cv-01570-RPM, now pending in the United States District Court for the District of Colorado (the "Lawsuit"). In the Lawsuit, Plaintiffs allege that the mental health services afforded to inmates at ADX did not meet the minimum level of care necessary to satisfy the Eighth Amendment to the U.S. Constitution. The Bureau denies the Transferred Plaintiffs' and other Plaintiffs' allegations.

2. Following the filing of the Lawsuit, the Bureau opened a Secure Mental Health Step Down Unit ("SMHSDU") at the United States Penitentiary in Atlanta, Georgia ("USP Atlanta"), and a second SMHSDU at the United States Penitentiary in Allenwood, Pennsylvania, ("USP Allenwood"). For purposes of this Agreement the "Programs" shall mean the secure mental health units at USP Atlanta and USP Allenwood.

3. Separate Institution Supplements were implemented at USP Allenwood and USP Atlanta, setting forth the policies applicable at the Programs (the "Institution Supplements"). Operations within the Programs are also governed in certain respects by BOP Program Statement 5310.16 (the "Program Statement"), and certain other Bureau-issued policies and procedures pertaining to mental health, including suicide prevention policies and policies relating to the discipline of inmates with mental illness. For purposes of this Agreement, the "Program Policies" shall consist of the Institution Supplements and the Program Statement.

4. As of the date the Lawsuit was filed, Plaintiffs were all housed at ADX. Following the filing of the Lawsuit, the Bureau transferred Plaintiff Fountain to the Program at USP Atlanta, and transferred Plaintiffs Hipps, Washington, and Cunningham to the Program at USP Allenwood.

5. The Parties and the Plaintiffs in the Lawsuit have agreed to the conditionalsettlement and dismissal of the Lawsuit (the "Settlement"). The conditions to the dismissal are set forth in an Addendum (the "Addendum") to a Joint Motion to Approve Settlement. The Settlement provides for, among other things, the monitoringof specific policies at ADX and also at the Secure STAGES (Steps Towards Awareness Growth and Emotional Strength) Program at the United States Penitentiary, High Security, Florence, Colorado. The Settlement does not provide for the monitoring of any policies at either of the Programs.

6. The Parties have entered into this Agreement to provide a mechanism for addressing claims or concerns about the Bureau's operation of the Programs in relation to the Transferred Plainitffs, or other inmates who are or were class members in the Lawsuit and for whom Plaintiff's counsel has a release.

Agreement

The Parties agree as follows:

1. **Effective Date and Term.** The term of this Agreement (the "Term") shall commence on the Effective Date specified in the Addendum, and shall terminate on the last day of the Compliance Period specified in the Addendum.

2. No Waiver or Monitoring.

a. This Agreement does not provide for the monitoring of any of the policies at either of the Programs. Any allegations of non-compliance with any material provision of any of the Program Policies in connection with the diagnosis or treatment of inmates' mental illness in either or both of the Programs cannot be used to support a finding of non-compliance under the Addendum.

b. This Agreement in no way waives or otherwise affects, limits, or modifies the obligations of inmates to comply with Bureau regulations, Program Statements, and Institutional Supplements; or any current or future federal law governing the rights and obligations of incarcerated persons. In particular, nothing in this agreement relieves any Plaintiff or other inmate from complying with the Bureau's Administrative Remedy Process for the purposes of complying with the exhaustion requirements of the Prisoner Litigation Reform Act, 42 U.S.C. § 1997e(a), or other applicable administrative exhaustion requirements, before filing a lawsuit. Moreover, nothing in this Agreement requires the Transferred Plaintiffs to utilize the procedures herein before complying with the Bureau's Administrative Remedy Process.

3. Resolution of Disputes Concerning the Programs.

a. If Plaintiffs' counsel have concerns about the operation of the Programs with respect to the Transferred Plaintiffs, or any other inmate who is or was class members in the Lawsuit and for whom Plaintiff's counsel has a release, Plaintiffs' counsel may contact the designated attorney at the Allenwood or Atlanta Program and Chris Synsvoll or his designee by email or telephone in an effort to resolve the matter informally.

b. If the foregoing informal effort does not resolve the issue within five (5) business days, then Plaintiffs' counsel may notify the Bureau in writing, in care of the designated attorney at the Allenwood or Atlanta Program and Chris Synsvoll or his designee, of the concerns in either or both of the Programs. The Bureau will investigate and respond in writing within thirty (30) calendar days; provided that if Plaintiffs' counsel

reasonably believes that an issue presents a substantial risk of death or serious injury, then the Bureau will investigate and provide a preliminary verbal response as soon as practicable and in all events within five (5) business days, and will provide a written response as soon thereafter as is practicable. The Bureau's response shall contain a description of the results of the investigation, and whether or not the Bureau proposes corrective action (and if so, a specific plan for addressing the issues).

c. If Plaintiffs' counsel contend that the Bureau's response does not adequately resolve the issue or issues, they shall request a prompt meet and confer with the Bureau, unless the Parties have already met and conferred on such issue prior to the Bureau's written response. Either Party may request at any time that Magistrate Judge Hegarty, or his successor, participate in a meeting to discuss and potentially facilitate informal resolution of the issue or issues. Magistrate Judge Hegarty or his successor shall have no authority to require the Bureau to take any action.

d. If the Parties are unable to resolve the issue informally, then any Party may request the assistance of Sally Johnson, M.D., and Jeffrey Metzner, M.D., or their successors (the "Psychiatry Experts"). In that event, the Psychiatry Experts may jointly request information or records from the Bureau concerning the matter, and the Bureau shall provide any responsive records that are not legally privileged and that relate to inmates for whom Plaintiff has a release, as soon as practicable. The Psychiatry Experts may assist the parties in attempting to resolve the issue, but shall have no authority to require the Bureau to take any action, nor shall they report to the Court presiding over the Lawsuit concerning conditions in either Program.

e. During the Term, the Bureau shall timely respond to written requests made by Plaintiffs' counsel for records concerning any Transferred Plaintiff, or other inmate who is or was a class member in the Lawsuit and for whom Plaintiffs' counsel has a release. The parties agree that any documents informally produced in response to an email or letter will be treated as confidential subject to the Privacy Act Protective Orders entered by th e Court, regardless of whether the information provided is specifically designated as confidential.

4. **Quality Assurance**. The Bureau will conduct a multi-disciplinary review of the Programs at least annually to promote the early identification of any concerns and, when indicated, recommend corrective action. This review will be conducted by Bureau employees who are not assigned to the Federal Correctional Complex where the Program is located. This review will include such things as interdisciplinary collaboration; program environment, structure and content; and documentation.

5. **No Waiver of Rights or Claims.** Nothing in the Agreement shall waive, release or otherwise affect in any way any right of any participant in either of the Programs to seek any legal remedy to which he is or may be entitled under applicable law.

6. Miscellaneous.

a. The Parties believe the Agreement is fair, reasonable, and adequate to protect the interests of all parties.

b. Nothing in this Agreement shall be deemed to limit any existing authority of Defendant to transfer inmates to other state or federal jurisdictions. Moreover, nothing in this Agreement shall be deemed to require or permit Defendant to violate the laws of the United States, or to violate any terms or conditions of any collective bargaining agreement to which Defendant is a party. Defendant is not aware of any conflict between any of the provisions of this Agreement and any such law or collective bargaining agreement referred to in this section.

c. This Agreement shall constitute the entire integrated agreement of the parties concerning its terms. No prior contemporaneous communications, oral or written, or prior drafts shall be relevant or admissible for purposes of determining the meaning of any provisions herein in the Lawsuit or in any other proceeding.

d. This Agreement shall be applicable to, and binding upon, all Parties, their officers, agents, employees, assigns, and their successors in office.

e. If any provision of this Agreement is declared invalid for any reason by a court of competent jurisdiction, said finding shall not affect the remaining provisions of this Agreement.

f. Neither the fact of this Agreement nor any statements contained herein may be used in any other case or administrative proceeding by any party, except that Defendant and its employees reserve the right to use this Agreement and the language herein to assert issue preclusion, res judicata, satisfaction, and release in other litigation matters seeking class or systemic relief regarding mental health services at ADX.

[SIGNATURES FOLLOW]

EXHIBIT 10

LEGAL NOTICE

If you are in ADX Florence now or in the future, you may be affected by a proposed settlement of a lawsuit about mental health care at ADX. Please read this notice carefully. The proposed settlement may affect your legal rights.

What is the lawsuit about?

The lawsuit is *Harold Cunningham et al. v. United States Bureau of Prisons*, Case 1:12-CV-01570-RPM-MEH. The lawsuit was filed in June 2012 in the United States District Court for the District of Colorado. The plaintiffs include a group of inmates at ADX who have mental illness. The lawsuit is a "proposed class action" and was filed on behalf of inmates who are housed at ADX or will be housed at ADX in the future. The lawsuit claims that BOP has violated the law by failing to properly diagnose and treat inmates at ADX with mental illness. The BOP has denied that its actions violated the law.

In addition to the claims brought on behalf of inmates at the prison, an organization called Center for Legal Advocacy is also a plaintiff in the lawsuit. This group is also sometimes referred to as Disability Law Colorado or DLC for short. DLC is a non-profit organization that helps people with mental illness protect their legal rights. The Judge in charge of the lawsuit has decided that DLC has the legal right to represent all inmates at ADX with mental illness concerning the issues raised in the lawsuit.

What are the main terms of the proposed settlement?

The lawyers for the plaintiffs and BOP have agreed to a -proposed settlement of the lawsuit. As part of the agreement, BOP has agreed to make changes to the mental health policies at ADX. The revised policies involve changes to several issues, including staffing changes, new treatment programs, and improvements in many other aspects of the mental health care system at ADX.

If the Judge approves the proposed settlement, he will also approve a "Settlement Class" and "Settlement Sub-Class" under Federal Rule of Civil Procedure 23(b)(2). The "Settlement Class" will be made up of all inmates housed at ADX at the time the Court approves the settlement or while the agreement is in effect. The main remedy for the settlement class will be changes in the procedures for diagnosing mental illness at ADX. The "Settlement Sub-Class" will be made up of all inmates housed at the ADX at the time the Court approves the settlement or while the agreement is in effect, who have been diagnosed by BOP with certain types of mental illness. The main remedy for the Settlement Sub-Class will be improvements in the mental health treatment available at ADX, and preventing certain inmates who have serious mental illnesses from being housed at ADX, with some exceptions. The Settlement Class and Settlement Sub-Class are "non opt-out classes," meaning that if the Judge approves the proposed settlement, and you qualify as a member of the class and/or subclass, you will be bound by the settlement.

You will not get any money as a result of the lawsuit.

The plaintiffs did not seek money in the lawsuit. They only requested changes to the mental health diagnosis and treatment systems at ADX. Any claims for money damages that you may have are not affected by the proposed settlement.

How will the terms of the proposed settlement be enforced?

If the proposed settlement is approved, two people will be appointed as "Monitors." The Monitors are both psychiatrists who have a lot of experience with mental health issues in prisons. The Monitors will be responsible for reviewing whether BOP is complying with the revised policies. They will visit ADX from time to time and may, during their visits, speak with you or other inmates. They will also have access to records relating to the issues involved in the settlement. If there is a dispute about whether BOP is complying with the revised policies discussed above, the proposed settlement creates a process to resolve that dispute, and gives the Judge the power to enter certain court orders. The proposed settlement also will allow inmates to write to DLC with information about compliance issues, and gives DLC certain rights if there is a dispute about BOP's compliance. The United States District Court for the District of Colorado will have continuing jurisdiction to enforce the provisions of the proposed settlement.

