THE INTERNATIONAL CENTRE FOR CRIMINAL LAW
REFORM AND CRIMINAL JUSTICE POLICY

MENTAL HEALTH AND SUBSTANCE USE SERVICES IN CORRECTIONAL SETTINGS

A Review of Minimum Standards and Best Practices

March 2009

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International Centre for Criminal Law Reform and Criminal Justice Policy

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MENTAL HEALTH AND SUBSTANCE USE SERVICES IN CORRECTIONAL SETTINGS

A Review of Minimum Standards and Best Practices

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Mental Health and Substance Use Services in Correctional Settings:
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1. INTRODUCTION

Research consistently demonstrates that custodial and community corrections populations have substantially higher prevalence rates of mental health and substance use problems compared with the general population (Arseneault, Moffitt, Caspi, Taylor, & Silva, 2000; Brink, 2005; Fazel & Danesh, 2002; Lurigio et al., 2003; Steadman, McCarty, & Morressey, 1989; Tiihonen, Isohanni, Rasanen, Koiranen, & Moring, 1997). When individuals with mental health and substance use problems are detained, imprisoned, or being supervised in the community, opportunities arise for detecting untreated illness, reducing suffering, and improving quality of life. Not only is it good practice to provide an appropriate level of high-quality mental health and substance use services to correctional populations, it is an ethical and legal responsibility. In Canada, this statutory obligation is enshrined in international, federal (i.e., *Charter of Rights and Freedoms*, the *Correctional and Conditional Release Act*), and provincial/ territorial health and correctional policy and legislation.

1.1. PURPOSE

BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority, has been commissioned by the International Centre for Criminal Law Reform and Criminal Justice Policy (the Centre) to undertake a review of minimum standards and best practices in relation to the provision of mental health and substance use services in correctional settings. The present report has been created to serve as a background document for the Centre as it prepares to undertake further work in relation to mental health practices in the criminal justice system.

1.2. SCOPE

The minimum standards and best practices described below apply to assessment and treatment services and supports in jails, prisons, and community corrections for adults with major mental health and substance use problems. In keeping with the literature under review, the term "major mental health and substance use problems" primarily relates to schizophrenia and other psychotic disorders, major mood and anxiety disorders, and substance abuse or dependence as defined by diagnostic classification schemes (i.e., DSM-IV-TR, Axis I). As deemed appropriate by the literature, limited attention has been paid to how mental health and substance use services can be tailored for individuals with co-occurring acquired brain impairment, which, for this review, refers to neurological dysfunction and cognitive deficit resulting from trauma (e.g., head injury, substance misuse, tumours, or cerebral vascular problems) to the brain.

This review largely excludes standards and best practices in relation to non-major mental health and substance use problems, juvenile populations, and interventions designed solely to modify offending behaviour. Strategies for diverting individuals with mental health and substance use problems from the criminal justice system are considered beyond the scope of this review. Though this report isolates mental health and substance use problems, it is necessary to recognize the importance of using a holistic approach to service development that also attends to – often co-occurring – serious health problems, such as HIV infection and AIDS, serious communicable diseases (e.g., tuberculosis, hepatitis), chronic health conditions (e.g., heart disease, diabetes, lung disease), and dental disease (World Health Organization, 2007a).

1.3. APPROACH

An extensive review of published literature was performed by entering relevant keywords into major databases, including NCBI PubMed, ISI Web of Science, Ovid, and Campbell Collaboration databases. Grey literature was also reviewed by entering keywords into internet search engines (i.e., Google) and retrieving electronically published documents. The references of all identified articles and reports were hand-inspected for further relevant studies and reports.

The search criteria were necessarily loose, owing to the breadth of subject matter, the range of theoretical and philosophical approaches, and the mixed methods encountered. As such, there were no methodological prerequisites for inclusion of studies and other literature in the review; therefore, the standards and selected best practices identified below are not based on formal ratings of quality or strength of the research evidence. The review includes substantive results from primary research as well as expert opinion drawn from discussion, position, and consensus documents.

The literature search yielded over 200 documents, including peer-reviewed articles, reports, books, and policy statements. Each document was reviewed and relevant information was extracted, synthesized and themed into major subject categories.

1.4. DEFINING 'MINIMUM STANDARD' AND 'BEST PRACTICE'

A 'minimum standard' is defined as a minimum rule beyond which service provision must not fall (Penal Reform International, 2001). Generally, these standards are formulated on the basis of ethical and legal considerations – particularly, those that concern human rights. As they pertain to correctional settings, minimum standards serve the following purposes (L. Hayes, 1995; Metzner, 2002; Rudd & Joiner, 1998; Steadman et al., 1989; World Health Organization, 2007a):

- To promote humane conditions in jails and prisons;
- To establish benchmarks for reasonable, fair, adequate, and humane conduct and care in correctional settings;
- To provide guidance to the courts in relation to assessing negligent conduct and the conditions of confinement;
- To increase organizational efficiency of correctional agencies; and
- To provide guidance to correctional administrators with regards to establishing policies and procedures, and manage their systems in a manner that reduces risk of civil and criminal liability.

For the purposes of this report, 'minimum standards' are conceptualized as the policies, procedures, and practices that have been identified as being ***essential*** for addressing mental health and substance use problems in correctional settings (Steadman et al., 1989).

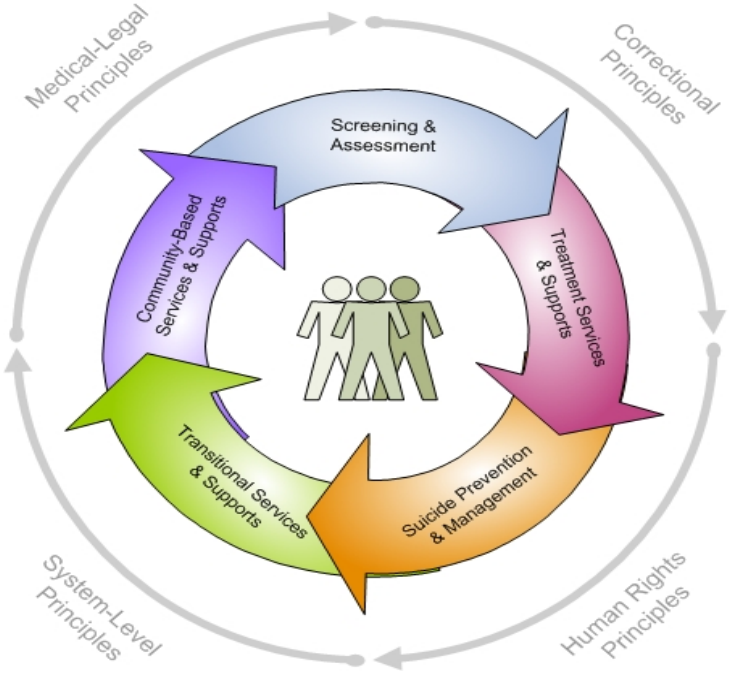
A 'best practice', for the purpose of this review, is considered to be an approach that is in keeping with the best possible available evidence, including research findings and expert opinion, about what works for addressing mental health and substance use problems in correctional settings. The best practices identified throughout this report highlight the ***optimal*** service elements, as suggested

by the cumulative evidence, that are likely to fulfil specific objectives for improving the lives of individuals with mental health and substance use problems who are under the control or supervision of correctional authorities. Best practices are intended to serve as guidance to assist with making decisions about the most appropriate, effective, or cost-effective services that can be delivered for specific circumstances (Health Canada, 2002).

1.5. FRAMEWORK

The conceptual framework that has been developed specifically for this report is illustrated in the figure below. The use of concentric arrows is intended to visually represent the integration of all elements contained within the framework. The outer ring consists of overarching principles that influence the development and provision of mental health and substance use services in correctional settings. The inner ring depicts five clusters of services and supports that are considered essential components of a correctional mental health and substance use service system. Note that individuals with mental health and substance use problems are situated in the centre of the framework to emphasize the importance of using person-centred approach – prioritizing each individual's rights, needs, strengths, and choices – for developing and delivering services and supports (National Treatment Strategy Working Group, 2008). The different shading of the figures in the centre of the framework represents the heterogeneity of correctional populations, which necessitates the use of a diversity lens when developing systems of care.

Figure 1
Conceptual Framework for Mental Health and Substance Use Minimum Standards and Best Practices



2. OVERARCHING PRINCIPLES

2.1. HUMAN RIGHTS PRINCIPLES

The minimum standards and best practices described throughout this report exist within a human rights context. Despite the fact that the population under consideration has had their freedom and privacy rights curtailed as a result of criminal sanctions, by virtue of being human, individuals involved with the correctional system retain their human rights even after being detained, convicted, sentenced, and/or imprisoned (see Ward & Birgden, 2007).

Minimum standards and best practices in relation to the provision of mental health and substance use services in correctional settings should be aligned with international human rights declarations, resolutions, covenants, and treaties. The various principles highlighted below were referenced by many of the documents that were reviewed and have been broadly used to guide and inform the development of this report.

- ***The International Covenant on Economic, Social and Cultural Rights*** *(Office of the United Nations High Commissioner for Human Rights, 1976)*

  The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

- ***Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*** *(Office of the United Nations High Commissioner for Human Rights, 1991)*

  All such persons [criminal offenders] should receive the best available mental health care…

- ***Standard Minimum Rules for the Treatment of Prisoners*** *(Office of the United Nations High Commissioner for Human Rights, 1977)*

  The medical services of the institution shall seek to detect and shall treat any physical or mental illnesses or defects which may hamper a prisoner's rehabilitation. All necessary medical, surgical and psychiatric services shall be provided to that end.

- ***Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*** *(Office of the United Nations High Commissioner for Human Rights, 1991)*

  Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

- ***European Prison Rules*** *(Committee of Ministers of the Council of Europe, 2006)*

  Prison conditions that infringe prisoners' human rights are not justified by lack of resources.

- ***International Council of Prison Medical Services - Oath of Athens*** *(1997)*

  We, the health professionals who are working in prison settings, meeting in Athens on September 10, 1979, hereby pledge, in keeping with the spirit of the Oath of Hippocrates, that we shall endeavour to provide the best possible health care for those who are incarcerated in prisons for whatever reasons, without prejudice and within our respective professional ethics.

- ***International Council of Nurses*** *(2006)*

  The ICN Code of Ethics for Nurses affirms that nurses have a fundamental responsibility to promote health, to prevent illness, to restore health and to alleviate suffering to all people, including detainees and prisoners. Nurses working in the prison system must observe the Standard Minimum Rules for the Treatment of Prisoners, which require that health services mush be available to prisoners without discrimination.

- ***United States Supreme Court*** *(Estelle v. Gamble, 1976)*

  Regardless of how evidenced, deliberate indifference to [a] prisoner's serious illness or injury states a cause of action.

- ***American Psychiatric Association*** *(Weinstein, 1989)*

  The fundamental goal of a mental health service should be to provide the same level of care to patients in the criminal justice process that is available in the community.

2.2. CORRECTIONAL PRINCIPLES

The standards and best practices described below operate within correctional environments – settings which are generally guided by seemingly divergent principles, including ("Corrections and Conditional Release Act," S.C. 1992; Watson, Stimpson, & Hostick, 2004):

- To contribute to the maintenance of a just, peaceful and safe society;
- To carry out sentences imposed by courts through the safe and humane custody and supervision of offenders;
- To separate individuals from society and confine individuals for society;
- To punish for a crime;
- To assist the rehabilitation of offenders and their reintegration into the community as law-abiding citizens through the provision of programs in penitentiaries and in the community.

Correctional systems act in the interests of many parties, including the public, the state, and the offenders. This stems from the range of purposes for sentencing individuals who have been convicted of crimes, which includes: denunciation, deterrence, protection of the public, rehabilitation and reparation. Correctional systems are also designed to serve a fourth party, the staff (e.g., correctional officers, health care staff), by ensuring that they are not harmed during the performance of their professional duties.

The day-to-day tensions (e.g., care versus control), dual professional roles, and competing demands (e.g., therapeutic versus security) inherent in correctional settings create a challenging environment for providing mental health and substance use services (R. K. Chandler, Peters, & Juliano-Bult, 2004; Fagan & Ax, 2003; Motiuk & Serin, 2000). Correctional programming is primarily concentrated on classifying offenders based on criminological risk factors and providing rehabilitative services that aim to increase pro-social attitudes/behaviours and reduce criminal behaviours. It is important to recognize the conflicting and competing principles and priorities, as well as the power-dynamics between correctional and health staff, inherent in correctional settings as these tensions are likely to affect the manner in which mental health and substance use services are provided in jails, prisons, and community corrections.

2.3. MEDICAL-LEGAL PRINCIPLES

The provision of mental health and substance use services in correctional settings raises a number of complex medical-legal issues and dilemmas (Ward & Birgden, 2007). These issues are not necessarily unique to correctional settings; however, they are amplified by the level of coercion and control inherent in correctional environments. Though an in-depth consideration of these issues is beyond the scope of this report, the major medical-legal issues that are raised in the literature are outlined below, along with a selection of existing principles, standards, and guidelines.

- *Determinations of Mental Illness*

  "A determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards. A determination of mental illness shall never be made on the basis of political, economic or social status, or membership of a cultural, racial or religious group, or any other reason not directly relevant to mental health status." (Office of the United Nations High Commissioner for Human Rights, 1991)

- *Confidentiality*

  "Persons with mental disorders have the right of confidentiality of information about themselves and their illness and treatment; such information should not be revealed to third parties without their consent." (World Health Organization, 2005)

- *Limits of Confidentiality*

  "All inmates will be informed, both verbally and in writing, regarding the limits of confidentiality and legally or administratively mandated "duties to warn" prior to any psychological service that places confidentiality at risk. This information is provided on a form that fully discloses these limits, possible uses of information the offender provides, to whom that information may be provided without the offender's consent, and recognition that the offender has been provided this information in advance of any participation in assessment, treatment, or other psychological service. The form will be signed and dated by the offender and/or the psychologist if the offender refuses to sign." (American Association for Correctional Psychology, 2000)

- *Informed Consent*

  "Free and informed consent should form the basis of the treatment and rehabilitation of most people with mental disorders. All patients must be assumed initially to have capacity and every

effort should be made to enable a person to accept voluntary admission or treatment, as appropriate, before implementing involuntary procedures." (World Health Organization, 2005)

- *Right of Refusal*

  "Inmates have a right to refuse evaluation and treatment without disciplinary action or punishment." (Metzner, 1998)

- *Involuntary Treatment*

  "Involuntary treatment, including the administration of psychotropic medication, placement in an observation status, and the use of restraints, will follow the ethical and practice guidelines of the American Psychological Association as well as federal laws, state statutes, and jurisdictional administrative codes." (American Association for Correctional Psychology, 2000)

- *Physical Restraint and Seclusion*

  "Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient." (Office of the United Nations High Commissioner for Human Rights, 1991)

- *Least Restrictive*

  "Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others." (Office of the United Nations High Commissioner for Human Rights, 1991)

2.4. SYSTEM-LEVEL PRINCIPLES

This section highlights system-level principles for organizing mental health and substance use service systems. Under the principle of "equivalence of care", these general principles are equally applicable to individuals with mental health and substance use problems who are either in correctional settings or in the general community. Five fundamental elements of an effectively organized mental health and substance use service system are briefly considered below, including: (1) providing a comprehensive and balanced continuum of services, (2) integrating services within and between systems; (3) matching services to individual need; (4) responding to population diversity; and (5) using evidence to make system-wide improvements. These elements are consistent with the World Health Organization's guiding principles for organizing mental health services (McDaid & Thornicroft, 2005) as well as several other systems-level principles and recommendations (Hogan et al., 2003; National Treatment Strategy Working Group, 2008; Roberts & Ogborne, 1999; U.S. Department of Health and Human Services, 1999).

a. Comprehensive and Balanced Service Continuum

An effective mental health and substance use system is one that provides access to a comprehensive and balanced continuum of services and supports. In a balanced care approach, a flexible range of services are primarily provided in community-based, local settings, that span the specialized and non-specialized sectors, and emphasize the following features (Thornicroft & Tansella, 2003):

- Care is provided close to home;
- Services are mobile;
- Interventions address both symptoms and disabilities;
- Treatment and care is tailored to the individual's diagnosis and needs;
- Interventions adhere to international conventions on human rights;
- Services reflect the priorities of the service users and support personal empowerment; and
- Care is coordinated and services are linked among care providers and agencies.

Many of the essential services and supports that are offered in a best practice, comprehensive and balanced mental health and substance use service system are highlighted below:

- Early identification and brief intervention;
- Withdrawal management and detoxification;
- Acute inpatient care;
- Community-based care (e.g., partial hospitalization, outpatient treatment, home treatment and crisis resolution teams, crisis houses)
- Case management (e.g., assertive community treatment);
- Family support services;
- Self-help, mutual support, and other consumer-led initiatives;
- Continuum of housing options and residential facilities; and
- Supported education and employment programs.

In keeping with a diversity lens, there is consensus that individuals are better served when they can access a wide range of flexible and individualized services (National Treatment Strategy Working Group, 2008).

b. Systems Integration

Systems integration has been described as neither an event, a document, or a position, but rather as an, "ongoing process of communicating, goal setting, assigning accountability, evaluating, and reforming" (Osher, Steadman, & Barr, 2002, 5). System integration has been identified as a fundamental approach for effectively organizing a balanced and comprehensive continuum of mental health and substance use services (Craven & Bland, 2006; Standing Senate Committee on Social Affairs Science and Technology, 2006; Thornicroft & Tansella, 2003). In correctional

settings, an integrated mental health and substance use system bridges the service delivery gaps that exist within and between mental health, addictions, corrections, and other sectors such as social services, health care, criminal justice. The purpose of systems integration is to encourage seamless service delivery, to promote efficiency, to optimize the use of scarce resources, and to improve patient outcomes. Models of systems integration between mental health, criminal justice, and community support services have been developed and are beginning to demonstrate promising outcomes (Weisman, Lamberti, & Price, 2004).

One aspect of systems integration focuses on linkages and coordination amongst the various components of the mental health, substance use, and correctional service continuum. Integrated mental health and substance use services in a correctional setting would have defined access points, efficiency, lack of duplication of services, multidisciplinary teams, and coordinated services among the interrelated service components of the system (Swenson & Bradwejn, 2002). Collaborations, partnerships, and communication among professionals and agencies are critical for systems integration. Integration between the custodial and community systems is essential for the efficient and effective delivery mental health and substance use services in correctional settings. While 'mental health and substance use services' will be been used as a single concept within this review, in reality 'mental health' and 'substance use' services operate as separate and distinct systems of care (Health Canada, 2001; Standing Senate Committee on Social Affairs Science and Technology, 2006). Accessing care from different systems is very problematic for persons with co-occurring mental health and substance use problems. Indeed, better integration and coordination of mental health and substance use services is urgently needed (Canadian Psychiatric Association, 2005; Els, 2007; Health Canada, 2001; Meuser, Torrey, Lynde, Singer, & Drake, 2003; Ziedonis, 2004).

c. Matching Services to Level of Need

Mental health and substance use services and supports are best organized in a manner that allows individuals to access a full range of services according to their level of need (British Columbia Ministry of Health, 2004; National Treatment Strategy Working Group, 2008; Swenson & Bradwejn, 2002; Thornicroft & Tansella, 2003; World Health Organization, 2007b). A system that offers services tailored to an individual's needs, also known as 'stepped care' model, can effectively respond to varying levels of illness chronicity, acuity, and complexity, and is responsive to a person's changing mental health needs (Bower & Gilbody, 2005).

A useful framework to conceptualize a stepped care mental health and substance use system divides the continuum of services and supports into the following four categories: (a) *first-line*, which include prevention, assessment and treatment services provided by frontline providers; (b) *intensive*, which include assessment and treatment services provided for people with serious mental illness and/or problematic substance use; (c) *specialized*, which include highly-specialized programs provided in specialized settings for persons with complex or co-occurring disorders; and (d) *cross-level* services and supports (e.g., housing, education, self-help, etc) that span the continuum (Standing Senate Committee on Social Affairs Science and Technology, 2006).

A comprehensive assessment that effectively matches an individual with the appropriate mental health and substance use services and supports is an essential feature of a system that is organized around a stepped care approach (Goldman, Thelander, & Westrin, 2000; Roberts & Ogborne, 1999). A universal principle of a stepped care system is that it provides individuals with the least

restrictive, least intensive, least expensive, and least intrusive interventions, with the ability for individuals to be stepped up to higher intensity care or stepped down to lower intensity care based on current service need (McDaid & Thornicroft, 2005; Von Korff & Tiemens, 2000).

d. Recognizing and Responding to Diversity

Inmates, probationers, and parolees are diverse populations with diverse needs. Mental health and substance use systems must aim to reduce inequities in health status among population groups and to remove systemic barriers that create disparities in access and utilization of mental health and substance use services. These inequities may be a consequence of race, culture, ethnicity, age, gender, language, disability, sexual orientation, socio-economic status, or other individual and collective factors (Standing Senate Committee on Social Affairs Science and Technology, 2006; U.S. Department of Health and Human Services, 1999).

Population-responsive approaches that appear to improve access and utilization of services for diverse populations include: initiatives to improve awareness of and access to informal help; specialized services through outreach efforts; greater involvement of primary health care providers in identifying mental illness and/or problematic substance use; culturally relevant services (e.g., healing lodges for First Nations); gender- and cultural-sensitivity and competency training programs for service providers; and case management services that can effectively attend to multiple, complex, and diverse needs (Health Canada, 2000, 2006; Roberts & Ogborne, 1999; Smye & Mussell, 2001). Correctional services have primarily been design to address the needs of men; therefore, gender-responsive strategies for women in correctional settings are highly recommended and may include (Center for Mental Health Services, 1995; Fagan & Ax, 2003; Hills, Siegfried, & Ickowitz, 2004; Kassebaum, 1999; Laishes, 2002; New Freedom Commission on Mental Health, 2004; Veysey, 1997):

- Assessing and providing additional services to women with histories of physical and/or sexual abuse;
- Modifying methods of crisis intervention, restraint, seclusion, and searches to avoid re-traumatizing women with histories of physical and/or sexual abuse (i.e., trauma-sensitive approaches);
- Attending to issues related to parenting and child care;
- Focusing on each individual woman's strengthens; and
- Using a holistic and integrated approach for understanding and addressing issues related to parenting, mental health, substance use, trauma, and violence.

Mental health and substance use service must be designed to address the needs of the persons they are meant to service. More broadly, employing a population health approach to the organization of mental health and substance use services, which attends to the interrelated conditions and factors that influence health and well-being, is a recommended strategy for creating an equitable system of care (M. V. Hayes & Dunn, 1998; Health Canada, 2001; National Treatment Strategy Working Group, 2008).

e. Evidence-Informed Decision and Practices

Measuring and monitoring system-level performance is essential for ensuring that the mental health and substance use service system, as a whole, is comprehensive, balanced, integrated, inclusive, efficient, needs-based, accessible, and cost-effective (Goering et al., 1997). A systems-focused evaluation considers the overall performance of the mental health and substance use service system, rather than simply assessing the effectiveness of specific interventions. Accordingly, it is recommended that a comprehensive, integrated computerized information system be established in order to routinely collect clinical and administrative data from all components of the correctional service continuum. Such information is critical in informing quality improvement initiatives, broad system and resource planning activities, and policy decisions.

System-wide improvements will also be achieved through facilitating the uptake of research evidence by mental health and substance use practitioners, administrators, and other decision-makers. This process, generally referred to as *knowledge exchange*, is described as, "the exchange, synthesis and ethically-sound application of knowledge – within a complex system of interactions among researchers and users – to accelerate the capture of the benefits of research" (Canadian Institutes of Health Research, 2004). Several systems-level strategies have been recommended to bridge the gap between evidence and practice, including (Rapp et al., 2005; Reimer, Sawka, & James, 2005):

- Encouraging practitioners and policy makers to adopt and implement the research-based evidence by providing individual instruction, incentives, reminders, feedback, and peer-influence processes; requiring funding bodies and research organizations to support knowledge exchange; offering incentives to researchers to focus on practical applications of their findings;
- Building relationships amongst, and encouraging dialogue between, researchers, practitioners, and policy-makers;
- Supporting clients in becoming better-informed about research-based evidence concerning particular treatments or interventions, by way of instruction, Web-based tutorials, or public awareness forums/programs; and
- Encouraging organizational and systematic changes through workforce development.

The motivation behind knowledge exchange is: to reduce the amount of resources that are wasted from unused research findings; to prevent the squandering of resources on ineffective programs, practices, and policies; and to achieve better patient outcomes (Landry, Lamari, & Amara, 2003).

3. REVIEW OF MINIMUM STANDARDS AND BEST PRACTICES

Numerous national and international organizations have independently produced minimum standards and guidelines focusing on service provision in correctional settings for individuals with mental health and substance use problems, including:

- American Psychiatric Association (2000)
- American Association for Correctional Psychology (2000)

- American Bar Association (1984)
- Correctional Services of Australia (Australia, 2004)
- Correctional Service of Canada (1994)
- Council of Europe (Committee of Ministers of the Council of Europe, 2006)
- National Commission on Correctional Health Care (2008a, 2008b, 2008c)
- Office of the United Nations High Commissioner for Human Rights (1977, 1982)
- Penal Reform International (2001)
- World Health Organization (2005, 2007a, n.d.)

The bulk of the literature in this area stems from organizations located in the United States – an apparent result of a series of significant decisions from the US Supreme Court related to issues of health provision in correctional settings. Standards tend to focus on inmate populations, rather than community corrections populations – largely on account of the potential for serious human rights problems associated with detaining and incarcerating individuals in jails and prisons.

The development and uptake of national standards related to mental health and criminal justice service provision appears to be best achieved through a coordinated, committed, well-funded effort of numerous influential organizations. For example, the development and ongoing revision of the *Standards for Mental Health Services in Correctional Facilities* (National Commission on Correctional Health Care, 2008c), is supported by approximately 40 leading medical and mental health professional associations in the United States, including the American Academy of Psychiatry and Law, the American Psychological Association, the American Society of Addiction Medicine, and the National Association of Social Workers. Another model for developing standards and best practices is the Criminal Justice / Mental Health Consensus Project (Council of State Governments, 2002), which, over the course of two-years, brought together representatives from leading US-based criminal justice and mental health organizations to make recommendations to local, state, and federal policy makers.

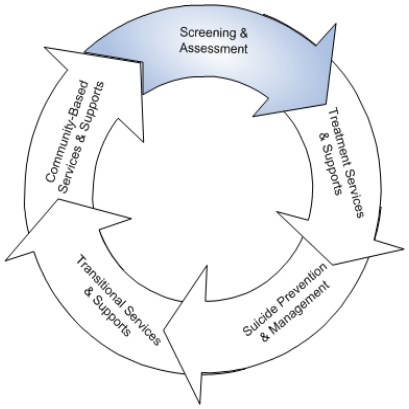
Prior to discussing the 'minimum standards' and 'best practices' it is necessary to briefly comment on the differences between the correctional settings (i.e., jails, prisons, and community corrections) and their impact on service levels for individuals with mental health and substance use problems. Jails are for individuals who are detained in custody for brief periods (i.e., awaiting trial) or sentenced to a relatively short term of incarceration; whereas, prisons are for individuals who are sentences to longer terms of incarceration (e.g., two years or more). On account of the short-term nature of jails, they should, at minimum, be charged with making available the following: screening, assessment, suicide prevention and management, emergency and short-term services and supports, and transitional services (Center for Mental Health Services, 1995; New Freedom Commission on Mental Health, 2004; Ogloff, 2002; Scott & Gerbasi, 2005). Prison and community corrections populations should also have access to these services in addition to intermediate- and long-term mental health and substance use services and supports (Lurigio, 2000b). Long-term jail populations should have access to the full service continuum, similar to that which is offered in prisons.

The scope and level of detail contained within each of the identified standards and guidelines vary considerably, with the most instructive standards being produced by the American Psychiatric Association (2000) and the National Commission on Correctional Health Care (2008a, 2008b, 2008c). A review of published standards and best practices reveals that they generally cluster around the following five service themes:

a. Screening and assessment services
b. Treatment services and supports
c. Suicide prevention and management services
d. Transitional services and supports
e. Community-based services and supports

Minimum standards and selected best practices within each of these five service themes will be discussed throughout the remainder of this report.

