No. _____

IN THE
SUPREME COURT OF THE UNITED STATES

DAVID HILL

Petitioner

v.

BRENT REINKE, RANDY BLADES, AND RICHARD CRAIG

Respondents

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

APPENDIX

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UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

DAVID TYLER HILL, Plaintiff-Appellant, v. BRENT REINKE; SHANE EVANS; JANE DOES, 1-2; RANDY BLADES, Warden; VICKI HANSEN; SHANNON BLACKBURN; RICHARD CRAIG; CLAUDIA LAKE, Defendants-Appellees.	No. 15-35061 DC No. CV 13-38 BLW MEMORANDUM*

Appeal from the United States District Court
for the District of Idaho
B. Lynn Winmill, Chief Judge, Presiding

Argued and Submitted April 10, 2018
Seattle, Washington

Before: TASHIMA and GRABER, Circuit Judges, and MIHM,** District Judge.

* This disposition is not appropriate for publication and is not precedent except as provided by Ninth Circuit Rule 36-3.

** The Honorable Michael M. Mihm, United States District Judge for the Central District of Illinois, sitting by designation.

Plaintiff-appellant David Tyler Hill, an Idaho state prisoner, appeals from the district court's summary judgment in his 42 U.S.C. § 1983 action against defendants Brent Reinke, Randy Blades, and Richard Craig, officials of the Idaho Department of Correction ("IDOC Defendants"). Hill alleges that the IDOC Defendants violated his due process rights under the Fourteenth Amendment by moving him to the Secure Mental Health Unit ("MHU") without a pre-transfer hearing.

1. Hill has not demonstrated that his transfer to the MHU imposed "atypical and significant hardship . . . in relation to the ordinary incidents of prison life." *Sandin v. Conner*, 515 U.S. 472, 483–84 (1995). The MHU is within an IDOC unit, Hill was transferred there only temporarily, and the transfer did not affect his sentence.

For the same reasons, *Vitek v. Jones*, 445 U.S. 480 (1980), does not control this case. The plaintiff in *Vitek* was transferred indefinitely to a hospital outside the corrections system. *Id.* at 483–84. By contrast, Hill was transferred temporarily to the MHU, an IDOC facility, for the purpose of evaluation. *See United States v. Jones*, 811 F.2d 444, 448 (8th Cir. 1987). Thus Hill lacked a liberty interest in his transfer to the MHU, and the IDOC Defendants were not required to provide him a hearing.

At a minimum, the IDOC Defendants are entitled to qualified immunity because Hill did not possess a clearly established right to a hearing at the time of his transfer. *See Chappell v. Mandeville*, 706 F.3d 1052, 1064–65 (9th Cir. 2013).

2. Hill's claims for injunctive relief would fail even if he had a liberty interest. It is only speculative that IDOC will transfer Hill to the MHU during his remaining year-plus of confinement. *See Melendres v. Arpaio*, 695 F.3d 990, 997 (9th Cir. 2012) ("To have standing to assert a claim for prospective injunctive relief, a plaintiff must demonstrate 'that he is realistically threatened by a repetition of [the violation].'" (alteration in original) (quoting *City of L. A. v. Lyons*, 461 U.S. 95, 109 (1983))).

• ● •

The judgment of the district court is **AFFIRMED**.

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

DAVID TYLER HILL,

Plaintiff,

v.

BRENT REINKE, SHANE EVANS, JANE DOE I, JANE DOE II, CORIZON (a/k/a CORRECTIONAL MEDICAL SERVICES), RANDY BLADES, VICKI HANSEN, SHANNON BLACKBURN, RICHARD CRAIG, and CLAUDIA LAKE,

Defendants.