What affect will the proposed settlement, if approved, have on my legal rights?

If the Judge approves the proposed settlement, and if you are a member of the Settlement Class or Settlement Sub-Class, the settlement will prevent you from seeking certain changes to the policies for diagnosing and treating mental illness at ADX. However, the proposed settlement would not affect your ability to go to court over your own personal mental health diagnoses or for damages.

Why has there been a settlement?

Counsel for plaintiffs have concluded that the terms and conditions of the proposed settlement are fair, reasonable, and adequate and are in the best interests of the members of the class and sub-class. In reaching this conclusion, plaintiffs' counsel have carefully analyzed the benefits of the proposed settlement, the risks of an unfavorable outcome in the lawsuit and the length of time that would be needed to prosecute this case through a trial and possible appeals.

Will there be a trial?

If the Judge approves the proposed settlement, there will not be a trial. If the Judge does not approve the proposed settlement, the proposed settlement will be voided and have no further effect. The case would not be settled, there would be discovery and eventually a trial, unless the case is dismissed before trial. At the end of a trial, the Judge would decide whether BOP violated the law, and, if so, the Judge would also decide what BOP would be required to do. If there is a trial, there is no guarantee that any decision will be in favor of the plaintiffs. Even if there were a favorable trial decision, it may not be as favorable to the plaintiffs as the proposed settlement would have been. There is no guarantee that a favorable trial decision would be upheld on appeal.

Will the lawyers who filed the lawsuit get any money from the proposed settlement?

The lawyers who filed the lawsuit have spent nearly $1 million of their firm's money to pay for expenses relating to the lawsuit, such as paying for expert witnesses. As part of the proposed settlement, BOP has agreed to pay the lawyers back for those expenses.

The law also allows lawyers, in some situations, to receive payment for attorneys fees. Three legal organizations are involved in the lawsuit. The first is the Washington Lawyers' Committee for Civil Rights and Urban Affairs, or WLC for short. One of WLC's programs is the DC Prisoners' Project, which provides legal representation to persons convicted or charged with a criminal offence under DC law, including inmates in the BOP. WLC is a non profit organization that relies on donations and attorney fee awards to support its work.

The second organization involved in the lawsuit is DLC. DLC is a non-profit organization that helps people with mental illness protect their legal rights. DLC receives some federal funds, but mostly relies on donations and attorney fee awards to support its work.

The third organization involved in the lawsuit is Arnold & Porter, a private law firm based in Washington DC. Arnold & Porter worked on the lawsuit on a pro bono basis, which means it did not get paid for the millions of dollars worth of time that the firm's lawyers and staff members spent on the lawsuit.

As part of the proposed settlement, BOP has agreed to pay a portion of those fees. Some of that money will be paid directly to DLC and WLC. The rest will go to a nonprofit organization called The Arnold & Porter LLP Foundation. The Foundation uses attorneys' fee awards from the firm's pro bono work to make gifts to legal services programs, such as funding two-year fellowships for recent law school graduates to work at public interest law firms and providing leadership training for legal aid providers. Funds paid to the Foundation do not directly or indirectly benefit the lawyers of Arnold & Porter. In connection with the proposed settlement, the Foundation has agreed to make contributions to four organizations involved in mental health issues and prison litigation, including WLC and DLC.

How can I see the whole proposed settlement?

If you want to review the proposed settlement, you can read a printed copy of it in the law library on your housing range. You can also obtain a copy of the proposed settlement by writing to:

Ed Aro, Arnold & Porter LLP, 370 Seventeenth Street, Suite 4400, Denver, Colorado 80202

Mark Ivandick, Disability Law Colorado, 455 Sherman Street, Suite 130, Denver, Colorado 80203

Deborah Golden, Washington Lawyers' Committee for Civil Rights and Urban Affairs, 11 Dupont Circle, N.W., Suite 400, Washington, D.C. 20036.

What happens next?

Before a settlement in a class action can become final, the judge in the case has to hold a court hearing called a "fairness hearing" to decide whether the settlement is fair and reasonable for the members of the class. The Judge in the lawsuit will hold the fairness hearing to consider the proposed settlement on [DATE] at [TIME]. Before or at that hearing, the Judge may also make other legal rulings relating to the case.

What if I am a class member, and I want to object to the proposed settlement?

If you are a member of either the Settlement Class or Settlement Sub-Class, you have a right to object to the proposed settlement. You can tell the Judge why you think the proposed settlement should or should not be approved. If you want to object or otherwise comment your letter must be post-marked no later than [DATE]. You can write to the Court at:

Clerk, Attention Cunningham v. Bureau of Prisons
Alfred A. Arraj United States Courthouse, Room A105
901 Nineteenth Street
Denver, Colorado 80294-3589

It is important to let the Court know if you are a member of the Settlement Class or Settlement Sub-Class because class members are entitled to rights not available to the general public. If you are writing from ADX, you can mark your letter as "legal mail."

What if I am not a member of the class or sub-class~~,~~ but I still wish to comment?

Any person may submit written comments to the Clerk of the United States District Court for the District of Colorado, at the address above.

What if I do not object to the proposed settlement?

If you have no objections to the proposed settlement, you do not have to do anything.

What if I have questions about the proposed settlement that are not answered above?

If you have questions about the proposed settlement, you may contact plaintiffs' counsel by writing to Ed Aro, Mark Ivandick, or Deborah Golden at the addresses listed above.

EXHIBIT 11

NOTIFICACIÓN LEGAL

Si usted se encuentra en el ADX Florence en este momento, o va a estar allí en un futuro, podría verse afectado por un acuerdo que se ha propuesto a raíz de la demanda relacionada con la atención psiquiátrica en el ADX. Le rogamos que lea esta notificación con cuidado, el acuerdo que se ha propuesto podría afectar sus derechos jurídicos.

¿De qué trata la demanda?

La demanda se intitula *Harold Cunningham et al. c. United States Bureau of Prisons*, Caso 1:12-CV-01570-RPM-MEH. Esta demanda fue entablada en junio de 2012 ante el Tribunal de Distrito de Estados Unidos para el Distrito de Colorado. Entre los demandantes se encuentra un grupo de reclusos del ADX que sufren de enfermedades mentales. La demanda es una "propuesta de demanda colectiva" y fue presentada en nombre de unos presos que están recluidos en el ADX, o de aquellos que lo estarán en un futuro. En la demanda se alega que la Oficina Federal de Prisiones (ODP) violó la ley al no diagnosticar y tratar adecuadamente a los presos del ADX que sufren de enfermedades mentales. La ODP niega que sus actos sean una violación de la ley.

Además de las reclamaciones presentadas en nombre de los presos, una organización llamada Centro para la Defensa Legal también es demandante en el caso. Este grupo a veces también se denomina Disability Law Colorado, o DLC, por su abreviación. La DLC es una organización sin fines de lucro que ayuda a proteger los derechos de las personas con enfermedades mentales. El Juez a cargo de la demanda ha decidido que la DLC tiene legalmente el derecho de representar a los presos del ADX que sufren de enfermedades mentales en los asuntos que se plantean en la demanda.

¿Cuáles son los términos principales del acuerdo propuesto?

Los abogados de los demandantes y de la ODP han llegado a la proposición de un acuerdo para resolver la demanda. Como parte de ese acuerdo, la ODP se ha comprometido a realizar modificaciones en las políticas de salud mental en el ADX, lo cual implica varios cambios, incluyendo cambios del personal, nuevos programas de tratamiento y mejoras en muchos otros aspectos del sistema de atención psiquiátrica en el ADX.

Si el juez aprueba el acuerdo propuesto, también aprobará una "Categoría de Acuerdo" y "Subcategoría de Acuerdo" conforme a la Regla Federal de Procedimiento Civil 23(b)(2). La "Categoría de Acuerdo" se compone de todos los presos recluidos en el ADX en la fecha en que el Tribunal apruebe el acuerdo y mientras el acuerdo esté vigente. El principal beneficio para esta Categoría es que se realizarán cambios en los procedimientos de diagnóstico de las enfermedades mentales en el ADX. La "Subcategoría de Acuerdo" se compone de todos los presos recluidos en el ADX en la fecha en que el Tribunal apruebe el acuerdo y mientras el acuerdo esté vigente, que han sido diagnosticados por la ODP con ciertos tipos de enfermedades mentales. El beneficio principal para esta Subcategoría es que habrá mejoras en los tratamientos disponibles en el ADEX para enfermedades mentales, y que se evitará que ciertos presos con enfermedades mentales graves sean recluidos en el ADX - con algunas excepciones. La "Categoría de Acuerdo" y la "Subcategoría de Acuerdo" son categorías sin "opción de exclusión

voluntaria", lo que significa que si el juez aprueba el acuerdo propuesto y usted califica como miembro de una de esas categorías, usted quedará vinculado por el acuerdo.

Usted no recibirá dinero alguno por concepto de la demanda.

Los demandantes no buscan dinero en la demanda. Sólo solicitaron que se hicieran cambios en los sistemas de diagnóstico y tratamiento de las enfermedades mentales en el ADX. Cualquier reclamación buscando compensación monetaria por daños que usted haya presentado no se verá afectada por este acuerdo.

¿Cómo se aplicarán los términos del acuerdo propuesto?

Si la solución propuesta es aprobada, dos personas serán designadas como "monitores". Estas dos personas son psiquiatras con mucha experiencia en cuestiones de salud mental en las prisiones. Los monitores se encargarán de verificar que la ODP cumple con las políticas modificadas, visitarán el ADX de vez en cuando y durante sus visitas podrán hablar con usted o con otros presos. También tendrán acceso a los registros relacionados con los temas involucrados en este acuerdo. Si existiera una disputa con respecto al cumplimiento por parte de la ODP de las políticas modificadas, el acuerdo creará un proceso para resolver esas diferencias y le otorgará al juez la facultad de emanar órdenes judiciales. El acuerdo propuesto también le permitirá a los presos escribirle a la DLC con respecto a incumplimientos por parte de la ODP, y le otorga algunos derechos a la DLC si existe una disputa por incumplimiento de la ODP. La Corte de Distrito de Estados Unidos para el Distrito de Colorado tendrá jurisdicción continua para hacer cumplir las disposiciones del acuerdo.

Si el acuerdo es aprobado, ¿afectará mis derechos jurídicos?

Si el juez aprueba el acuerdo y usted es miembro de la "Categoría de Acuerdo" o la "Subcategoría de Acuerdo", entonces usted ya no podrá solicitar que se hagan modificaciones a las políticas de diagnóstico y tratamiento de las enfermedades mentales en ADX. Sin embargo, la solución propuesta no afectará a su capacidad de recurrir a tribunales en relación con su propio diagnóstico de salud mental, o daños personales.

¿Por qué se llegó a un acuerdo?

Los abogados de las demandantes han llegado a la conclusión de que los términos y condiciones del acuerdo propuesto son justos, razonables y adecuados, y son lo más conveniente para los miembros de la Categoría y Subcategoría. Para llegar a esta conclusión, los abogados analizaron cuidadosamente los beneficios del acuerdo propuesto, los riesgos de un resultado desfavorable en la demanda, y la cantidad de tiempo que llevaría ir a juicio y procesar las posibles apelaciones.

¿Habrá un juicio?