3.1. SCREENING AND ASSESSMENT SERVICES



Screening and assessment generally describes a systematic process for gathering information about an individual in an effort to identify mental health and substance use problems. Available published guidelines and standards pertaining to correctional mental health and substance use services unanimously assert that providing systematic screening and assessment in jails and prisons is a necessary and essential service (Abramowitz, 2005; American Association for Correctional Psychology, 2000; Correctional Service of Canada, 1994; Hills et al., 2004; National Commission on Correctional Health Care, 2008a, 2008b, 2008c; Office of the United Nations High Commissioner for Human Rights, 1977; Ogloff, 2002).

Generally, the purpose of screening and assessment is to (Hills et al., 2004; Peters & Hills, 1997; Scott & Gerbasi, 2005; Wettstein, 1998):

- Discover and diagnose urgent and emergent mental health and substance use problems;
- Identify individuals who require treatment, particularly emergency services;
- Identify individuals who are at risk of harming themselves or others;
- Mitigate the negative mental health consequences associated with delaying treatment onset and exacerbated by incarceration;
- Detect issues that might hamper correctional rehabilitation;
- Assess an individual's potential for functioning in the jail or prison;
- Identify severe medical problems, severe cognitive deficits, or other important service needs; and
- Make recommendations for placing individuals within the jail or prison (i.e., specialized housing unit).

The detention or incarceration of individuals in jails or prisons provides an opportunity for case finding and initiating effective treatment (Scott & Gerbasi, 2005). Regardless of the size of the jail or prison, screening and assessment is viewed as one of the most important and critical components of a correctional mental health and substance use service system (Lurigio, 2000b).

3.1.1. Minimum Standards

A review of published standards and guidelines suggests the following minimum standards for screening and assessing mental health and substance use problems in jails and prisons.

SCR-01: Staff Training

Staff members who work with inmates are trained to recognize and respond to mental health and substance use problems. (American Psychiatric Association, 2000; Correctional Service of Canada, 1994; National Commission on Correctional Health Care, 2008c; Scott & Gerbasi, 2005)

SCR -02: Initial Screening

Screening is performed by a trained staff member on all inmates upon arrival at the facility in order to identify emergent and urgent mental health and substance use problems. (American Association for Correctional Psychology, 2000; American Psychiatric Association, 2000; Correctional Service of Canada, 1994; National Commission on Correctional Health Care, 2008c; Penal Reform International, 2001)

SCR -03: Ongoing Evaluation

Mechanisms are established to ensure the ongoing evaluation and identification of emergent and urgent mental health and substance use problems among all inmates, and, in particular, segregated inmates. (National Commission on Correctional Health Care, 2008c; Scott & Gerbasi, 2005)

SCR -04: Comprehensive Assessment

Inmates who are identified as likely to have mental health and/or substance use problems are referred to a qualified mental health professional for a comprehensive assessment. (American Association for Correctional Psychology, 2000; American Psychiatric Association, 2000; Correctional Service of Canada, 1994; National Commission on Correctional Health Care, 2008c)

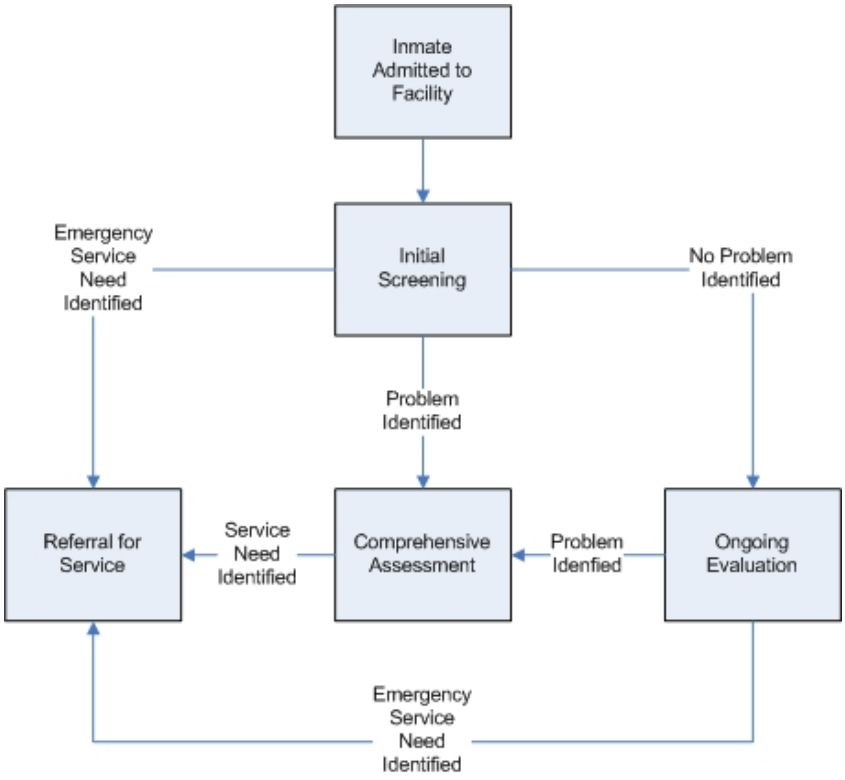
SCR -05: Referral for Service

Inmates with mental health and/or substance use problems that are assessed as needing treatment are referred to appropriate services in a timely manner, with the nature of the problem indicating the urgency of the referral. (American Association for Correctional Psychology, 2000; American Psychiatric Association, 2000; Scott & Gerbasi, 2005)

3.1.2. Best Practices

Various models have been developed to describe effective and cost-effective screening and assessment procedures for identifying mental health and substance use problems in jails and prisons (Wettstein, 1998). Figure 2 depicts a basic model for screening, assessing, and referring inmates.

Figure 2
Model for Identifying Inmates with Mental Health and Substance Use Problems



Recommended strategies regarding how soon after incarceration to initiate initial screening of an inmate vary; however, there is a consensus that screening should be completed as soon as possible upon admission of an inmate to a correctional facility – ideally within the first day (Ogloff, 2002). This includes inmates who are newly admitted to a facility as well as those who are transferred from another facility (Hills et al., 2004). A two-part strategy for initial screening is recommended by some guidelines (American Psychiatric Association, 2000; Hills et al., 2004; New Freedom Commission on Mental Health, 2004; Wettstein, 1998), which includes brief receiving screening within 2 hours of admission that is part of the normal reception and classification process, and a more comprehensive intake screening by health professionals of all inmates within 14 days of arrival at an institution as part of the physical examination of the inmate. Regardless of whether a one- or two-step process is chosen, screening should be initiated prior to an inmate bring placed in the general population or housing area (American Association for Correctional Psychology, 2000).

It is generally preferred that initial screening be conducted by qualified mental health professionals (American Association for Correctional Psychology, 2000; National Commission on Correctional Health Care, 2008c); however, this approach is often considered infeasible on account of limited mental health resources in jails and prisons. In light of this, guidelines are generally supportive of the involvement of correctional personnel or other non-mental health staff in conducting initial screening so long as they have received appropriate training related to the identification of mental health and substance use problems and appropriate referral procedures (Hills et al., 2004; National Commission on Correctional Health Care, 2008c). It is recommended that individuals providing

screening and assessment receive training on diversity (culture, ethnicity, gender, sexuality, etc), especially on issues relevant to the groups they serve (Hills et al., 2004). If non-mental health personnel are involved in conducting initial screening, it is suggested that their work be reviewed by mental health personnel on a regular basis (National Commission on Correctional Health Care, 2008c).

The screening process should not exclusively rely on information provided directly by the inmates (i.e., self-report); rather, information should be gathered from multiple sources. Three components of effective screening include: review of health-related records or documents; interviewing inmates about their mental health and substance use problems; and brief mental status examination (Lurigio & Swartz, 2000). Collateral information can also be obtained from the arresting officer, correctional officers, family members, and others as appropriate. Comprehensive substance use screening also involves drug testing, urinalysis, and toxicology screening (Hills et al., 2004). The assessment process, completed by mental health professionals, requires more comprehensive information gathering methods, including: reviewing earlier screening information and psychological evaluation data, contacting prior treatment providers, conducting an extensive diagnostic interview, collecting information to complete the individual's mental health and substance use history, collecting behavioural information from correctional staff, and administering tests to assess levels of cognitive and emotional functioning (American Association for Correctional Psychology, 2000).

For some inmates, mental health and substance use problems only emerge after a period of incarceration – sometimes as consequence of the stress associated with imprisonment. Jails and prisons should have ongoing evaluation procedures in place to ensure the identification of emergent mental health and substance use problems (Hills et al., 2004; National Commission on Correctional Health Care, 2008c; Ogloff, 2002; Scott & Gerbasi, 2005). Staff training is typically the primary mechanism for ongoing evaluation of inmates. All staff who have contact with an inmate should receive training on how to identify signs and symptoms of mental health problems (i.e., decompensation) and substance use problems (i.e., intoxication, withdrawal, overdose) (American Association for Correctional Psychology, 2000; Hills et al., 2004; Lurigio, 2000b). Cross training for mental health and correctional staff has been suggested as a way of increasing mutual respect, and improving working relationships and teamwork (Lurigio & Swartz, 2000).

Staff and inmates must be made aware of formal and informal pathways for referring inmates who have possible mental health and substance use problems to appropriate professionals and services (American Association for Correctional Psychology, 2000; Hills et al., 2004). Self-referrals for non-emergency mental health and substance use services should be encouraged and inmates should have daily opportunities to request access to such services (National Commission on Correctional Health Care, 2008c; Ogloff, 2002).

Ongoing evaluation is particularly important for segregated inmates, who are particularly vulnerable and susceptible to mental decomposition. It is recommended that the level of evaluation and monitoring be based on the inmates degree of isolation and level of clinical need (National Commission on Correctional Health Care, 2008c): segregated inmates with little or no contact with others should be monitored daily by medical staff and at least once a week by mental health staff.

Every inmate who is identified, either through initial screening or ongoing evaluation, as having a potential mental health and substance use problem should be referred to a qualified mental health

professional for a comprehensive assessment (L. Hayes, 1995). The purpose of a comprehensive assessment is to reach an in-depth understanding regarding the nature and severity of, and interaction between, the inmate's problems, so as to recommend the appropriate level and type of services and supports for the individual (Hills et al., 2004; Ogloff, 2002). A 2-step assessment process has been suggested to ensure timely identification of urgent issues, which includes a brief assessment within 72 hours of the screening and a comprehensive assessment (review of all available heath records and collateral information, diagnostic formulation, initial treatment plan) for inmates with serious mental health and substance use problems within a timeframe appropriate to the level of urgency (Scott & Gerbasi, 2005).

The following are recommended practices for carrying out screening and assessment procedures: all inmates are asked the same standardized questions, responses are documented in writing on a standard form, interviews are conducted in private, and inquiries are made into the following areas of mental health and substance use (Hills et al., 2004; National Commission on Correctional Health Care, 2008c; Peters & Hills, 1997; Scott & Gerbasi, 2005; Wettstein, 1998):

Mental Health

- Mental illness, mental health conditions, or special mental health requirements;
- History of mental health hospitalizations and outpatient treatment;
- Current mental health status, including behavioural observations; stressors; measures of daily functioning; orientation to person, place, and time;
- Current and past use of psychiatric medication(s);
- Current and past suicidal behaviour and ideations;
- History of cerebral trauma or seizure;
- Current and past emotional response to incarceration;
- Current intellectual and neurocognitive functioning, including developmental and educational difficulties;
- Family history of mental illness; and
- Perceived level of mental health problems.

Substance Use

- Current and past patterns of alcohol and drug (legal and illegal) use/misuse;
- Self reported alcohol and drug (legal and illegal) use/misuse (including time of last use);
- Withdrawal symptoms or tolerance effects;
- Acute signs of drug or alcohol Intoxication;
- Current and past use of alcohol or drugs to self medicate painful or unpleasant emotions;
- Treatment readiness and level of motivation to change;

- Negative consequences associated with substance use;
- Past involvement in treatment or attempts to stop alcohol and drug use;
- Family history of substance abuse; and
- Perceived level of substance use problems.

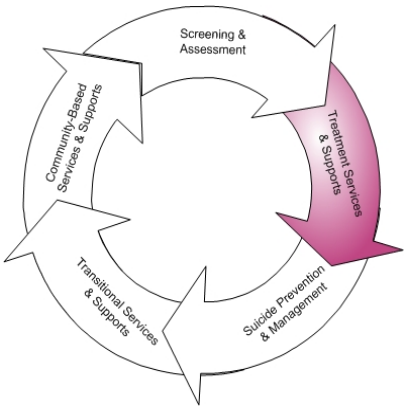
It is also important to query interactions between co-occurring mental health and substance use disorders by examining patterns of symptom expression and the effects of one disorder on the other. The collection of the above information can be facilitated through the use of existing standardized tools for screening and assessing mental health and substance use problems, some of which have been developed specifically for correctional populations, such as the Correctional Mental Health Screen (CMHS), the Jail Screening Assessment Tool (JSAT), or the Referral Decision Scale (RDS) (see Ford et al., 2007; Hills et al., 2004; Nicholls, Roesch, Olley, Ogloff, & Hemphill, 2005; Peters et al., 2000; Peters & Hills, 1997; Scott & Gerbasi, 2005; Teplin & Swartz, 1989). Rather than prescribing specific tools, the literature tends to emphasize the importance of using measures with established reliability and validity in correctional settings.

Routine, brief screening of brain impairment is recognized as good practice in correctional settings. As a consequence of brain impairment, inmates may have emotional, cognitive, and behavioural deficits that create a host of problems for themselves, other inmates, staff, and administrators (Centers for Disease Control and Prevention, n.d.). The results of neuropsychological screening are informative for tailoring inmate management strategies and modifying treatment interventions for this special needs population (see Centers for Disease Control and Prevention, n.d.-a, n.d.-b; Corrigan, 2005; Fowles, 1988; Iverson, Franzen, Demarest, & Hammond, 1993; Lightfoot, 2000; Nedopil, 2000; Wettstein, 1998).

In addition to the standard set of items outlined above, screening and assessment processes should attend to issues related to diversity (Hills et al., 2004). Women should receive gender-responsive assessments that query population-specific needs, such as trauma caused by physical, emotional, and sexual abuse; symptoms of mood, anxiety, or post-traumatic stress disorder; evidence of recent injury; parenting status and skills; and prenatal care and birth control practices (Hills et al., 2004; Kassebaum, 1999; Veysey, 1997). Screening and assessment procedures should also be responsive to the cultural, ethnic, and linguistic diversity of the population, which may include conducting the screening/assessment in the inmate's own language (Hills et al., 2004).

It is important for the screening and assessment process to be linked to treatment planning for inmates with mental health and/or substance use problems requiring services and supports (Ogloff, 2002). Results of the screening and assessment should be documented in a written report that outlines recommendations for further testing and follow-up treatment (American Association for Correctional Psychology, 2000; National Commission on Correctional Health Care, 2008c). The results and recommendations should be communicated to the inmate and the referral source. Inmates who require emergency care, such as those who are acutely suicidal and/or psychotic, should be immediately referred, or transferred, to appropriate mental health services for stabilization (American Psychiatric Association, 2000). Inmates who require non-emergency care should be referred to appropriate services in a timely manner (New Freedom Commission on Mental Health, 2004; Ogloff, 2002).

3.2. TREATMENT SERVICES AND SUPPORTS



For the purposes of this report, treatment services and supports refer to processes, settings, modalities, and interventions used to alleviate symptoms resulting from mental health and substance use problems that significantly interfere with an inmate's well-being and ability to function (American Psychiatric Association, 2000). In addition to the human rights principles outlined in Section 2.1, other reasons for providing mental health and substance use treatment services and supports in correctional settings include: (a) decreasing disability; (b) decreasing human suffering; (c) maximizing the ability to participate in the correctional programs; and (d) creating safe environments for those who live, work, or visit jails and prisons (American Psychiatric Association, 2000; New Freedom Commission on Mental Health, 2004; Wettstein, 1998).

3.2.1. Minimum Standards

A review of published standards and guidelines suggests the following minimum standards for the providing mental health and substance use treatment services and supports in jails and prisons.

TRE-01: Equivalence of Care

Inmates with mental health and substance use problems have access to the same level and standard of care as is available to individuals in the community. (American Psychiatric Association, 2000; Committee of Ministers of the Council of Europe, 2006; Correctional Service of Canada, 1994; Office of the United Nations High Commissioner for Human Rights, 1982)

TRE-02: Information

Upon admission to jail or prison, inmates receive written information describing available mental health and substance use services and explaining the procedures for accessing such services. (American Association for Correctional Psychology, 2000; Penal Reform International, 2001)

TRE-03: Staff Qualifications

Mental health and substance use treatment services and supports are provided by professionals who are legally qualified and professionally competent to deliver such services. (American Bar Association, 1984; Correctional Service of Canada, 1994; National Commission on Correctional Health Care, 2008c; Steadman et al., 1989)

TRE-04: Treatment Plan

Written, individualized treatment plans are created, and regularly reviewed, for inmates with mental health and substance use problems that require treatment services and supports. (American Association for Correctional Psychology, 2000; American Psychiatric Association, 2000; Correctional Service of Canada, 1994; National Commission on Correctional Health Care, 2008c)

TRE-05: Emergency Services

Inmates have immediate and continuous (24 hours a day, 7 days a week) access to emergency mental health and substance use services as required. (American Association for Correctional Psychology, 2000; American Bar Association, 1984; American Psychiatric Association, 2000; Correctional Service of Canada, 1994; National Commission on Correctional Health Care, 2008c)

TRE-06: Psychotropic Medication Services

Inmates with mental health and substance use problems have timely access to psychotropic medication services, as clinically appropriate. (American Psychiatric Association, 2000; Correctional Service of Canada, 1994; Scott & Gerbasi, 2005)

TRE-07: Mental Health and Substance Use Services

Inmates with mental health and substance use problems that require treatment have access to an appropriate continuum of mental health and substance use services, either in the facility or in a more appropriate setting/facility to which they are referred. (American Association for Correctional Psychology, 2000; American Bar Association, 1984; American Psychiatric Association, 2000; Correctional Service of Canada, 1994; National Commission on Correctional Health Care, 2008c; Office of the United Nations High Commissioner for Human Rights, 1977)

TRE-08: Environment

Inmates with seriously acute or chronic mental health and substance use problems are housed in an environment that offers a safe and therapeutic milieu. (American Association for Correctional Psychology, 2000)

3.2.2. Best Practices

Individualized treatment plans are considered to be an essential and professionally mandated element of providing mental health and substance use treatment services and supports (Office of the United Nations High Commissioner for Human Rights, 1991). It is recommended that the treatment plans for inmates with mental health and substance use problems document the following information (American Association for Correctional Psychology, 2000; Hills et al., 2004; Metzner, 1998; National Commission on Correctional Health Care, 2008c):

- An objective description of the problems the inmate faces as a result of the mental health and substance use problems;
- Notation of clinical status progress (stable, improving, deteriorating);
- Objective description of short- and long-term treatment goals;
- The settings or types of therapeutic interventions that will be used to achieve those goals;
- The providers who will deliver the interventions identified in the plan;
- Frequency of follow-up for evaluation and adjustment of treatment modalities, including psychotropic medications, if indicated;
- Relapse prevention and risk management strategies;

- Referrals for further testing and evaluation; and
- Instructions about diet, exercise, personal hygiene issues, and adaptation to the correctional environment, when appropriate.

In essence, the individualized treatment planning process serves as a way for the inmate and the service provider(s) – ideally a multidisciplinary team – to discuss an appropriate strategy for addressing their mental health and substance use service needs. The treatment plan also provides a vehicle for tracking the progress of inmates and measuring the effectiveness of the interventions on an ongoing basis through periodic reviews of the plan, as is indicated by inmate's clinical condition (Metzner, 1998).

A comprehensive continuum of services and supports for addressing emergency, acute, and chronic mental health and substance use problems in correctional settings generally include the following (American Association for Correctional Psychology, 2000; American Psychiatric Association, 2000; Center for Mental Health Services, 1995; Council of State Governments, 2002; Fagan & Ax, 2003; L. Hayes, 1995; Hills et al., 2004; Lightfoot, 2000; Metzner, 1998; National Commission on Correctional Health Care, 2008a, 2008b, 2008c; World Health Organization, 2007a):

Emergency and Short-Term Services and Supports

- Crisis intervention with stabilization beds to provide short-term emergency care for inmates who are an immediate danger to themselves or others;
- Acute inpatient care for inmates with significant psychiatric symptoms that interfere with their ability to care for themselves;
- Brief counselling and supportive psychological therapy;
- Full range of psychotropic medication prescribed and monitored by psychiatrists and administered by qualified health professionals;
- Medically supervised detoxification and withdrawal services;
- Capability for special observation (e.g., for drug and/or alcohol intoxication), seclusion, restraint, and emergency medication administration; and
- Seven-day-a-week mental health coverage, including 24-hour nursing coverage in areas where inmates with acute or emergent mental health and/or substance use problems are housed.

Intermediate- and Long-Term Services and Supports

- Outpatient treatment services and supports;
- Individual and group psychological therapy;
- Individual and group counselling, focusing on psycho-education and coping strategies;
- Full range of psychotropic medication prescribed and monitored by psychiatrists and administered by qualified health professionals;
- Substitution treatment (e.g., methadone maintenance);

- Self-help and mutual support;
- Family interventions;
- Case management;
- Relapse prevention education and treatment;
- Long-term harm reduction programs;
- Programs that provide productive, out-of cell activity and necessary psychosocial and living skills;
- Specialized residential treatment units and therapeutic communities to provide safe and therapeutic environments; and
- Gender- and culturally-specific services and supports.

It is widely recognized that inmates should have access to a continuum of care consistent with that which is offered in the community (Abramowitz, 2005; Metzner, 2002; Penal Reform International, 2001; Steadman et al., 1989; Weinstein, 1989). This principle, however, does not imply the development of a correctional mental health and substance use service system that runs parallel to the community-based service system. Rather, it simply means that correctional administrators have the responsibility of ensuring that inmates have ***access*** to necessary mental health and substance use services. Inmates with mental health and substance use problems should be conceptualized as a community (or public health) issue (Ogloff, 2002; Steadman et al., 1989; Wilson, 2004; World Health Organization, 2003). England and Wales has recently adopted an innovative model for ensuring that health authorities uphold their responsibility of providing treatment services and supports to inmates with mental health and substance use problems (Hayton & Boyington, 2006). Limited evidence suggests that this approach improves standards of care; however, more research is needed to reach a firm conclusion as to the prison health service model that is most effective (Hayton & Boyington, 2006). Other promising practices to facilitate the transfer of responsibility for mental health and substance use services from correctional authorities to health authorities include: establishing prison psychiatric in-reach teams (Wilson, 2004), allocating mental health staff's time between jail and community service agencies, appointing a trans-agency administrator to coordinate the provision of mental health and correctional services (Steadman et al., 1989), using telehealth technology to link inmates to community service providers (Fagan & Ax, 2003), and developing formal and long-term working agreements to bring service providers into the jails and prisons as well as to transfer inmates to community- and hospital-based services when necessary (Center for Mental Health Services, 1995). Correctional authorities may be required to create in-house programs (e.g., therapeutic communities, specialized care units) in order to fill services gaps that are created by health authorities not assuming responsibility for mental health and substance use service provision in jails and prisons.

On account of the voluminous literature on the topic of mental health and substance use services and supports in jails and prisons, only a sample of best practice approaches are briefly described below, including: (a) psychotropic medication, (b) cognitive behaviour therapy, (c) specialized care units, (d) substitution treatment, (e) case management, (f) therapeutic communities, and (g) integrated concurrent disorders treatment.

a. Psychotropic Medication

Availability of psychotropic medication is vital to addressing a range of mental health and substance use problems in jails and prisons. Medications can be used to treat major mental illness, as well as less severe mental health problems (e.g., trouble sleeping, anxiety, etc) (Hills et al., 2004; Metzner, 1998). Administration and prescribing practises in jails and prisons must be consistent with current community standards, with some modifications necessary to contend special issues in correctional settings, including the high rates of substance use abuse, the high rates of suicide, the inherent coerciveness of the environment, and prescription drug dealing (National Commission on Correctional Health Care, 2008a, 2008b, 2008c).

Below are some best practices specific to providing psychotropic medication in jails and prisons (American Psychiatric Association, 2000; Hills et al., 2004; Metzner, 1998; National Commission on Correctional Health Care, 2008a, 2008b, 2008c; Office of the United Nations High Commissioner for Human Rights, 1991; Scott & Gerbasi, 2005):

- Individuals who are prescribing medication should be familiar with the facility's medication administration procedures;
- Medications should only be prescribed in the context of an adequate clinical evaluation;
- Medications should be dispensed in single doses;
- Inmates should have access to newer antidepressant medications and atypical antipsychotic;
- Inmates taking certain antipsychotic medications associated with difficulties regulating body temperature should have access to plenty of fluids and air conditioned spaces during periods of hot weather;
- The use of certain medications should be restricted (i.e., benzodiazepines, and stimulant drugs) or avoided (i.e., sedatives, hypnotics) due to their potential for abuse. Benzodiazepine use should be restricted to medication detoxification from alcohol and/or benzodiazepines and prevention of withdrawal symptoms;
- Medications should only be dispensed by licensed health care professionals, not correctional officers or inmates;
- Medication should be given to a patient only for therapeutic or diagnostic purposes. Excessive dosing or polypharmacy with the goal of controlling or managing inmate behaviour is inappropriate;
- Forced medication is employed only when: the inmate is immediately dangerous to self or others due to mental disorder; less restrictive or intrusive measures have been employed and judged as inadequate; and the inmate's condition, the threat posed, the reason for forced medication, and the other treatments that have been employed are clearly documented;
- Appropriate psychiatric staffing levels should be maintained (i.e., Jails: 1 full-time psychiatrist per 75-100 inmates receiving psychotropic medication; Prisons: 1 full time psychiatrist per 150 inmates receiving psychotropic medication); and
- Inmates being released from jail or prison and who are receiving psychotropic medication should be provided with a sufficient supply of medication that can last at least until the inmate is able to see a community health care service provider.

b. Cognitive Behaviour Therapy

Though not as readily available as other forms of treatment in jail and prison settings, evidence-based psychological therapy should be considered a critical ingredient of the service continuum (Hills et al., 2004). Treatment guidelines for mental health and substance use disorders typically recommend evidence-based psychological therapies. Relying exclusively on medications as the predominant – or only – method for treating inmates with mental health and substance use problems contributes to rising health care costs and high rates of untreated mental illness for those who would prefer nonpharmacological treatment options. Currently, one of the most extensively researched psychotherapeutic interventions is Cognitive Behaviour Therapy (CBT).

CBT is a psychological therapy that seeks to explore and change maladaptive ways of thinking, feeling, and behaving. There is a strong research base to support CBT as an effective and cost-effective modality for the treatment of a range of mental health and substance use problems (Butler, Chapman, Forman, & Beck, 2006; Myhr & Payne, 2006). The effectiveness of CBT has also been demonstrated in criminal justice populations (Aos, Miller, & Drake, 2006; Lipsey, Landenberger, & Wilson, 2007). Factors that contribute to CBT's effectiveness include high quality implementation, close monitoring of quality and fidelity, and adequate CBT training for service providers (Lipsey et al., 2007). Adapted forms of CBT, including self-management tools, bibliotherapy, computerized CBT and group CBT, have demonstrated efficacy, providing the potential for interventions at multiple levels of the services system, by various types of providers, and for mild to severe mental health and substance use problems.

c. Specialized Care Units

Specialized care units, also known as residential treatment units or psychiatric service units, have been identified as a best practice for dealing with problems associated with mainstreaming inmates with mental health problems (Fagan & Ax, 2003). These therapeutic units are considered to be a transitional level (i.e., step-down), situated between the inpatient care and the general population. Specialized care units are most appropriate for inmates with serious mental health problems who are unable to function adequately in the general offender population, but do not require hospitalization (Hills et al., 2004; Metzner, 1998). Depending on whether or not inmates are able to return to the general population, they may be placed in a special care unit for temporary (e.g., following crisis, transfer from inpatient care) or long-term residency.