Case No. 1:13-cv-00038-BLW

MEMORANDUM DECISION AND ORDER

Plaintiff David Tyler Hill, a prisoner in the custody of the Idaho Department of Correction (IDOC), is proceeding pro se and in forma pauperis in this civil rights action. Pending before the Court are Defendant Corizon's Motion for Summary Judgment (Dkt. 34); Defendants Brent Reinke's, Shane Evans's, Randy Blades's, Vicky Hansen's,

Shannon Blackburn's and Richard Craig's Motion for Summary Judgment (Dkt. 37) [1]; Plaintiff David Hill's Motion to Amend Complaint (Dkt. 40) and his Motion for Judicial Notice (Dkt. 42); the IDOC Defendants' Motion to Strike, in which Defendant Corizon joins (Dkt. 44); Plaintiff Hill's Motion to File a Response to Motion (Dkt. 48); and Plaintiff Hill's renewed motion for appointment of counsel (Dkt. 50).

Having fully reviewed the record, the Court finds that the facts and legal arguments are adequately presented in the briefs and record and that the decisional process would not be significantly aided by oral argument. Accordingly, the Court will decide this matter on the record without oral argument. D. Idaho L. R. 7.1. For the reasons that follow, the Court concludes that there is no genuine dispute as to any material fact and that Defendants are entitled to judgment as a matter of law. Therefore, the Court will grant Defendants' Motion for Summary Judgment. All other motions are denied as explained below.

INTRODUCTION

The present lawsuit is the second lawsuit filed by plaintiff concerning the treatment provided to him on C-Block, Tier Three, located within the Secure Mental Health Unit (MHU) at Idaho Maximum Security Institution (IMSI) beginning on April 11, 2011. *See Hill v. Wamble-Fisher et al.*, Case 1:11-cv-00101-REB. This tier is known as C-3. C-3 is a specialized mental health treatment unit, which is located within IMSI. The unit is "designed to help identify an offender's acute mental health needs and to

[1] Defendant Claudia Lake is alleged to be the Mental Health Unit's head psychologist and employed by Defendant Corizon to provide medical services at the IDOC. She was never served in this matter. It appears Plaintiff no longer desires to include Lake in his complaint, as he filed a motion to amend/correct that indicated he wished to "drop" her as a defendant. (Dkt. 40.) The individually named defendants will be referred to as the IDOC Defendants.

initiate appropriate treatment. Placement in C-3 is by referral only." (Eliason Aff. ¶ 8, Dkt. 34-3 at 3). The decision for an inmate to be admitted into C-3 is made by the IDOC mental health treatment team supervised and under the direction of psychologist Richard Craig. *Id*.

Defendant Richard Craig is the Chief Psychologist for the IDOC, and coordinates the care of patients at IMSI. *Id.* ¶ 7. In 2011, C-3 was staffed by a psychologist from the IDOC, Dr. Craig, and Corizon staff, which included two psychiatrists, a nurse practitioner, social workers, psychiatric technicians, and a mental health coordinator. *Id.* ¶ 10. Psychiatrist Scott Eliason was part of the treatment team in 2011 when Hill was housed at C-3. Dr. Eliason describes the treatment and behavioral system in C-3 as follows:

> Offenders are expected to take all prescribed medications and respect all staff and treatment team members as well as other offenders. They are also expected to follow the directions of the treatment and custody staff and the Idaho Department of Correction's rules and regulations.
>
> ***
>
> All offenders entering the Mental Health Unit are initially placed on Tier 3. Offenders housed in C-3 are subject to a level system that was designed to keep them and staff safe and secure. Levels are assigned based on offender behaviors, security risk, level of functioning, program compliance, treatment participation and psychiatric presentation. There are four levels with Level 1 being the most restrictive and, non-level, the least restrictive. Level 2 does not allow personal property, which includes reading books, photo albums, bibles, personal letters and paper, although legal paperwork is allowed. Phone privileges and access to security pens and writing paper are coordinated by treatment team staff.

> Offenders are not allowed any contact with other offenders. Showers and linen exchanges are done on schedule.
>
> Level status is discussed by the treatment team on a weekly basis and adjusted depending upon an offender's behavior, progress with treatment, and participation for the prior week. If an offender has not engaged in any disruptive, aggressive or threatening behavior, has been compliant with his treatment plan, which includes medication adherence, and establishes appropriate activities of daily living, then their offender level could be assessed for moving to a less restrictive level.