Si el juez aprueba el acuerdo propuesto no habrá juicio. Si el juez no aprueba el acuerdo, la solución propuesta será anulada. El caso no se habrá decidido, se llevará a cabo un descubrimiento y, finalmente, un juicio, a menos que el caso sea desestimado antes del juicio. Al concluir el juicio, el juez decidirá si la ODP violó la ley y, de ser así, también podría determinar

lo que la ODP debe hacer. Si vamos a juicio no tenemos garantías de que la decisión sea favorable para los demandantes y aunque lo fuese, no sería tan favorable como los términos del acuerdo propuesto. Además, no se puede garantizar que se produzca una decisión favorable en caso de producirse una apelación.

¿Los abogados que entablaron la demanda recibirán alguna suma de dinero proveniente del acuerdo propuesto?

Los abogados que presentaron la demanda han gastado casi US$1 millón de dólares, aportado por su bufete, para cubrir los gastos relacionados con la demanda, tales como el pago de peritos. Como parte del acuerdo propuesto, la ODP ha acordado reembolsarle a los abogados esos gastos.

En algunos casos la ley también le permite a los abogados recibir un pago por sus honorarios de abogados. Tres organizaciones están involucradas en la demanda. La primera es Washington Lawyers' Committee for Civil Rights and Urban Affairs, o WLC para abreviar. Uno de los programas del WLC es el Proyecto de Prisioneros de DC, que ofrece representación legal a las personas condenadas o acusadas de un delito bajo las leyes de DC, lo cual incluye a los presos de la ODP. El WLC es una organización sin fines de lucro que para respaldar su trabajo depende de donaciones y del otorgamiento de pago de honorarios.

La segunda organización involucrada en la demanda es la DLC. Esta es una organización sin fines de lucro, que ayuda a proteger los derechos de las personas con enfermedades mentales. La DLC recibe algunos fondos federales pero para desarrollar su trabajo depende sobre todo de las donaciones y del otorgamiento de pago de honorarios.

La tercera organización involucrada en la demanda es Arnold & Porter LLP, un bufete privado de abogados con sede en Washington, DC. Arnold & Porter ha trabajado en esta demanda de forma gratuita, lo que significa que no recibe remuneración por los millones de dólares que cuesta el tiempo de sus abogados y de los miembros de su personal que laboran en la demanda.

Como parte del acuerdo propuesto, la ODP ha acordado pagar una parte de esos honorarios. Parte de ese dinero se pagará directamente a la DLC y al WLC. El resto se destinará a una organización sin fines de lucro llamada Fundación Arnold & Porter LLP. La Fundación utiliza los honorarios otorgados en los casos pro bono del bufete para hacer donaciones a los programas de servicios legales, tales como financiar becas de dos años para abogados recién graduados a fines de que trabajen en bufetes de abogados de interés público, y proporcionar una capacitación de liderazgo a los proveedores de asistencia legal. Las sumas de dinero que se pagan a la Fundación no benefician, directa o indirectamente, a los abogados de Arnold & Porter. En relación con el acuerdo propuesto, la Fundación ha acordado hacer donaciones a cuatro organizaciones involucradas en las cuestiones de salud mental y litigios en las prisiones, incluyendo al WLC y la DLC.

¿Cómo hago para ver el acuerdo propuesto?

Si desea revisar el acuerdo propuesto, podrá leer una copia impresa del mismo en la biblioteca jurídica de su lugar de reclusión. También puede obtener una copia del acuerdo enviando una carta a:

Ed Aro, Arnold & Porter LLP, 370 Seventeenth Street, Suite 4400, Denver, Colorado 80202

Mark Ivandick, Disability Law Colorado, 455 Sherman Street, Suite 130, Denver, Colorado 80203

Deborah Golden, Washington Lawyers' Committee for Civil Rights and Urban Affairs, 11 Dupont Circle, N.W., Suite 400, Washington, D.C. 20036.

¿Qué ocurre luego?

Antes de que el acuerdo en una demanda colectiva sea definitivo, el juez de la causa tiene que celebrar una audiencia en la corte llamada "audiencia de equidad", para decidir si el acuerdo es justo y razonable para los miembros de la categoría. El juez llevará a cabo dicha audiencia, para analizar el acuerdo propuesto, el día [DATE] a las [TIME]. Antes de la audiencia, o durante la misma, el juez también podrá fallar sobre otras cuestiones del caso.

¿Qué ocurre si soy miembro de una categoría y deseo oponerme al acuerdo propuesto?

Si usted es miembro de la Categoría o Sub-categoría, tiene derecho a oponerse al acuerdo. Le puede decir al Juez el motivo por el cual usted cree que el acuerdo debe ser aprobado, o no. Si desea oponerse, o expresar algún comentario, su carta deberá llevar como fecha de matasello el día [DATE] a más tardar, y enviarla a:

Clerk, Attention Cunningham v. Bureau of Prisons
Alfred A. Arraj United States Courthouse, Room A105
901 Nineteenth Street
Denver, Colorado 80294-3589

Es importante hacerle saber al Tribunal si usted es miembro de la Categoría o Sub-Categoría Acuerdo, porque los miembros de esas categorías tienen derechos que el público en general no tiene. Si nos escribe desde el ADX, puede marcar su carta como "correo legal".

¿Qué ocurre si no soy miembro de una categoría, o sub-categoría, pero deseo hacer un comentario?

Toda persona puede enviar sus comentarios escritos a: Clerk of the United States District Court for the District of Colorado, a la dirección antes mencionada.

¿Qué ocurre si no me opongo al acuerdo propuesto?

Si no tiene objeción alguna no debe hacer nada.

¿Qué hacer si tengo preguntas que no han sido respondidas en esta notificación?

Si tiene usted alguna otra pregunta con respecto al acuerdo propuesto, puede contactar a los abogados de los demandantes por medio de una carta, dirigida a Ed Aro, Mark Ivandick o Deborah Golden, a las direcciones que se indican arriba.

EXHIBIT 12

JEFFREY L. METZNER, M.D., P.C.

[redacted]

CURRICULUM VITAE

December 2015

BIOGRAPHICAL DATA

Place of Birth: Hagerstown, Maryland
Citizenship: U.S.A.
Marital Status: Married

Education:

University of Maryland (College Park, Maryland), B.S., 1972.
University of Maryland Medical School (Baltimore, Maryland), M.D., 1975.
Internship: University of Colorado Health Sciences Center (UCHSC), January 1975 – July 1975.
Psychiatric Residency: UCHSC, July 1975 - July 1979.

Licensure:

State of Colorado License (#20007), July 1975 to present (expires 4/30/2017).
State of California License (#G43933), March 3, 2000 to present (expires 3/31/2018).
State of Georgia License (#051986), September 19, 2002 to December 31, 2005).
State of New Mexico (#2003-0547), August 18, 2003 to present (expires 7/1/2018).
State of Pennsylvania (#MD425683), January 25, 2005 to present (expires 12/31/2016).

Academic Appointments:

Chief Resident, Psychiatric Liaison Division, University of Colorado School of Medicine (July 1978 to July 1979).
Clinical Instructor, Department of Psychiatry, University of Colorado School of Medicine (July 1978 to July 1981).
Assistant Clinical Professor, Department of Psychiatry, University of Colorado School of Medicine (July 1981 - July 1989).
Associate Clinical Professor, Department of Psychiatry, University of Colorado School of Medicine (July 1989 to October 1995).
Clinical Professor, Department of Psychiatry, University of Colorado School of Medicine (October 1995 to present).
Clinical Professor, Department of Pediatrics, University of Colorado School of Medicine (October 1995 to 2006).
Member, Committee on Senior Clinical Appointments, University of Colorado School of Medicine (December 1996 to June 2006).
Lecturer-in-Law, University of Denver, College of Law (October 1984 to 1986).
Associate Director, Forensic Psychiatry Fellowship Program, Department of Psychiatry,

University of Colorado School of Medicine
(1992 to present).
Member, Search Committee (for Department of Psychiatry Chairperson)
(October 1999 to August 2000).

Other Activities:

Governor's Criminal Insanity Task Force (1978-1979):
Member, Subcommittee concerning release procedures.
Member, Subcommittee concerning the issues of treatment of criminally insane in correctional or mental health facilities.
Member, Disability Law Committee, Colorado Bar Association (1981-1995).
Member, Colorado Medical Society's Committee on Medical Care in Correctional Institutions (1983-1990).
Reviewer, Child Abuse and Neglect: The International Journal (1986 to 2005).
Reviewer, J Amer. Acad. Psychiatry and the Law (1993 to present)
Reviewer, Hosp. Community Psychiatry (1993 to present)
Reviewer, American Psychologist (February 1999 to 2001)
Reviewer, American Journal of Evaluation (May 2009)
Reviewer, JAMA (2001)
Reviewer, Administration and Policy in Mental Health and Mental Health Services Research (June 2005)
Reviewer, Journal of Dual Diagnosis (November 2005)
Reviewer, American Journal of Psychiatry (June 2006 to present)
Reviewer, The Journal of Clinical Psychiatry (2008)
Reviewer, Acta Astronautica (2011)
Reviewer, International Journal of Environmental Research and Public Health (August 2015 to present)
Editorial Board, Behavioral Sciences & the Law (2001 to present)
Co-chairman, Civil Commitment Task Force (a coalition of major mental health care professional organizations, pertinent consumer and family advocacy organizations, and relevant legal organizations) (April 1987 to September 1990).
American Board of Psychiatry and Neurology, Inc.
Examiner (October 1988 to 2006, Senior Examiner, 1997 to 2006).
Member, Committee on Certification for Added Qualifications in Forensic Psychiatry (August 1995 to present).
Member, Steering Committee on Certification for Added Qualifications in Forensic Psychiatry (June 2002 to present); Chair, (June 2008 to present).
American Board of Forensic Psychiatry, Inc.
Examiner, American Board of Forensic Psychiatry, Inc. (October 1989 to 1994).
Member, Written Examination Committee (October 1989 to 1993).
Member, Board of Directors (July 1, 1992 - March 17, 1995).
Chairman, Oral Examination Committee (July 1992 to May 1993).
Chairperson, Expert Panel-Psychiatric Disorders and Commercial Drivers, U.S. Department of Transportation (February 1990 to May 1991).

Member, State of Colorado Mental Health Advisory Board for Service Standards and Regulations (April 1990 - July 1996).

Chairperson, Psychological/Psychiatric Task Force on Impairment, State of Colorado, Department of Labor and Employment December 1992 to 1995, November 1999 – December 2000).

Member, Work Group Advisors for the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), 1994.

Member, Advisors on Forensic Issues for the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), 1993-1994.

Member, Board of Directors, Accreditation Council on Fellowships in Forensic Psychiatry (May 1994 to 1996).

Member, Colorado Supreme Court Grievance Committee (December 1995 to 1999).

Member, Attorney Regulation Committee (Colorado Supreme Court), (1999 to 2004).

Site Reviewer, Accreditation Council for Graduate Medical Education (1996 to 1998).

Member, Institute of Medicine Committee on Ethical Considerations for Revisions to DHHS Regulations for Protection of Prisoners Involved in Research, March 2005 to 2006.

Medical Panel Expert, Federal Motor Carrier Safety Administration, Psychiatric Disorders and Commercial Motor Vehicle Driver Safety, 2009.

Honors:

AOA (1975).

University of Colorado Health Sciences Center, Department of Psychiatry Clinical Faculty Award, June 1992.