Specialized care units typically house a small group of inmates (e.g., 30-50) and are staffed with an appropriate team of health professional with various backgrounds (e.g., psychiatrists, nurses, therapists, psychologists) (Fagan & Ax, 2003; Metzner, 1998). They are separated, self-contained units that provide standard services as well as intensive mental health services and supports, such as individual and group therapy, medication, and therapeutic vocational and recreational activities (Robison, 2005). The purpose of these units is to enable adequate observation of inmates, and to stabilize and transition inmates with serious mental health problems (Center for Mental Health Services, 1995). These units have been associated with reductions in institutional crises and management problems, and improvements in inmate quality of life (Hills et al., 2004).

d. Substitution Treatment

Substitution treatment (mainly provided in the form of methadone) is widely recognized as an effective treatment for opioid dependent individuals, including those in jails and prisons (Correctional Service of Canada, 2003; Stallwitz & Stover, 2007; Stover, Casselman, & Hennebel, 2006; World Health Organization, 2007a). Substitution treatment involves the administration, under medical supervision, of a prescribed psychoactive substance to people with substance use problems (World Health Organization, 2007a). It is effective in terms of reduced opiate use, reduced HIV risk behaviours, reduced HIV and viral hepatitis transmission rates, decreased criminal involvement, and a host of other positive outcomes in correctional settings (Stallwitz & Stover, 2007). It is recommended that inmates on methadone maintenance prior to imprisonment be able to continue this treatment while in jail or prison, as disruption in the treatment is associated with serious adverse physical and psychological consequences (Stallwitz & Stover, 2007; World Health Organization, 2007a). Jails and prisons have an ethical obligation to make substitution treatment available to all inmates with substance use problems, when clinically appropriate, if such treatment is available in the community (Bruce & Schleifer, 2008; World Health Organization, 2007a). It is imperative to ensure continuity of care for inmates receiving substitution treatment who are subsequently transferred to other correctional facilities or released to the community (World Health Organization, 2007a).

e. Case Management

Case management is a key component of the mental health and substance use service system in prisons and jails (R. K. Chandler et al., 2004; Hills et al., 2004). Described as both an intervention and an approach for organizing services, case management is a model in which professionals monitor, coordinate, broker, and, in some cases, provide services and supports that are required by inmates with mental health and substance use problems (Peters & Hills, 1997). Case management may be provided by an individual or by multidisciplinary teams with shared caseloads. The extensive activities performed by jail- and prison-based case managers may include (Hills et al., 2004):

- Creating and monitoring treatment plans;
- Assessing the inmate's service needs and referring to services as appropriate;
- Meeting regularly with the inmate to monitor and assess their mental health and substance use problems;
- Providing counselling and psychotherapy;
- Acting as a liaison between classification, security, and health services;
- Providing information to security and classification staff to help them in their decisions regarding such issues as an inmate's housing and responsibilities;
- Communicating with various institutional staff who have contact with the inmate to help monitor his or her level of functioning;
- Transition planning to ensure continuity of care for the inmate after release from jail or prison; and

- Communicating with the probation or parole agency.

Several models of case management exist that differ in content, structure, intensity, and effectiveness. While evidence about the effectiveness of case management – particularly in the area of problematic substance use – is modest and variable (Vanderplasschen, Wolf, Rapp, & Broekaert, 2007), it is an approach that is often referred to as a critical resource for integrating and coordinating services for complex-needs clients who experience difficulty navigating multiple systems.

f. Therapeutic Communities

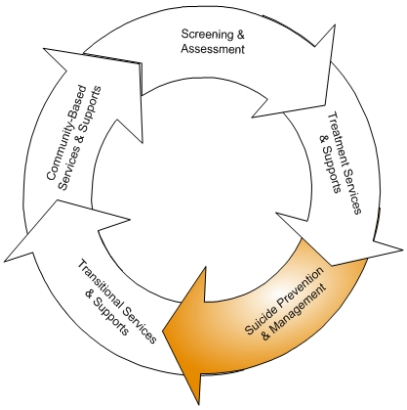
Therapeutic communities (TC) are a best practice approach commonly used for treating inmates with substance use problems (Aos et al., 2006; Council of State Governments, 2003; Hiller, Knight, & Simpson, 1999; McCollister et al., 2003; National Institute on Drug Abuse, 1999). TC's are long-term (ranging from 3 months to 2 years), intensive treatment programs situated within highly structured, self-contained, drug-free units (Peters & Hills, 1997; World Health Organization, 2007a). Typically, inmates in therapeutic community programs are kept isolated from the general inmate population. Because they are long-term, TC's are most appropriate for prison settings, rather than jails. TC's are designed to restructure the lifestyles and personalities of inmates to help them abstain from drug use, achieve employment, and develop pro-social values, attitudes and behaviour through positive peer pressure (Hills et al., 2004; McCollister et al., 2003; Peters & Hills, 1997). Though varying between programs, a comprehensive set of treatment services and supports are offered in TC's, including community meetings, individual and group counselling, and peer support. Some of the key features of successful TC's include: motivated and enthusiastic staff, isolation from the general prison population, administrative support, operating in a climate that permits the program's autonomy, and follow-up treatment services in the community (National Institute on Drug Abuse, n.d.). Prison-based TC's are often connected to TC's in the community, which has the benefit of enhancing continuity of care for inmates being released from prison. Minimum standards for prison-based TC's have been developed to assure fidelity to the TC model (McCollister et al., 2003; Office of the National Drug Control Policy, 1999). Building on their success in treating substance use problems, TC's are being modified, and show promise, to treat inmates with co-occurring mental health and substance use problems (National Institute on Drug Abuse, 2006; Peters & Hills, 1997; Wexler, 2003) and personality disorders (Lees, Manning, & Rawlings, 1999).

g. Integrated Concurrent Disorders Treatment

Concurrent disorders in correctional settings most commonly refers to co-occurring DSM-IV Axis I major mental health and substance use disorders (R. K. Chandler et al., 2004). The literature indicates that a best practice approach for treating individuals with severe and persistent concurrent disorders, including those in correctional settings, is to use an integrated service delivery model that simultaneously addresses mental health and substance use problems (R. K. Chandler et al., 2004; Drake et al., 2001; Health Canada, 2002; Minkoff, 2001; National Institute on Drug Abuse, 2006). Developments in understanding the nature of concurrent disorders has led to a shift from parallel or sequential treatment approaches to an integrated approach at the service- and system-level, which aims to address the gaps of parallel treatment by combining mental health and substance use interventions. The key to this approach is for mental health and substance use services to be

integrated for the individual into a coherent package so that both problem areas, as well as the interaction between them, can be addressed in a consistent and coordinated manner (Drake et al., 2001; Edens, Peters, & Hills, 1997). One evidence-based approach for treating concurrent disorders is the Integrated Dual Disorder Treatment [IDDT] model, which aims to help individuals with mental health and substance use problems manage both disorders (Substance Abuse and Mental Health Services Administration, n.d.). Critical ingredients of the IDDT model include individualized assessment, multidisciplinary teams, stage-wise interventions, assertive outreach, motivational interventions, medication management, and peer support groups (Substance Abuse and Mental Health Services Administration, n.d.). The empirical evidence for integrated concurrent disorders treatment is conflicting, with a dearth rigorous research in this area; however, expert consensus does endorse an integrated approach at the service- and system-level for treating severe and persistent concurrent disorders (D. W. Chandler & Spicer, 2006; Rush & Koegl, 2008; Wexler, 2003).

3.3. SUICIDE PREVENTION AND MANAGEMENT SERVICES



On account of the high rates of suicide in jail and prison settings, organizations have spent considerable effort developing comprehensive guidelines, standards, and programs to prevent and manage inmate suicide. Regardless of the size or nature of the facility, all jails and prisons should establish an adequate suicide prevention and management program. Suicide prevention and management involves strategies that aim to identify potentially suicidal inmates and to intervene in the effort of reducing the risk of suicide. In practice, these standards and procedures are integrated with the screening, assessment, and treatment services discussed above: however, suicide prevention and management is recognized by existing guidelines as being distinctly important in the context of jails and prisons (American Psychiatric Association, 2000; L. Hayes, 1995; Hills et al., 2004; National Commission on Correctional Health Care, 2008c; Scott & Gerbasi, 2005; World Health Organization, 2000). While it is important to be aware of the significant problem of self-injurious behaviours within inmate populations, the scope of this section – due to conceptual contradictions (see Camilleri & McArthur, 2008; Camilleri, McArthur, & Webb, 1999) and time constraints – is limited to attempted or actual suicide (i.e., self-inflicted and self-intentional death).

3.3.1. Minimum Standards

A review of published standards and guidelines suggests the following minimum standards for preventing and managing suicide in jails and prisons.

SUI-01: Staff Training

Staff members who work with inmates are trained to recognize verbal and behavioural cues that indicate potential suicide and how to intervene. (American Psychiatric Association, 2000; Scott & Gerbasi, 2005; World Health Organization, 2000)

SUI-02: Screening

Inmates are screened for potential suicide immediately upon entering a jail or prison and periodically throughout their detention or incarceration. (American Psychiatric Association, 2000; National Commission on Correctional Health Care, 2008c; Scott & Gerbasi, 2005; World Health Organization, 2000)

SUI-03: Assessment

Potentially suicidal inmates are referred to a qualified mental health professional for assessment. Procedures are in place for periodic follow-up assessment of inmates discharged from suicide precautions. (American Psychiatric Association, 2000; Scott & Gerbasi, 2005)

SUI-04: Monitoring

Potentially suicidal inmates are monitored by staff according to their level of suicide risk. (American Psychiatric Association, 2000; Scott & Gerbasi, 2005; World Health Organization, 2000)

SUI-05: Treatment

Potentially suicidal inmates receive appropriate mental health services in a timely manner. (American Psychiatric Association, 2000; World Health Organization, 2000)

SUI-06: Housing

Potentially suicidal inmates are housed in safe environments that maximize interaction with staff and others, and minimize experiences of isolation. (American Psychiatric Association, 2000; Penal Reform International, 2001; Scott & Gerbasi, 2005; World Health Organization, 2000)

3.3.2. Best Practices

The linchpin of a suicide prevention program is ensuring that any staff member who has contact with an inmate is capable of identifying, preventing, and properly managing potentially suicidal inmates (Hayes, 1995; Hills et al., 2004; Konrad et al., 2007; National Commission on Correctional Health Care, 2008c) – "Bluntly stated, lives will be lost and jurisdictions will incur unnecessary liability from these deaths if administrators do not create and maintain effective training programs" (Scott & Gerbasi, 2005). The following curriculum has been suggested for training staff in suicide prevention and management (Howells, Hall, & Day, 1999; Konrad et al., 2007; Ogloff, 2002; Scott & Gerbasi, 2005):

- Suicide risk factors (static and dynamic), particularly those inherent in the correctional environment;
- Staff attitudes about suicide;
- Identification of potential predisposing factors to suicide;
- Identification of high-risk suicide periods (e.g., admission, adjudication, segregation, personal loss);
- Identification of suicide warning signs and symptoms;
- Identification of suicide risk despite the denial of risk;
- Identification of signs of intoxication and withdrawal;
- Liability issues;
- Critical incident stress debriefing;
- Discussion about past completed suicides and/or serious attempts in the facility;
- Components of the facility/agency's suicide prevention policy, including the procedures for rapid referrals and handling a suicide attempt in progress; and

- Standard first aid and cardiopulmonary resuscitation (CPR).

In addition to training staff on how to identify potentially suicidal inmates, they should be educated about the procedures and protocols for intervening in a suicide in progress (National Commission on Correctional Health Care, 2008c). It is recommended that all staff be provided with refresher training on an annual basis (Konrad et al., 2007; National Commission on Correctional Health Care, 2008c; World Health Organization, 2000).

Ensuring that suicide risk is embedded into the mental health screening processes for all inmates who are admitted to jail or prison (including transfers from other facilities) is a standard element of any suicide prevention program. Suicide screening provides a short term estimate of risk based on known risk factors associated with suicide (Ogloff, 2002; Rudd & Joiner, 1998). It identifies inmates who require further assessment and those who should be continually monitored throughout the critical first hours of incarceration (Hills et al., 2004). It is recommended that the following topics be covered during the suicide screening process (L. Hayes, 1995; Hills et al., 2004; Konrad et al., 2007; Scott & Gerbasi, 2005):

- Past suicidal gestures, ideation and/or attempts and their seriousness;
- Prior mental health treatment and hospitalization;
- Current suicidal ideation, suicide threat, suicide plan, and suicide intent;
- Current mental health symptoms;
- The relationship between mental health symptoms and suicidal behaviour;
- Recent significant loss (e.g., job, relationship, death of family member);
- Suicide risk during prior periods of confinement;
- Arresting/transporting officer(s) view of inmate's current risk;
- Signs of intoxication and history of substance use problems;
- Internal and/or external supportive resources; and
- Family history of suicide.

As with any other type of screening, suicide screening should be standardized; this ensures that all inmates are asked the same questions and that findings are documented in writing. Individuals conducting suicide screening should be trained to do so and aided by a suicide checklist or rating scale, such as the Suicide Checklist (Arboleda-Florez & Holley, 1988; Dahle, Lohner, & Konrad, 2005; Konrad et al., 2007; World Health Organization, 2000). Similar to mental health and substance use screening, the key for suicide screening measures is that they are reliable and valid for use in correctional settings. To maximize the effectiveness of suicide prevention, screening must occur immediately following admission to the facility (i.e., within the first 24 hours) (Hills et al., 2004; Konrad et al., 2007; World Health Organization, 2000). In addition to screening for suicide risk at intake, it is recommended that inmates be screened if their circumstances or conditions change (World Health Organization, 2000).

Inmates who are identified as potentially suicidal should be immediately referred to a qualified mental health professional for a compressive assessment of suicide. The purpose of the assessment is to ascertain: the underlying problems associated with the suicide risk, level of suicide risk, the level of monitoring needed, and the mental health and substance use services required (National Commission on Correctional Health Care, 2008a, 2008b, 2008c). It is suggested that the following topics be covered in a comprehensive suicide assessment (Hills et al., 2004; Ogloff, 2002; Rudd & Joiner, 1998; World Health Organization, 2000):

- Historical/demographic variables related to suicide attempts or completions;
- History of substance use problems;
- Current suicide ideation and plans, distinguishing between morbid thinking and active suicidal thought;
- Current level of hopelessness, including reasons for living and dying;
- Lethality, availability, and accessibility of chosen methods;
- Preparatory behaviours;
- Subjective and objective markers of inmate's self-control;
- Marital or economic crisis;
- Serious physical and mental illness;
- Agitation and/or anger;
- Current intoxication;
- Levels of shame, guilt and worry over the arrest and incarceration; and
- Assessment of intent including both objective and subjective markers.

The assessment should place inmates on continuum of suicidality, ranging from nonexistent to extreme risk (Rudd & Joiner, 1998), that will guide the development of safe and effective monitoring, treatment, and housing strategies (Hills et al., 2004; Howells et al., 1999; World Health Organization, 2000). Inmates with extreme and severe suicide risk require immediate evaluation for inpatient hospitalization, with close observation (i.e., physical observation at least every 15 minutes) for those inmates who are not actively suicidal and constant one-to-one observation for inmates who are actively suicidal (e.g., threatening or engaging in suicidal behaviour) (Hills et al., 2004; National Commission on Correctional Health Care, 2008c; Scott & Gerbasi, 2005). Inmates with moderate to low risk may be effectively managed with outpatient treatment and close observation (Rudd & Joiner, 1998). Outpatient management of moderate-risk inmates requires that several strategies be followed, including recurrent evaluation of: the need for hospitalization, treatment plan goals, and suicide risk (Rudd & Joiner, 1998). Inmates at mild risk for suicide may only require recurrent evaluation of suicidal ideation to identify any escalation in risk (Rudd & Joiner, 1998).

While it is uniformly recommended that potentially suicidal inmates receive appropriate mental health treatment, the literature reviewed provides little guidance on the interventions and modalities demonstrated to be most effective in reducing suicidal ideation and attempts (Rudd & Joiner, 1998).

However, the literature does suggest that treatment should address the underlying reasons for the inmate's suicidality (e.g., depression, anxiety) (National Commission on Correctional Health Care, 2008c), which seemingly consists a basic mental health services – crisis intervention, psychotropic medication, evidence-based psychotherapies, and psychosocial/psychoeducational interventions – that are either provided by internal resources or by in-reach mental health services from community agencies (American Psychiatric Association, 2000; Konrad et al., 2007; Rudd & Joiner, 1998).

Suicide prevention research has consistently identified a relationship between inmate segregation and completed suicides (L. Hayes, 1995; Hills et al., 2004; Scott & Gerbasi, 2005; World Health Organization, 2000); therefore, a best practice in preventing suicide is to ensure that potentially suicidal inmates are housed in either the general population, mental health unit, or medical infirmary, and located in close proximity to staff (Hills et al., 2004; Howells et al., 1999; National Commission on Correctional Health Care, 2008c). The key is to maximize meaningful social interaction between the potentially suicidal inmate, staff, and other inmates (Scott & Gerbasi, 2005). Administrators are cautioned against relying on other inmates (i.e., inmate companions) or other supervision aides (e.g., closed circuit television) as a substitute for direct staff monitoring of potentially suicidal inmates (Fagan & Ax, 2003; World Health Organization, 2000). Cells or rooms that house potentially suicidal inmates should be suicide-resistant (i.e., free from obvious protrusions). If it is necessary to house potentially suicidal inmates in isolated conditions, then constant supervision must be maintained.

The best practice literature also identifies the importance of effective communication strategies and protocols in suicide prevention and management. Poor communication has been found to be a common element of completed suicides in jails and prisons (National Commission on Correctional Health Care, 2008c; Scott & Gerbasi, 2005). Communication strategies should attend to sharing information pertaining to the specific needs, risks, and current status of potentially suicidal inmates amongst and between staff who are in contact with potentially suicidal inmates (including arresting/transporting officers; facility medical, mental health, and correctional staff; staff at a receiving facility). Mutual respect between the different professional groups who work in jails and prisons has been identified as the key to effective communication (Scott & Gerbasi, 2005). Ensuring mutual respect can be facilitated by following a multidisciplinary approach to managing inmates and establishing regular team meetings that involve medical, mental health, and correctional staff to discuss the status of potentially suicidal inmates (Konrad et al., 2007; Scott & Gerbasi, 2005). Effective communication also involves ensuring that staff know how to employ good communication skills with inmates, such as not diminishing any reports of potential suicidality and using active listening skills with potentially suicidal inmates (American Psychiatric Association, 2000; Scott & Gerbasi, 2005).

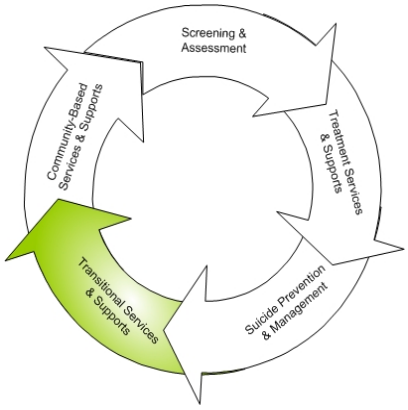
Another best practice component of a comprehensive suicide prevention and management program involves carrying out administrative/clinical reviews and critical incident debriefing following any serious suicide attempt or completed suicide (American Psychiatric Association, 2000; L. Hayes, 1995; Hills et al., 2004; National Commission on Correctional Health Care, 2008c; Scott & Gerbasi, 2005; World Health Organization, 2000). The purpose of post-incident review and critical incident debriefing is to: identify ways to improve institutional practices for detecting, monitoring, and managing future occurrences of suicide, and to assist staff and inmates in dealing with feelings (guilt, fear, sadness, and anger) resulting from a completed suicide. The effectiveness of the critical incident debriefing in helping staff and inmates cope with the emotional fall-out of a suicide will be

maximized by providing it within three days of the incident (Scott & Gerbasi, 2005). It is recommended that the post-incident review critically appraise the following topics (Hills et al., 2004; Scott & Gerbasi, 2005; World Health Organization, 2000):

- Circumstances surrounding and leading up to the incident;
- Relevant policies and procedures;
- Factors that may have led to the suicide and any factors that may have been missed or inadequately addressed;
- Relevant training received by staff who were involved;
- Adequacy of the emergency response;
- Pertinent medical, mental health, and substance use services and reports involving the victim; and
- Physical environment in which the victim completed the suicide.

Gaps that are detected in the suicide prevention and management program should be addressed by making appropriate changes in policy, training, physical environment, medical or mental health services, and operational procedures. The impartiality of the review is best maintained by having the process coordinated by an external agency (Scott & Gerbasi, 2005).

3.4. TRANSITIONAL SERVICES AND SUPPORTS



Transitional services and supports are the interventions and procedures that aim to assist inmates in the process of community re-entry, which includes supports provided just before, at the point of, and following release from jail or prison (Borzycki, 2005). The term "transitional" is preferred, as opposed to "discharge" or "release", since it best captures the shared responsibility between custodial and community services for ensuring continuity of care for inmates being released to the community. Transitional services and supports have been identified as being essential for all inmates – with and without mental health and substance use problems – who are re-entering the community, with a number of documents highlighting best practices for general inmate populations (Borzycki, 2005; Carter, Gibel, Giguere, & Stroker, 2007; Council of State Governments, 2003; Griffiths, Dandurand, & Murdoch, 2007; National Association of Counties, 2008; Seiter & Kadela, 2003; Solomon et al., 2008). While the principles underpinning transitional services and supports are similar for all inmates, the minimum standards and best practices identified below pertain only to the strategies that are specifically designed to support inmates with mental health and substance use problems following their release from jail or prison.

3.4.1. Minimum Standards

A review of published standards and guidelines suggests the following minimum standards in relation to the provision of transitional services and supports for inmates with mental health and substance use problems that are being released from jails or prisons.

TRA-01: Transition Plan

Inmates with mental health and/or substance use problems requiring continued care are provided with a written transition plan that identifies available and appropriate community resources prior to their release/transfer from jail or prison. (Council of State Governments, 2002; National Commission on Correctional Health Care, 2008c; Osher et al., 2002; Osher, Steadman, & Barr, 2003; Scott & Gerbasi, 2005)

TRA-02: Referral and Linking

Inmates with mental health and/or substance use problems requiring continued care are referred and/or linked to specific mental health and/or substance use services that are available in the community as identified by the transition plan. (American Association for Correctional Psychology, 2000; American Psychiatric Association, 2000; Council of State Governments, 2002; Osher et al., 2002, 2003)

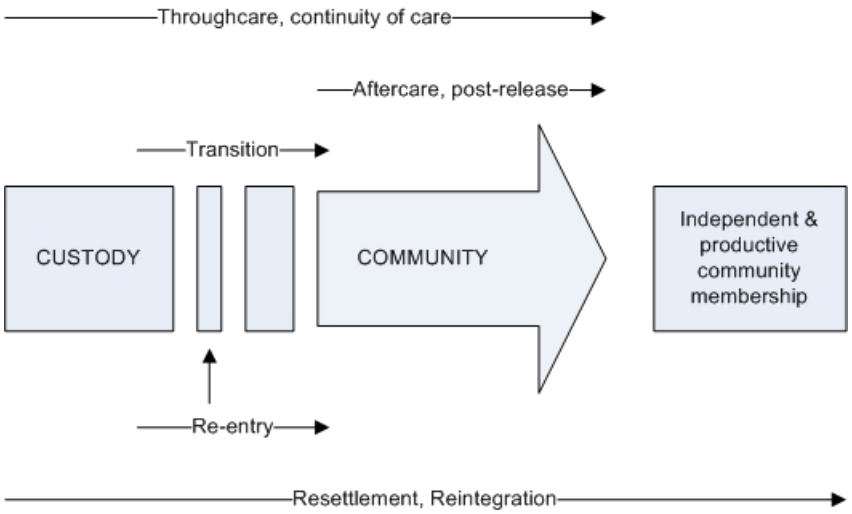
TRA-03: Medication Continuity

Inmates with mental health and/or substance use problems who require continued pharmacological treatment are provided with a sufficient supply of medication that can last at least until the inmate is able to see a community health care service provider. (American Association for Correctional Psychology, 2000; Council of State Governments, 2002; Osher et al., 2003)

3.4.2. Best Practices

For inmates with mental health and substance use problems, the transition between custody and community can be acutely stressful, psychologically distressing, and disruptive to their recovery and treatment (Daniel, 2007). Indeed, good transitional planning is required to ensure continuity of care for inmates with mental health and substance use problems (Metzner, 2002; Ogloff, 2002). Borzycki (2005) provides a useful diagram (Figure 3) for understanding the transition and other processes surrounding an inmate's return to the community.

Figure 3
Service Continuum for Inmates Re-Entering the Community (Borzycki, 2005)



Transition planning is equally important in jails and prisons; however, each of these environments offers unique challenges for providing transition planning services to inmates with mental health and substance use problems. Transition planning in jails is challenged by the brief, and often unpredictable, duration of detention or incarceration, which necessarily requires rapid planning. In contrast, the lengthy duration of incarceration in prisons means that inmates who had been previously involved in treatment in the community have likely lost contact with previous services and supports and may have diminished informal social supports (Osher et al., 2002). Though jail and prison settings offer unique challenges, the literature generally recommends similar transitional services and supports for jails and prisons (American Psychiatric Association, 2000; National Commission on Correctional Health Care, 2008a, 2008b).

The structure for discussing best practices in relation to transitional services and supports for inmates with mental health and substance use problems will be guided by the core components of a best practice transition model, known as the APIC [Assess, Plan, Identify, Coordinate] Model (Council of State Governments, 2003; New Freedom Commission on Mental Health, 2004; Osher et al., 2002; Osher, Steadman, & Barr, 2003). Though the APIC model is being used for the purposes of structuring this section of the report, it should be noted that several other jail- and prison-based best practice models exist in the literature (see Draine & Herman, 2007; Lurigio & Swartz, 2000; New Freedom Commission on Mental Health, 2004; World Health Organization, 2007a)

The **assessment** phase of the APIC Model involves examining the clinical and social needs of inmates as well as their potential risk of violence and harm (Osher et al., 2002, 2003). The details of this phase were thoroughly covered in Section 3.1. For the purposes of transitional services and supports, it is important to ensure that the information gathered about an inmate's problems and service needs is current at the time of transition and is incorporated into the transition plan. Indeed, effective transition planning is dependent on the accuracy and comprehensiveness of information collected during the assessment phase (Hills et al., 2004).

During the **planning** phase of the APIC Model, the approach for addressing an inmate's service needs is formulated through the following processes (Osher et al., 2002, 2003):

- Planning for the immediate (hours/days), intermediate (weeks/months), and long-term (years) periods following release to the community;
- Discussing with the inmate strategies that have, or have not, worked during past transitions;
- Acquiring the input of family members and friends;
- Addressing housing needs;
- Arranging an integrated treatment approach for inmates with co-occurring disorders;
- Reviewing the appropriateness of an inmate's current medication regimen and making plans to ensure that they have a sufficient supply of medication to last at least until a follow-up appointment;
- Assisting inmates apply for and receive the public-assistance benefits to which they are entitled, and that this is arranged prior to release (for a detailed discussion on this issue see: Bazelon Center for Mental Health Law, n.d.); and
- Ensuring an inmate's basic necessities are taken care of (i.e., clothing, adequate nutrition, transportation, and childcare) and that the inmate is capable of attending appointments with mental health and/or substance use service providers (e.g., has access to child care, transportation).

Planning for an inmate's release to community should begin as soon as a mental health and/or substance use problem is identified – forming part of the treatment plan and continuing throughout the period of detention or incarceration (Hills et al., 2004; Metzner, 2002; Osher et al., 2002; Sowers & Rohland, 2004). It is recommended that the transition plan crosses the entire course of a

mental health and/or substance use problem to anticipate transitions that result from changes to the inmate's mental condition and to provide continuity of care (Sowers & Rohland, 2004).