Id. ¶ 10-12.

Hill alleges that Defendants violated his Eighth Amendment rights to be free from cruel and unusual punishment, and to adequate mental health care during his time in C-3, as well as his Fourteenth Amendment right to due process by transferring him to C-3 without a hearing.

PLAINTIFF'S MOTION TO AMEND COMPLAINT

Hill filed a motion to amend his complaint on May 29, 2014. He proposes to correct the misspelled names of the Defendants; identify the Doe Defendants; dismiss Defendant Claudia Lake; dismiss his due process claim; include additional factual details against Corizon; and explain the injunctive relief he is seeking. (Dkt. 40.)

The Court's case management order, entered on September 18, 2013 (Dkt. 27), required the parties to amend pleadings and join parties within 90 days after entry of the scheduling order, and for discovery to be completed within 150 days. Dispositive motions were due within sixty days after the close of discovery, and were timely filed by Defendants on April 15 and 16, 2014. Defendants oppose Hill's motion on the grounds

that it was untimely made, citing Fed. R. Civ. P. 16(b). Hill contends he was unaware of Rule 16(b)'s requirements.

Motions to amend a pleading filed after the scheduling order deadline has expired are governed by the restrictive provisions of Fed. R. Civ. P. 16(b), which require a showing of "good cause." *Johnson v. Mammoth Recreations, Inc*., 975 F.2d 604, 608 (9th Cir. 1992). A court should find good cause only if the moving party shows he "could not reasonably meet the established timeline in a scheduling order despite [his] diligence." *DIRECTV, Inc. v. Busdon,* No. CV–04–265–S–LMB, 2005 WL 1364571, at * 1 (D. Idaho June 8, 2005). Rule 16 was designed to facilitate more efficient disposition of cases by settlement or by trial. *Johnson*, 975 F.2d at 610–11. If disregarded, it would "undermine the court's ability to control its docket, disrupt the agreed-upon course of the litigation, and reward the indolent and the cavalier." *Id*.; *see also* Rule 16 Advisory Committee Notes (1983 Amendment). The moving party's diligence governs the good cause standard. *Johnson*, 975 F.2d at 608. "When determining whether to grant a motion to amend a scheduling order, a court may also consider "the existence or degree of prejudice to the party opposing the modifications." *Id*. But if the moving party "was not diligent, the inquiry should end." *Id*.

Here, the only grounds Hill cited in support of his motion were his general unawareness of Rule 16(b)'s requirements, and his desire to remedy the technical requirements of his complaint in light of Defendants' motions for summary judgment. The Court is mindful that Hill is proceeding pro se and is incarcerated. "Pro se prison inmates, with limited access to legal materials, occupy a position significantly different

from that occupied by litigants represented by counsel." *Jacobsen v. Filler*, 790 F.2d 1362, 1365 n. 4 (9th Cir. 1986) (citation omitted). Courts have a duty to liberally construe the pleadings of pro se litigants, particularly those filed by pro se prisoners. *See Zichko v. Idaho*, 247 F.3d 1015, 1020 (9th Cir. 2001). But, pro se litigants are nonetheless bound by "the same rules of procedure that govern other litigants," *King v. Atiyeh*, 814 F.2d 565, 567 (9th Cir. 1987), including Rule 16(b)'s requirements.

The Court can discern no good cause based upon Hill's rationale that he will correct deficiencies in his Complaint. First, he proposes to add defendants by naming the Doe Defendants. Hill has offered no explanation why those defendants could not have been named earlier. Next, he proposes to "add" factual information. But, Hill has not offered any legitimate reason why he could not have included these facts prior to the deadline for amending pleadings. And finally, granting Hill's motion would unfairly prejudice Defendants in this matter, given that discovery is now closed and Defendants have timely filed their respective motions for summary judgment.

The Court is therefore not inclined to amend its case management order considering the lack of good cause to do so and Hill's neglect in proposing to file his proposed amended complaint after the deadline. The motions for summary judgment will therefore proceed based upon the initial Complaint filed in this matter, and the Motion to Amend will be denied.