University Colorado of Health Sciences Center, Department of Psychiatry Clinical Faculty Award Outstanding Overall Achievement, March 21, 2002.

American Academy of Psychiatry and the Law
Outstanding Service Award (October 1999).

Pfizer Visiting Professor, University of Massachusetts Medical School, Department of Psychiatry, (September 26-28, 2000).

Seymour Pollack Distinguished Achievement Award for distinguished contributions to forensic psychiatry (October 2003).

American Psychiatric Association
Fellow, American Psychiatric Association (December 1987 to present).
Distinguished Fellow, American Psychiatric Association (January 2003 to 2012).
Distinguished Life Fellow, American Psychiatric Association (May 2012 to present).

Visiting Professor, University of Hawaii, John A Burns School of Medicine, Department of Psychiatry, May 2-6, 2005.

Recipient, 2005 National Adolescent Perpetration Network Brandt F. Steele Memorial Award

Recipient, Colorado Psychiatric Society Outstanding Achievement Award, 2005

Recipient, National Alliance for the Mentally Ill Exemplary Psychiatrist Award, 2005

Yochelson Visiting Scholar, Yale Medical School, Department of Psychiatry, April 23- 25,

2008

Recipient, Isaac Ray Award, awarded by the American Psychiatric Association and the American Academy of Psychiatry and the Law, May 5, 2008

Recipient, B. Jaye Anno Award of Excellence in Communication, awarded by the National Commission on Correctional Health Care, October 11, 2010.

Professional Society Memberships:

Colorado Psychiatric Society:

Membership Committee (1981-1990; Chairman, 1981-1983).

Legislative Committee (1979-present; Chairman, 1983-1991, 1992 to 2000.

Member, Forensic Committee (1981 to 2002).

Treasurer (1982-1984).

Member, Committee on Medical and Psychiatric Care for the Canon City Facility (December 1979 - June 1980 and July 1981 to 1983).

Trustee (1984-1986).

Fellowship Committee (1987 to 2004).

President-Elect (May 1990 to May 1991).

President (May 1991-May 1992).

Assembly Representative (May 1994-May 2000).

Member, Board of Directors, Colorado for Physicians Mental Health/Political Action Committee (1988 to 2000; Chairman, 1988-1990).

American Correctional Health Services Association, Member (1984 - present).

Rocky Mountain Chapter of the American Correctional Health Services Association:

Member at large, Board of Directors (January 1984 to March 1988).

American Psychiatric Association (1978 to present):

Member, Task Force on Psychiatric Services in Correctional Facilities (December 1985-1989; Work Group to Revise the APA Guidelines on Psychiatric Services in Correctional Facilities (2014-2015).

Member, Council on Psychiatry and the Law (May 1989-May 1994), Vice-Chairman (May 1993-May 1994), May 1999–May 2004, Vice-Chairman (May 1999-May 2000), Chairman (May 2000-May 2004), Member 2015-2018).

Assembly Liaison, Council on Psychiatry and the Law (May 1994 to May 2000).

Member, Task Force on Sexually Dangerous Offenders (1993 to 1999).

Consultant, Commission on Judicial Action (1994-1996).

Member, Commission (Committee) on Judicial Action (1997-2002; 2004-2009), Chairperson (May 2004 to May 2008).

Area VII Member, APA Nominating Committee (May 1997 - May 1999).

Member, Task Force to Revise Task Force Report # 22 Seclusion and Restraint: The Psychiatric Uses (2003 to December 2006).

Member, Committee on Public Policy, Litigation and Advocacy (May 2002 to May 2004), Consultant (May 2004 to May 2006), Chairperson, (May 2008-May 2011), Consultant May 2011 to December 2015)

Consultant, Council on Advocacy and Public Policy (May 2008-May 2011).

American Academy of Psychiatry and the Law (1983 to present):
- Member, Public Information Committee (November 1984 to 1994; Chairman, October 1989 to January 1993).
- Member, Committee on Psychiatric Services for Correctional Facilities (November 1984 to October 1995).
- Member, Committee on International Relations (November 1984 to October 1986).
- Member, Site Selection Committee (October 1988 to 1996, Chairman, January 1993 to 1996).
- Member, Institutional Forensic Psychiatry Committee (1991-1994).
- Member, Nominating Committee (1991-1993, 2003, 2005, 2007, 2008).
- Member, Peer Review of Psychiatric Testimony (1992-1995, 1997-1999).
- Associate Editor, American Academy of Psychiatry and the Law Newsletter (July 1988 - July 1992).
- Councilor (October 1991 - October 1994).
- Program Committee (1994 to 2002).
- Chairman, Program Committee for the 1995 Annual Meeting.
- Treasurer (October 1995 - October 1997).
- Vice-President (October 1997 - October 1998).
- President-elect (October 1999 – October 2000).
- President (October 2000-October 2001).
- Member, Board of Directors, AAPL Institute on Education and Research, (2002 to 2010).
- Member, task force on disability guidelines (2006- 2008).

American Correctional Association, Member (1986 to present).
- Member, Mental Health Committee (1996-2002).

American College of Legal Medicine, Associate-In-Medicine (February 1986 to December 2005).

American Academy of Forensic Sciences, Member (February 1991 to 2007).

Member, Medical Committee, Colorado Guardianship Center for Persons with Developmental Disabilities (1989-1993).

Group for the Advancement of Psychiatry: Psychiatry and Law Committee (1991 to 1998).

Correctional Psychiatry:

Chief of Psychiatry, Colorado State Penitentiary (June 1980 to July 1981).

Consulting Psychiatrist, National Prison Project (1981 to present).

Consulting Psychiatrist, U.S. Department of Justice, Civil Rights Division (1990 to present).

Court Monitor (United States District Court, Southern District of New York), Reynolds et al. v. Sielaff et al., (1991-1994).

Consultant, Office of the Court Monitor (United States District Court for the District of Puerto Rico), Morales Feliciano et al. v. Rossello Gonzales et al., (1991-1997).

Member, Monitoring Team (United States District Court for the District of Kansas, Judge Richard D. Rogers), Porter et al. v. Finney et al. (No. 77-3045-R), (September 1992 to May 1994).

Certified Correctional Health Professional - Advanced Status (February 1, 1994).

Accreditation Surveyor, National Commission on Correctional Health Care (1995 to 2006).

Consultant, Office of the Court Monitor (United States District Court, Southern District of Ohio, Western Division, Magistrate Judge Robert Steinberg and Judge Spiegel), Dunn et al. v. Voinovich et al. (No. C1-93-0166), (1995 to 2000).

Consultant, Office of the Special Master and to The Honorable Thelton E. Henderson (United States District Court, Northern Division of California), Madrid et al. v. Gomez et al. (No. C90-30-94-TEH), (1995 to 2008).

Court-Appointed Expert (United States District Court for the Northern District of Illinois, Eastern Division, Judge James B. Zagel), Harrington et al. v. Kiley et al. (No. 74 C 3290), (June 20, 1995 to 2006).

Court-Appointed Expert (United States District Court for the Eastern District of California, Judge Lawrence K. Karlton), Coleman et al. v. Wilson et al. (No. CIV S-90-0520), (March 1996 to present).

Member, Monitoring Team (United States District Court for the Middle District of Georgia, Judge Claude Hicks, Jr.), Cason et al. v. Seckinger (No. 84-313-1-MAC), (1996 to 1998).

Consultant to the Office of the Monitor, Goldsmith v. Dean (No. 2: 93-CV-383), (1996 to 1998.).

Member, Monitoring Team (United States District Court for the District of Montana, Helena Division), USA v. Montana et al. (No. 94-90-H-CCL), (1996 to 1999).

Consultant to the Monitor (United States District Court, Western District of Washington), Hallet v. Payne, (No. C93-5496)(T)(D), (1998 to 1999).

Consultant to the Court (United States District Court, Southern District of Florida), Carruthers, et al. v. Jenne, II, et al. (Case No. 76-6086-CIV-Hoeveler), (January 2002 to 2007).

Psychiatric Monitor for the Memorandum of Agreement between the U.S. Department of Justice and the Los Angeles County, California re: mental health services at the Los Angeles County Jail (December 2002 to 2014).

Monitor for the Stipulated Agreement Re: McClendon, et. al. v. The City of Albuquerque, et. al. USDC No. CIV 95-0024 MV/ACT (May 2005 to present).

Psychiatric Expert for the Independent Monitor Re: the Settlement Agreement between the U.S. Department of Justice and the Delaware Department of Corrections (February 2007 to 2010).

Psychiatric Monitor for the Agreed Order in the U.S.A. v. Dallas County Jail CRIPA Investigation (July 2007 to 2015).

Psychiatric Monitor for the Memorandum of Agreement between the U.S. Department of Justice and the State of Maryland re: the Baltimore City Detention Center (July 2007 to 2014)

Jointly appointed consultant for the Memorandum of Agreement between the U.S. Department of Justice and the State of Wisconsin re: the Taycheedah Correctional Institution (TCI) (May 2008 to 2012).

Member, Society for Correctional Physicians (2009 to present).

Psychiatric Monitor for the Memorandum of Agreement between the U.S. Department of Justice and the Cook County Board of Commissioners and the Cook County

Sheriff's Office (June 2010 to present)

Other Information:

Chief of Psychiatry, Division of Forensic Psychiatry, Colorado State Hospital (1978).
Staff Psychiatrist, Denver General Hospital (July 1, 1979 to July 1980).
Private Practice: Denver, Colorado (July 1979 to present).
Spalding Rehabilitation Hospital:
Consulting Psychiatrist - Pain Rehabilitation Program (December 1979-1995).
Medical Staff President (May 1983 - May 1984).
Member, Board of Directors (May 1986-1995).
Chairman, Board of Directors (January 1992 to October 31, 1995).
Consulting Psychiatrist, Institute of Forensic Psychiatry, Colorado Mental Health Institute at Pueblo (July 1981 to November 1986; December 1991 to present).
Consulting Psychiatrist, Denver Veterans Administration Hospital, Administrative Medicine disability examinations (1981 to 2006).
Clinical Director, Perpetration Prevention Program, C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect, Department of Pediatrics, UCHSC (1986 to 2006).
Diplomate, American Board of Psychiatry and Neurology (April 1981).
Diplomate, American Board of Forensic Psychiatry (October 1985).
Certified, Added Qualifications in Forensic Psychiatry, American Board of Psychiatry and Neurology (1994), Recertified (2002-2014; April 2011-December 2021).
Full operating level treatment provider and full operating level evaluator, as per standards established by the Colorado Sex Offender Management Board (October 2003 to 2007).
Monitor for the Neiberger et al. v Schoenmakers et al. Settlement Agreement (Colorado Mental Health Institute – Pueblo Institute for Forensic Services) January 2005 to December 2006.

PUBLICATIONS

National Newsletters

1. Metzner JL: The Role of the Psychiatric Resident in Medical Student Education. Association of Academic Psychiatry, 5: July 1979.

2. Metzner JL: Brady et al v. Hopper: The Special Relationship Between Foreseeability and Liability. American Academy Psychiatry and the Law Newsletter, 8: Dec. 1983.

3. Metzner JL: Bee v. Greaves: Pretrial Detainees and Involuntary Medication. Amer. Acad. Psychiatry and the Law Newsletter, 10: April 1985.

4. Metzner JL: The Right to Refuse Treatment in Colorado: People v. Medina. Amer. Acad. Psychiatry and the Law Newsletter, 10: Dec. 1985.