Effective transition planning attends to the inmate's multiple needs, not only those concerning their mental health and substance use problem. To be effective, transition planning must address issues related to mental health, substance use, medical, housing, finances, social network, employment, education, and legal problems (National Institute on Drug Abuse, 1999). All involved service providers have the responsibility of ensuring that care is coordinated and integrated as part of the transition planning process (Sowers & Rohland, 2004). Inmates, and their social support system, should be involved in the development of their own transition plan and the inmate's choice should be respected (Sowers & Rohland, 2004). Transitional planning should consider characteristics of relevance to the inmates, such as gender-related factors, age, social milieu and living environment, cultural factors, sexual identity issues, and family characteristics (American Psychiatric Association, 2006; Sowers & Rohland, 2004). Transitions should be managed in a culturally sensitive manner, integrating individual beliefs, customs, and social context into transition planning (Sowers & Rohland, 2004). For women, transition planning that attends to gender-specific needs will tend to focus on trauma-related issues, parenting skills, the mother-child relationship, and preventing intergenerational criminality (Sacks, 2004). Transition plans should include a comprehensive relapse prevention strategy, including an assessment of social skills deficits, to help inmates recognize early signs of relapse and know how to manage it (National Treatment Agency for Substance Misuse, 2006; Sowers & Rohland, 2004).

The third phase of the APIC Model requires the **identification** of required community and correctional programs and service providers that will be responsible for providing services and supports to the inmate upon release from jail or prison. The elements of this phase include (Osher et al., 2002, 2003):

- Identifying specific community programs and providers that are appropriate to the inmate based on: clinical diagnosis, demographic factors, financial arrangements, geographic location, cultural considerations, legal circumstances, level of disability, motivation for change, and availability of community resources;
- Sharing health records – including a complete discharge summary, diagnosis, medications and dosage, legal status, and transition plan – to the community service providers as appropriate for the purposes of care;
- Ensuring that inmates receive their personal belongings upon release from jail or prison and that the inmate has photo ID;
- Supporting conditions of release and community corrections supervision that match the severity of the inmate's criminal behaviour; and
- Addressing the community treatment provider's role (with regards to limits of confidentiality) vis-à-vis other social service agencies, parole and probation, and the court system.

The final, and perhaps most critical, phase of the APIC model involves **coordinating** the implementation of the transition plan, which includes the following (Osher et al., 2002, 2003):

- Coordinating the timing and delivery of services to assist inmates span the jail-community boundary after release from jail or prison – typically via a case manager entity;
- Case assignment to a community treatment agency that is made in a cooperative manner between the inmate, community and custodial corrections providers, and community-based mental health and substance service providers;
- Explicitly communicating – to the individual, the family, the releasing facility and the community treatment agency – the name(s) and contact information of the person(s) who will be responsible for care of the ex-inmate between the time of release and the first follow-up appointment;
- Confirming that the inmate: knows details regarding the first follow-up visit; has adequate medications; knows who to contact if there are problems related to medication, health, social services, or the appointment itself; and
- Establishing a mechanism to track and handle those who do not attend their first follow-up appointment.

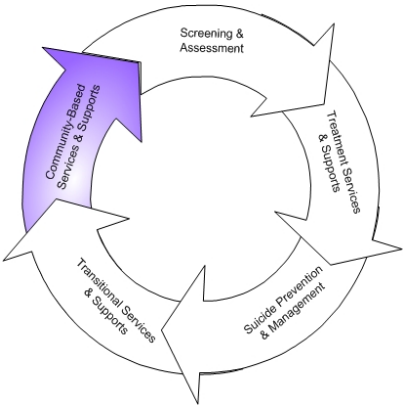
Engaging community-based service providers in providing services to inmates with mental health and substance use problems – and establishing a therapeutic relationship – before, during, and after the transition to the community has been identified as an effective strategy for ensuring continuity of care (Council of State Governments, 2003; National Commission on Correctional Health Care, 2008c). Relationships with community partners should be formalized to allow for the flow of clear and consistent information related to the inmate's problems and needs (Hills et al., 2004). Other strategies for enhancing continuity of care and systems integration in relation to transitional services include (Council of State Governments, 2002, 2003; Draine & Herman, 2007; Hills et al., 2004; Ogloff, 2002):

- Overcoming geographic barriers by using telehealth technology to link inmates, jail/prison service providers, and community-based service providers;
- Strengthening inmate's long term ties to services, family, and friends;
- Providing emotional and practical support and advocacy during the transition from jail/prison to community;
- Assertive advocacy and negotiating entry for inmates perceived as less than desirable;
- Avoiding middle-of-the-night releases;
- Discontinuing unplanned releases from mental health units to the community;
- Discontinuing anonymous referrals to community programs and providers;
- Creating step down programs, transitional housing, and allowing for gradual transitions to the community; and
- Ensuring that clinical expertise and familiarity with community-based mental health resources inform release decisions and determination of conditions of release.

The use of case managers for coordinating transitional services and supports for inmates with mental health and substance use problems has been identified as a best practice (Borzycki, 2005;

Lurigio, 2000b; Ogloff, 2002). The role of the case manager is to identify, recommend, and facilitate the referral of inmates to services that will help them maintain stability in their functioning, and to ensure that relevant service systems (e.g., corrections, mental health, addictions) interact effectively and efficiently (Hills et al., 2004; Ogloff, 2002). This method for delivering care emphasizes coordination of services across and between agencies, and ensures that inmates remain in contact with services (Thornicroft & Tansella, 2003). Case management is a critical "boundary spanning" resource for inmates transitioning to the community.

3.5. COMMUNITY-BASED SERVICES AND SUPPORTS



The community corrections system has a significant role to play in the ensuring that probationers and parolees have access to appropriate mental health and substance use services. On account of the high prevalence of mental health problems amongst probationers and parolees, the community corrections system has been referred to as a de facto community mental health system (Lurigio, 1996). However, unlike the mental health and substance use services system, traditional probation and parole departments often lack the resources and specialized training needed to identify and appropriately deal with the needs of individuals with mental health and substance use problems (Lurigio et al., 2003). Probationers and parolees with mental health and substance use problems require the availability of a full continuum services that are accessible, appropriate, and relevant to their needs (Center for Mental Health Services, 1995).

3.5.1. Minimum Standards

A review of published standards and guidelines suggests the following minimum standards for the provision of community-based services and supports for probationers and parolees with mental health and substance use problems.

COM-01: Equivalence of Care

Probationers and parolees with mental health and substance use problems have access to the same level and standard of care as is available to individuals in the community who are not involved with the criminal justice system. (Committee of Ministers of the Council of Europe, 2006; Correctional Service of Canada, 1994)

COM-02: Staff Training

Staff members who work with probationers and parolees are trained to recognize mental health and substance use problems, and potential suicide risk. (Center for Mental Health Services, 1995; Correctional Service of Canada, 1994; Council of State Governments, 2002; Lurigio, 1996; National Commission on Correctional Health Care, 2008c; Sentencing Project, 2002)

COM-03 - Screening

Screening is performed by a trained staff member on all probationers and parolees in order to identify emergent and urgent mental health and substance use problems, including potential suicidality. (Lurigio, 1996; Peters & Hills, 1997; Sentencing Project, 2002)

COM -04: Ongoing Evaluation

Mechanisms are established to ensure the ongoing evaluation and identification of emergent and urgent mental health and substance use problems, including suicidality, among all probationers and parolees. (Lurigio, 1996; Peters & Hills, 1997; Sentencing Project, 2002)

COM-05: Referral for Service

Probationers and parolees with potential mental health and/or substance use problems are referred to appropriate assessment and treatment services in a timely manner, with the nature of the problem indicating the urgency of the referral. (Correctional Service of Canada, 1994; Lurigio, 1996)

3.5.2. Best Practices

The role of community corrections in relation to the supervision of individuals with mental health and substance use problems is to: monitor active symptoms and high risk situations, respond to infractions and violations, refer to treatment services and supports, and monitor involvement in treatment services and supports (Peters & Hills, 1997). Accordingly, the literature draws attention to the following five best practice strategies for community corrections: (a) staff training, (b) screening, (c) managing treatment conditions and technical violations, (d) intensive and specialized case management, and (e) specialized caseloads. The literature does contain references to specialized community mental health and substance use programs that are directly funded and operated by correctional agencies (e.g., therapeutic communities); however, the best practices contained in this section will concentrate on strategies that aim to identify persons with mental health and substance use problems and link them to appropriate services.

a. Staff Training

As with staff in jails and prisons, probation and parole officers should be trained to: identify the signs and symptoms of mental health and substance use problems, identify potentially suicidal probationers/parolees, understand the unique problems and issues facing probationers/parolees with mental health and substance use problems in the community, accommodate unusual and other behaviour resulting from mental health and substance use problems, and identify existing services that are available in the local community (Center for Mental Health Services, 1995). Knowing the early warning signs of substance use is particularly important, as it can trigger recurrence of mental health symptoms or other behavioural problems (Peters & Hills, 1997). Cross-training has been identified as the most important factor in improving mutual understanding and building cooperative working arrangements between community corrections and mental health/addictions staff (Center for Mental Health Services, 1995; Lurigio & Swartz, 2000; Sentencing Project, 2002).

b. Screening

Effective screening at different stages in the community corrections system is essential for properly identifying and addressing mental health and substance use problems (Lurigio & Swartz, 2006; Peters & Hills, 1997; Sentencing Project, 2002). Many individuals serving sentences in the community (i.e., probation, parole) have unidentified mental health and/or substance use needs. In fact, few probationers and parolees with mental disorders are identified prior to sentencing and few are mandated to participate in treatment (Veysey, 1996). This is particularly true if the individuals' mental health or substance use problems were not an explicit part of their offence, or were not exhibited prior to sentencing or, in case of parolees, during incarceration (Lurigio, 2000a; Lurigio et al., 2003).

Upon intake, the mental health and substance use problems of probationers and parolees should be routinely evaluated by trained staff members using a standardized screening instrument (Lurigio & Swartz, 2006). Because some probationers and parolees may be initially reluctant to discuss issues related to mental health and substance use, it is suggested that screening should be administered periodically following intake (Peters & Hills, 1997). Ongoing screening for potential suicide is also indicated in the literature. For individuals with substance use problems, screening for co-occurring mental health problems should be delayed until they reach sobriety (Peters & Hills, 1997). As is discussed in Section 3.1 of this report, the screening should cover major topic areas concerning current and past mental health and substance use problems, including suicidality and brain impairment.

Probationers and parolees with brain impairment may have problems with attention, concentration, memory, insight, and problem solving, which may cause them to miss hearing dates or appointments, or fail to recognize the consequences of their behaviour (Peters & Hills, 1997). Identifying the presence of brain impairment allows probation and parole offers to understand the underlying cause of these problems and modify their strategies for managing the individual (e.g., providing writing reminders of upcoming appointments) (Peters & Hills, 1997).

Several screening instruments can be used by trained lay persons with criminal justice populations (Hills et al., 2004; Peters et al., 2000; Peters & Hills, 1997; Scott & Gerbasi, 2005; Teplin & Swartz, 1989); however, few instruments have been validated in community corrections populations. Random drug tests has been identified as an important methods for screening for potential substance use problems in probationers and parolees (Peters & Hills, 1997). The results of mental health and substance use screening should be used to ascertain the need for a subsequent referral to a qualified mental health professional for a more comprehensive assessment and treatment (Lurigio, 1996).

c. Managing Treatment Conditions and Technical Violations

The participation of probationers and parolees in treatment services may be mandated by the Court or parole board, or it may be initiated by a probation or parole officer with the understanding that failure to comply may result in revocation. In either case, the responsibility of choosing the most appropriate intervention and monitoring compliance may be left to the discretion of the probation and parole officer. Research has shown that probationers and parolees with mental health and substance use problems have trouble complying with their conditions and are, therefore, at increased risk for technical violations, new arrests/charges, and new sentences including incarceration (Center for Mental Health Services, 1995; Skeem & Louden, 2006). Probation and parole officers should be prepared to use non-traditional methods for managing the conditions and dealing with the technical violations of probationers and parolees with mental health and substance use problems.

In order to break the criminal justice cycle that can be produced by these technical violations, several jurisdictions have established specific strategies for dealing with probationers and parolees in a manner that recognizes their mental health needs while simultaneously holding them accountable for their actions. This allows probationers and parolees with mental health and substance use problems to make some mistakes before being sent to jail or prison. These revocation prevention strategies generally employ one of more of the following practices (Center for Mental

Health Services, 1995; Council of State Governments, 2002; Hills et al., 2004; Lurigio, 2000a; Sentencing Project, 2002):

- Establishing incentives for probationers and parolees with mental health and substance use problems to comply with conditions, such as reducing the frequency of reporting after a period of compliance;
- Providing increased daily structure and/or external monitoring (i.e., increased frequency of check-ins with probation/parole officer) for probationers and parolees who fail to attend mandated treatment appointments or are non-compliant with the treatment plan;
- Employing a graduated scheme of responses before employing the most serious response (i.e., revocation of probation/parole);
- Consulting with treatment service providers before taking action on a violation related to treatment or failure to undergo a mental health evaluation. For example, in response to a technical violation, probation and parole officers can refer probationers/parolees with non-violent offences to more intensive treatment and services in lieu of a court hearing and more punishment;
- Responding to minor technical violations early to obviate the need for revocation and to prevent more serious violations;
- Establishing agreements and written guidelines with service providers regarding the support that they will provide and the actions that will be taken for failure to participate in treatment or if other problems arise; and
- Enlisting the assistance of mental health and/or substance use providers to help probationers/parolees better understand the consequences of their behaviour in terms of sanctions. For example, a joint meeting between the officer, the provider, and the probationer/parolee to identify barriers to compliance and to make changes in the treatment plan or probation rules as necessary.

These strategies emphasize the use of non-custodial alternatives when dealing with technical violations for probationers or parolees who have not committed a new criminal offence and are not a public safety risk. Effective communication and cooperation between probation/parole, mental health and substance use providers, and other relevant service providers is necessary for revocation prevention strategies to work (Center for Mental Health Services, 1995).

For cases that require removing a probationer or parolee from the community, the goal should be to minimize their length of incarceration, as is done in the Parole Restoration Project, operated by the Center for Alternative Sentencing and Employment Services (CASES) in New York City (Council of State Governments, 2002). Under this program, technical parole violators with special needs (i.e., mental illness, substance abuse) are linked with case management, mental health and social services in order to return them to the community in an expeditious manner. Using a relapse prevention approach – focusing on identification of, and response to, early warning signs, high risk situations, and other precursors of mental health and substance use problems – has also been suggested as a strategy to help probationers/parolees with mental health and substance use problems avoid more serious problems in the future (Lurigio & Swartz, 2000; Peters & Hills, 1997).

d. Intensive and Specialized Case Management

Intensive case management is identified as a best practice for managing probationers and parolees with mental health and/or substance use problems (Godley et al., 2000; Loveland & Boyle, 2007). The most promising case management model is assertive community treatment (ACT), which combines a team-based and outreach approach to case management. The key elements of assertive community treatment are: a low staff-to-consumer ratio (usually 1:10), multi-disciplinary teams who share responsibility of client, services that are tailored to the individual needs of the clients, full-time coverage, and assertive outreach primarily delivered in the community (Lurigio & Swartz, 2000). There is ample evidence to support assertive community treatment as a best practice, particularly for individuals with serious mental health and substance use problems who have the highest service needs (i.e., an extensive history of hospitalizations or poor engagement with community-based services) (Burns et al., 2007; Dumont et al., 2002; Meuser et al., 2003; Ontario, 2005; Vanderplasschen et al., 2007).

Several jurisdictions have developed specialized "forensic" ACT teams (FACT) that shift the focus from preventing hospitalization to preventing arrest and incarceration for persons with mental disorders (Morrissey, Meyer, & Cuddeback, 2007). In practice, the FACT model often deviates from high-fidelity ACT models, such as not providing 24/7 availability or employment specialists, and adds new elements, such including probation, parole, or police officers to the treatment team (Morrissey et al., 2007). FACT is distinct in that it requires all clients to have criminal justice histories, accepts the majority of referrals from criminal justice agencies, and incorporates supervised residential treatment for high-risk clients particularly those with co-occurring substance use disorders (Morrissey et al., 2007). As a less costly, yet effective, alternative to the FACT model, the forensic intensive case management (FICM) model has similar features to FACT (i.e., assertive, in-vivo, and time-unlimited services), but does not have individual caseloads, self-contained teams, or 24/7 capacity. FICM programs that are effective at reducing rates of arrest and incarceration tend to integrate substance use services within their program, and emphasize jail diversion and coordination of mental health and criminal justice systems (Loveland & Boyle, 2007). Research suggests that specialized programs that are used in criminal justice settings (i.e., FACT or FICM) need to incorporate modules that explicitly focus on reduction of criminal behaviour and recidivism (Morrissey et al., 2007).

e. Specialized Caseloads

A growing body of literature suggests that the 'specialized mental health caseload' model is a promising approach for managing probationers and parolees with mental health and substance use problems (Center for Mental Health Services, 1995; Lurigio, 2001; Lurigio & Swartz, 2000; Skeem & Louden, 2006). The 'specialized mental health caseload' model includes the following core elements (Skeem & Louden, 2006):

- Officers exclusively supervise persons with mental illness;
- Officers have reduced caseloads (approximately one-third the size of traditional caseloads);
- Officers receive sustained training in relevant mental health issues;
- Officers intervene directly with probationers or parolees and actively coordinate with external service providers;

- Officers work as teams with treatment providers, attend treatment team meetings, and advocate to secure such appropriate treatment and social services; and
- Officers are likely to address treatment non-compliance by talking with the probationer or parolee to identify any obstacles to compliance, resolve these problems, and agree on a compliance plan, rather than merely remind probationers or parolees of the rules or threaten them with incarceration.

The specialized caseload model can also serve as a transitional approach for persons who require short-term intensive assistance, such as mentally disordered persons released from jail or prison, until they are ready to be moved to a standard probation caseload (Lurigio, 1996). The Cook County (Chicago) Adult Probation Department's Mental Health Unit (MHU) is an example of a best practice specialized caseload model (Council of State Governments, 2002). The MHU is staffed by probation officers with mental health training and the program provides clinical assessments, intensive supervision, and service linkage to probationers with mental health problems.

4. CONCLUSION

While it is necessary to establish minimum standards in relation to providing mental health and substance use services in correctional settings; there is no single blueprint for creating a correctional mental health and substance use service system (Ogloff, 2002; Steadman et al., 1989). Implementation of minimum standards and best practices should be flexible – varying according the type of setting and population (American Psychiatric Association, 2000), as well as other contextual factors such as geography, resources, and size of the facility (Lurigio & Swartz, 2000; Ogloff, 2002).

Legislative realities, such as the distribution of legislative authority under the section 92 of the Canadian *Constitution Act*, create obstacles for implementing mental health and substance use service standards and best practices in correctional settings. The multiple, co-occurring problems of inmates, probationers, and parolees (i.e., personality disorders, brain impairment, antisocial behaviour, and criminogenic risks) also add a level of complexity to delivering mental health and substance use services in correctional settings. Moreover, a number of other barriers, many of which are tied to restricted fiscal and human resources, hamper the extent to which correctional authorities can comply with mental health and substance use service standards and/or implement best practice approaches (Chandler, Peters, & Juliano-Bult, 2004; Fagan & Ax, 2003; Friedmann, Taxman, & Henderson, 2007; McLearen & Ryba, 2003). Lack of resources, however, is never justification for human rights violations caused by failure to provide timely access to necessary mental health and substance use services (Committee of Ministers of the Council of Europe, 2006).

It is important to note a number of limitations of the present review. First, the review concentrates on mental health and substance use problems and services without full consideration of the impact of other multifaceted, complex, and co-occurring problems that are prevalent within correctional populations, including a range of medical conditions, personality disorders, malingering, cognitive impairment, and behavioural disturbances. The intent of focusing exclusively on mental health and substance use problems was to narrow the scope of this review rather than to endorse a service delivery model that fails to use a holistic approach for dealing with the intersecting and multiple problems and service needs of individuals in correctional settings. Secondly, the breadth of literature covered in the review necessitated the use of a broad definition of "best practice" that included both empirical evidence and expert opinion; therefore, the strength and quality of evidence for particular best practices was not evaluated or indicated. Thirdly, the best practice literature that was uncovered in relation to the special needs of individuals with acquired brain impairment was weak, which may, in part, be attributable to the literature search methods used for this review (i.e., relying on keywords related to 'mental illness' and 'addiction'). Lastly, although important issues related to the differences between jail and prison settings as well as the influence of correctional rehabilitation programs and strategies (i.e., criminogenic, behavioural) on the management of individuals in correctional settings were observed, they were largely overlooked in the review. The extent to which the aforementioned minimum standards and best practices have actually been, or could most effectively be, implemented in correctional settings remains unanswered.

Despite the limitations noted above, this review has revealed that a considerable body of literature exists in relation to mental health and substance use service standards and best practices in correctional settings. Rather than dictating a specific course of action, the conceptual framework,

minimum standards, and best practices described throughout this report are intended to serve as a useful guide to inform decision-making concerning mental health and substance use services in correctional settings.

5. REFERENCES

Abramowitz, M. Z. (2005). Prisons and the human rights of persons with mental disorders. *Current Opinion in Psychiatry, 18,* 525-529.

American Association for Correctional Psychology. (2000). Standards for Psychology Services in Jails, Prisons, Correctional Facilities, and Agencies. *Criminal Justice and Behavior, 27*(4), 433-494.

American Bar Association. (1984). *ABA Criminal Justice Mental Health Standards*. Retrieved January 13, 2009, from http://www.abanet.org/crimjust/standards/mentalhealth.pdf

American Psychiatric Association. (2000). *Psychiatric Services in Jails and Prisons: A Task Force Report of the American Psychiatric Association*. Washington, DC: Author.

American Psychiatric Association. (2006). *Practice guidelines for the treatment of patients with substance use disorders* (2nd ed.). Washington: Author.

Aos, S., Miller, M., & Drake, E. (2006). *Evidence-Based Adult Corrections Programs: What Works and What Does Not*. Retrieved January 8, 2009, from www.wsipp.wa.gov/rptfiles/06-01-1201.pdf

Arseneault, L., Moffitt, T. E., Caspi, A., Taylor, P. J., & Silva, P. A. (2000). Mental disorders and violence in a total birth cohort - Results from the Dunedin study. *Archives of General Psychiatry, 57*(10), 979-986.

Australia. (2004). *Standard Guidelines for Corrections in Australia*. Retrieved January 7, 2009, from http://www.aic.gov.au/research/corrections/standards/aust-stand_2004.pdf

Bazelon Center for Mental Health Law. (n.d.). *Best Practices: Assess to Benefits for Prisoners with Mental Illness*. Washington, DC.

Borzycki, M. (2005). *Interventions for Prisoners Returning to the Community*. Retrieved January 20, 2009, from http://www.aic.gov.au/publications/reports/2005-03-prisoners.pdf

Bower, P., & Gilbody, S. (2005). Stepped care in psychological therapies: access, effectiveness and efficiency. *British Journal of Psychiatry, 186,* 11-17.

Brink, J. (2005). Epidemiology of mental illness in a correctional system. *Current Opinion in Psychiatry, 18*(5), 536-541.

British Columbia Ministry of Health. (2004). *Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction*. Retrieved October 1, 2007, from http://www.health.gov.bc.ca/library/publications/year/2004/framework_for_substance_use_and_addiction.pdf

Bruce, R. D., & Schleifer, R. A. (2008). Ethical and human rights imperatives to ensure medication-assisted treatment for opiod dependence in prisons and pre-trial detention. *International Journal of Drug Policy, 19*(1), 17-23.

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review, 26*, 17-31.

Camilleri, P., & McArthur, M. (2008). Suicidal behaviour in prisons: Learning from Australian and international experiences. *International Journal of Law and Psychiatry, 31*(4), 297-307.

Camilleri, P., McArthur, M., & Webb, H. (1999). *Suicidal Behaviour in Prisons: A Literature Review*. Retrieved March 26, 2009, from http://www.cs.act.gov.au/__data/assets/pdf_file/0009/26694/suicide.pdf

Canadian Institutes of Health Research. (2004). *KT Strategy 2004-2009* Retrieved February 5, 2009, from http://www.cihr-irsc.gc.ca/e/26574.html

Canadian Psychiatric Association. (2005). Clinical practice guidelines: Treatment of schizophrenia. *Canadian Journal of Psychiatry, 50 (suppl. 1)*, 1S-56S.

Center for Mental Health Services. (1995). *Double Jeopardy: Persons with Mental Illness in the Criminal Justice System*. Retrieved January 14, 2009, from http://gainscenter.samhsa.gov/pdfs/disorders/Double_Jeopardy.pdf

Centers for Disease Control and Prevention. (n.d.). *Traumatic Brain Injury in Prisons and Jails: An Unrecognized Problem*. Retrieved January 7, 2009, from www.cdc.gov/ncipc/tbi/FactSheets/Prisoner_TBI_Prof.pdf

Chandler, D. W., & Spicer, G. (2006). Integrated Treatment for Jail Recidivists with Co-occurring Psychiatric and Substance Use Disorders. *Community Mental Health Journal, 42*(4), 405-425.

Chandler, R. K., Peters, R. H., & Juliano-Bult, D. (2004). Challenges in implementing evidence-based treatment practices for co-occuring disorders in the criminal justice system. *Behavioral Sciences and the Law, 22*, 431-448.

Committee of Ministers of the Council of Europe. (2006). *Recommendation No. R (2006) 2 of the Committee of Ministers to Member States on the European Prison Rules (adopted 11 January 2006)* Retrieved February 10, 2009, from https://wcd.coe.int/ViewDoc.jsp?id=955747

Correctional Service of Canada. (1994). *Standards for Health Services*. Retrieved January 7, 2009, from http://www.csc-scc.gc.ca/text/prgrm/fsw/hlthstds/toc-eng.shtml

Corrections and Conditional Release Act, c. 20 (S.C. 1992).

Council of State Governments. (2002). *Criminal Justice / Mental Health Consensus Project*. Retrieved January 7, 2009, from http://consensusproject.org/downloads/Entire_report.pdf

Council of State Governments. (2003). *Report of the Re-Entry Policy Council: Charting the Safe and Successful Return of Prisoners to the Community*. Retrieved January 7, 2009, from http://reentrypolicy.org/Report/Download

Craven, M. A., & Bland, R. (2006). Better practices in collaborative mental health care: An analysis of the evidence base. *Canadian Journal of Psychiatry, 51 (suppl. 1)*(7S-72S).

Daniel, A. E. (2007). Care of the mentally ill in prisons: Challenges and solutions. *Journal of the American Academy of Psychiatry and the Law, 35*(4), 406-410.

Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., et al. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services, 52*(4), 469-476.

Edens, J. F., Peters, R. H., & Hills, H. A. (1997). Treating prison inmates with co-occurring disorders: an integrative review of existing programs. *Behavioral Sciences & the Law, 15*(4), 439-457.

Els, C. (2007). Addiction is a mental disorder, best managed in a (public) mental health setting - but our system is failing us. *Canadian Journal of Psychiatry, 53*(3), 167-169.

Fagan, T. J., & Ax, R. K. (Eds.). (2003). *Correctional Mental Health Handbook*. Thousand Oaks, California: Sage Publications.

Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys. *The Lancet, 359*(9306), 545-550.

Goering, P., Cochrane, J., Durbin, J., Lesage, A., Rogers, J., Trainor, J., et al. (1997). *Review of Best Practices in Mental Health Reform* Retrieved October 1, 2007, from http://www.phac-aspc.gc.ca/mh-sm/pubs/bp_review/pdf/e_bp-rev.pdf

Goldman, H. H., Thelander, S., & Westrin, C.-G. (2000). Organizing mental health services: An evidence-based approach. *Journal of Mental Health Policy and Economics, 3*(2), 69-75.

Hayes, L. (1995). *Prison Suicide: An Overview and Guide to Prevention*. Retrieved January 13, 2009, from http://www.nicic.org/pubs/1995/012475.pdf

Hayes, M. V., & Dunn, J. R. (1998). *Population Health in Canada: A Systematic Review*. Retrieved February 19, 2009, from http://www.cprn.org/documents/19187_en.pdf

Hayton, P., & Boyington, J. (2006). Prisons and Health Reforms in England and Wales. *American Journal of Public Health, 96*(10), 1730-1733.