However, the Court will construe Hill's motion to amend as a motion to dismiss Defendant Claudia Lake. Lake was never served with the original complaint, and Hill has not continued to prosecute this matter against her. *See* Response brief at 2 (Dkt. 39 at 2)

(indicating Lake has not been served). Lake may be dismissed from this action for failure to comply with Fed. R. Civ. P. 4(m). Further, Hill's motion explains he intends to "drop" Lake from his complaint. Accordingly, Defendant Claudia Lake will be dismissed from this action.

PLAINTIFF'S MOTION TO TAKE JUDICIAL NOTICE

Hill requests the Court to take judicial notice of Idaho Code §§ 66-326, 335, and 1301-1318. Hill argues the statues are relevant and applicable to his complaint, because the Idaho Secure Medical Facility constitutes a "Mental Health Unit" covered by the statutes. Defendants oppose Hill's motion for judicial notice, asserting that Idaho statutes are not proper "adjudicative facts" to which Fed. R. Evid. 201 applies. Defendant further asserts that the Idaho code sections cited are irrelevant to Hill's federal constitutional claims.

Title 66, Chapter 3 of Idaho Code applies to govern the voluntary or involuntary admittance of mentally ill individuals, including prisoners, to any public or private hospital designated as a covered "facility" pursuant to board of health and welfare rules and regulations. Idaho Code §§ 66-317(7), 66-315. Hill did not identify any violations of state law in his complaint. Nor has Hill provided evidence, beyond his own speculation, that the acute mental health unit at IMSI constitutes a "facility" as defined by Idaho Code § 66-371(7). Moreover, the Idaho code sections cited are irrelevant to the federal constitutional claims alleged in Hill's complaint and allowed to proceed pursuant to the Court's Initial Review Order (Dkt. 3.) Finally, violation of state law does not lead to liability under Section 1983. *Campbell v. Burt*, 141 F.3d 927, 930 (9th Cir. 1998).

Hill's motion will therefore be denied.

PLAINTIFF'S MOTION TO FILE OBJECTION TO REPLIES

Hill explains in his third motion that he does not wish to file a sur-reply to Defendants' reply memorandums filed in support of their motions for summary judgment, but rather to object to the untimely and late-filed reply memorandums. Hill argues that, because Defendants objected to his late filed response brief, he should be permitted the opportunity to object to Defendants' untimely reply briefs and have them stricken from the record. Defendants do indeed complain that Hill filed his response brief late. The Court will therefore address the relative timeliness of the briefs as they pertain to Defendants' motions for summary judgment.

Corizon timely filed its motion for summary judgment on April 15, 2014, (Dkt. 34), and the IDOC Defendants timely filed their motion for summary judgment on April 16, 2014, (Dkt. 37).[2] Because of the interplay among Fed. R. Civ. P. 5, 6, and Dist. Idaho L. Rule 7.1, a party has twenty-one days, plus an additional three days, within which to file a response brief. Thus, Hill's response to Corizon's Motion was due Friday, May 9, 2014, and his response to IDOC Defendant's motion was due Monday, May 12, 2014. Hill's "objection" to Defendants' motions for summary judgment is dated May 16, 2014, and was received by the Court and filed on May 20, 2014. (Dkt. 39.) Hill's response brief was therefore untimely.

[2] The Court's Order required the parties to file all motions for summary judgment within 60 days after the close of discovery, which was February 15, 2014 (150 days from September 18, 2013, the date of the Scheduling Order). Thus, the last day upon which to file a motion for summary judgment was April 16, 2014.

Defendants' reply briefs were due within seventeen days (14 days plus an additional 3 days) after service of Hill's (tardy) response brief. Dist. Idaho L. Rule 7.1(b)(3); Fed. R. Civ. P. 5, 6. That deadline expired on Monday, June 2, 2014. Defendants' respective replies were indeed filed late, on June 3, 2014, and June 5, 2014. (Dkt. 43, 45.) Reply briefs are, however, optional under Dist. Idaho L. Rule 7.1(b).