5. Metzner JL: Ward v. Kort: Forensic Hospitals and Legal Access to the Courts. Amer. Acad. Psychiatry and the Law Newsletter, 10: Dec. 1985.

6. Metzner JL: Colorado v. Connelly: Confessions of the Mentally Ill. Amer. Acad. Psychiatry and the Law Newsletter, 11: Sept. 1986.

7. Metzner JL: Colorado v. Connelly: Confessions of the Mentally Ill. Amer. Acad. Psychiatry and the Law Newsletter, 12: April 1987.

8. Metzner JL: Miller v. District Court: Psychiatric Evaluation and the Attorney-Client Privilege. Amer. Acad. Psychiatry and the Law Newsletter, 12: Sept. 1987.

9. Metzner JL: Romero v. Colorado: The Admissibility of Posthypnotic Testimony. Amer. Acad. Psychiatry and the Law Newsletter, 13: April 1988.

10. Metzner JL: Rotman v. Mirin. Amer. Acad. Psychiatry and the Law Newsletter, 13: Dec. 1988.

11. Metzner JL: Perreira v. Colorado. Amer. Acad. Psychiatry and the Law Newsletter, 14: Sept. 1989.

12. Metzner JL: Washington v. Harper: Treatment Refusal in a Penal Setting Revisited. Amer. Acad. Psychiatry and the Law Newsletter, 15: Sept. 1990.

13. Metzner JL: Colorado v. Serravo: Insanity Clarified. Amer. Acad. Psychiatry and the Law Newsletter, 17: April 1992.

14. Metzner JL: Rufo v. Inmates of Suffolk County Jail. Amer. Acad. Psychiatry and the Law Newsletter, 17: Dec. 1992.

15. Metzner JL: Amendment to Rule 26: Information Essential for the Forensic Psychiatrist. Amer. Acad. Psychiatry and the Law Newsletter, 19: Sept. 1994.

16. Metzner JL: Prison Litigation Reform Act. Amer. Acad. Psychiatry and the Law Newsletter, 21: Sept 1996.

Book Chapters

1. Metzner JL: Insanity Plea, in Psychiatric Decision Making. Edited by Dubovsky SL, Feiger AJ, Eiseman B. Philadelphia, B.C. Decker, Inc., 1984.

2. Metzner JL: Competency to Stand Trial, in Psychiatric Decision Making.

3. Metzner JL: Civil Commitment of Adults, in Psychiatric Decision Making.

4. Metzner JL: Chronic Depression, in Psychiatric Decision Making.

5. Ryan G, Metzner JL, and Krugman RD: When the Abuser is a Child, in Understanding and Managing Child Sexual Abuse. Edited by Oates, RK. Philadelphia, W.B. Saunders, 1990.

6. Metzner JL, Struthers DR, and Fogel MA: Psychiatric Disability Determinations and Personal Injury Litigation, in Principles in Practice of Forensic Psychiatry. Edited by Rosner, R. New York, Chapman & Hall, 1994.

7. Metzner J, Ryan G: Sexual Abuse Perpetration, in Conduct Disorders in Children and Adolescents. Edited by Sholevar, GP. Washington, D.C., American Psychiatric Press, Inc., 1995.

8. Metzner JL: Confidentiality and Privilege, in Psychiatric Secrets. Edited by Jacobson JL & Jacobson AM. Philadelphia, Hanley & Belfus, Inc., 1995.

9. Metzner JL, Cohen F, Grossman LS, Wettstein RM; Treatment in Jails and Prisons, in Treatment of Offenders with Mental Disorders. Edited by Wettstein, RM. New York, NY, The Guilford Press, 1998.

10. Metzner JL, Becker J, Juvenile Sex Offenders, in Dangerous Sex Offenders: A Task Force Report of the American Psychiatric Association. Edited by Zonana H. Washington, D.C., American Psychiatric Association, 1999.

11. Metzner JL: Confidentiality and Privilege, in Psychiatric Secret (2nd Edition). Edited by Jacobson JL & Jacobson AM. Philadelphia, Hanley & Belfus, Inc., 2000.

12. Metzner JL: Trends in Correctional Mental Health Care, in Management and Administration of Correctional Health Care. Edited by Moore J. Kingston, New Jersey, Civic Research Institute, 2003.

13. Metzner JL, Buck JB: Psychiatric Disability Determinations and Personal Injury Litigation, in Principles in Practice of Forensic Psychiatry, (Second Edition). Edited by Rosner, R. London, Arnold, 2003.

14. Dvoskin JA, Spiers EM, Metzner JL, Pitt SE: The Structure of Correctional Mental Health Services, in Principles in Practice of Forensic Psychiatry, (Second Edition). Edited by Rosner, R. London, Arnold, 2003.

15. Metzner JL, Dvoskin JA: Psychiatry in Correctional Settings, in Textbook of Forensic Psychiatry. Edited by Simon, RI and Gold, LH. Washington, American Psychiatric Press, 2004.

16. Metzner JL (associate editor): Mental health chapters, in Clinical Practice in Correctional Medicine, Second Edition. Edited by Puisis, M. Philadelphia, Mosby Elsevier, 2006.

17. Metzner JL (associate editor): Mental health chapters, in Clinical Practice in Correctional Medicine, Second Edition. Edited by Puisis, M. Philadelphia, Mosby Elsevier, 2006.

18. Metzner JL, Hayes LM: Suicide Prevention in Jails and Prisons, in Textbook of Suicide Assessment and Management. Edited by Simon, RI and Hales, RE. Washington, American Psychiatric Press, 2006.

19. Metzner JL, Humphreys S and Ryan G: Juveniles Who Sexually Offend: Psychosocial Intervention and Treatment, in Textbook of Sex Offenders: Identification, Risk Assessment, Treatment, and Legal Issues. Edited by Saleh, FM, Grudzinskas, AJ Bradford, JM and Brodsky, DJ. New York, Oxford University Press, 241-264, 2009.

20. Metzner JL, Monitoring a Correctional Mental Health System, in Handbook of Correctional Mental Health (Second Edition). Edited by Scott CL. Washington, DC, American Psychiatric Publishing, Inc. 377-394, 2009.

21. Ruiz A, Dvoskin JA, Scott CL, Metzner JL (eds): Manual of Forms and Guidelines for Correctional Mental Health. Washington, DC, American Psychiatric Publishing, Inc. March 2010.

22. Metzner JL, Dvoskin JA: Psychiatry in Correctional Settings, in Textbook of Forensic Psychiatry. Edited by Simon, RI and Gold, LH. Washington, American Psychiatric Press, 2010.

23. Metzner JL, Current Issues in Correctional Psychiatry, in Practical Guide to Correctional Mental Health and the Law. Edited by Cohen F. Kingston, NJ: Civic Research Institute, 2011.

24. Metzner JL, Hayes LM: Suicide Prevention in Jails and Prisons, in Textbook of Suicide Assessment and Management, Second Edition. Edited by Simon, RI and Hales, RE. Washington, American Psychiatric Press, 2012.

25. Maloney MP, Metzner JL & Dvoskin JA. Screening and Assessments, Chapter 3.1. Edited by Trestman RL, Appelbaum KL, Metzner JL. The Oxford Textbook of Correctional Psychiatry, New York: Oxford University Press, May 2015.

26. Metzner JL. Systems Monitoring and Quality Improvement, Chapter 13.5. Edited by Trestman RL, Appelbaum KL, Metzner JL. The Oxford Textbook of Correctional

Psychiatry, New York: Oxford University Press, May 2015.

27. Metzner JL & Appelbaum KL. Levels of Care, Chapter 4.7. Edited by Trestman RL, Appelbaum KL, Metzner JL. The Oxford Textbook of Correctional Psychiatry, New York: Oxford University Press, May 2015.

28. Hughes K & Metzner JL. Suicide Risk Management, Chapter 9. Edited by Trestman RL, Appelbaum KL, Metzner JL. The Oxford Textbook of Correctional Psychiatry, New York: Oxford University Press, May 2015.

29. Appelbaum KL, Trestman RL. Metzner JL. The Future of Correctional Psychiatry: Evolving and Recommended Standards, Chapter 13.11. Edited by Trestman RL, Appelbaum KL, Metzner JL. The Oxford Textbook of Correctional Psychiatry, New York: Oxford University Press, May 2015.

Peer Reviewed Journals

1. Dubovsky SL, Metzner JL, Warner R: Problems with Internalization of a Transplanted Liver, Amer. J. Psychiatry, 136: 1090-1091, 1979.

2. Metzner JL, Dubovsky SL: The Role of the Psychiatrist in Evaluating a Prison Mental Health System in Litigation. Bull.Amer.Acad. Psychiatry and the Law, 14:89-93, 1986.

3. Metzner JL, Fryer GE, Usery D: Prison Mental Health Services: Results of a National Survey of Standards, Resources, Administrative Structure, and Litigation. J. Forensic Sciences, 13: 433-438, March 1990.

4. Metzner JL: Applied Criminology. Current Opinion in Psychiatry, 4:856-860, 1991.

5. Metzner JL: A Survey of University-Prison Collaboration and Computerized Tracking Systems in Prisons. Hosp. Community Psychiatry, 43:713-716, July 1992.

6. Metzner JL: Prisons, Hospitals, and Other Institutions. Current Opinion in Psychiatry, 5:809-812, 1992.

7. Metzner JL, Dentino AN, Goddard SL, Hay DP, Hay L, Linnoila M: Impairment in Driving and Psychiatric Illness. J. Neuropsychiatry and Clinical Neurosciences, 5:211-220, 1993.

8. Metzner JL: Guidelines for Psychiatric Services in Prisons. Criminal Behaviour and Mental Health, 3:252-267, 1993.

9. Metzner JL, Miller RD, Kleinsasser D: Mental Health Screening and Evaluation

within Prisons. Bull. Amer. Acad. Psychiatry and the Law, 22:451-457, 1994.

10. Hoge SK, Appelbaum P, Jorgenson L, Goldstein N, Metzner J, Patterson R, Robinson G: APA Resource Document: Legal Sanctions for Mental Health Professional/Sexual Misconduct. Bull. Amer. Acad. Psychiatry and the Law, 23:433-448, 1995.

11. Ryan G, Miyoshi TJ, Metzner JL, Krugman RD, Fryer GE: Trends in a National Sample of Sexually Abusive Youths. J. Am. Acad. Child Adolesc. Psychiatry 35: 17-25, 1996.

12. Metzner JL: Correctional Psychiatry. Current Opinion in Psychiatry, 10:441-444, 1997.

13. Metzner JL: An Introduction to Correctional Psychiatry: Part I. J. Amer. Acad. Psychiatry and the Law, 25:375-381, 1997.

14. Metzner JL: An Introduction to Correctional Psychiatry: Part II. J. Amer. Acad. Psychiatry and the Law, 25:571-579, 1997.

15. Metzner JL: An Introduction to Correctional Psychiatry: Part III. J. Amer. Acad. Psychiatry and the Law, 26:107-116, 1998.

16. Metzner JL: Pennsylvania Department of Corrections et al. v. Ronald R. Yeskey: Prisons and the Americans with Disabilities Act of 1990. J. Amer. Acad. Psychiatry and the Law, 26:665-668, 1999.

17. Metzner JL: Class Action Litigation in Correctional Psychiatry. J. Amer. Acad. Psychiatry and the Law, 30: 19-29, 2002.