Health Canada. (2000). *A Report on Mental Illness in Canada*. Retrieved February 7, 2009, from http://www.phac-aspc.gc.ca/publicat/miic-mmac/pdf/men_ill_e.pdf

Health Canada. (2001). *Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems*. Ottawa, ON: Author.

Health Canada. (2002). *Best Practices - Concurrent Mental Health and Substance Use Disorders: The Approach to Defining Best Practices for this project*. Retrieved February 1, 2009, from http://www.hc-sc.gc.ca/hl-vs/pubs/adp-apd/bp_disorder-mp_concomitants/approach-eng.php

Health Canada. (2006). *Best Practices: Early Intervention, Outreach and Community Linkages for Women with Substance Use Problems* Retrieved February 20, 2009, from http://www.hc-sc.gc.ca/hl-vs/pubs/adp-apd/early-intervention-precoce/index_e.html

Hills, H., Siegfried, C., & Ickowitz, A. (2004). *Effective Prison Mental Health Services: Guidelines to Expand and Improve Treatment*. Retrieved January 7, 2009, from http://www.nicic.org/pubs/2004/018604.pdf

Hogan, M. F., Adams, J., Arredondo, R., Carlile, P., Curie, C. G., Fisher, D. B., et al. (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report for the President's New Freedom Commission on Mental Health*. Retrieved February 15, 2009, from http://www.mentalhealthcommission.gov/reports/reports.htm

International Council of Nurses. (2006). *Nurses' Role in the Care of Detainees and Prisoners*. Retrieved January 7, 2009, from http://www.icn.ch/psdetainees.htm

International Council of Prison Mental Health Services. (1997). *The Oath of Athens*. Retrieved February 27, 2009, from http://www.prisonhealthcarepractitioners.com/Medical_ethics.shtml

Kassebaum, P. A. (1999). *Substance Abuse Treatment for Women Offenders: Guide to Promising Practices*. Retrieved January 16, 2009, from http://tie.samhsa.gov/Taps/Tap23.pdf

Konrad, N., Daigle, M. S., Daniel, A. E., Dear, G. E., Frottier, P., Hayes, L. M., et al. (2007). Preventing suicide in prisons, Part I: Recommendations from the International Association for Suicide Prevention Task Force on Suicide in Prisons. *Crisis, 28*(3), 113-121.

Laishes, J. (2002). *The 2002 Mental Health Strategy for Women Offenders*. Retrieved January 19, 2009, from http://www.csc-scc.gc.ca/text/prgrm/fsw/mhealth/toc-eng.shtml

Landry, R., Lamari, M., & Amara, N. (2003). The extent and determinants of the utilization of university research in government agencies. *Public Administration Review, 63*(2), 192-205.

Lees, J., Manning, N., & Rawlings, B. (1999). *Therapeutic Community Effectiveness: A Systematic International Review of Therapeutic Community Treatment for People with Personality Disorders and Mentally Disordered Offenders*. Retrieved January 12, 2009, from http://www.york.ac.uk/inst/crd/CRD_Reports/crdreport17.pdf

Lipsey, M. W., Landenberger, N. A., & Wilson, S. J. (2007). *Effects of Cognitive-Behavioral Programs for Criminal Offenders*. Retrieved January 7, 2009, from http://db.c2admin.org/doc-pdf/lipsey_CBT_finalreview.pdf

Loveland, D., & Boyle, M. (2007). Intensive case management as a jail diversion program for people with a serious mental illness: a review of the literature. *International Journal of Offender Therapy and Comparative Criminology, 51*(2), 130-150.

Lurigio, A. J. (1996). *Community Corrections in America: New Directions and Sounder Investments for Persons with Mental Illness and Codisorders*. Retrieved January 22, 2009, from http://www.nicic.org/pubs/1996/014000.pdf

Lurigio, A. J. (2000a). Drug treatment availability and effectiveness: Studies of the general and criminal justice populations. *Criminal Justice and Behavior, 27*(4), 495-528.

Lurigio, A. J. (2000b). Persons with Serious Mental Illness in the Criminal Justice System: Background, Prevalence, and Principles of Care. *Criminal Justice Policy Review, 11*(4), 312-328.

Lurigio, A. J., Cho, Y. I., Swartz, J. A., Johnson, T. P., Graf, I., & Pickup, L. (2003). Standardized assessment of substance-related, other psychiatric, and comorbid disorders among probationers. *International Journal of Offender Therapy and Comparative Criminology, 47*(6), 630-652.

Lurigio, A. J., & Swartz, J. A. (2000). *Changing the contours of the criminal justice system to meet the needs of persons with serious mental illness*. Retrieved January 13, 2009, from http://www.ncjrs.gov/criminal_justice2000/vol_3/03c.pdf

Lurigio, A. J., & Swartz, J. A. (2006). Mental illness in correctional populations: the use of standardized screening tools for further evaluation or treatment. *Federal Probation, 70*(2), 29-35.

McCollister, K. E., French, M. T., Prendergast, M., Wexler, H., Sacks, S., & Hall, E. (2003). Is In-Prison Treatment Enough? A Cost-Effectiveness Analysis of Prison-Based Treatment and Aftercare Services for Substance-Abusing Offenders. *Law & Policy, 25*(1), 63-82.

McDaid, D., & Thornicroft, G. (2005). *Mental health II: Balancing Institutional and Community-based Care. European Observatory on Health Systems and Policies. World Health Organization*. Retrieved February 14, 2009, from http://www.euro.who.int/document/e85488.pdf

Metzner, J. L. (1998). An introduction to correctional psychiatry: Part III. *Journal of the American Academy of Psychiatry and the Law, 26*(1), 107-115.

Metzner, J. L. (2002). Class action litigation in correctional psychiatry. *Journal of the American Academy of Psychiatry and the Law, 30*(1), 19-29.

Meuser, K. T., Torrey, W. C., Lynde, D., Singer, P., & Drake, R. E. (2003). Implementing evidence-based practices for people with severe mental illness. *Behavior Modification, 27*(3), 387-411.

Minkoff, K. (2001). Developing standards of care for individuals with co-occurring psychiatric and substance use disorders. *Psychiatric Services, 52*(5), 597-599.

Morrissey, J., Meyer, P., & Cuddeback, G. (2007). Extending Assertive Community Treatment to Criminal Justice Settings: Origins, Current Evidence, and Future Directions. *Community Mental Health Journal, 43*(5), 527-544.

Motiuk, L. L., & Serin, R. C. (2000). *Compendium 2000 on Effective Correctional Programming* Retrieved February 27, 2009, from http://www.csc-scc.gc.ca/text/rsrch/compendium/2000/index-eng.shtml

Myhr, G., & Payne, K. (2006). Cost-effectiveness of cognitive-behavioural therapy for mental disorders: Implications for public health care funding policy in Canada. *Canadian Journal of Psychiatry, 51*(10), 662-670.

National Commission on Correctional Health Care. (2008a). *Standards for Health Services in Jails*. Chicago, IL: Author.

National Commission on Correctional Health Care. (2008b). *Standards for Health Services in Prisons*. Chicago, IL: Author.

National Commission on Correctional Health Care. (2008c). *Standards for Mental Health Services in Correctional Facilities*. Chicago, IL: Author.

National Institute on Drug Abuse. (1999). *Principles of Drug Addiction Treatment*. Retrieved February 17, 2009, from http://www.nida.nih.gov/podat/PODATIndex.html

National Institute on Drug Abuse. (2006). *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*. Retrieved January 13, 2009, from http://www.drugabuse.gov/PDF/PODAT_CJ/PODAT_CJ.pdf

National Institute on Drug Abuse. (n.d.). *Findings from the National Criminal Justice Treatment Practices Survey (NCJTPS)*

National Treatment Strategy Working Group. (2008). *A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy*. Retrieved February 14, 2008, from http://www.nationalframework-cadrenational.ca/uploads/files/TWS_Treatment/nts-report-eng.pdf

New Freedom Commission on Mental Health. (2004). *Subcommittee on Criminal Justice: Background Paper*. Retrieved January 7, 2009, from http://www.mentalhealthcommission.gov/papers/CJ_ADACompliant.pdf

Office of the National Drug Control Policy. (1999). *Therapeutic Communities in Correctional Settings*. Retrieved February 26, 2009, from http://www.whitehousedrugpolicy.gov/publications/therap_comm/thera_9.html

Office of the United Nations High Commissioner for Human Rights. (1976). *International Covenant on Economic, Social and Cultural Rights*. Retrieved February 27, 2009, from http://www.unhchr.ch/html/menu3/b/a_cescr.htm

Office of the United Nations High Commissioner for Human Rights. (1977). *Standard Minimum Rules for the Treatment of Prisoners*. Retrieved January 23, 2009, from http://www.unhchr.ch/html/menu3/b/h_comp34.htm

Office of the United Nations High Commissioner for Human Rights. (1982). *Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. Retrieved January 7, 2009, from http://www.unhchr.ch/html/menu3/b/h_comp40.htm

Office of the United Nations High Commissioner for Human Rights. (1991). *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*. Retrieved January 16, 2009, from http://www.unhchr.ch/html/menu3/b/68.htm

Ogloff, J. R. P. (2002). Identifying and accommodating the needs of mentally ill people in gaols and prisons. *Psychiatry, Psychology and Law, 9*(1), 1-33.

Osher, F., Steadman, H. J., & Barr, H. (2002). *A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occuring Disorders: The APIC Model*. Retrieved January 7, 2009, from http://gainscenter.samhsa.gov/pdfs/reentry/apic.pdf

Osher, F., Steadman, H. J., & Barr, H. (2003). A best practice approach to community reentry from jails for inmates with co-occurring disorders: The Apic model. *Crime & Delinquency, 49*(1), 79-96.

Penal Reform International. (2001). *Making Standards Work: An International Handbook on Good Prison Practice*. Retrieved January 16, 2009, from http://www.penalreform.org/publications/man-2001-making-standards-work-en.pdf

Peters, R. H., & Hills, H. (1997). *Intervention Strategies for Offenders with Co-Occuring Disorders: What Works?* Retrieved January 21, 2009, from http://gainscenter.samhsa.gov/pdfs/disorders/Intervention_Strat.pdf

Rapp, C. A., Bond, G. R., Becker, D. R., Carpinello, S. E., Nikkel, R. E., & Gintoli, G. (2005). The role of state mental health authorities in promoting improved client outcomes through evidence-based practice. *Community Mental Health Journal, 41*(3), 347-363.

Reimer, B., Sawka, E., & James, D. (2005). Improving research transfer in the addictions field: a perspective from Canada. *Substance Use and Misuse, 40*(1707-1720).

Roberts, G., & Ogborne, A. (1999). *Best Practices: Substance Abuse Treatment and Rehabilitation* Retrieved February 15, 2009, from http://www.hc-sc.gc.ca/hppb/alcohol-otherdrugs

Robison, C. (2005). *National Overview of Mental Health Issues in Corrections*. Retrieved January 7, 2009, from www.ciic.state.oh.us/reports/mentalhealthissues.pdf

Rudd, M. D., & Joiner, T. (1998). The Assessment Management and Treatment of Suicidality: Toward Clinically Informed and Balanced Standards of Care. *Clinical Psychology: Science and Practice, 5*(2), 135-150.

Rush, B., & Koegl, C. J. (2008). Prevalence and Profile of People with Co-occurring Mental and Substance Use Disorders Within a Comprehensive Mental Health System. *Canadian Journal of Psychiatry, 53*(12), 810-821.

Sacks, J. Y. (2004). Women with co-occuring substance use and mental disorders (COD) in the criminal justice system: A research review. *Behavioral Sciences & the Law, 22*, 449-466.

Scott, C. L., & Gerbasi, J. B. (Eds.). (2005). *Handbook of Correctional Mental Health*. Washington, DC: American Psychiatric Publishing.

Sentencing Project. (2002). *Mentally Ill Offenders in the Criminal Justice System: An Analysis and Prescription*. Retrieved January 20, 2009, from http://www.soros.org/initiatives/usprograms/focus/justice/articles_publications/publications/mi_offenders_20020101/mentallyill.pdf

Skeem, J. L., & Louden, J. E. (2006). Toward Evidence-Based Practice for Probationers and Parolees Mandated to Mental Health Treatment. *Psychiatric Services, 57*(3), 333-342.

Smye, V., & Mussell, B. (2001). *Aboriginal Mental Health: 'What Works Best'*. Retrieved February 25, 2009, from www.carmha.ca/publications/.../pub.../Aboriginal%20Mental%20Health%20-%20What%20Works%20Best%20%5BJuly%202001%5D.pdf

Sowers, W. E., & Rohland, B. (2004). American Association of Community Psychiatrists' Principles for Managing Transitions in Behavioral Health Services. *Psychiatric Services, 55*(11), 1271-1275.

Stallwitz, A., & Stover, H. (2007). The impact of substitution treatment in prisons: A literature review. *International Journal of Drug Policy, 18*, 464-474.

Standing Senate Committee on Social Affairs Science and Technology. (2006). *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*. Retrieved February 7, 2009, from www.parl.gc.ca/39/1/parlbus/commbus/senate/Com-e/SOCI-E/rep-e/rep02may06-e.htm

Steadman, H. J., McCarty, D. W., & Morressey, J. P. (1989). *The Mentally Ill in Jail: Planning for Essential Services*. New York: Guilford Press.

Substance Abuse and Mental Health Services Administration. (n.d.). *Evidence-Based Practices: Shaping Mental Health Services Toward Recovery - Co-Occurring Disorders: Integrated Dual Disorders Treatment*. Retrieved March 27, 2009, from http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/

Swenson, J. R., & Bradwejn, J. (2002). Mental health reform and evolution of general psychiatry in Ontario. *Canadian Journal of Psychiatry, 47*(7), 644-651.

Thornicroft, G., & Tansella, M. (2003). *What Are the Arguments for Community-based Mental Health Care?* Retrieved October 1, 2007, from http://www.euro.who.int/document/E82976.pdf

Tiihonen, J., Isohanni, M., Rasanen, P., Koiranen, M., & Moring, J. (1997). Specific major mental disorders and criminality: A 26-year prospective study of the 1966 Northern Finland birth cohort. *American Journal of Psychiatry, 154*(6), 840-845.

U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General—Executive Summary*. Retrieved February 13, 2009, from http://www.surgeongeneral.gov/library/mentalhealth/summary.html

Vanderplasschen, W., Wolf, J., Rapp, R. C., & Broekaert, E. (2007). Effectiveness of different models of case management for substance-abusing populations. *Journal of Psychoactive Drugs, 39*(1), 81-95.

Veysey, B. M. (1996). Effective strategies for providing mental health services to probationers with mental illness. In A. J. Lurigio (Ed.), *Community Corrections in America: New Directions and Sounder Investments for Persons with Mental Illness and Codisorders*. Seattle, WA: National Coalition for Mental and Substance Abuse Health Care in the Justice System.

Veysey, B. M. (1997). *Specific Needs of Women Diagnosed with Mental Illnesses in U.S. Jails*. Retrieved January 16, 2009, from http://gainscenter.samhsa.gov/pdfs/Women/Needs_of_Women_Mono.pdf

Von Korff, M., & Tiemens, B. (2000). Individualized stepped care of chronic illness. *Western Journal of Medicine, 172*(2), 133-137.

Ward, T., & Birgden, A. (2007). Human rights and correctional clinical practice. *Aggression and Violent Behavior, 12*, 628-643.

Watson, R., Stimpson, A., & Hostick, T. (2004). Prison health care: a review of the literature. *International Journal of Nursing Studies, 41*(2), 119-128.

Weinstein, H. C. (1989). Psychiatric services in jails and prisons: who cares? *American Journal of Psychiatry, 146*(9), 1094-1095.

Weisman, R. L., Lamberti, J. S., & Price, N. (2004). Integrating criminal justice, community healthcare, and support services for adults with severe mental disorders. *Psychiatric Quarterly, 75*(1), 71-85.

Wettstein, R. M. (Ed.). (1998). *Treatment of Offenders with Mental Disorders*. New York: Guilford Press.

Wexler, H. K. (2003). The promise of prison-based treatment for dually diagnosed inmates. *Journal of Substance Abuse Treatment, 25*(3), 223-231.

Wilson, S. (2004). The principle of equivalence and the future of mental health care in prisons. *British Journal of Psychiatry, 184*(1), 5-7.

World Health Organization. (2000). *Preventing Suicide: A Resource for Prison Officers*. Retrieved January 8, 2009, from www.who.int/mental_health/media/en/60.pdf

World Health Organization. (2005). *WHO Resource Book on Mental Health, Human Rights and Legislation*. Retrieved February 3, 2009, from http://www.who.int/mental_health/policy/who_rb_mnh_hr_leg_FINAL_11_07_05.pdf

World Health Organization. (2007a). *Health in Prisons: A WHO Guide to the Essentials in Prison Health*. Retrieved January 8, 2009, from www.euro.who.int/document/e90174.pdf

World Health Organization. (2007b). *The Optimal Mix of Services*. Retrieved August 1, 2008, from http://www.who.int/mental_health/policy/services/2_Optimal%20Mix%20of%20Services_Infosheet.pdf

World Health Organization. (n.d.). *Mental Health and Prisons*. Retrieved January 7, 2009, from www.euro.who.int/Document/MNH/WHO_ICRC_InfoSht_MNH_Prisons.pdf

Ziedonis, D. M. (2004). Integrated treatment of co-occurring mental illness and addiction: Clinical intervention, program, and system perspectives. *CNS Spectrums, 9*(12), 892-904.

6. APPENDIX A - SELECTION OF EXISTING STANDARDS

Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care

(Office of the United Nations High Commissioner for Human Rights, 1991)

Application

These Principles shall be applied without discrimination of any kind such as on grounds of disability, race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, legal or social status, age, property or birth.

Definitions

In these Principles:

"Counsel" means a legal or other qualified representative;

"Independent authority" means a competent and independent authority prescribed by domestic law;

"Mental health care" includes analysis and diagnosis of a person's mental condition, and treatment, care and rehabilitation for a mental illness or suspected mental illness;

"Mental health facility" means any establishment, or any unit of an establishment, which as its primary function provides mental health care;

"Mental health practitioner" means a medical doctor, clinical psychologist, nurse, social worker or other appropriately trained and qualified person with specific skills relevant to mental health care;

"Patient" means a person receiving mental health care and includes all persons who are admitted to a mental health facility;

"Personal representative" means a person charged by law with the duty of representing a patient's interests in any specified respect or of exercising specified rights on the patient's behalf, and includes the parent or legal guardian of a minor unless otherwise provided by domestic law;

"The review body" means the body established in accordance with Principle 17 to review the involuntary admission or retention of a patient in a mental health facility.

General limitation clause

The exercise of the rights set forth in these Principles may be subject only to such limitations as are prescribed by law and are necessary to protect the health or safety of the person concerned or of others, or otherwise to protect public safety, order, health or morals or the fundamental rights and freedoms of others.

Principle 1 - Fundamental freedoms and basic rights

1. All persons have the right to the best available mental health care, which shall be part of the health and social care system.

2. All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.

3. All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.

4. There shall be no discrimination on the grounds of mental illness. "Discrimination" means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory. Discrimination does not include any distinction, exclusion or preference undertaken in accordance with the provisions of these Principles and necessary to protect the human rights of a person with a mental illness or of other individuals.

5. Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.

6. Any decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it. The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest. Decisions regarding capacity and the need for a personal representative shall be reviewed at reasonable intervals prescribed by domestic law. The person whose capacity is at issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision.

7. Where a court or other competent tribunal finds that a person with mental illness is unable to manage his or her own affairs, measures shall be taken, so far as is necessary and appropriate to that person's condition, to ensure the protection of his or her interest.

Principle 2 - Protection of minors

Special care should be given within the purposes of these Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative other than a family member.

Principle 3 - Life in the community

Every person with a mental illness shall have the right to live and work, as far as possible, in the community.

Principle 4 - Determination of mental illness

1. A determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards.

2. A determination of mental illness shall never be made on the basis of political, economic or social status, or membership of a cultural, racial or religious group, or any other reason not directly relevant to mental health status.

3. Family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community, shall never be a determining factor in diagnosing mental illness.

4. A background of past treatment or hospitalization as a patient shall not of itself justify any present or future determination of mental illness.

5. No person or authority shall classify a person as having, or otherwise indicate that a person has, a mental illness except for purposes directly relating to mental illness or the consequences of mental illness.

Principle 5 - Medical examination

No person shall be compelled to undergo medical examination with a view to determining whether or not he or she has a mental illness except in accordance with a procedure authorized by domestic law.

Principle 6 - Confidentiality

The right of confidentiality of information concerning all persons to whom these Principles apply shall be respected.

Principle 7 - Role of community and culture

1. Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives.

2. Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible.

3. Every patient shall have the right to treatment suited to his or her cultural background.

Principle 8 - Standards of care

1. Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons.

2. Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.

Principle 9 - Treatment

1. Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.

2. The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.

3. Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics adopted by the United Nations General Assembly. Mental health knowledge and skills shall never be abused.

4. The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

Principle 10 - Medication

1. Medication shall meet the best health needs of the patient, shall be given to a patient only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others. Subject to the provisions of paragraph 15 of Principle 11, mental health practitioners shall only administer medication of known or demonstrated efficacy.

2. All medication shall be prescribed by a mental health practitioner authorized by law and shall be recorded in the patient's records.

Principle 11 - Consent to treatment

1. No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 below.

2. Informed consent is consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:

(a) The diagnostic assessment;

(b) The purpose, method, Likely duration and expected benefit of the proposed treatment;

(c) Alternative modes of treatment, including those less intrusive; and

(d) Possible pain or discomfort, risks and side-effects of the proposed treatment.

3. A patient may request the presence of a person or persons of the patient's choosing during the procedure for granting consent.

4. A patient has the right to refuse or stop treatment, except as provided for in paragraphs 6, 7, 8, 13 and 15 below. The consequences of refusing or stopping treatment must be explained to the patient.

5. A patient shall never be invited or induced to waive the right to informed consent. If the patient should seek to do so, it shall be explained to the patient that the treatment cannot be given without informed consent.

6. Except as provided in paragraphs 7, 8, 12, 13, 14 and 15 below, a proposed plan of treatment may be given to a patient without a patient's informed consent if the following conditions are satisfied:

(a) The patient is, at the relevant time, held as an involuntary patient;

(b) An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 above, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent; and

(c) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs.

7. Paragraph 6 above does not apply to a patient with a personal representative empowered by law to consent to treatment for the patient; but, except as provided in paragraphs 12, 13, 14 and 15 below, treatment may be given to such a patient without his or her informed consent if the personal representative, having been given the information described in paragraph 2 above, consents on the patient's behalf.

8. Except as provided in paragraphs 12, 13, 14 and 15 below, treatment may also be given to any patient without the patient's informed consent if a qualified mental health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose.

9. Where any treatment is authorized without the patient's informed consent, every effort shall nevertheless be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan.

10. All treatment shall be immediately recorded in the patient's medical records, with an indication of whether involuntary or voluntary.

11. Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.

12. Sterilization shall never be carried out as a treatment for mental illness.

13. A major medical or surgical procedure may be carried out on a person with mental illness only where it is permitted by domestic law, where it is considered that it would best serve the health needs of the patient and where the patient gives informed consent, except that, where the patient is unable to give informed consent, the procedure shall be authorized only after independent review.

14. Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health facility and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient only where the patient has given

informed consent and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient.

15. Clinical trials and experimental treatment shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose.

16. In the cases specified in paragraphs 6, 7, 8, 13, 14 and 15 above, the patient or his or her personal representative, or any interested person, shall have the right to appeal to a judicial or other independent authority concerning any treatment given to him or her.

Principle 12 - Notice of rights

1. A patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all his or her rights in accordance with these Principles and under domestic law, which information shall include an explanation of those rights and how to exercise them.

2. If and for so long as a patient is unable to understand such information, the rights of the patient shall be communicated to the personal representative, if any and if appropriate, and to the person or persons best able to represent the patient's interests and willing to do so.

3. A patient who has the necessary capacity has the right to nominate a person who should be informed on his or her behalf, as well as a person to represent his or her interests to the authorities of the facility.

Principle 13 - Rights and conditions in mental health facilities

1. Every patient in a mental health facility shall, in particular, have the right to full respect for his or her:

(a) Recognition everywhere as a person before the law;

(b) Privacy;

(c) Freedom of communication, which includes freedom to communicate with other persons in the facility; freedom to send and receive uncensored private communications; freedom to receive, in private, visits from a counsel or personal representative and, at all reasonable times, from other visitors; and freedom of access to postal and telephone services and to newspapers, radio and television;

(d) Freedom of religion or belief.

2. The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age and in particular shall include:

(a) Facilities for recreational and leisure activities;

(b) Facilities for education;

(c) Facilities to purchase or receive items for daily living, recreation and communication;

(d) Facilities, and encouragement to use such facilities, for a patient's engagement in active occupation suited to his or her social and cultural background, and for appropriate vocational rehabilitation measures to

promote reintegration in the community. These measures should include vocational guidance, vocational training and placement services to enable patients to secure or retain employment in the community.

3. In no circumstances shall a patient be subject to forced labour. Within the limits compatible with the needs of the patient and with the requirements of institutional administration, a patient shall be able to choose the type of work he or she wishes to perform.

4. The labour of a patient in a mental health facility shall not be exploited. Every such patient shall have the right to receive the same remuneration for any work which he or she does as would, according to domestic law or custom, be paid for such work to a non-patient. Every such patient shall, in any event, have the right to receive a fair share of any remuneration which is paid to the mental health facility for his or her work.

Principle 14 - Resources for mental health facilities

1. A mental health facility shall have access to the same level of resources as any other health establishment, and in particular:

(a) Qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a programme of appropriate and active therapy;

(b) Diagnostic and therapeutic equipment for the patient;

(c) Appropriate professional care; and

(d) Adequate, regular and comprehensive treatment, including supplies of medication.

2. Every mental health facility shall be inspected by the competent authorities with sufficient frequency to ensure that the conditions, treatment and care of patients comply with these Principles.

Principle 15 - Admission principles

1. Where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission.

2. Access to a mental health facility shall be administered in the same way as access to any other facility for any other illness.

3. Every patient not admitted involuntarily shall have the right to leave the mental health facility at any time unless the criteria for his or her retention as an involuntary patient, as set forth in Principle 16, apply, and he or she shall be informed of that right.

Principle 16 - Involuntary admission

1. A person may (a) be admitted involuntarily to a mental health facility as a patient; or (b) having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with Principle 4, that person has a mental illness and considers:

(a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or

(b) That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.

In the case referred to in subparagraph (b), a second such mental health practitioner, independent of the first, should be consulted where possible. If such consultation takes place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs.

2. Involuntary admission or retention shall initially be for a short period as specified by domestic law for observation and preliminary treatment pending review of the admission or retention by the review body. The grounds of the admission shall be communicated to the patient without delay and the fact of the admission and the grounds for it shall also be communicated promptly and in detail to the review body, to the patient's personal representative, if any, and, unless the patient objects, to the patient's family.

3. A mental health facility may receive involuntarily admitted patients only if the facility has been designated to do so by a competent authority prescribed by domestic law.

Principle 17 - Review body

1. The review body shall be a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law. It shall, in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account.

2. The review body's initial review, as required by paragraph 2 of Principle 16, of a decision to admit or retain a person as an involuntary patient shall take place as soon as possible after that decision and shall be conducted in accordance with simple and expeditious procedures as specified by domestic law.

3. The review body shall periodically review the cases of involuntary patients at reasonable intervals as specified by domestic law.

4. An involuntary patient may apply to the review body for release or voluntary status, at reasonable intervals as specified by domestic law.

5. At each review, the review body shall consider whether the criteria for involuntary admission set out in paragraph 1 of Principle 16 are still satisfied, and, if not, the patient shall be discharged as an involuntary patient.

6. If at any time the mental health practitioner responsible for the case is satisfied that the conditions for the retention of a person as an involuntary patient are no longer satisfied, he or she shall order the discharge of that person as such a patient.

7. A patient or his personal representative or any interested person shall have the right to appeal to a higher court against a decision that the patient be admitted to, or be retained in, a mental health facility.

Principle 18 - Procedural safeguards

1. The patient shall be entitled to choose and appoint a counsel to represent the patient as such, including representation in any complaint procedure or appeal. If the patient does not secure such services, a counsel

shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.