The Court sees no reason to strike any party's brief on the grounds of untimeliness under the circumstances. While the Court does not condone lackadaisical adherence to generally applicable procedural rules, the Court cannot grant a motion for summary judgment solely because the opposing party has failed to file an opposition, or in this case, a tardy opposition that Defendants seek to have this Court ignore as if never filed. *Cristobal v. Siegel*, 26 F.3d 1488, 1494-95 & n.4 (9th Cir. 1994) (unopposed motion may be granted only after the court determines there are no material issues of fact); *see also United States v. Real Property at Incline Village*, 47 F.3d 1511, 1520 (9th Cir. 1995) (local rule cannot mandate automatic entry of judgment for moving party without consideration of whether motion and supporting papers satisfy Fed. R. Civ.P. 56), *overruled on other grounds by Degen v. United States*, 517 U.S. 820, 116 S.Ct. 1777, 135 L.Ed.2d 102 (1996); *see also Marshall v. Gates*, 44 F.3d 722, 725 (9th Cir. 1995) (summary judgment may not be granted simply because opposing party violated a local rule, if movant did not meet burden of demonstrating absence of genuine issue for trial).

Thus, the Court must still determine if Defendants have met their burden. Consideration of Hill's arguments and the relevant authority cited in that regard will aid the Court, as will Defendants' respective reply briefs. Although the Court would be well

within its authority to not consider Hill's response brief or defendants' replies, in the exercise of its discretion, and in light of Ninth Circuit authority, it declines to do so here and will reach the merits of the summary judgment motions giving consideration to Hill's arguments advanced in his response brief, and Defendants' arguments in their reply briefs. Therefore, Plaintiff's motion will be denied as moot.

PLAINTIFF'S MOTION FOR APPOINTMENT OF COUNSEL

Unlike criminal defendants, prisoners and indigents in civil actions have no constitutional right to counsel unless their physical liberty is at stake. *Lassiter v. Dept. of Social Services*, 452 U.S. 18, 25, 101 S.Ct. 2153, 68 L.Ed.2d 640 (1981). Whether a court appoints counsel for indigent litigants is within the court's discretion. *Wilborn v. Escalderon*, 789 F.2d 1328, 1330–31 (9th Cir. 1986); *Terrell v. Brewer*, 935 F.2d 1015, 1017 (9th Cir. 1991).

The Court finds none of the factual information contained in Hill's new Motion shows that the earlier decision denying appointment of counsel should be disturbed. *See* Order (Dkt. 32).[3] Hill generally cites the difficulties he has had conducting discovery, contending that Defendants have failed to "reveal" information relevant to Hill's claims in their respective initial disclosures. But, nothing prevented Hill from propounding his own discovery, which would have allowed Hill to draft and serve written discovery upon Defendants relevant to his claims and thereby obtain the documents he complains are in

[3] Defendants also generally oppose Hill's motion because Hill now has more than three outstanding motions, contravening the Court's order prohibiting any party from having more than three pending motions before the Court at one time. Order (Dkt. 8.) Although Defendants are correct, and violation of the Court's order would be sufficient grounds to deny Hill's motion for appointment of counsel, the Court nevertheless considered the merits given the context and the issues raised.

Defendants' custody and control. Second, Hill asserts he is having difficulty in presenting his response to Defendants' motions for summary judgment, contending he is unable to present the evidence properly before the Court in light of Defendants' motion to strike. Hill further contends he has no access to the relevant law, which appointment of counsel would alleviate.

There is no doubt that it is difficult to litigate from a prison cell and that pro se individuals do not have the legal training or resources to do what they could if they were lawyers or had lawyers. However, prisoner status and lack of legal expertise are not enough to warrant appointment of counsel. Here, Hill's inability to more fully litigate his claims is an "incidental (and perfectly constitutional) consequence[] of conviction and incarceration." *Lewis v. Casey*, 518 U.S. 343, 355, 116 S.Ct. 2174, 135 L.Ed.2d 606 (1996). Accordingly, Hill's Motion for Appointment of Counsel will be denied.