18. Metzner JL: Prison Litigation in the USA: It Helps. J. Forensic Psychiatry, 13: 240-244, 2002.

19. Metzner JL: Commentary: The Role of Mental Health in the Disciplinary Process. J. Amer. Acad. Psychiatry and the Law, 30: 497-499, 2002.

20. Metzner JL: Improving Correctional Mental Health Systems: An Academic/Forensic Psychiatrist's Perspective. Acad. Psychiatry, 27: 201-203, 2003.

21. Metzner JL: Commentary: Physician Reporting of Impaired Drivers. J. Amer. Acad. Psychiatry and the Law, 32:80-82, 2004.

22. Metzner JL and Dvoskin JA: An Overview of Correctional Psychiatry. Psychiatric Clinics N Am , 29: 761-772, 2006

23. Gold LH and Metzner JL: Psychiatric Employment Evaluations and the Health Insurance Portability and Accountability Act. Am J Psychiatry 153: 1878-1882, 2006

24. Wortzel H and Metzner J: *Clark v. Arizona*: Diminishing the Right of Mentally Ill Individuals to a Full and Fair Defense. J. Amer. Acad. Psychiatry and the Law, 34:545-8, 2006.

25. Metzner JL: Introduction to: Resource Document on the Use of Restraint and Seclusion in Correctional Health Care. J. Amer. Acad. Psychiatry and the Law, 35:415-416, 2007.

26. Metzner JL, Tardiff K, Lion J, et al: Resource Document on the Use of Restraint and Seclusion in Correctional Health Care. J. Amer. Acad. Psychiatry and the Law, 35:417-425, 2007.

27. Gold LH, Anfang SA, Drukteinis AM, Metzner JL, Price M, Wall BW, Wylonis L, Zonana HV: AAPL Practice Guideline for the Forensic Evaluation of Psychiatric disability. J Am Acad Psychiatry Law 36 (Suppl 4):S3–50, 2008

28. Metzner JL: Monitoring a Correctional Mental Health Care System: the Role of the Mental Health Expert. Behav. Sci. Law 27: 727–741, 2009.

29. Metzner JL, Ash P: Commentary: The Mental Status Examination in the Age of the Internet--Challenges and Opportunities. J Am Acad Psychiatry Law 38:27-31, 2010.

30. Metzner JL, Fellner J: Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics. J Am Acad Psychiatry Law 38:104-108, 2010.

31. Appelbaum KL, Savageau J, Trestman RL, Metzner JL, Baillargeon, JG: A National Survey of Self Injurious Behavior in American Prisons. Psychiatric Services 62:285-290, 2011.

32. Metzner JL: Treatment for Prisoners: A U.S. Perspective. Psychiatric Services 63: 276, 2012.

33. O'Keefe ML, Klebe KJ, Metzner J, Dvoskin J, Fellner J, Stucker A: A Longitudinal Study of Administrative Segregation. J Am Acad Psychiatry Law 41:1:49-60, 2013.

Books

1. Trestman RL, Appelbaum KL, Metzner JL (Editors): The Oxford Textbook of Correctional Psychiatry, New York: Oxford University Press, May 2015.

Book Reviews

1. Metzner JL: A Review of The Psychopathic Mind: Origins, Dynamics, and Treatment. J. Forensic Sciences, 13: 1502-1503, Nov. 1990.

2. Metzner JL: Males at Risk: The Other Side of Child Sexual Abuse. Child Abuse & Neglect, 15:153-157, 1991.

3. Metzner JL: The Crimes Women Commit, The Punishments They Receive. Bull. Amer. Acad. Psychiatry and the Law, 19:323-324, 1991.

4. Metzner JL: When a Child Kills: Abused Children Who Kill Their Parents. JAMA, 267:3214, 1992.

5. Metzner JL: Children of Chemically Dependent Parents: Multiperspectives from the Cutting Edge. Child Abuse & Neglect, 17:566, 1993.

6. Metzner JL: Before and After Hinckley: Evaluating Insanity Defense Reform. J. Nervous and Mental Disease, 182:362-363, 1994.

7. Metzner JL: Caring For Victims. JAMA, 273: 1796-1797, 1995.

8. Metzner JL: Explorations in Criminal Psychopathology: Clinical Syndromes with Forensic Implications. Psychiatric Services, 49:393, 1998.

9. Metzner JL: Legal and Ethical Dimensions for Mental Health Professionals. Psychiatric Services, 51:1056, 2000.

10. Metzner JL: A Handbook for Correctional Psychologists: Guidance for the Prison Practitioner. J Amer. Acad. Psychiatry and the Law, 30: 328, 2002.

11. Metzner JL: Concise Guide to Psychiatry and Law for Clinicians, 3rd ed. J Clin Psychiatry 63: 1052-1053, November 2002.

12. Metzner JL: Going up the river. Travels in a prison nation. J Forensic Psychiatry & Psychology. 14: 642-643, 2003.

Other

1. Metzner JL: The Adolescent Sex Offender: An Overview. The Colorado Lawyer, 16: Oct. 1987.

2. Weinstein HC, Hoover JO, Metzner JL, Shah SA, Steadman HJ: Task Force Report

29: Psychiatric Services in Jails and Prisons, American Psychiatric Association, March 1989.

3. Metzner JL: Perreira v. Colorado - A Psychiatrist's Duty to Protect Others. The Colorado Lawyer, 18: Dec. 1989.

4. Metzner JL, Tucker GH, Black DW, Felthous A, Linnoila M: Conference on Psychiatric Disorders and Commercial Drivers. Federal Highway Administration, Publ. No. FHWA-MC-91-006, Washington, DC, May 1991.

5. Metzner JL: Mental Health Considerations for Segregated Inmates, in Standards for Health Services in Jails. Chicago, IL, National Commission on Correctional Healthcare, 2003.

6. Metzner JL: Mental Health Considerations for Segregated Inmates, in Standards for Health Services in Prisons. Chicago, IL, National Commission on Correctional Healthcare, 2003.

7. Metzner, JL: Clinical Case 3. Confidentiality of Patient Records Requested by the Court. Available at: http://www.ama-assn.org/ama/pub/category/11088.html Accessed October 1, 2003.

8. Metzner JL: HIPAA: Does it cause barriers to conducting mortality reviews? Jail Suicide/Mental Health Update, 13: Summer 2004.

9. Dvoskin JA and Metzner JL: Commentary: The Physicians' Torture Report. Correctional Mental Health Reporter, 8, May/June 2006.

10. Metzner JL: Mental Health Problems of Prison and Jail Inmates. Correctional Mental Health Reporter, 8, January/February 2007.

11. Metzner JL, Tardiff K, Lion J, Reid W, Recupero PR, M.D., Schetky DH, Edenfield BM, Mattson M, Janofsky JS: The Use of Restraint and Seclusion in Correctional Mental Health Care. Approved as a resource document by the American Psychiatric Association. December 2006.

12. Martinez R, Metzner JL: In memoriam: Robert D. Miller, M.D., Ph.D.: September 4, 1941-July 13, 2006. Beh Sci Law, 25: 333-335, 2007

13. Metzner JL: Correctional Mental Health. *Virtual Mentor*. 2007; 10(2):92-95. http://virtualmentor.ama-assn.org/2008/02/ccas3-0802.html. Accessed February 1, 2008.

14. Metzner JL: Mental Health Considerations for Segregated Inmates, in Standards for

Health Services in Jails. Chicago, IL, National Commission on Correctional Healthcare, 2008.

15. Metzner JL: Mental Health Considerations for Segregated Inmates, in Standards for Health Services in Prisons. Chicago, IL, National Commission on Correctional Healthcare, 2008.

16. Metzner JL: Appendix E: Mental Health Considerations for Segregated Inmates, in Standards for Mental Health Services in Correctional Facilities. Chicago, IL, National Commission on Correctional Healthcare, 2008, pp 129-131

17. Metzner JL: Appendix E: Mental Health Considerations for Segregated Inmates, in Standards for Mental Health Services in Correctional Facilities. Chicago, IL, National Commission on Correctional Healthcare, 2014 http://www.ncchc.org/other-resources Accessed July1, 2014.

18. Trestman RL, Champion MK, Ford E, Metzner JL, Newkirk CF, Penn JV, Pinals DA, Scott C, Stellman RE, Weinstein HC, Weinstock R, Appelbaum KL Young JL: Psychiatric Services in Correctional Facilities, Third Edition. American Psychiatric Association, June 2015.

EXHIBIT 13

CURRICULUM VITAE
Sally Ann Cunningham Johnson, M.D.
Forensic Psychiatry and Consultation
University of North Carolina Department of Psychiatry
Forensic Psychiatry Program & Clinic

CONTACT INFORMATION

[redacted]

CURRENT POSITION

Professor of Psychiatry, University of North Carolina at Chapel Hill
Clinical Director Forensic Psychiatry Program and Clinic

Conducts forensic evaluations and provides consultation to attorneys, the courts, and various agencies regarding psychiatric, forensic and correctional issues. Actively involved in research, teaching and supervision of law students, psychiatric residents and fellows, regarding forensic mental health issues.

Particular Areas of Interest/Experience

Criminal and Civil Forensic Evaluations / Expert Witness Testimony
Correctional Psychiatry / Mental Health and Medical Services
Competency to Stand Trial / Competency Restoration
Criminal Responsibility / Wrongful Convictions
Sentencing / Death Penalty / Mitigation
Dangerousness Assessments / Violence Risk Assessment
Civil Commitment
Competency to Consent to Hospitalization / Competency to Consent to Medical Care
Right to Treatment / Right to Refuse Treatment
Involuntary Medication / Administrative Review Processes
Guardianship
Veterans Issues / PTSD / TBI
Violence Risk Assessment / Risk Management
Suicide / Significant Incident Review and Assessment
Bioterrorism
Evaluation / Treatment of Sexual Offenders
Management of Transsexuals in Correctional Settings
Medical and Psychiatric Healthcare in Correctional Environments/ Rehabilitation
Seclusion and Restraint / Conditions of Confinement/Psychiatric Impact
Quality Assurance / Accreditation
Training in Forensic Psychiatry

PREVIOUS POSITIONS

Private Practice of Forensic Psychiatry July 2004 to June 2007

Psychiatric Consultant to the Medical Director of the Federal Bureau of Prisons
October 2001 to June 30, 2004.

> Served as Psychiatrist and Consultant to the Director Health Services Division of the Federal Bureau of Prisons. Conducted forensic evaluations for the federal courts on high profile and complex cases, and served as expert witness. Consulted on psychiatric, medical and forensic issues for the Federal Bureau of Prisons, other federal agencies, and state correctional health care operations. Conducted research, training, and taught in areas of psychiatry and forensic psychiatry.

Director of Forensic Fellowship Program for Federal Bureau of Prisons/Duke University Department of Psychiatry 1990-2004

Associate Warden Medical/Chief Psychiatrist
Health Services Division
Federal Correctional Complex (FCC)
Butner, North Carolina
October 1999 to October 2001

> Administered psychiatric inpatient and outpatient services and medical inpatient and outpatient services at the Federal Medical Center for the Federal Bureau of Prisons.

Associate Warden Health Services/Chief Psychiatrist
Federal Correctional Institution (FCI)
Butner, North Carolina
January 1989 to October 1999

Director of Forensic Services and Clinical Research
FCI Butner, North Carolina
1983 to January 1989

Staff Psychiatrist
FCI Butner, North Carolina
1979 to 1983

Experience within medical school and residency training in a variety of adult, adolescent, child, and forensic treatment settings and treatment modalities.