2. The patient shall also be entitled to the assistance, if necessary, of the services of an interpreter. Where such services are necessary and the patient does not secure them, they shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.

3. The patient and the patient's counsel may request and produce at any hearing an independent mental health report and any other reports and oral, written and other evidence that are relevant and admissible.

4. Copies of the patient's records and any reports and documents to be submitted shall be given to the patient and to the patient's counsel, except in special cases where it is determined that a specific disclosure to the patient would cause serious harm to the patient's health or put at risk the safety of others. As domestic law may provide, any document not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any part of a document is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and shall be subject to judicial review.

5. The patient and the patient's personal representative and counsel shall be entitled to attend, participate and be heard personally in any hearing.

6. If the patient or the patient's personal representative or counsel requests that a particular person be present at a hearing, that person shall be admitted unless it is determined that the person's presence could cause serious harm to the patient's health or put at risk the safety of others.

7. Any decision whether the hearing or any part of it shall be in public or in private and may be publicly reported shall give full consideration to the patient's own wishes, to the need to respect the privacy of the patient and of other persons and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.

8. The decision arising out of the hearing and the reasons for it shall be expressed in writing. Copies shall be given to the patient and his or her personal representative and counsel. In deciding whether the decision shall be published in whole or in part, full consideration shall be given to the patient's own wishes, to the need to respect his or her privacy and that of other persons, to the public interest in the open administration of justice and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.

Principle 19 - Access to information

1. A patient (which term in this Principle includes a former patient) shall be entitled to have access to the information concerning the patient in his or her health and personal records maintained by a mental health facility. This right may be subject to restrictions in order to prevent serious harm to the patient's health and avoid putting at risk the safety of others. As domestic law may provide, any such information not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any of the information is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and it shall be subject to judicial review.

2. Any written comments by the patient or the patient's personal representative or counsel shall, on request, be inserted in the patient's file.

Principle 20 - Criminal offenders

1. This Principle applies to persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings or investigations against them, and who are determined to have a mental illness or who it is believed may have such an illness.

2. All such persons should receive the best available mental health care as provided in Principle 1. These Principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances. No such modifications and exceptions shall prejudice the persons' rights under the instruments noted in paragraph 5 of Principle 1.

3. Domestic law may authorize a court or other competent authority, acting on the basis of competent and independent medical advice, to order that such persons be admitted to a mental health facility.

4. Treatment of persons determined to have a mental illness shall in all circumstances be consistent with Principle 11.

Principle 21 - Complaints

Every patient and former patient shall have the right to make a complaint through procedures as specified by domestic law.

Principle 22 - Monitoring and remedies

States shall ensure that appropriate mechanisms are in force to promote compliance with these Principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient.

Principle 23 - Implementation

1. States should implement these Principles through appropriate legislative, judicial, administrative, educational and other measures, which they shall review periodically.

2. States shall make these Principles widely known by appropriate and active means.

Principle 24 - Scope of principles relating to mental health facilities

These Principles apply to all persons who are admitted to a mental health facility.

Principle 25 -Saving of existing rights

There shall be no restriction upon or derogation from any existing rights of patients, including rights recognized in applicable international or domestic law, on the pretext that these Principles do not recognize such rights or that they recognize them to a lesser extent.

Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

(Office of the United Nations High Commissioner for Human Rights, 1982)

Principle 1

Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

Principle 2

It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment.<1>

Principle 3

It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health.

Principle 4

It is a contravention of medical ethics for health personnel, particularly physicians:

(a) To apply their knowledge and skills in order to assist in the interrogation of prisoners and detainees in a manner that may adversely affect the physical or mental health or condition of such prisoners or detainees and which is not in accordance with the relevant international instruments; <2>

(b) To certify, or to participate in the certification of, the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health and which is not in accordance with the relevant international instruments, or to participate in any way in the infliction of any such treatment or punishment which is not in accordance with the relevant international instruments.

Principle 5

It is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, of his fellow prisoners or detainees, or of his guardians, and presents no hazard to his physical or mental health.

Principle 6

There may be no derogation from the foregoing principles on any ground whatsoever, including public emergency.

<1> See the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel. Inhuman or Degrading Treatment or Punishment (resolution 3452 (XXX), annex).

<2> Particularly the Universal Declaration of Human Rights (resolution 217 A (111)), the International Covenants on Human Rights (resolution 2200 A (XXI). annex), the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (resolution 3452 (XXX), annex) and the Standard Minimum Rules for the Treatment of Prisoners (First United Nations Congress on the Prevention of Crime and the Treatment of Offenders: report by the Secretariat (United Nations publication, Sales No. E.IV.4, annex I.A).

Standards for Mental Health Services in Correctional Facilities

(National Commission on Correctional Health Care, 2008c)

Section A - Governance and Administration

MH-A-01 Access to Care (essential)

Inmates have *access to care* to meet their serious mental health needs.

MH-A-02 Responsible Mental Health Authority (essential)

The facility has a designated mental health authority responsible for mental health services.

MH-A-03 Clinical Autonomy (essential)

Clinical decisions and actions regarding mental health care provided to inmates with mental health needs are the sole responsibility of qualified mental health professionals.

MH-A-04 Administrative Meetings and Reports (essential)

Mental health services are discussed at administrative meetings. In addition, mental health staff meetings are help to review administrative issues.

MH-A-05 Policies and Procedures (essential)

There is a manual or compilation of written policies and defined procedures regarding mental health services at the facility that address each applicable standard in the Standards of Mental Health Services in Correctional Facilities.

MH-A-06 Continuous Quality Improvement Program (essential)

A continuous quality improvement (CQI) program monitors and improves mental health care delivered in the facility.

MH-A-07 Emergency Response Plan (essential)

All mental health staff are prepared to implement the mental health aspects of the facility's emergency response plan.

MH-A-08 Communication on Patients' Mental Health Needs (essential)

Communication occurs between appropriate nonclinical staff and treating mental health professionals regarding inmates' significant mental health needs that must be considered in classification decisions in order to preserve the health and safety of that inmate, other inmates, or staff.

MH-A-09 Privacy of Care (important)

Mental health services are conducted in private and carried out in a manner designed to encourage the patient's subsequent use of services.

MH-A-10 Procedure in the Event of an Inmate Death (important)

Deaths of mental health patients and those who commit suicide are reviewed to determine the appropriateness of mental health care; to ascertain whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study.

MH-A-11 Grievance Mechanism for Mental Health Complaints (important)

A grievance mechanism addresses inmates' complaints about mental health services.

Section B - Safety

MH-B-01 Infection Control Program (essential)

There is an effective infection control program.

MH-B-02 Patient Safety (important)

The responsible mental health authority promotes patient safety by instituting systems to prevent adverse and near-miss clinical events.

MH-B-03 Staff Safety (important)

Mental health staff work in a safe environment.

MH-B-04 - Federal Sexual Assault Reporting regulations (important)

The facility has written policy and procedures regarding the detection, prevention, reduction, and punishment of rape consistent with federal law.

Section C - Personnel and Training

MH-C-01 Credentialing (essential)

All mental health staff who provide services to inmates are appropriately credentialed according to the licensure, certification, and registration requirements of the jurisdiction.

MH-C-02 Clinical Performance Enhancement (important)

A clinical performance enhancement process evaluates the appropriateness of mental health professionals' services.

MH-C-03 Training for Mental Health Staff (essential)

Mental health care professional are appropriately oriented and participate annually in continuing education appropriate for their positions.

MH-C-04 Mental Health Training for Correctional Officers (essential)

A training program guides the mental-health-related training of all correctional officers who work with inmates.

MH-C-05 Medication Administration Training (essential)

Personnel who administer or deliver psychotropic medication are appropriately trained.

MH-C-06 Inmate Workers (essential)

Inmates involved in augmenting mental health services are appropriately trained and supervised.

MH-C-07 Mental Health Staffing (important)

A sufficient number of mental health staff of varying types (e.g., psychiatrists, psychologists, social workers, nurses) is available to provide adequate and timely evaluation, treatment, and follow-up consistent with contemporary standards of care.

MH-C-08 Mental Health Liaison (important)

A designated, trained mental health liaison coordinates the delivery of mental health services in the facility on days or shifts when qualified mental health professionals are not on site.

Section D - Health Care Services and Support

MH-D-01 Mental Health Pharmaceutical Operations (essential)

Mental health pharmaceutical operations are sufficient to meet the needs of the facility and are in accordance with legal requirements.

MH-D-02 Medication Services (essential)

Medication services are clinically appropriate and provided in a timely, safe, and sufficient manner.

MH-D-03 Clinic Space, Equipment, and Supplies (important)

Sufficient and suitable space, supplies, and equipment are available for mental health services.

MH-D-04 Diagnostic Services (important)

On-site diagnostic services are registered, accredited, or otherwise meet applicable state and federal law.

MH-D-05 Inpatient Psychiatric Care (important)

Inpatient psychiatric hospitalizations are provided to patients who need these services.

Section E - Inmate Care and Treatment

MH-E-01 Information on Mental Health Services (essential)

Information about the availability of, and access to, mental health services is communicated orally and in writing to inmates on their arrival at the facility in a form and language that they understand.

MH-E-02 Receiving Screening for Mental Health Needs (essential)

Receiving screening is performed on all inmates on arrival at the intake facility to ensure that emergent and urgent mental health needs are met.

MH-E-03 Transferred Inmates (essential)

A transfer screening is performed on all intrasystem transfers.

MH-E-04 Mental Health Assessment and Evaluation (essential)

All inmates receive an initial mental health assessment. Inmates with positive findings receive a mental health evaluation.

MH-E-05 Nonemergency Mental Health Care Requests and Services (essential)

All inmates have the opportunity daily to request mental health care. Their requests are documented and reviewed for immediacy of need and intervention required. Mental health appointments and providers' clinics are conducted on a timely basis and in a clinical setting by qualified mental health professionals.

MH-E-06 Emergency Services (essential)

Mental health emergencies are appropriately managed.

MH-E-07 Segregated Inmates (essential)

The mental health of segregated inmates is monitored regularly.

MH-E-08 Patient Escort (important)

Patients are transported safely and in a timely manner for mental health appointments both inside and outside the facility.

MH-E-09 Continuity of Mental Health Care During Incarceration (essential)

Throughout their incarceration, inmates receive mental health services and tests ordered by clinicians.

MH-E-10 Discharge Planning (important)

Discharge planning is provided for inmates with serious mental health needs whose release is imminent.

Section F - Health Promotion

MH-F-01 Mental Health Education and Self-care (important)

Mental health education and self-care instruction are given to inmates with mental illness.

MH-F-02 Healthy Lifestyle Education and Promotion (important)

All inmates have access to mental health education materials and are encouraged to participate in programs that encourage healthy lifestyle choices.

Section G - Special Mental Health Needs and Services

MH-G-01 Basic Mental Health Services (essential)

A range of mental health services are available for all inmates who require them.

MH-G-02 Mental Health Programs and Residential Units (essential)

When offered on site, mental health programs or residential units meet the serious mental health needs of patients.

MH-G-03 Treatment Plans (essential)

Mental health services are provided according to individual treatment plans.

MH-G-04 Suicide Prevention Program (essential)

The facility identifies suicidal inmates and intervenes appropriately.

MH-G-05 Substance Abuse Services (essential)

Inmates with alcohol or other drug (AOD) problems are assessed and properly managed.

MH-G-07 Behavioral Consultation (important)

Mental health staff provide behavioural consultation when such services are needed.

Section H - Clinical Records

MH-H-01 Clinical Record Format and Content (essential)

The method of recording entries and the format of the clinical record are approved by the mental health authority.

MH-H-02 Confidentiality of Clinical Records and Information (essential)

The confidentiality of a patient's written or electronic clinical record, as well as orally conveyed mental health information, is maintained.

MH-H-03 Access to Custody Information (important)

Qualified mental health professionals have access to information in the inmate's custody record when the mental health authority determines that such information may be relevant to the inmate's mental health and course of treatment.

MH-H-04 Management of Mental Health Information (important)

A clinical record is maintained to facilitate continuity of care.

Section I - Medical-Legal Issues

MH-I-01 Restraint and Seclusion (essential)

Clinically ordered restraint and clinically ordered seclusion are available for patients exhibiting behaviour dangerous to self or others as a result of mental illness.

MH-I-02 Emergency Psychotropic Medication (essential)

Mental Health staff follow policies developed for the emergency use of forced psychotropic medication as governed by the laws applicable in the jurisdiction.

MH-I-03 Forensic Information (important)

Mental health staff are prohibited from participating in the collection of forensic information.

MH-I-04 Informed Consent and Refusal of Mental Health Care (important)

All examinations, treatment, and procedures are governed by informed consent practices applicable in the jurisdiction.

MH-I-05 Research (important)

Behavioral, biomedical, or other research using inmates as participants is consistent with established ethical, medical, legal, and regulatory standards for human research.

MH-I-06 Executions (important)

Mental health staff do not participate in inmate executions.

Standards for Psychology Services in Jails, Prisons, Correctional Facilities, and Agencies

(American Association for Correctional Psychology, 2000)

I. Administration

Mission Statement

1. The mission of psychological services and the work of its personnel are governed by a current written statement of mission, objectives, job descriptions, policies, and procedures approved by the facility's or agency' administration (and the headquarters staff person responsible for psychology services in multisite of agency systems).

Service Guidelines, Licensure

2. All aspects of psychological services conform to provider and ethical guidelines established by the American Psychological Association, specialty guidelines for forensic psychologists, and state and federal laws and regulations. Specific state licensure and/or certification requirements are also applicable. Verification of necessary and current credentials is on file in the facility (or at central headquarters in multisite organizations or agencies).

3. There is a current formal organizational chart that shows psychological services as a separate entity and details lines of authority in the chain of command. Such an organizational chart exists and is implemented at the institutional (or at headquarters) level and shows a full-time qualified psychologist as the individual responsible in a prison setting for overseeing psychological services. In a jail or agency setting, the psychologist may be less than full-time as the service needs of the setting and offender population dictate.

4. The facility has a designated qualified psychologist with responsibility for the organization and operation of psychological services pursuant to a current written agreement, contract, or job description. Similar documentation exists describing the duties of other psychological services personnel.

Professional Autonomy

5. Within the constraints of appropriate security regulations applicable to all institutional personnel, psychologists have professional autonomy regarding psychological services and psychology staff activities for which they are responsible.

Support Services

6. When psychological services are provided by a facility or agency (as opposed to contracted services), adequate space, support staff, and funds for equipment, supplies, training needs, and materials – as determined by the chief psychologist (and in accordance with headquarters directives in multisite organizations) – are provided for the delivery of those services.

Integration of Services

7. At least monthly, administrative meetings are held that include the chief psychologist and the facility administration (and preferably, other institutional heads of departments) to provide a forum for general discussion, including the operation of psychological services.

8. There is a periodic (at least quarterly) and annual report on the psychological services delivery system. These reports include workload demand and delivery figures, diagnostic and treatment trend analysis, comparative analysis with prior data, and other issues of importance or concern. These reports are provided to the facility or agency's administration and other interested management personnel by the chief psychologist (in a multisite or agency organization) or by the on-site supervisor psychologist.

Quality Assessment/Improvement Oversight (Internal)

9. The quality of psychological services is assessed at least annually, and the results are reported to appropriate management and professional staff in writing. The chief psychologist is responsible for overseeing the internal quality assurance and improvement review.

Quality Assessment/Improvement Oversight (External)

10. A formal documented annual review (with a subsequent report to the facility's chief executive and copies to the chief psychologist and other appropriate headquarters staff) is conducted by an outside agent to monitor conformity to these standards and established policies.

II. Roles, Services, Staffing, and Professional Development

Roles and Services

11. The roles and services of correctional psychologists shall be directly related, or contribute to, mental health services, treatment, and programming for offenders. Appropriate roles for correctional psychologists may include (but are not limited to) the following: consultation to correctional administration for mental health program design; psychological screening of security staff employed in specialized mental health units; classification for mental health program assignments; training of institutional and agency staff; assessment, diagnosis, and treatment of mental illness; crisis intervention; and both advocacy for and evaluation of correctional mental health programs and services.

Staffing Requirements

12. At the facility (and at the headquarters level in multisite organizations), there is at least one person responsible for psychological services who has a doctoral degree from a regionally accredited university or professional school in a program that is primarily psychological in nature, who is licensed/certified for the independent practice of psychology by the state where the facility is located, and who has training/experience specific to the field of correctional psychology.

13. The minimum ratio of full-time psychology staff to adult inmates is 1 for every 150 to 160 inmates. In specialized units (e.g., drug treatment and special management units for mentally ill inmates), the minimally acceptable ration is 1 full-time psychologist for every 50 to 75 adult inmates. The minimum ratio in facilities for juveniles is 1 full-time psychologist for every 60 to 75 juveniles in general population and 1 full-time psychologist for every 20 to 25 juveniles in a special management unit. In jail settings, the following minimum staffing pattern applies:

    A. average daily population fewer than 10 - psychologist on call;

    B. average daily population between 11 and 75 - contract psychologist in the facility at least 8 hours per week;

C. average daily population between 76 and 125 - contract psychologist in the facility at least 16 hours per week;

D. average daily population more than 125 - at least one full-time psychologist

Professional Development

14. A written plan, approved by the chief psychologist and facility, organization, and/or agency administration, requires psychology staff to receive orientation training as well as regular continuing education appropriate to their psychological activities. Documentation of these training experiences will be maintained by both the individual psychology staff and the employing agency.

III. Ethical Guidelines

General Principle

15. All psychological services (e.g., screening, assessment, treatment, referrals, transfers, expert testimony, and forensic reports) will comply with the current American Psychological Association and forensic speciality principles and guidelines as well as federal law, state statutes, and licensing and administrative codes in the jurisdiction of the facility or agency. In the event that there is a conflict among or between practice standards, the standard that provides for the highest level of professional practices shall be followed.

16. To the greatest extent possible, psychological resources are used only for clearly defined psychological and mental health purposes. (See Section II, Standard 11.)

Competence

17. Psychologists shall limit their functioning to their demonstrated areas of professional competence.

Documentation

18. All psychological services, significant contacts (e.g., resulting in clinically important information), and mental health information will be documented and/or maintained in a psychological services file specific to the offender in compliance with current professional and legal standards and guidelines.

Confidentiality (Files and Records)

19.
a. All psychological services files and records will be confidential to the inmate in accordance with current American Psychological Association and forensic guidelines as well as statues, licensing, and administrative codes of the jurisdiction. If there is a difference in the levels of required confidentiality, the highest level will be followed.

b. A documented policy and process to ensure confidentiality of all psychological files, records, and test protocols will be in place, including clearly labelling confidential files and records as “confidential” and keeping psychological services files/information in secured physical and/or computer storage separate from general institution or agency correctional/incarceration files or other information. A documented access process/policy for nonpsychological services staff for access to, and interpretation of, confidential psychological records only on a “need-to-know” basis will be on record at the agency, institution, and central

headquarters (in a multisite organization). This process will be supervised by an on-site psychological services staff member designated as the psychological records custodian. All staff will be trained regarding this policy.

Limits of Confidentiality

20. All inmates will be informed, both verbally and in writing, regarding the limits of confidentiality and legally or administratively mandated "duties to warn" prior to any psychological service that places confidentiality at risk. This information is provided on a form that fully discloses these limits, possible uses of information the offender provides, to whom that information may be provided without the offender's consent, and recognition that the offender has been provided this information in advance of any participation in assessment, treatment, or other psychological service. The form will be signed and dated by the offender and/or the psychologist if the offender refuses to sign. (NOTE: An offender's signature is not an attestation to accepting the limits, only that he or she received the information.)

Informed Consent

21. All psychological screenings, assessments, treatments, and procedures (e.g., audio/video recording, observation of treatment for training and research procedures) shall be preceded by an "informed consent" process and documented on the appropriate form. In the case of assessment and treatment, such consent shall include an explanation of the diagnosis, available treatment options, risks of treatment (including nontreatment), anticipated outcomes, and time frames. The form(s) shall be signed by both client (or designated guardian in the case of minor or adults with a legally designated guardian/custodian) and psychologist(s) and placed with the offender's psychological services file.

Involuntary Commitment/Treatment

22. Involuntary treatment, including the administration of psychotropic medication, placement in an observation status, and the use of restraints, will follow the ethical and practice guidelines of the American Psychological Association as well as federal laws, state statutes, and jurisdictional administrative codes. The role of the psychologist in these procedures will be clearly defined in written policies and procedures. Such procedures will be advocated and/or maintained only after initial and ongoing assessments to determine the necessity of their use. Psychologists should refuse to participate in such processes if they are inconsistent with legal, professional, or ethical standards.

Employer and Ethical/Practice Standards Conflicts

23. There is a documented and implemented policy regarding the resolution of ethical/professional conflicts between the employing correctional facility, organization, or agency and psychological services staff.

IV. Mental Health Services/Programs

Standard Operating Policies/Procedures

24. Current written standard operating policies and procedures approved by the chief or supervisor psychologist are maintained and are implemented for all activities carried out by all psychological services personnel.

25. At least one staff member per shift within sight or sound of all inmates has training sufficient to recognize symptoms of mental disturbance most common to the facility and knows how to rapidly contact psychological services staff.

IV.A. Access to Psychological Services/Programs

Reception

26. At the time of admission to the facility, inmates receive a written communication explaining the procedures for gaining access to psychological and mental health services, possible limits of confidentiality, and information regarding informed consent to treatment.

27. There is a written an implemented policy approved by the chief psychologist regarding offender access to psychological services for (a) postadmission inmates with emergency problems and (b) daily referrals of nonemergency problems covering both scheduled and unscheduled psychological care.

IV.B. Screening/Evaluation

Reception Screening/Evaluation

28. The collection of psychological evaluation/screening data is performed only by psychological services staff personnel or facility/agency staff trained by them. Written intake/screening reports, recommendations, and treatment plans are reviewed by a qualified psychologist. All such information is recorded on data forms approved by the chief psychologist (in a multisite system) or supervising psychologist (in a single-site facility or agency). *At no time is the responsibility for test administration, scoring, or filing of psychological data given to inmate workers*. No screening or psychological evaluations will be implemented without first informing the offender of the need for this information, providing information regarding the limits of confidentiality, and obtaining informed consent. This process will be documented, including obtaining the offender's signature and date. This documentation will be placed in the offender's psychological services file (see Section II, Standard 21).

29. Reception screening is performed on all inmates upon admission to a facility before being placed in the general population or housing area. The findings are recorded on a printed screening for. This form is placed in the inmate's psychological services file. Inmates identified by the intake screening as having mental health problems are referred for a more comprehensive psychological evaluation. The screening will include inquiry into (a) past and present mental health difficulties including suicidal ideation, suicide attempts, psychiatric hospitalizations, and psychotropic medications and (b) current mental status including behavioural observations, stressors, measures of daily functioning (e.g., appetite, sleeping, and activity level), and psychotropic medications.

30. In a prison setting, all newly committed inmates with sentences longer than 1 year shall be given a psychological evaluation within 1 month of admission. Such routine evaluations should be brief and include (but not necessarily be limited to) behavioural observations, record review, group testing to screen for emotional and intellectual abnormalities, and a written report of initial findings. Referral for more intensive individual assessment is made on the basis of these results.

31. The individual assessment of all inmates referred for a special comprehensive psychological evaluation is completed within 14 days after the date of the referral unless otherwise required.

    As applied in a jail or to offenders diagnosed with a major mental illness and/or placed in a mental health treatment program, this standard includes

    A. reviewing earlier screening information;

B. contacting prior psychotherapists or the individual's family physician regarding any history of mental symptomatology;

C. conducting an extensive diagnostic interview;

D. writing and filing a brief report;

E. if evidence of mental disturbance is found, placing the individual in a separate area where closer supervision is possible; and either

F. referring the individual to an appropriate mental health resource or to his or her family physician (if indicated and when release is imminent); or

G. beginning appropriate care in the jail by staff members of the psychological and/or psychiatric services.

This standard as applied in a prison setting includes

A. reviewing earlier screening information and psychological evaluation data;

B. collecting and reviewing any additional data to complete the individual's mental health history;

C. collecting behavioural data from observations by correctional staff;

D. administering tests that assess levels of cognitive and emotional functioning and the adequacy of psychological coping mechanisms;

E. writing a report describing the results of the assessment procedures, including an outline of a recommended plan and treatment that mentions any indication by the inmate of a desire for help;

F. communicating results to the referral source; and

G. writing and filing a report of findings and recommendations.

Crisis Evaluations

32. Prisons and jails should have criteria and a procedure that ensures rapid notification of qualified psychological services staff of inmate crises needing consultation or intervention during both working and nonworking hours. Psychological staff should conduct and document crisis evaluations as soon as possible, but no later than 24 hours after the staff member has been notified and/or the inmate seen.

IV.C. Inmate Treatment and Management

33. Diagnostic and treatment mental health services are provided to inmates of the facility as part of the facility's total program.

34. If mental disturbance is identified in pretrial and/or presentenced detainees, the courts and/or the inmate's attorney are notified according to a written policy or procedure approved by the facility's and/or organization's chief executive. Such notification will be documented and placed in the inmate's psychological services file.

35. Inmates held for emergency evaluation and/or treatment are housed in a specially designated area with close staff or trained volunteer supervision and sufficient security to protect these individuals.

36. Only those treatment methodologies recognized and accepted by the state and general psychological community are employed in a facility unless specifically prohibited by facility or organizational administration policies. When such prohibitions apply, the reasons for the prohibitions will be documented and incorporated in the psychological services policies and procedures.

Informed Consent to Treatment

37. Prior to the initiation of any treatment protocol, the offender is assessed, diagnosed, and reasonably informed regarding the nature, length, expected duration, and expected risks and outcomes of the proposed treatment as well as professionally recognized/reasonable treatment alternatives (the offender's legal guardian mush be contacted according to jurisdictional standards). This process will be documented on an *informed consent* form signed and dated by the offender (or legal guardian) and placed in the offender's psychological services file.

Treatment Plans

38. A written treatment plan exists for all offenders requiring psychological treatment (e.g., individual, group, and specialized treatment such as sex offender treatment) and related services. This is developed by a psychologist and, when necessary, in collaboration with other personnel. It includes directions for nonpsychological services staff regarding their roles in the care and supervision of these offenders. This plan is maintained in the offender's psychological services file. When the offender is enrolled in a treatment or a psychoeducational program, an outline of the treatment or program including (a) its start and end date, purpose, and methodology; (b) chronological attendance record; and (c) notes will be maintained in the offender's psychological services file.

39. Inmates requiring acute, chronic, and/or convalescent mental health care receive these services either at the facility or a more appropriate mental health care facility to which they are referred.

40. Prison systems will have their own resources for managing and providing mental health care and services for severely psychologically disturbed inmates, either in specifically designated on-site special management units or a separate facility. If a transfer to a separate mental health facility is necessary, such transfer will be carried out expeditiously.

41. Correctional facilities must ensure that security staff who are assigned to special management units are screened and trained to interact with mentally ill offenders.

42. Transfers that result in offenders being involuntarily placed in facilities that are specifically designated for the care and treatment of the severely mentally ill shall comply with due process procedures as specified in state/federal statues.

43. There are written and implemented policies and procedures that require the responsible psychologist be consulted prior to taking the following actions with respect to emotionally disturbed inmates: housing assignment changes (including cell status), program assignment changes, disciplinary sanctions, and transfer in and out of the facility.

44. Inmates in segregation must be accorded crisis, psychological/psychiatric assessment, diagnosis, and treatment opportunities, irrespective of their segregation status.

45. Inmates who are mentally retarded or developmentally disabled are referred to appropriate specialized resources for care, training, and treatment according to a written plan approved by the chief psychologist (an in accordance with departmental administrative policy in multifacility organization).

Discharge and Transitional Care

46. There is a written, implemented procedure that provides for the orderly discharge of inmate clients from psychological treatment. It includes (but is not limited to) the writing and filing of a treatment summary report within 30 days after treatment termination.

47. There are written, implemented policies and procedures that require psychological services personnel to ensure that provisions are made for appropriate postrelease follow-up care in the community. Such policies will include a due process procedure for offenders who treatment, including psychotropic medication, is a condition of their probation or parole.