DEFENDANTS' MOTION TO STRIKE

The Court has reviewed the motion to strike filed by IDOC Defendants, and joined by Defendant Corizon, directed at Hill's affidavit and various other submissions filed in opposition to Defendants' summary judgment motions. (Dkt. 44.) In addition to the untimeliness of Hill's submissions, the Court finds the remaining contested portions of the affidavit and other documents are not relevant to resolving the motions for summary judgment. While the contested statements are speculative and based upon hearsay, and the documents lack the requisite foundation, the Court has determined it need not consider the contested portions of the Affidavit of David Beckett or the Affidavit of Tyler

Hill, as well as Exhibits A, B, D, H, and K attached thereto. The motion to strike will be denied as moot.

DEFENDANTS' MOTIONS FOR SUMMARY JUDGMENT

1. Factual Background

This section includes facts that are undisputed and material to the resolution of the issues in this case. Where material facts are in dispute, the Court has included Plaintiff's version of facts, insofar as that version is not contradicted by clear documentary evidence in the record. *See Scott v. Harris*, 550 U.S. 372, 380 (2007) ("When opposing parties tell two different stories, one of which is blatantly contradicted by the record, so that no reasonable jury could believe it, a court should not adopt that version of the facts for purposes of ruling on a motion for summary judgment.")

Corizon is a private corporation under contract to provide medical services to inmates in the custody of certain Idaho Department of Correction facilities. Corizon contracts with medical doctors and other care providers who provide care to inmates in the custody of IDOC facilities.

Dr. Richard Craig is the Chief Psychologist for the IDOC, and Corizon staff members who were part of the treatment team at IDOC included psychiatrist Dr. Scott Eliason, psychologist Claudia Lake, and psychiatric technicians Micaela Cathey and Julie Keller. Dr. Eliason assisted in the development of treatment plans and coordinated the care of patients with Dr. Craig and the treatment team. Dr. Eliason was personally involved with the care and treatment provided to Hill while incarcerated at IMSI in April and May of 2011. Eliason Aff. ¶ 6 (Dkt. 34-3.) Dr. Eliason authenticated Hill's medical

records from his stay at IMSI, and submitted them attached to his affidavit. Eliason Aff. Ex. A (Dkt. 34-3).

IMSI's MHU is generally referred to as IMSI's C-block, which is comprised of two tiers: Tier 2 (C-2) and Tier 3 (C-3). C-2 is less restrictive, focusing on providing group therapy and education to prisoners who have moved through the level system while housed in C-3 and established compliance with their individualized treatment plan and with appropriate activities of daily living. Upon arriving at the MHU unit, prisoners were placed in C-3, so that staff could identify the individual prisoner's acute mental health needs and initiate appropriate treatment. Aff. of Bennett ¶ 5, 6 (Dkt. 37-3 at 2). Prisoners housed in C-3 were given a green jumpsuit, underwear, t-shirt, socks, shower shoes and canvas tennis shoes, as well as hygiene items as needed. *Id.* ¶ 7.

Hill was confined to the MHU from April 11, 2011, to May 27, 2011. Defendant Richard Craig ordered the transfer from ICC upon referral from social worker Alexander Black. Eliason Aff. ¶ 13. Black evaluated Hill on April 11, 2011, noting that Hill had been admitted to the medical observation cell four times since March 20, 2011, for cutting on himself, thoughts of suicide, anxiety, and depression. Black noted that the reason for referral was due to continued instability of moods and inability to manage depression and anxiety. At the time he was admitted, Hill had self-inflicted a superficial wound on his right inner thigh, and for that, he was placed in an isolation cell for observation for 23 hours. (Dkt. 34-4 at 10.) Black's notes reflect that he observed Hill, who appeared as if he had not slept, had dark circles under his eyes, and moved slowly. Black noted that Hill had a flat affect and his voice lacked emotion. Hill was thereafter

placed on C-3. Although Hill denied any suicidal intent, hallucinations or delusions at the time, Hill indicated to Black that, if given the opportunity, Hill would engage in self-harm. (Dkt. 34-4 at 7.) In Dr. Craig's opinion, an emergency condition existed on April 11, 2011. Aff. of Craig ¶ 17 (Dkt. 37-4 at 6.) Prior to his admittance to MHU, Hill had been seeing mental health clinicians twice weekly, and had not been compliant with his behavior contract. (Dkt. 37-5 at 9.