MILITARY EXPERIENCE

Retired Captain (06) U.S. Public Health Service - Active Duty Commissioned Officer assigned to the Bureau of Prisons, July 1, 1979 to July 1, 2004.

EDUCATION

B.S. - Pennsylvania State University
University Park, Pennsylvania, November 1974.

M.D. - Jefferson Medical College-Thomas Jefferson University (now the Sidney Kimmel Medical College-Thomas Jefferson University)
Philadelphia, Pennsylvania, June 1976.

> Completed undergraduate and medical degrees in special accelerated, combined, five-year undergraduate/graduate program. Undergraduate degree was awarded following completion of initial two years of medical school classes in conjunction with completion of all required credits within the Pennsylvania State University Five Year combined BS/MD Program.

Psychiatry Residency - Duke University Medical Center
Durham, North Carolina, 1976-1979. Completed June 1979.

LICENSE AND CERTIFICATION

North Carolina Medical License # 22128
Diplomate of American Board of Psychiatry and Neurology (ABPN) - 1981
Diplomate of American Board of Forensic Psychiatry - 1990
Subspecialty Certification in Forensic Psychiatry/ABPN - 1994, recertification 2003, 2013

PROFESSIONAL APPOINTMENTS AND MEMBERSHIPS

Professor, Department of Psychiatry, The University of North Carolina at Chapel Hill

Assistant Consulting Professor, Department of Psychiatry and Behavioral Sciences, Duke University Medical Center.

Senior Lecturing Fellow Duke University School of Law
Teaches seminars in Psychiatry and Law (civil and criminal issues).

Adjunct Professor University of North Carolina School of Law
Teaches seminars on Forensic Issues

American Psychiatric Association, Distinguished Life Fellow; Served on Manfred S. Guttmacher Award Board; Committee on Health Care in Federal Government Institutions

American Academy of Psychiatry and the Law: Served on various committees regarding correctional and institutional psychiatry and Committee of Training Directors for Fellowship Programs. Currently serving on Ethics Committee.

North Carolina Psychiatric Association: Chaired Psychiatry and Law Committee; serve on Psychiatry and Law Committee; previously served on Committee on Women

American Medical Association

North Carolina Medical Association: Served as Consultant to Committee on Mental Health

Consultant/ Psychiatric Expert for Civil Rights Division in regard to Mental Health Care in State Correctional Institutions

Adjunct Professor University of Tennessee Knoxville School of Law

Member Expert Behavioral Analysis Panel for review of Anthrax mailings

Served as Board Examiner, American Board of Forensic Psychiatry

Consultant to Federal Judge monitoring Louisiana State Prison System

Member of Mental Health Advisory Group, Federal Bureau of Prisons

Consultant to review operations at the Federal Transportation Center, Oklahoma City, OK

Federal Bureau of Prisons Task Force on Development of Federal Sex Offender Program

Member of Design Team for new Federal Medical Center, Federal Bureau of Prisons

Consultant to North Carolina Department of Corrections Task Force on Health Care Delivery

Member of Bureau of Prisons Task Force for Restructuring of Healthcare Operations and Staffing

Secretary North Carolina Symphony Board

Member National Council Eastman School of Music

Member National Board of Carolina Performing Arts, University of North Carolina at Chapel Hill 2004-2012

AWARDS/RECOGNITIONS

U.S. Public Health Services Commendation Award, 1982.

Federal Bureau of Prisons Special Commendation Award, 1983.

J.D. Lane Clinical Research Award, Open Category, 1987.

U.S. Public Health Service Outstanding Service Award, 1990.

United States Department of Justice Attorney General's Award for Distinguished Service, July 1998.

Bureau of Prisons Commendation Medal, January 2000.

U.S. Public Health Services Distinguished Service Award 2001.

Distinguished Service Medal, Federal Bureau of Prisons, May 2004.

Triangle Business Journal, Women in Business Award, 2004

Seymour Pollack Distinguished Achievement Award, American Academy of Psychiatry and the Law, 2014

PUBLICATIONS

Sex Offenses: A Short Questionnaire Assessing Knowledge and Attitudes Bulletin of the American Academy of Psychiatry and the Law. Sally C. Johnson M.D.; et al Volume VIII, No. 3, 1980, pp. 280-287.

Treating the Multiple Problem Exhibitionist's Fantasies in a Restrictive Setting Corrective and Social Psychiatry& Journal of Behavior Technology, Methods &Therapy. Johnson, Sally; Edinger, Jack D., Volume 27, No. 2, 1981, pp. 100-104.

Of Interest to All Psychiatrists, Contemporary Psychiatry. Volume II, No. 3, 1983.

Detecting cocaine abuse in a patient. Johnson, Sally et al. Medical Aspects of Human Sexuality, Vol. 20(7) Jul 1986 pp 66-82..

Guest Editor: Psychiatric Annals, Mental Health Care in the Federal Bureau of Prisons December 1988, Volume 18, No. 12, pp. 680-683.

Mental health services within the Federal Bureau of Prisons. Psychiatric Annals,
Volume 18, No. 12, pp. December 1988, pp. 673-674 Johnson, Sally C., Hoover, James O.

The prison forensic unit: Training ground. Johnson, Sally C.; Psychiatric Annals, Vol 18(12), Dec, 1988. Pp. 680-683.

Treating Mental Ill Inmates, Corrections Today, December 1993, Vol. 55, No. 7, pp. 84-89
Sally C. Johnson M.D., J. David Ramseur.

Depression and anxiety disorder among older male inmates at a federal correctional facility. Koenig, Harold G., Johnson, Sally, Bellard, James, Denker, Michele; et al. Psychiatric Services, April 1995, Vol. 46, No. 4, pp. 399-401.

Mental Health Services in a Correctional Setting, Part IV, Chapter 15 in Prison and Jail Administration, Practice and Theory, Peter M. Carlson and Judith Simon Garrett. Aspen 1999.

Mental Health Part II, Chapter 10 in Prison and Jail Administration Practice and Theory, Second Edition, Peter M. Carlson and Judith Simon Garrett. Jones and Bartlett Publishers 2008.

The intricate link between violence and mental disorder: results from the National Epidemiological Survey of Alcoholism and Related Conditions." Elbogen, Eric B., Johnson, Sally C.; Archives of General Psychiatry, Vol.66(2), Feb, 2009. pp. 152-161.

Improving Risk Assessment of Violence among Military Veterans: An Evidenced-based Approach for Clinical Decision Making. E.B. Elbogen, S. Fuller, S. Brooks, P. Kineer, P. Calhoun and J. Beckham Clinical Psychology Review, Vol. 30(6), August, 2010, pp.595-607.

The Amerithrax Case: Report of the Expert Behavioral Analysis Panel August 2010
(Coauthored with panel)
Writing for the US federal courts. In A. Buchanon and M. Norko (Eds.). Writing Forensic Reports. New York, NY: Cambridge University Press. 2011 coarthured with Eric Elbogen and Alyson Kuroski-Mazzei

Treatment of Anger and Aggression Associated with PTSD. In B.A. Moore and W.E. Penk (Eds.). Treating PTSD in Military Personnel: A Clinical Handbook. New York, NY: Guilford Press. 2011 coauthored with E. B. Elbogen and J. Beckham

Protective Factors and Risk Modification of Violence in Iraq and Afghanistan War Veterans. Journal of Clinical Psychiatry. Elbogen, E. B., Johnson, S. C., Wagner, H. R., Newton, V.M., Timko, C., Vasterling, J. J.,& Beckham, J. C. J. Clinical Psychiatry 2012 June;73(6):e767-73

Financial well-being and postdeployment adjustment among Iraq and Afghanistan war veterans. Military Medicine. 2012 Jun; 177(6):669-75 Elbogen, EB**,** Johnson, S C, Wagner, H R, Newton, VM, Beckham, J.C

Criminal Justice Involvement trauma and Negative Affect in Iraq and Afghanistan War Era Veterans. J Consult Clin Psychol 2012 Dec 1: 80(6): 1097-102. Elbogen, E. B.**,** Johnson, S. C.,Beckham, J., Vasterling, J., Straits-Troster, K., Wagner,H.R., Newton, V.

Are Iraq and Afghanistan Veterans Using Mental health Services? New data From a National Random-Sample Survey. Psychiatric Services, 2013, Feb 64(2):134-141. Eric B. Elbogen, Ph.D; H. Ryan Wagner, Ph.D.; Sally C. Johnson, M.D.; Jean C. Beckham, Ph.D.

Personality disorders at the interface of psychiatry and the law: legal use and clinical classification. Dialogues Clin Neurosci 2013 June; 15 (2): 203-11. Sally C. Johnson MD and Eric B. Elbogen PhD

Mental Health Chapter 14 in Prison and Jail Administration Practice and Theory, Third Edition, Peter M. Carlson and Judith Simon Garrett. Jones and Bartlett Publishers 2013.

Self-Report and Longitudinal Predictors of Violence in Iraq and Afghanistan War Era Veterans. Journal of Nervous and Mental Disease. Elbogen, E.B**.,** Johnson, S.J., Newton, V., Wagner, H.R., Fuller, S, & Beckham. JC. J Nerv Ment Dis 2013 Oct; 201(10): 872-6

Violent behavior and posttraumatic stress disorder in US Iraq and Afghanistan Veterans. Br. J. Psychiatry 2014, Feb 27. Eric B. Elbogen, Sally C. Johnson, H. Ryan Wagner, Connor Sullivan, Casey T. Taft, Jean C. Beckham.

Protective mechanisms and prevention of violence and aggression in veterans. Elbogen, Eric B.; Johnson, Sally C.; Newton, Virginia M.; Timko, Christine; Vasterling, Jennifer J.; Van Male, Lynn M.; Wagner, H. Ryan; Beckham, Jean C.; Psychological Services, Vol 11(2), May, 2014. pp.220-228. Publisher: Educational Publishing Foundation [Journal Article]

Violence, suicide, and all-cause mortality. The Lancet Psychiatry, Volume 1, Issue 1, Pages6-8, June 2014. Eric B. Elbogen and Sally C. Johnson

PARTIAL LIST OF PRESENTATIONS/WORKSHOPS/SEMINARS

"Social Change and Mental Health in Professional Women" Annual Meeting and Scientific Program, North Carolina Neuropsychiatric Association, 1980.

"The Prison Psychiatric Unit as a Training Site" USPHS COA Annual Meeting, Boston, MA, 1981.

"Dealing with Phobias" Family Practice Review Course, University of Tennessee, Chattanooga, TN, 1981.

"Treatment of the Rape Victim" Family Practice Review Course, University of Tennessee, Chattanooga, TN, 1981.

"The Forensic Evaluation" Conference in Prison and Forensic Psychiatry," Butner, NC, 1982.

"The Role of the Psychiatrist in Insanity Defense Trials" Grand Rounds East Carolina School of Medicine, Greenville, NC, 1982.

"The Hinckley Trial: A Retrospective" C.S.I. Program, Philadelphia, PA, 1982.

"The Insanity Defense and the Relationship to the Purposes of the *Law* Sentencing Institute for the Fourth and Eleventh Circuits, Butner, NC, 1983.

"Treating the Mentally Disordered Offenders Symposium in Psychiatry and Law, North Carolina State Department of Mental Health at John Umstead Hospital, Butner, NC, 1985.