Quality Assessment

48. There are written policies and procedures that require formal evaluations of the quantity, efficiency, compliance with professional/agency standards of psychological services, and the effectiveness of psychological treatment programs. Such evaluations shall be made at least annually. The results are submitted to the psychology staff, the chief psychologist in a multisite system or regional system, and to the administration in a single-site facility or correctional agency.

IV.D. Consultation

49. A written policy exists and is implemented outlining the purposes and procedures for hiring contract, part-time, and consultant staff, which requires these individuals to participate in screening and documented orientation sessions conducted by the chief psychologist.

50. The psychological services staff coordinates and consults on a regular basis with the facility's advisory committee (if any), administrative staff in multisite organizations and agencies, and other professional administrative, and technical groups both within and outside the facility.

51. The psychological services staff coordinates and consults with other facility/agency staff regarding psychological services referrals and care of inmates.

IV.E. In-Service Training

52. Written standard operating procedures are implemented that provide for and require psychological services staff to participate in training facility and community staff (e.g., probation and parole agents) with respect to the following: (a) types of potential psychological emergency situations, signs, and symptoms of various mental disturbances and (b) procedures for making referrals to psychological services and program areas (e.g., drug treatment and counselling).

IV.F. Psychology Internships

53. Correctional organizations, facilities, or agencies that sponsor or provide for psychology internships shall follow current jurisdictional and professional psychology internship program and supervisory guidelines.

IV.G. Volunteers

54. Psychological services personnel use volunteers in a variety of program under the supervision of the chief psychologist. The implemented written policies and procedures include a system for selection and training and specifying term of service, level of supervision, definition of tasks, responsibilities, and level of authority. Documentation is required that will indicate that the volunteer has participated in an appropriate orientation session conducted by the chief psychologist.

IV.H. Other Programs

55. The psychological services staff participate in the preparation and implementation of facility-wide planning – for example, the institution's master plan, facility design, disaster plan, staffing, and staff screening.

V. Records

Psychological Services Records: Access, Dissemination, Security, Storage, and Destruction

56. There are written and implemented policies and procedures approved by the chief psychologist (in a multisite or agency organization) or on-site psychology supervisor and coordinated by the chief psychologist, site supervisor, or designee that specify the process of access, dissemination, security, storage, and destruction of psychological material and mental health records. This process will be in compliance with current professional and legal standards.

Documentation

57. There is a written and implemented policy, approved by the chief psychologist in a multifacility organization or on-site psychology supervisor, regarding standardized documentation and organization of psychological/mental health information in the offender's psychological services file including format, content, and time frames for entry. This policy will conform to current professional, administrative, legal, and forensic guidelines.

Psychological Services Files: Contents and Storage

58. The offender's psychological/mental health record is maintained in a psychological services file. This file contains, but is not limited to, historical mental health information, the completed admissions psychological screening form, test results (excluding raw data and/or protocols), findings, diagnoses, referral and consultation information, treatment plans and dictations (both psychological and psychiatric), dispositions, confidentiality, consent and release of information forms, terminations from treatment, and plans for community follow-up. The psychological file is stored separately from the offender's primary incarceration/correctional record and is located at the facility in which the offender is incarcerated. Files containing raw data will be stored separately but in a manner that facilitates both confidentiality and easy access by trained psychology staff. If the offender has been released to community supervision, the psychological services file will be kept at a central location that facilitates access by correctional agency psychology staff.

Confidentiality

59. Prior to an offender receiving any significant psychological service or entering into a screening, assessment, or therapeutic or treatment relationship or program, the offender is informed, verbally and in writing, of the limits of confidentiality. This shall be documented on a form designed for that purpose,

signed by the offender and the psychologist, and placed in the offender's psychological services file. Ideally, this should be done during initial mental health screening upon reception into a facility or agency and periodically thereafter as circumstances dictate (e.g., entering into a specialized program such as sex offender treatment where self-disclosure is a high priority). If the offender's mental status precludes this process, it shall be done at the earliest possible time following stabilization. Should the need arise, the offender will be provided the opportunity to document any refutation of correction of information obtained from these contacts, relationships, or programs.

Inmate Psychological Services File Review/Copies

60. There are written, implemented policies and processes that provide for an offender to review and/or receive copies of his or her psychological services file records in a timely manner. This should not exceed 10 days and should be expedited when requests involve a legal matter. When such a request involves reviewing test or assessment results, a qualified psychology staff person should be present for consultation. Policies and procedures exist to provide for correction or refutation of psychological information in the offender's psychological services file.

Transfer of Records

61. There are written policies and procedures providing for the transfer of the offender's psychological services file that are implemented when the offender is transferred from one facility to another, from a facility to the community, and from the community to a facility. When an individual is to be transported to another facility, the offender's psychological services file arrives at the receiving institution either before or with the offender.

Release of Psychological Information

62. There is an implemented policy and process that both informs offenders regarding the limits of their control over the release of psychological information from their file to a third part with and without their consent and provides for their (or their custodian/legal guardian) documented authorized release of the information. A release of information for will be designated that meets the following minimal standards: (a) to whom and by whom the information is to be sent, (b) specific purpose, (c) the date the release is effective or withdrawn, (d) signature of offender (or custodian/guardian), and (e) date approved. The original will be placed in the offender's psychological services file and a copy provided to the offender.

Destruction of Records

63. There will be a written policy in keeping with federal/state law regarding length of storage and the destruction of the offender's psychological/mental health file, which will be implemented following his or her release from correctional or department of justice jurisdiction (e.g., when the client has been found "not guilty" or the offender has completed his or her sentence).

Research

64. Psychological services personnel are encouraged to conduct applied and/or basic research that will improve the delivery of psychological services and contribute to the development of theory and practice as related to correctional psychology.

65. All psychological research in correctional facilities or agencies will be in compliance with the ethical standards proposed by the National Commission for the Protection of Human Subjects and the current standards of the American Psychological Association.

66. There are written and implemented policies and procedures for reviewing and processing research proposals that comply with the current professional and legal standards of the *Ethical Principles of Psychologists and Code of Conduct* of the American Psychological Association (1992) and are in accordance with department and institutional policies. Research must require prior approval by a designated research advisory committee and institution/agency review board prior to commencing. Such a review board shall be composed of professionals with appropriate educational credentials to determine ethical/legal compliance and importance of the research. Potential researchers will be advised of the research policies and procedures prior to commencing their research. Offender participants in research will be appropriately advised regarding their freedom to decline to participate in research without disciplinary or other negative consequences. The limits of confidentiality need to be fully disclosed, documented, and placed in their psychological services file. Offenders and third parties will be informed, in advance, that they will not receive any compensation for their participation in department- or correctional-agency-approved psychological research.

Delivery of Health Services by the Correctional Service of Canada

(Correctional Service of Canada, 1994)

LEGISLATIVE MANDATE

The Corrections and Conditional Release Act states that:

1) The Service shall provide every inmate with

a) essential health care; and

b) reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community.

2) The provision of health care under subsection 1) shall conform to professionally accepted standards.

CORRECTIONAL SERVICE OF CANADA MISSION STATEMENT

The Correctional Service of Canada (CSC), as part of the criminal justice system, contributes to the protection of society by actively encouraging and assisting offenders to become law-abiding citizens, while exercising reasonable, safe, secure and humane control.

POLICY STATEMENT

We recognize and support that primary responsibility for the health status of inmates rests with individual inmates and that CSC will work with them in the management of their health related issues.

OBJECTIVE OF HEALTH SERVICES

The inmate has the primary responsibility for his/her own health decisions, habits and behaviours. CSC is responsible for ensuring appropriate, equitable and adequate access to professional physical and mental health services. These services sustain and enhance health status, contribute to the inmates' adjustment within the institution and assist them to become law-abiding citizens.

PRINCIPLES GOVERNING THE MANAGEMENT AND DELIVERY OF HEALTH SERVICES BY THE CORRECTIONAL SERVICE OF CANADA

In order to ensure an integrated, comprehensive service to meet the identified needs of individual offenders and specific offender groups, the following principles are essential to the organization and delivery of health services:

1. The Correctional Service of Canada will deliver essential health services comparable to provincial and community standards, notwithstanding the constraints inherent in the correctional environment.

2. Inmates will bear the primary responsibility for maintaining and improving their individual and collective health.

3. Health promotion/illness prevention will be the primary activity for health service staff.

4. The inmate who is mentally competent has the right to refuse any health services as per Section 88 of the CCRA.

5. The inmate has the right to have health care information dealt with in a confidential manner. Standards of confidentiality shall be consistent with the CCRA, the Privacy Act, Commissioner's Directives, professional standards and other federal and provincial legislation, as applicable.

6. Health services will be delivered in an effective and efficient manner and subjected to audit as well as progressive management and measurement techniques.

7. Incentives will be developed and applied which encourage appropriate use of health services by inmates and efficient delivery by health providers.

8. Health service decision-making will be based on data from valid and reliable health service information systems.

9. A multidisciplinary and holistic approach shall be implemented in the provision of health services to the inmate throughout his/her sentence.

10. Health service delivery shall be appropriate to the inmate's age, gender, and clinical presentation and shall consider relevant religious and cultural values.

11. All research undertaken shall be approved by a research review committee charged with the responsibility to ensure that ethical standards, proper design and supervision are met, and that the full voluntary and informed written consent of the participant is obtained.

PROGRAM COMPONENTS

100 General

Standard 101: Informed Consent and the Right of Refusal
Informed consent of a mentally competent inmate shall be obtained before commencing a diagnostic investigation/treatment regimen.

Criteria: Outlined in CCRA, Section 88 (2) and CD 803.

Standard 102: Involuntary Treatment

Involuntary treatment shall be governed by legislative requirements and standards of professional ethics.

Criteria: Involuntary treatment must meet the requirements of the provincial health legislation under which the health facility is designated.

Standard 103: Confidentiality

Health care records shall be confidential and access controlled by a health professional.

Criteria: In accordance with CD 835.

Standard 104: Consent to Release Information

In circumstances outside of the provisions of CD 803, informed consent of an inmate is necessary before providing health record information to any third party, unless the release of the information is otherwise authorized or required by law.

Criteria: In accordance with CD 803.

Standard 105: Information for Case Managers

Information judged necessary to the Case Management function shall be communicated by the appropriate health professional either during a case conference or in writing.

Criteria:

1) Information regarding conditions affecting correctional management and strategies to ensure consistency of approach shall be added to the Case Management Record.
2) The offender shall be advised of information to be shared for this purpose.

Standard 106: Exceptions to Confidentiality

All information obtained in the course of treatment shall be confidential, with the only exceptions being the legal and ethical obligations to respond to a clear and present danger of grave injury to self or others, or with respect to a threat to the security of an institution.

Criteria:

1) The health professional shall explain the limits of confidentiality in accordance with CD 803.
2) The exceptional disclosure of information shall be documented on a protected file.

Standard 107: Professional Qualifications

Health professionals shall be appropriately registered/licensed with a Canadian provincial authority, preferably in the province of practice.

Criteria: Personnel files shall contain documentation to verify current registration/licensing.

Standard 108: Inmate Employment

Inmates shall not be in a position to determine the access of other inmates to health services but may participate in the provision of selected health service activities under the direction of a health professional.

Standard 109: Volunteers

There shall be written policies and procedures established for the selection, training and use of volunteers in health services.

Criteria:

1) Policies shall state, specifically, the purpose for the use of volunteers and the criteria for selection.

2) Training and orientation manuals shall be prepared for each purpose.
3) A monitoring system shall be established to evaluate the effectiveness of the activity and the volunteers.
4) Appropriate recognition shall be provided on a regular basis.

Standard 110: Research

Any research which involves inmates as subjects shall be approved by a research review committee. This committee shall ensure that all research meets the highest ethical standards and has proper design and supervision. Inmate participation shall be contingent upon voluntary and informed written consent.

Criteria: As per CD 009 - Research.

200 Assessment Services

Standard 201: Admission Screening and Assessment

An initial screening followed by a comprehensive assessment of inmate's health status shall be completed at initial reception into CSC.

Criteria: CD 800 - #15-16 - Requirements - Reception

300 Accessibility to Health Services

Standard 301: Services Provided

The Correctional Service of Canada shall ensure the provision of essential health services for an inmate including mental health and general health care.

Criteria:

Essential Health Services

Inmates shall have access to screening, referral and treatment services.

Essential services shall include:

1) emergency health care (i.e., delay of the service will endanger the life of the inmate);
2) urgent health care (i.e., the condition is likely to deteriorate to an emergency or affect the inmate's ability to carry on the activities of daily living);
3) mental health care provided in response to disturbances of thought, mood, perception, orientation or memory that significantly impairs judgment, behaviour, the capacity to recognize reality or the ability to meet the ordinary demands of life. This includes the provision of both acute and long-term mental health care services; and
4) dental care for acute dental conditions where the inmate is experiencing swelling, pain or trauma; preventive treatment (i.e, necessary fillings, extractions, etc.) subject to the motivation displayed by the inmate to take an active part in the process; and removable dental prostheses as recommended by the institutional dentist. All other dental care will be initiated and funded by the inmate.

Inmates shall have reasonable access to other health services (i.e., conditions not outlined above) which may be provided in keeping with community practice. The provision of these services will be subject to considerations such as the length of time prior to release and operational requirements. In support of providing essential health services, emphasis will be placed on health promotion/illness prevention.

Standard 302: Access to Services

While incarcerated, all inmates shall be responsible for their own health and shall be responsible for accessing health services as required. Inmates shall have access to health services on a 24-hour basis.

Criteria:

1) Access can be provided through on-site coverage, on an on-call basis, or through other CSC institutions or other community services.
2) Requests for services shall be reviewed and priorized by the nurse on receipt of same.
3) As clinically indicated the nurse shall refer to the most appropriate and available clinician.
4) Where 24-hour nursing coverage is not provided, staff with current certification in basic first aid and cardiopulmonary resuscitation (CPR) training will be available on site.

Standard 303: Psychiatric Care in RPCs/RTCs

There shall be in-patient psychiatric beds available which will provide a continuum of care. Such units shall be designated under mental health legislation so that involuntary treatment may be provided, when necessary, with proper legal and ethical safeguards.

Criteria: These psychiatric facilities shall seek and maintain accreditation status with the Canadian Council on Health Services Accreditation.

Standard 304: Referrals

Referrals by institutional health professionals to outside agencies for consultation and/or treatment shall be for essential services only. The referring clinician shall be the final authority with respect to acting on the advice of the consulting specialist.

400 Diagnostic and Treatment Services

Standard 401: Program Objectives

Therapeutic treatment programs shall have specific written objectives to allow evaluation of the program.

Standard 402: Program Admission Criteria

Therapeutic treatment programs shall have written admission criteria.

Criteria: The admission criteria and the program objectives should enhance appropriate referral to specialized programs.

Standard 403: Diagnostic Services

Diagnostic and treatment services shall be available to all inmates as prescribed by the institutional clinician.

Criteria: Essential services not available within the institution shall be accessed through other regional or community resources.

Standard 404: Health Education and Promotion

Health education and promotion are essential elements in the thrust to encourage inmates to assume more responsibility for their health status. Inmates shall have access to health education and promotion aimed at health promotion and illness prevention.

Criteria:

1) Each health service encounter shall be used, whenever possible, as an opportunity for health promotion/illness prevention.
2) Educational materials and activities shall be provided which meet the identified health needs of specific inmates and inmate groups.
3) Inmates shall be provided with information regarding the availability of health services and procedures for accessing these services upon admission.
4) Preventive measures such as immunizations shall be made available according to CSC policy or as prescribed by the institutional physician.
5) Promotion of a healthy diet should be an integral part of health promotion and illness prevention and should preferably be done by a registered dietician.

Standard 405: Physician Services

Access to physician services shall be provided.

Criteria:

1) Request for physician services shall be reviewed and priorized by nursing staff.
2) Offenders shall be seen without delay in emergency situations.

Standard 406: Mental Health Team

Each institution shall have a mental health team to priorize mental health services.

Criteria: The team shall be comprised of at least three members including representatives from psychology, nursing, case management and will function as a coordinating body to those inmates in need of mental health services.

Standard 407: Treatment Plan

Each offender undergoing therapeutic intervention by a registered practitioner shall have, as part of the health care record, a written treatment plan with regular progress reports. For each offender participating in group therapy there shall be a written record of participation and relevant clinical data. Progress report recording should be done expeditiously and must be completed within 30 days.

Standard 408: Transfers to Psychiatric Facilities

Inmates who require mental health services beyond the resources available in the facility shall be considered for transfer or committal to a facility where appropriate services are available.

Criteria:

1) Each case shall be priorized according to need.
2) A function of the Mental Health Team will be to monitor the identification, priorization and referral process.

Standard 409: Emergency Mental Health Services

Every institution shall make provisions for an appropriate clinical response to inmates exhibiting signs of serious mental illness.

Criteria:

1) Inmates exhibiting signs of serious mental illness shall be placed under close observation of trained staff.
2) As soon as possible such inmates shall be assessed by a health professional who shall ensure appropriate services are provided.
3) An appropriate clinician shall be on call and able to be consulted at all times.
4) There shall be provision for transfer as soon as possible to an appropriate health care facility as deemed necessary.
5) Emergency mental health services shall be accessible on a 24-hour basis.

Standard 410: Community Mental Health Services

Offenders in the community phase of their sentence shall be made aware of, and given the opportunity to benefit from, mental health services available to other citizens in the community.

Criteria:

1) Case Management shall have an updated list of community resources.
2) Case Management, in conjunction with the Mental Health Team/District Psychologist where applicable, shall ensure that the identified treatment needs are communicated to the appropriate service resources in the community.
3) If the required services are not provided by community resources, CSC will make a reasonable effort to arrange for their provision.

Standard 411: Post-Release Health Services Bridging

Where deemed appropriate and necessary, arrangements shall be made for continuing service to offenders after their release to the termination of CSC's legal responsibility.

Standard 412: Dental Services

Dental services shall be made available to assist the inmate in maintaining oral health and function.

Criteria:

1) Inmates requests for dental services shall be reviewed by nursing staff prior to referral to the dentist. Referrals for dental services shall be made on a priority basis as determined by the nursing staff review.

2) CSC will provide essential dental care throughout the inmate's incarceration. Preventative treatment includes necessary fillings, extractions, etc., subject to the motivation displayed by the inmate to take an active part in the process.

Standard 413: Optometric Services

Access to essential optometric services shall be made available to inmates.

Criteria: The provision of glasses may be authorized once every three years unless there is a change in the inmate's prescription.

Standard 414: Pharmaceutical Services

All prescribed medications shall be dispensed/administered in an efficient and effective manner by qualified professionals in accordance with relevant legislation.

Criteria

1) Pharmacy services shall be provided to all institutions by pharmacists whenever possible.
2) Medications shall be provided by monitored dose system whenever possible.
3) A selection of over-the-counter hygiene and medical products shall be made available for purchase.
4) Documentation of all dispensed/administered medication shall be maintained by Health Service staff.
5) Each Region shall have a Regional Pharmacy and Therapeutics Committee in accordance with CD 805.

Standard 415: Dietetic Services

Dietetic Services should be available to inmates for health promotion, illness prevention and treatment when dietetic counselling could improve the inmate's health or prognosis.

Criteria

1) Inmates identified as requiring a therapeutic diet shall be referred by the appropriate clinician to a registered dietician and their cases shall be handled in order of priority, depending on the urgency of the need for dietetic counselling.
2) Inmates requesting dietetic counselling should first be evaluated to determine the appropriateness of their request before they are referred to a registered dietician.
3) The dietician, after doing a comprehensive evaluation of the inmate's nutritional status and with the approval of the attending physician, may modify a prescribed diet with a view to developing and applying more appropriate nutritional treatment.

Standard 416: Medication

Medication shall be prescribed in accordance with generally accepted standards of medical practice.

Criteria:

1) Medications shall be prescribed only by a duly licensed clinician.
2) Medications, including psychotropics, sedatives and hypnotics shall be prescribed only when clinically indicated and shall never be used for disciplinary or control purposes.

3) Sedatives and hypnotics will normally not be included in the institutional formularies.

Standard 417: Discipline

Before imposing any disciplinary action on an inmate identified as having a serious mental disorder, consultation shall take place with the appropriate mental health professional.

500 Physical Plant and Human Resources

Standard 501: Physical Plant

There shall be adequate space, equipment, supplies and materials for health services with appropriate regard for security, confidentiality and safety.

Criteria:

1) Interview, meeting and treatment rooms with provision for proper ventilation should be readily available to meet identified needs.
2) In-patient care units shall be designed:
   a) to achieve efficient, safe and healthful use of resources; and
   b) to enhance the effective delivery of health services.

Standard 502: Human Resources

All institutional health centres shall have clerical assistance/support designated.

Standard 503: Staff Training

All correctional staff working with inmates shall be provided with sufficient training commensurate with the skills required:

1) to assist in medical emergencies (i.e., CPR and first aid); and
2) to recognize and refer those with significant behavioral changes or signs of mental health difficulties.

600 Records

Standard 600 - Health Records Management

Health Care records shall conform wherever practical to norms established by the general health care community. The management of such records shall be the responsibility of health service staff.

European Prison Rules

(Committee of Ministers of the Council of Europe, 2006)

Part I

Basic principles

1. All persons deprived of their liberty shall be treated with respect for their human rights.

2. Persons deprived of their liberty retain all rights that are not lawfully taken away by the decision sentencing them or remanding them in custody.

3 Restrictions placed on persons deprived of their liberty shall be the minimum necessary and proportionate to the legitimate objective for which they are imposed.

4. Prison conditions that infringe prisoners' human rights are not justified by lack of resources.

5. Life in prison shall approximate as closely as possible the positive aspects of life in the community.

6. All detention shall be managed so as to facilitate the reintegration into free society of persons who have been deprived of their liberty.

7. Co-operation with outside social services and as far as possible the involvement of civil society in prison life shall be encouraged.

8. Prison staff carry out an important public service and their recruitment, training and conditions of work shall enable them to maintain high standards in their care of prisoners.

9 All prisons shall be subject to regular government inspection and independent monitoring.

Part III

Health

Health care

39. Prison authorities shall safeguard the health of all prisoners in their care.

Organisation of prison health care

40.1 Medical services in prison shall be organised in close relation with the general health administration of the community or nation.

40.2 Health policy in prisons shall be integrated into, and compatible with, national health policy.

40.3 Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.

40.4 Medical services in prison shall seek to detect and treat physical or mental illnesses or defects from which prisoners may suffer.

40.5 All necessary medical, surgical and psychiatric services including those available in the community shall be provided to the prisoner for that purpose.

Medical and health care personnel

41.1 Every prison shall have the services of at least one qualified general medical practitioner.

41.2 Arrangements shall be made to ensure at all times that a qualified medical practitioner is available without delay in cases of urgency.

41.3 Where prisons do not have a full-time medical practitioner, a part-time medical practitioner shall visit regularly.

41.4 Every prison shall have personnel suitably trained in health care.

41.5 The services of qualified dentists and opticians shall be available to every prisoner.

Duties of the medical practitioner

42.1 The medical practitioner or a qualified nurse reporting to such a medical practitioner shall see every prisoner as soon as possible after admission, and shall examine them unless this is obviously unnecessary.

42.2 The medical practitioner or a qualified nurse reporting to such a medical practitioner shall examine the prisoner if requested at release, and shall otherwise examine prisoners whenever necessary.

42.3 When examining a prisoner the medical practitioner or a qualified nurse reporting to such a medical practitioner shall pay particular attention to:

a. observing the normal rules of medical confidentiality;

b. diagnosing physical or mental illness and taking all measures necessary for its treatment and for the continuation of existing medical treatment;

c. recording and reporting to the relevant authorities any sign or indication that prisoners may have been treated violently;

d. dealing with withdrawal symptoms resulting from use of drugs, medication or alcohol;

e. identifying any psychological or other stress brought on by the fact of deprivation of liberty;

f. isolating prisoners suspected of infectious or contagious conditions for the period of infection and providing them with proper treatment;

g. ensuring that prisoners carrying the HIV virus are not isolated for that reason alone;

h. noting physical or mental defects that might impede resettlement after release;

i. determining the fitness of each prisoner to work and to exercise; and

j. making arrangements with community agencies for the continuation of any necessary medical and psychiatric treatment after release, if prisoners give their consent to such arrangements.

43.1 The medical practitioner shall have the care of the physical and mental health of the prisoners and shall see, under the conditions and with a frequency consistent with health care standards in the community, all sick prisoners, all who report illness or injury and any prisoner to whom attention is specially directed.

43.2 The medical practitioner or a qualified nurse reporting to such a medical practitioner shall pay particular attention to the health of prisoners held under conditions of solitary confinement, shall visit such prisoners daily, and shall provide them with prompt medical assistance and treatment at the request of such prisoners or the prison staff.

43.3 The medical practitioner shall report to the director whenever it is considered that a prisoner's physical or mental health is being put seriously at risk by continued imprisonment or by any condition of imprisonment, including conditions of solitary confinement.

44. The medical practitioner or other competent authority shall regularly inspect, collect information by other means if appropriate, and advise the director upon:

a. the quantity, quality, preparation and serving of food and water;
b. the hygiene and cleanliness of the institution and prisoners;
c. the sanitation, heating, lighting and ventilation of the institution; and
d. the suitability and cleanliness of the prisoners' clothing and bedding.

45.1 The director shall consider the reports and advice that the medical practitioner or other competent authority submits according to Rules 43 and 44 and, when in agreement with the recommendations made, shall take immediate steps to implement them.

45.2 If the recommendations of the medical practitioner are not within the director's competence or if the director does not agree with them, the director shall immediately submit the advice of the medical practitioner and a personal report to higher authority.

Health care provision

46.1 Sick prisoners who require specialist treatment shall be transferred to specialised institutions or to civil hospitals, when such treatment is not available in prison.

46.2 Where a prison service has its own hospital facilities, they shall be adequately staffed and equipped to provide the prisoners referred to them with appropriate care and treatment.

Mental health

47.1 Specialised prisons or sections under medical control shall be available for the observation and treatment of prisoners suffering from mental disorder or abnormality who do not necessarily fall under the provisions of Rule 12.

47.2 The prison medical service shall provide for the psychiatric treatment of all prisoners who are in need of such treatment and pay special attention to suicide prevention.

Other matters

48.1 Prisoners shall not be subjected to any experiments without their consent.

48.2 Experiments involving prisoners that may result in physical injury, mental distress or other damage to health shall be prohibited.

Standard Minimum Rules for the Treatment of Prisoners

(Office of the United Nations High Commissioner for Human Rights, 1977)

Preliminary Observations

1. The following rules are not intended to describe in detail a model system of penal institutions. They seek only, on the basis of the general consensus of contemporary thought and the essential elements of the most adequate systems of today, to set out what is generally accepted as being good principle and practice in the treatment of prisoners and the management of institutions.

2. In view of the great variety of legal, social, economic and geographical conditions of the world, it is evident that not all of the rules are capable of application in all places and at all times. They should, however, serve to stimulate a constant endeavour to overcome practical difficulties in the way of their application, in the knowledge that they represent, as a whole, the minimum conditions which are accepted as suitable by the United Nations.

3. On the other hand, the rules cover a field in which thought is constantly developing. They are not intended to preclude experiment and practices, provided these are in harmony with the principles and seek to further the purposes which derive from the text of the rules as a whole. It will always be justifiable for the central prison administration to authorize departures from the rules in this spirit.

4. (1) Part I of the rules covers the general management of institutions, and is applicable to all categories of prisoners, criminal or civil, untried or convicted, including prisoners subject to "security measures" or corrective measures ordered by the judge.

(2) Part II contains rules applicable only to the special categories dealt with in each section. Nevertheless, the rules under section A, applicable to prisoners under sentence, shall be equally applicable to categories of prisoners dealt with in sections B, C and D, provided they do not conflict with the rules governing those categories and are for their benefit.

5. (1) The rules do not seek to regulate the management of institutions set aside for young persons such as Borstal institutions or correctional schools, but in general part I would be equally applicable in such institutions.

(2) The category of young prisoners should include at least all young persons who come within the jurisdiction of juvenile courts. As a rule, such young persons should not be sentenced to imprisonment.