Hill signed a consent for treatment form on April 11, 2011, authorizing Correctional Medical Services employees to diagnose and treat him. (Dkt. 34-4 at 2.) On that date, IMSI's intake form indicated Hill was diagnosed with Bipolar disorder and depression. (Dkt. 34-4 at 3.) Black also noted Hill was currently taking Paxil and Elavil. Eliason Aff. ¶ 13.

Hill next underwent an intake mental health screening on April 12, 2011, which was reviewed on April 14, 2011, by Claudia Lake, Psy.D. Eliason Aff. ¶ 13. Dr. Lake made a mental health referral and scheduled Hill to be seen by Dr. Eliason on April 19, 2011. *Id.* ¶ 15. Medication orders for Elavil and Paxil were continued, and Hill was then released from segregation on April 13, 2011. *Id.* ¶ 15. Dr. Lake, in conjunction with other treatment team members Micaela Cathey and Julie Keller, created a thirty day treatment plan on April 14, 2011. *Id.* ¶ 16. (Dkt. 34-4 at 16.) The treatment plan noted the reason for Hill's referral to IMSI C-Block was due to his decrease in coping skills, increase in suicidal ideation, and behavioral issues. *Id.* The plan indicated the short term goal for Hill was to display appropriate behavior and medication compliance, with a long term goal of moving to a less restrictive environment. Hill did not agree with the treatment plan.

During the treatment plan review, Hill became argumentative and threatened to hang himself. Hill was moved to medical and placed on suicide watch. (Dkt. 34-4 at 18.)

IDOC clinician Vicki Hansen evaluated Hill and performed a suicide risk assessment on April 14, 2011. (Dkt. 34-4 at 14.) In her report, she noted Hill was currently housed in the medical holding cell at IMSI. Hansen noted that his past diagnoses included several Axis I disorders of Bipolar mood disorder, and depression. Hill was referred for assessment because he threatened to harm himself, believed he should be living on C-2 and not C-3, and staff had observed him beginning to tear up his sheets. During the assessment, Hill stated that he refused to be returned to C-3. Hanson's review of psychological factors noted Hill was adamant he would be determining his own housing. Although Hanson questioned Hill's intent to die, Hanson assessed Hill as having a high risk for suicide.

The next day, on April 15, 2011, Vicki Hansen again assessed Hill for suicide risk. (Dkt. 34-4 at 20.) During the interview, Hill reported he was cold, and he was no longer threatening self-harm or demanding to determine his housing. Hansen determined Hill was a low suicide risk, and observed Hill as being more subdued than the prior day. Hanson recommended Hill be reduced to close observation and kept in medical over the weekend.

On April 18, 2011, Hill completed a Health Services Request (HSR) seeking medication for his eczema. Hill was seen for that complaint on April 19, 2011 and received instructions regarding how to apply the prescription ordered for him.

On April 19, 2011, Dr. Eliason personally assessed Hill. (Dkt. 34-4 at 22.) During Dr. Eliason's examination, Hill reported eating well and being concerned about the side effects from Elavil. Hill stated to Dr. Eliason that "I won't kill myself if they would just put me where I need to go." Dr. Eliason noted that the reason for Hill's referral to IMSI was because of Hill's threats of suicide, unless he was sent to the BHU. Dr. Eliason noted that Hill had been difficult to manage and he would attempt to get Hill off his medications to see how he did in order to improve the team's ability to accurately diagnose him. In Dr. Eliason's opinion, Hill's mood problems could be primarily Axis II, which is characterized by a personality disorder that would not be responsive to medication. Eliason Aff. ¶ 20. Personality disorders are characterized by rigid, inflexible, and maladaptive behavior patterns that impair an individual's ability to function in society, as well as in the correctional setting. *Id.* The plan was to taper Hill's medication (Paxil and Elavil), and have him return to clinic in three weeks. Dr. Eliason noted that the treatment plan was for medication and follow up only, with the short-term goal being medication compliance and the long term goal to improve Hill's ability to function in a less restrictive environment. (Dkt. 34-4 at 22.)