"Prediction of Dangerousness/The New Federal Crime Legislation" Panel Discussion, Rochester, MN, 1985.

"Pretrial Psychiatric Evaluations and Forensic Report Writing" Psychiatrists Workshop, Rochester, MN, 1986.

Component Presentation "Delivering Care Within Federal Institutions" APA, Dallas, TX, 1985.

"Psychological Problems of Law Students" Duke University, Durham, NC, 1986.

"Violent Behavior Among Prisoners" and "Prison Forensic Services" presented at Annual Psychiatric Conference in Springfield, MI, September 1986.

"Violence in Prisons" Annual USPHS Meeting in Las Vegas, NV, 1987.

"Psychological Motivation of Pedophiles" and "Interviewing Child Sex Offenders" Exploitation and Pornography Seminar in Charleston, WV, September 1988.
"Treating the Sex Offender" the Fifth Annual Correctional Symposium: Casework and Mental Health Service in Lexington, KY, 1988.

"Assessing the Impact of Changes in Federal Law on Forensic Criminal Responsibility Evaluations in the Federal Bureau of Prisons" the American Society of Criminology meeting in Chicago, IL, 1988.

"Research on Pre-Trial Defendants Referred for Pretrial Evaluations" Research Roundup in Washington, DC, April 1989.

"Mental Health Issues" Bureau of Prisons Conference, 1989.

"Substance Abusers Referred for Pretrial Evaluations" Annual Meeting of the American Academy of Psychiatry and the Law, October 1989.

"The Whole Diagnostic Picture: The Forgotten Factor in the Mad versus Bad Dilemma" American Society of Criminology in Reno, NV, November 1989.

"State Placement of Federal Inmates under Current Criminal Code" Association of State Forensic Directors, Santa Fe, NM, 1990.

"Assessment and Treatment of Sexual Offenders" Grand Rounds Presentations, Duke University Medical Center, 1990.

Mock Trials/ACA, 1990.

"Mental Health Issues" BOP Legal Conference, 1990.

BOP Forensic and Clinical Conference in Rochester, MN, 1990.

Training for Completion of Forensic Evaluations (two day workshop) in Denver, Colorado, 1990.

"Mental Health Initiatives" Warden's Conference Lancaster, PA, June 1991.

"New Treatment Methods with Federal Bureau of Prisons" October 1991, Annual AAPL meeting.

"Medical Problems Presenting as Psychiatric Problems," Forensic Training Conference, Fort Lauderdale, FL, 1992.

"Criminal Responsibility," Forensic Training Conference, Fort Lauderdale, FL, 1992.

"Management and Placement of 4246 Cases Under Federal Law," Meeting of State Forensic Hospital Directors, Seattle, WA, 1993.

"Parenting Programs Within Federal Correctional Facilities," Conference on Women's Health Issues, Pensacola, FL, 1994.

"Sexual Harassment," Conference on Women's Health Issues, Pensacola, FL, 1994.

"Healthcare Delivery Within Correctional Settings," National Prison Construction and Maintenance Conference (NPCMC), Tempe, AZ, 1995.

"Managing Suicidal and Mentally Ill Inmates," BOP Conference, Durham, NC, 1995.

"Workplace Violence," Institute of Business Law at California State University/Los Angeles, CA, Raleigh, NC, 1996.

"Mental Health Design Issues within a Correctional Setting," Panel Discussion on Mental Health Issues, American Institute of Architects, Albuquerque, NM, 1996.

"Extent of Care with a Pretrial Defendent," Surgical Grand Rounds, UNC Hospital, Chapel Hill, NC, 1997.

"Infectious Disease, Transsexualism, Extent of our Duty of Care in Treating Inmates", "Hemodialysis/Organ Transplants," BOP Legal Training Conference, Durham, NC, 1997.

"Assessing and Managing Threats of Violence in the Workplace," Continuing Legal Education Presention, Raleigh, NC, 1997.

"Newer Psychotropic Medications: Guidelines for Treatment," Clinical Directors Meeting, San Diego, CA, 1998.

“Informed Consent Issues Within Correctional Mental Health Care Systems Clinical/Legal/Ethical Issues in Federal Death Penalty Cases,” Forensic Conference, Washington, DC, 1998.
“Guidelines for Court Ordered Expert Witnesses,” Forensic Conference, Washington, DC, 1998.

“Physician’s Role in Criminal Responsibility Evaluations,” Grand Rounds Presentation, Tennessee, 1999.

"Psychotropic Medications," Overview and Update, San Diego, CA, 1999.

"History and Process of Evaluation of Insanity," North Carolina Criminal Justice Meeting, 2000.

"Involuntary Medication Issues," Rochester, MN, 2000.

"Diagnosis and Treatment of Depression and Schizophrenia," Clinical Directors' Meeting, Baltimore, MD, 2001.

Conducting Criminal Responsibility Evaluations (workshop), Unicoy, GA, 2001.

"Legal Issues in Psychiatric Practice," Duke University Medical Center Comprehensive Psychiatric Update. 2002.

Presentation on review of Forensic Evaluation Process in the Federal Bureau of Prisons (BOP), BOP Psychiatric Conference, 2002.

"An Integrated Approach to Conducting Forensic Evaluations and Providing Treatment Services," BOP Staff Conference, 2003.

"Juvenile Murderers Grow Up: Challenges of Disposition", Panel Presentation AAPL Annual Meeting, Chicago 2006

"Dementia and Capacity: How Would You Handle It?" Festival of Legal Learning
Chapel Hill, NC 2008

"What Lawyers Need to Know: Using Mental Health Experts", Festival of Legal Learning Chapel Hill, NC 2008

"Mental Health and Substance Abuse for Attorneys", Festival of Legal Learning
Chapel Hill, NC 2008

"Psychiatry and Law: Law and Psychiatry", UNC School of Medicine Chapel Hill, NC 2008

"Malpractice: An Overview and Update", Grand Rounds Presentation New Hanover Regional Medical Center, Wilmington, NC 2008

"Campus Risk Assessment: Challenges and Barriers", American Academy of psychiatry and the Law, 39th Annual Meeting, Seattle, WA 2008

"Dementia and Estate Planning: Ethical Considerations", American Academy of Psychiatry and the Law, 39th Annual Meeting, Seattle, WA 2008

"On Becoming a Forensic Expert", American Academy of Psychiatry and the Law, 39th Annual Meeting, Seattle, WA 2008

"Dementia and Estate Planning: Ethical Considerations, North Carolina Conference on Aging, Greenville, NC 2008

"PTSD: An Overview and Update", UNC Law School Festival of Legal Learning, Chapel Hill, NC 2009

"Substance Abuse and Mental Illness: What Lawyers Need to Know", UNC Festival of Legal Learning, Chapel Hill, NC 2009

"Review of Tarasoff Issues in NC", Grand Rounds Panel, UNC Department of Psychiatry, Chapel Hill, NC 2009

"Establishing Rehabilitation Programs in Prisons", Riyadh, Saudi Arabia Conference on Deradicalization, 2009

"Developing Programs in the Prison Context: Challenges and Opportunities", Avenues for Dialogue II, Stockholm, Sweden, 2009

"Suicide Assessment and Intervention", The Resilient Lawyer, North Carolina Bar Association, Pinehurst, NC, 2010

"Integrating Forensic Psychiatry into Your Practice", 2010 George Ham Symposium for Psychiatry, Chapel Hill, NC, 2010

"Dead Right, Dead Wrong, or the Jury is Still Out: The Complex Worlds of Violence and Mental Illness", 2010 University of Maryland Grand Rounds, Baltimore, MD

"Suicide Assessment and Intervention"; "Mental Illness: It Can Happen to Anybody"; "Mental Health Issues of Lawyers in Transition", 2011 UNC School of Law Festival of Legal Learning, Chapel Hill, NC

Human Reliability/ Insider Threat Technical Exchange, Washington DC, July 2011

Mental Health and Competency Evaluations: Case Studies and training, Charlottesville, VA October 2011

"A Handful of Pearls: A Quick Review on Mental Illness and Substance Abuse"; "Managing Your Mental Health Throughout Your Career", 2012 UNC School of Law Festival of Legal Learning Chapel Hill NC, February 2012; (Repeated February 2013)

Documentation: Thinking About What You Write Before Someone Else Thinks About What You Have Written, UNC Psychiatry Residency Seminar Series September 2012

Violence Risk Assessment and Management, 2013 UNC School of Law Festival of Legal Learning, Chapel Hill, NC, February 2013

Finding the Forensic Psychiatrist Within: How the Principles and Practice of Forensic Psychiatry Can Inform Your Psychiatric or Psychological Practice. Grand Rounds Presentation, Duke University Medical Center, Durham, North Carolina. October, 2013

Violence and Mental Illness: Science, Sensationalism, and Societal Perceptions. Grand Rounds Presentation, Einstein Medical Center, Philadelphia, Pennsylvania. January 2014; Presentation Cooper Hospital Psychiatry grand rounds, Camden New Jersey, June 2014.

Amerithrax Briefing: Forensic Expert Behavioral Analysis Panel- How psychiatry Fits In. Presentation to the Capitol Police, Washington DC June 2014

Law Enforcement Executive Development Seminar, Mashantucket, CT, February 2015

Forensics and Open Source Intelligence, European conference on Social Media and Policing, Rome, Italy, July 2015

Co-Coordinator Threat Management Strategies to Disrupt Targeted Shootings Conference, FBI/ Critical Incident Analysis Group, July 2015

RESEARCH

Use of the Grade of Membership Technique in Review of Federal Pretrial Forensic Evaluations for Competency to Stand Trial and Criminal Responsibility, preliminary report presented at National Institute of Justice, April 1986; Final Report February 1987.

Co-Chairperson of Work Group on Sexual Offenders Within the Federal Bureau of Prisons, Report June 1988.

Comparison of Pre- and Post-Law Change. Referrals for Competency and Responsibility Evaluations within the Federal Bureau of Prisons. Presented at the American Society of Criminology meeting in Chicago, IL, 1988.

Ongoing Study of Population referred for Forensic Evaluations.

Clinical Research within Forensic Division of the Federal Bureau of Prisons has included development of data collection instruments and review analysis of large data basis regarding demographic, criminal, legal, psychiatric, and medical aspects of incarcerated persons in a mental health setting.

United States Secret Service Exceptional Case Studies Project, jointly conducted by Bureau of Prisons, Secret Service and National Institution of Justice.

Review of forensic evaluation process with Federal Bureau of Prisons.

Review of conditions of confinement, psychiatric impact, and management of long term incarceration and segregation.

Study of violence in the mentally ill populations

Forensic Issues among Veterans including Violence Risk Assessment, identification of protective factors and Risk Modification

NC TRACS Grant to establish registry for veterans receiving care outside VA system at UNC Healthcare

DoD Grant to study self-administered cognitive rehabilitation techniques in veterans with TBI and PTSD

DoD Grant to study family intervention with seriously injured Veterans (FOCUS-CI)

CONTINUING EDUCATION/LEADERSHIP TRAINING

Remains current with continuing medical education requirements for physicians

Center for Creative Leadership, Greensboro, NC.

Interagency Institute for Federal Health Care Executive, Washington, DC.

Leadership for Physician Executive Seminar, Harvard Medical School, Boston, MA.

Completed extensive training in hospital and behavioral healthcare and ambulatory care accreditation programs / improving organizational performance.