PART I

RULES OF GENERAL APPLICATION

Basic principle

6. (1) The following rules shall be applied impartially. There shall be no discrimination on grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

(2) On the other hand, it is necessary to respect the religious beliefs and moral precepts of the group to which a prisoner belongs.

Register

7. (1) In every place where persons are imprisoned there shall be kept a bound registration book with numbered pages in which shall be entered in respect of each prisoner received:

(a) Information concerning his identity;

(b) The reasons for his commitment and the authority therefor;

(c) The day and hour of his admission and release.

(2) No person shall be received in an institution without a valid commitment order of which the details shall have been previously entered in the register. Separation of categories

8. The different categories of prisoners shall be kept in separate institutions or parts of institutions taking account of their sex, age, criminal record, the legal reason for their detention and the necessities of their treatment. Thus,

(a) Men and women shall so far as possible be detained in separate institutions; in an institution which receives both men and women the whole of the premises allocated to women shall be entirely separate;

(b) Untried prisoners shall be kept separate from convicted prisoners;

(c) Persons imprisoned for debt and other civil prisoners shall be kept separate from persons imprisoned by reason of a criminal offence;

(d) Young prisoners shall be kept separate from adults.

Accommodation

9. (1) Where sleeping accommodation is in individual cells or rooms, each prisoner shall occupy by night a cell or room by himself. If for special reasons, such as temporary overcrowding, it becomes necessary for the central prison administration to make an exception to this rule, it is not desirable to have two prisoners in a cell or room.

(2) Where dormitories are used, they shall be occupied by prisoners carefully selected as being suitable to associate with one another in those conditions. There shall be regular supervision by night, in keeping with the nature of the institution.

10. All accommodation provided for the use of prisoners and in particular all sleeping accommodation shall meet all requirements of health, due regard being paid to climatic conditions and particularly to cubic content of air, minimum floor space, lighting, heating and ventilation.

11. In all places where prisoners are required to live or work,

(a) The windows shall be large enough to enable the prisoners to read or work by natural light, and shall be so constructed that they can allow the entrance of fresh air whether or not there is artificial ventilation;

(b) Artificial light shall be provided sufficient for the prisoners to read or work without injury to eyesight.

12. The sanitary installations shall be adequate to enable every prisoner to comply with the needs of nature when necessary and in a clean and decent manner.

13. Adequate bathing and shower installations shall be provided so that every prisoner may be enabled and required to have a bath or shower, at a temperature suitable to the climate, as frequently as necessary for general hygiene according to season and geographical region, but at least once a week in a temperate climate.

14. All pans of an institution regularly used by prisoners shall be properly maintained and kept scrupulously clean at all times.

Personal hygiene

15. Prisoners shall be required to keep their persons clean, and to this end they shall be provided with water and with such toilet articles as are necessary for health and cleanliness.

16. In order that prisoners may maintain a good appearance compatible with their self-respect, facilities shall be provided for the proper care of the hair and beard, and men shall be enabled to shave regularly.

Clothing and bedding

17. (1) Every prisoner who is not allowed to wear his own clothing shall be provided with an outfit of clothing suitable for the climate and adequate to keep him in good health. Such clothing shall in no manner be degrading or humiliating.

(2) All clothing shall be clean and kept in proper condition. Underclothing shall be changed and washed as often as necessary for the maintenance of hygiene.

(3) In exceptional circumstances, whenever a prisoner is removed outside the institution for an authorized purpose, he shall be allowed to wear his own clothing or other inconspicuous clothing.

18. If prisoners are allowed to wear their own clothing, arrangements shall be made on their admission to the institution to ensure that it shall be clean and fit for use.

19. Every prisoner shall, in accordance with local or national standards, be provided with a separate bed, and with separate and sufficient bedding which shall be clean when issued, kept in good order and changed often enough to ensure its cleanliness.

Food

20. (1) Every prisoner shall be provided by the administration at the usual hours with food of nutritional value adequate for health and strength, of wholesome quality and well prepared and served.

(2) Drinking water shall be available to every prisoner whenever he needs it.

Exercise and sport

21. (1) Every prisoner who is not employed in outdoor work shall have at least one hour of suitable exercise in the open air daily if the weather permits.

(2) Young prisoners, and others of suitable age and physique, shall receive physical and recreational training during the period of exercise. To this end space, installations and equipment should be provided.

Medical services

22. (1) At every institution there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry. The medical services should be organized in close relationship to the general health administration of the community or nation. They shall include a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality.

(2) Sick prisoners who require specialist treatment shall be transferred to specialized institutions or to civil hospitals. Where hospital facilities are provided in an institution, their equipment, furnishings and pharmaceutical supplies shall be proper for the medical care and treatment of sick prisoners, and there shall be a staff of suitable trained officers.

(3) The services of a qualified dental officer shall be available to every prisoner.

23. (1) In women's institutions there shall be special accommodation for all necessary pre-natal and post-natal care and treatment. Arrangements shall be made wherever practicable for children to be torn in a hospital outside the institution. If a child is born in prison, this fact shall not be mentioned in the birth certificate.

(2) Where nursing infants are allowed to remain in the institution with their mothers, provision shall be made for a nursery staffed by qualified persons, where the infants shall be placed when they are not in the care of their mothers.

24. The medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary, with a view particularly to the discovery of physical or mental illness and the taking of all necessary measures; the segregation of prisoners suspected of infectious or contagious conditions; the noting of physical or mental defects which might hamper rehabilitation, and the determination of the physical capacity of every prisoner for work.

25. (1) The medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed.

(2) The medical officer shall report to the director whenever he considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.

26. (1) The medical officer shall regularly inspect and advise the director upon:

(a) The quantity, quality, preparation and service of food;

(b) The hygiene and cleanliness of the institution and the prisoners;

(c) The sanitation, heating, lighting and ventilation of the institution;

(d) The suitability and cleanliness of the prisoners' clothing and bedding;

(e) The observance of the rules concerning physical education and sports, in cases where there is no technical personnel in charge of these activities.

(2) The director shall take into consideration the reports and advice that the medical officer submits according to rules 25 (2) and 26 and, in case he concurs with the recommendations made, shall take immediate steps to give effect to those recommendations; if they are not within his competence or if he does not concur with them, he shall immediately submit his own report and the advice of the medical officer to higher authority.

Discipline and punishment

27. Discipline and order shall be maintained with firmness, but with no more restriction than is necessary for safe custody and well-ordered community life.

28. (1) No prisoner shall be employed, in the service of the institution, in any disciplinary capacity.

(2) This rule shall not, however, impede the proper functioning of systems based on self-government, under which specified social, educational or sports activities or responsibilities are entrusted, under supervision, to prisoners who are formed into groups for the purposes of treatment.

29. The following shall always be determined by the law or by the regulation of the competent administrative authority:

(a) Conduct constituting a disciplinary offence;

(b) The types and duration of punishment which may be inflicted;

(c) The authority competent to impose such punishment.

30. (1) No prisoner shall be punished except in accordance with the terms of such law or regulation, and never twice for the same offence.

(2) No prisoner shall be punished unless he has been informed of the offence alleged against him and given a proper opportunity of presenting his defence. The competent authority shall conduct a thorough examination of the case.

(3) Where necessary and practicable the prisoner shall be allowed to make his defence through an interpreter.

31. Corporal punishment, punishment by placing in a dark cell, and all cruel, inhuman or degrading punishments shall be completely prohibited as punishments for disciplinary offences.

32. (1) Punishment by close confinement or reduction of diet shall never be inflicted unless the medical officer has examined the prisoner and certified in writing that he is fit to sustain it.

(2) The same shall apply to any other punishment that may be prejudicial to the physical or mental health of a prisoner. In no case may such punishment be contrary to or depart from the principle stated in rule 31.

(3) The medical officer shall visit daily prisoners undergoing such punishments and shall advise the director if he considers the termination or alteration of the punishment necessary on grounds of physical or mental health.

Instruments of restraint

33. Instruments of restraint, such as handcuffs, chains, irons and strait-jacket, shall never be applied as a punishment. Furthermore, chains or irons shall not be used as restraints. Other instruments of restraint shall not be used except in the following circumstances:

(a) As a precaution against escape during a transfer, provided that they shall be removed when the prisoner appears before a judicial or administrative authority;

(b) On medical grounds by direction of the medical officer;

(c) By order of the director, if other methods of control fail, in order to prevent a prisoner from injuring himself or others or from damaging property; in such instances the director shall at once consult the medical officer and report to the higher administrative authority.

34. The patterns and manner of use of instruments of restraint shall be decided by the central prison administration. Such instruments must not be applied for any longer time than is strictly necessary.

Information to and complaints by prisoners

35. (1) Every prisoner on admission shall be provided with written information about the regulations governing the treatment of prisoners of his category, the disciplinary requirements of the institution, the authorized methods of seeking information and making complaints, and all such other matters as are necessary to enable him to understand both his rights and his obligations and to adapt himself to the life of the institution.

(2) If a prisoner is illiterate, the aforesaid information shall be conveyed to him orally.

36. (1) Every prisoner shall have the opportunity each week day of making requests or complaints to the director of the institution or the officer authorized to represent him.

(2) It shall be possible to make requests or complaints to the inspector of prisons during his inspection. The prisoner shall have the opportunity to talk to the inspector or to any other inspecting officer without the director or other members of the staff being present.

(3) Every prisoner shall be allowed to make a request or complaint, without censorship as to substance but in proper form, to the central prison administration, the judicial authority or other proper authorities through approved channels.

(4) Unless it is evidently frivolous or groundless, every request or complaint shall be promptly dealt with and replied to without undue delay.

Contact with the outside world

37. Prisoners shall be allowed under necessary supervision to communicate with their family and reputable friends at regular intervals, both by correspondence and by receiving visits.

38. (1) Prisoners who are foreign nationals shall be allowed reasonable facilities to communicate with the diplomatic and consular representatives of the State to which they belong.

(2) Prisoners who are nationals of States without diplomatic or consular representation in the country and refugees or stateless persons shall be allowed similar facilities to communicate with the diplomatic representative of the State which takes charge of their interests or any national or international authority whose task it is to protect such persons.

39. Prisoners shall be kept informed regularly of the more important items of news by the reading of newspapers, periodicals or special institutional publications, by hearing wireless transmissions, by lectures or by any similar means as authorized or controlled by the administration.

Books

40. Every institution shall have a library for the use of all categories of prisoners, adequately stocked with both recreational and instructional books, and prisoners shall be encouraged to make full use of it.

Religion

41. (1) If the institution contains a sufficient number of prisoners of the same religion, a qualified representative of that religion shall be appointed or approved. If the number of prisoners justifies it and conditions permit, the arrangement should be on a full-time basis.

(2) A qualified representative appointed or approved under paragraph (1) shall be allowed to hold regular services and to pay pastoral visits in private to prisoners of his religion at proper times.

(3) Access to a qualified representative of any religion shall not be refused to any prisoner. On the other hand, if any prisoner should object to a visit of any religious representative, his attitude shall be fully respected.

42. So far as practicable, every prisoner shall be allowed to satisfy the needs of his religious life by attending the services provided in the institution and having in his possession the books of religious observance and instruction of his denomination.

Retention of prisoners' property

43. (1) All money, valuables, clothing and other effects belonging to a prisoner which under the regulations of the institution he is not allowed to retain shall on his admission to the institution be placed in safe custody. An inventory thereof shall be signed by the prisoner. Steps shall be taken to keep them in good condition.

(2) On the release of the prisoner all such articles and money shall be returned to him except in so far as he has been authorized to spend money or send any such property out of the institution, or it has been found necessary on hygienic grounds to destroy any article of clothing. The prisoner shall sign a receipt for the articles and money returned to him.

(3) Any money or effects received for a prisoner from outside shall be treated in the same way.

(4) If a prisoner brings in any drugs or medicine, the medical officer shall decide what use shall be made of them.

Notification of death, illness, transfer, etc.

44. (1) Upon the death or serious illness of, or serious injury to a prisoner, or his removal to an institution for the treatment of mental affections, the director shall at once inform the spouse, if the prisoner is married, or the nearest relative and shall in any event inform any other person previously designated by the prisoner.

(2) A prisoner shall be informed at once of the death or serious illness of any near relative. In case of the critical illness of a near relative, the prisoner should be authorized, whenever circumstances allow, to go to his bedside either under escort or alone.

(3) Every prisoner shall have the right to inform at once his family of his imprisonment or his transfer to another institution.

Removal of prisoners

45. (1) When the prisoners are being removed to or from an institution, they shall be exposed to public view as little as possible, and proper safeguards shall be adopted to protect them from insult, curiosity and publicity in any form.

(2) The transport of prisoners in conveyances with inadequate ventilation or light, or in any way which would subject them to unnecessary physical hardship, shall be prohibited.

(3) The transport of prisoners shall be carried out at the expense of the administration and equal conditions shall obtain for all of them.

Institutional personnel

46. (1) The prison administration, shall provide for the careful selection of every grade of the personnel, since it is on their integrity, humanity, professional capacity and personal suitability for the work that the proper administration of the institutions depends.

(2) The prison administration shall constantly seek to awaken and maintain in the minds both of the personnel and of the public the conviction that this work is a social service of great importance, and to this end all appropriate means of informing the public should be used.

(3) To secure the foregoing ends, personnel shall be appointed on a full-time basis as professional prison officers and have civil service status with security of tenure subject only to good conduct, efficiency and physical fitness. Salaries shall be adequate to attract and retain suitable men and women; employment benefits and conditions of service shall be favourable in view of the exacting nature of the work.

47. (1) The personnel shall possess an adequate standard of education and intelligence.

(2) Before entering on duty, the personnel shall be given a course of training in their general and specific duties and be required to pass theoretical and practical tests.

(3) After entering on duty and during their career, the personnel shall maintain and improve their knowledge and professional capacity by attending courses of in-service training to be organized at suitable intervals.

48. All members of the personnel shall at all times so conduct themselves and perform their duties as to influence the prisoners for good by their example and to command their respect.

49. (1) So far as possible, the personnel shall include a sufficient number of specialists such as psychiatrists, psychologists, social workers, teachers and trade instructors.

(2) The services of social workers, teachers and trade instructors shall be secured on a permanent basis, without thereby excluding part-time or voluntary workers.

50. (1) The director of an institution should be adequately qualified for his task by character, administrative ability, suitable training and experience.

(2) He shall devote his entire time to his official duties and shall not be appointed on a part-time basis.

(3) He shall reside on the premises of the institution or in its immediate vicinity.

(4) When two or more institutions are under the authority of one director, he shall visit each of them at frequent intervals. A responsible resident official shall be in charge of each of these institutions.

51. (1) The director, his deputy, and the majority of the other personnel of the institution shall be able to speak the language of the greatest number of prisoners, or a language understood by the greatest number of them.

(2) Whenever necessary, the services of an interpreter shall be used.

52. (1) In institutions which are large enough to require the services of one or more full-time medical officers, at least one of them shall reside on the premises of the institution or in its immediate vicinity.

(2) In other institutions the medical officer shall visit daily and shall reside near enough to be able to attend without delay in cases of urgency.

53. (1) In an institution for both men and women, the part of the institution set aside for women shall be under the authority of a responsible woman officer who shall have the custody of the keys of all that part of the institution.

(2) No male member of the staff shall enter the part of the institution set aside for women unless accompanied by a woman officer.

(3) Women prisoners shall be attended and supervised only by women officers. This does not, however, preclude male members of the staff, particularly doctors and teachers, from carrying out their professional duties in institutions or parts of institutions set aside for women.

54. (1) Officers of the institutions shall not, in their relations with the prisoners, use force except in self-defence or in cases of attempted escape, or active or passive physical resistance to an order based on law or regulations. Officers who have recourse to force must use no more than is strictly necessary and must report the incident immediately to the director of the institution.

(2) Prison officers shall be given special physical training to enable them to restrain aggressive prisoners.

(3) Except in special circumstances, staff performing duties which bring them into direct contact with prisoners should not be armed. Furthermore, staff should in no circumstances be provided with arms unless they have been trained in their use.

Inspection

55. There shall be a regular inspection of penal institutions and services by qualified and experienced inspectors appointed by a competent authority. Their task shall be in particular to ensure that these institutions are administered in accordance with existing laws and regulations and with a view to bringing about the objectives of penal and correctional services.

PART II

RULES APPLICABLE TO SPECIAL CATEGORIES

A. PRISONERS UNDER SENTENCE

Guiding principles

56. The guiding principles hereafter are intended to show the spirit in which penal institutions should be administered and the purposes at which they should aim, in accordance with the declaration made under Preliminary Observation I of the present text.

57. Imprisonment and other measures which result in cutting off an offender from the outside world are afflictive by the very fact of taking from the person the right of self-determination by depriving him of his liberty. Therefore the prison system shall not, except as incidental to justifiable segregation or the maintenance of discipline, aggravate the suffering inherent in such a situation.

58. The purpose and justification of a sentence of imprisonment or a similar measure deprivative of liberty is ultimately to protect society against crime. This end can only be achieved if the period of imprisonment is used to ensure, so far as possible, that upon his return to society the offender is not only willing but able to lead a law-abiding and self-supporting life.

59. To this end, the institution should utilize all the remedial, educational, moral, spiritual and other forces and forms of assistance which are appropriate and available, and should seek to apply them according to the individual treatment needs of the prisoners.

60. (1) The regime of the institution should seek to minimize any differences between prison life and life at liberty which tend to lessen the responsibility of the prisoners or the respect due to their dignity as human beings.

(2) Before the completion of the sentence, it is desirable that the necessary steps be taken to ensure for the prisoner a gradual return to life in society. This aim may be achieved, depending on the case, by a pre-release regime organized in the same institution or in another appropriate institution, or by release on trial under some kind of supervision which must not be entrusted to the police but should be combined with effective social aid.

61. The treatment of prisoners should emphasize not their exclusion from the community, but their continuing part in it. Community agencies should, therefore, be enlisted wherever possible to assist the staff of the institution in the task of social rehabilitation of the prisoners. There should be in connection with every institution social workers charged with the duty of maintaining and improving all desirable relations of a prisoner with his family and with valuable social agencies. Steps should be taken to safeguard, to the maximum extent compatible with the law and the sentence, the rights relating to civil interests, social security rights and other social benefits of prisoners.

62. The medical services of the institution shall seek to detect and shall treat any physical or mental illnesses or defects which may hamper a prisoner's rehabilitation. All necessary medical, surgical and psychiatric services shall be provided to that end.

63. (1) The fulfilment of these principles requires individualization of treatment and for this purpose a flexible system of classifying prisoners in groups; it is therefore desirable that such groups should be distributed in separate institutions suitable for the treatment of each group.

(2) These institutions need not provide the same degree of security for every group. It is desirable to provide varying degrees of security according to the needs of different groups. Open institutions, by the very fact that they provide no physical security against escape but rely on the self-discipline of the inmates, provide the conditions most favourable to rehabilitation for carefully selected prisoners.

(3) It is desirable that the number of prisoners in closed institutions should not be so large that the individualization of treatment is hindered. In some countries it is considered that the population of such institutions should not exceed five hundred. In open institutions the population should be as small as possible.

(4) On the other hand, it is undesirable to maintain prisons which are so small that proper facilities cannot be provided.

64. The duty of society does not end with a prisoner's release. There should, therefore, be governmental or private agencies capable of lending the released prisoner efficient after-care directed towards the lessening of prejudice against him and towards his social rehabilitation.

Treatment

65. The treatment of persons sentenced to imprisonment or a similar measure shall have as its purpose, so far as the length of the sentence permits, to establish in them the will to lead law-abiding and self-supporting lives after their release and to fit them to do so. The treatment shall be such as will encourage their self-respect and develop their sense of responsibility.

66. (1) To these ends, all appropriate means shall be used, including religious care in the countries where this is possible, education, vocational guidance and training, social casework, employment counselling, physical development and strengthening of moral character, in accordance with the individual needs of each prisoner, taking account of his social and criminal history, his physical and mental capacities and aptitudes, his personal temperament, the length of his sentence and his prospects after release.

(2) For every prisoner with a sentence of suitable length, the director shall receive, as soon as possible after his admission, full reports on all the matters referred to in the foregoing paragraph. Such reports shall always include a report by a medical officer, wherever possible qualified in psychiatry, on the physical and mental condition of the prisoner.

(3) The reports and other relevant documents shall be placed in an individual file. This file shall be kept up to date and classified in such a way that it can be consulted by the responsible personnel whenever the need arises.

Classification and individualization

67. The purposes of classification shall be:

(a) To separate from others those prisoners who, by reason of their criminal records or bad characters, are likely to exercise a bad influence;

(b) To divide the prisoners into classes in order to facilitate their treatment with a view to their social rehabilitation.

68. So far as possible separate institutions or separate sections of an institution shall be used for the treatment of the different classes of prisoners.

69. As soon as possible after admission and after a study of the personality of each prisoner with a sentence of suitable length, a programme of treatment shall be prepared for him in the light of the knowledge obtained about his individual needs, his capacities and dispositions.

Privileges

70. Systems of privileges appropriate for the different classes of prisoners and the different methods of treatment shall be established at every institution, in order to encourage good conduct, develop a sense of responsibility and secure the interest and co-operation of the prisoners in their treatment.

Work

71. (1) Prison labour must not be of an afflictive nature.

(2) All prisoners under sentence shall be required to work, subject to their physical and mental fitness as determined by the medical officer.

(3) Sufficient work of a useful nature shall be provided to keep prisoners actively employed for a normal working day.

(4) So far as possible the work provided shall be such as will maintain or increase the prisoners, ability to earn an honest living after release.

(5) Vocational training in useful trades shall be provided for prisoners able to profit thereby and especially for young prisoners.

(6) Within the limits compatible with proper vocational selection and with the requirements of institutional administration and discipline, the prisoners shall be able to choose the type of work they wish to perform.

72. (1) The organization and methods of work in the institutions shall resemble as closely as possible those of similar work outside institutions, so as to prepare prisoners for the conditions of normal occupational life.

(2) The interests of the prisoners and of their vocational training, however, must not be subordinated to the purpose of making a financial profit from an industry in the institution.

73. (1) Preferably institutional industries and farms should be operated directly by the administration and not by private contractors.

(2) Where prisoners are employed in work not controlled by the administration, they shall always be under the supervision of the institution's personnel. Unless the work is for other departments of the government the full normal wages for such work shall be paid to the administration by the persons to whom the labour is supplied, account being taken of the output of the prisoners.

74. (1) The precautions laid down to protect the safety and health of free workmen shall be equally observed in institutions.

(2) Provision shall be made to indemnify prisoners against industrial injury, including occupational disease, on terms not less favourable than those extended by law to free workmen.

75. (1) The maximum daily and weekly working hours of the prisoners shall be fixed by law or by administrative regulation, taking into account local rules or custom in regard to the employment of free workmen.

(2) The hours so fixed shall leave one rest day a week and sufficient time for education and other activities required as part of the treatment and rehabilitation of the prisoners.

76. (1) There shall be a system of equitable remuneration of the work of prisoners.

(2) Under the system prisoners shall be allowed to spend at least a part of their earnings on approved articles for their own use and to send a part of their earnings to their family.

(3) The system should also provide that a part of the earnings should be set aside by the administration so as to constitute a savings fund to be handed over to the prisoner on his release.

Education and recreation

77. (1) Provision shall be made for the further education of all prisoners capable of profiting thereby, including religious instruction in the countries where this is possible. The education of illiterates and young prisoners shall be compulsory and special attention shall be paid to it by the administration.

(2) So far as practicable, the education of prisoners shall be integrated with the educational system of the country so that after their release they may continue their education without difficulty.

78. Recreational and cultural activities shall be provided in all institutions for the benefit of the mental and physical health of prisoners.

Social relations and after-care

79. Special attention shall be paid to the maintenance and improvement of such relations between a prisoner and his family as are desirable in the best interests of both.

80. From the beginning of a prisoner's sentence consideration shall be given to his future after release and he shall be encouraged and assisted to maintain or establish such relations with persons or agencies outside the institution as may promote the best interests of his family and his own social rehabilitation.

81. (1) Services and agencies, governmental or otherwise, which assist released prisoners to re-establish themselves in society shall ensure, so far as is possible and necessary, that released prisoners be provided with appropriate documents and identification papers, have suitable homes and work to go to, are suitably and adequately clothed having regard to the climate and season, and have sufficient means to reach their destination and maintain themselves in the period immediately following their release.

(2) The approved representatives of such agencies shall have all necessary access to the institution and to prisoners and shall be taken into consultation as to the future of a prisoner from the beginning of his sentence.

(3) It is desirable that the activities of such agencies shall be centralized or co-ordinated as far as possible in order to secure the best use of their efforts.

B. INSANE AND MENTALLY ABNORMAL PRISONERS

82. (1) Persons who are found to be insane shall not be detained in prisons and arrangements shall be made to remove them to mental institutions as soon as possible.

(2) Prisoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialized institutions under medical management.

(3) During their stay in a prison, such prisoners shall be placed under the special supervision of a medical officer.

(4) The medical or psychiatric service of the penal institutions shall provide for the psychiatric treatment of all other prisoners who are in need of such treatment.

83. It is desirable that steps should be taken, by arrangement with the appropriate agencies, to ensure if necessary the continuation of psychiatric treatment after release and the provision of social-psychiatric after-care.

C. PRISONERS UNDER ARREST OR AWAITING TRIAL

84. (1) Persons arrested or imprisoned by reason of a criminal charge against them, who are detained either in police custody or in prison custody (jail) but have not yet been tried and sentenced, will be referred to as "untried prisoners,' hereinafter in these rules.

(2) Unconvicted prisoners are presumed to be innocent and shall be treated as such.

(3) Without prejudice to legal rules for the protection of individual liberty or prescribing the procedure to be observed in respect of untried prisoners, these prisoners shall benefit by a special regime which is described in the following rules in its essential requirements only.

85. (1) Untried prisoners shall be kept separate from convicted prisoners.

(2) Young untried prisoners shall be kept separate from adults and shall in principle be detained in separate institutions.

86. Untried prisoners shall sleep singly in separate rooms, with the reservation of different local custom in respect of the climate.

87. Within the limits compatible with the good order of the institution, untried prisoners may, if they so desire, have their food procured at their own expense from the outside, either through the administration or through their family or friends. Otherwise, the administration shall provide their food.

88. (I) An untried prisoner shall be allowed to wear his own clothing if it is clean and suitable.

(2) If he wears prison dress, it shall be different from that supplied to convicted prisoners.

89. An untried prisoner shall always be offered opportunity to work, but shall not be required to work. If he chooses to work, he shall be paid for it.

90. An untried prisoner shall be allowed to procure at his own expense or at the expense of a third party such books, newspapers, writing materials and other means of occupation as are compatible with the interests of the administration of justice and the security and good order of the institution.

91. An untried prisoner shall be allowed to be visited and treated by his own doctor or dentist if there is reasonable ground for his application and he is able to pay any expenses incurred.

92. An untried prisoner shall be allowed to inform immediately his family of his detention and shall be given all reasonable facilities for communicating with his family and friends, and for receiving visits from them, subject only to restrictions and supervision as are necessary in the interests of the administration of justice and of the security and good order of the institution.

93. For the purposes of his defence, an untried prisoner shall be allowed to apply for free legal aid where such aid is available, and to receive visits from his legal adviser with a view to his defence and to prepare and hand to him confidential instructions. For these purposes, he shall if he so desires be supplied with writing material. Interviews between the prisoner and his legal adviser may be within sight but not within the hearing of a police or institution official.

D. CIVIL PRISONERS

94. In countries where the law perm its imprisonment for debt, or by order of a court under any other non-criminal process, persons so imprisoned shall not be subjected to any greater restriction or severity than is necessary to ensure safe custody and good order. Their treatment shall be not less favourable than that of untried prisoners, with the reservation, however, that they may possibly be required to work.

E. PERSONS ARRESTED OR DETAINED WITHOUT CHARGE

95. Without prejudice to the provisions of article 9 of the International Covenant on Civil and Political Rights, persons arrested or imprisoned without charge shall be accorded the same protection as that accorded under part I and part II, section C. Relevant provisions of part II, section A, shall likewise be applicable where their application may be conducive to the benefit of this special group of persons in custody, provided that no measures shall be taken implying that re-education or rehabilitation is in any way appropriate to persons not convicted of any criminal offence.