The MHU Treatment Team met on April 19, 2011, as well. Treatment team notes indicate Hill was housed at C-3 on level 2 status, and was in medical. On April 26, 2011, staffing notes indicate Hill had written on the walls with food, and cut his wrists after returning from the shower. (Dkt. 34-5 at 25.)

On April 29, 2011, at Hill's request, Micaela Cathey submitted a Health Service Request Form to address Hill's complaints of back pain. Bruce Cooper, CMS, evaluated

Hill on May 2, 2011. (Dkt. 34-5 at 1.) Hill submitted another Health Service Request Form on May 1, 2011, requesting his topical ointments prescribed for his eczema be provided to him at pill call that evening. (Dkt. 34-5 at 4.) The response to Hill's request indicated the medication had been ordered.

Staff notes from C-Block on May 3, 2011, reflect Hill had regular level 2 status. (Dkt. 34-5 at 26.) It was noted Hill did not need medication, and that Dr. Lake would be performing tests and considering whether to discharge Hill from the unit.

On May 6, 2011, technician Micaela Cathey evaluated Hill to follow up on Hill's complaints about his placement in C-Block and his complaint that he was taken off his medications. Cathey noted that Hill stated, "I won't be here much longer. I'm not going to kill myself or anything but you guys took me off my meds and the thoughts are there." (Dkt. 34-5 at 6.) Cathey noted also that Hill presented with an appropriate affect and was clear speaking, and that Hill was attempting to rile up staff.

On May 9, 2011, Vicki Hansen evaluated Hill for suicide risk, determining that it was low. (Dkt. 34-5 at 8.) It was noted that Hill stated he was suicidal to "get off the tier," but retracted that statement after being taken to medical. He was placed on suicide watch at that time. Hansen determined Hill's status would be changed to close observation and Hill would be kept in the medical unit. Following Hansen's visit with Hill, Hill found a screw in his quarters and used it to superficially scratch his leg. Hill was then moved to another medical cell for closer observation.

On May 10, 2011, Dr. Eliason evaluated Hill because of his continued behavioral problems. (Dkt. 34-5 at 10.) Hill indicated he had found a screw while he was in the

medical unit and used it to scratch on his leg. At that time, Hill was dressed in a suicide smock. Hill claimed he was not eating well, had low energy and was depressed to the point that he could not read a newspaper without crying. But Dr. Eliason's notes indicated Hill did not have access to a newspaper, staff reported Hill was eating well, and Hill appeared to be misreporting his symptoms. Dr. Eliason's examination reported Hill's behavior was not indicative of an active mood episode, and noted Hill's suicidal threats appeared primarily to be made to control his environment. (Dkt. 34-5 at 10.) Nevertheless, Dr. Eliason ordered that Paxil be restarted, because it might calm down Hill's impulsivity and irritability and help Hill's Axis II pathology to not be quite as bad. Dr. Eliason's treatment plan was again for medication and follow-up only.

The weekly staffing minutes dated May 10, 2011, indicated Hill was in medical and was going back on anti-depressants. (Dkt. 34-5 at 27.) It was noted Hill would be sent to segregation and remain in medical until discharge. Dr. Craig ordered a behavior plan to be prepared, as it was apparent to Dr. Craig that Hill would not succeed in the MHU because Hill would not work through the C-3 levels. Aff. of Craig ¶ 43 (Dkt. 37-4 at 18.) According to Dr. Craig, because of Hill's behavior and apparent lack of mental illness, it appeared Hill would be more successful in an administrative setting with a behavioral plan to follow. *Id*.

On May 11, 2011, Vicki Hansen met with Hill, noting he had been on suicide watch since May 9, 2011, after threatening self-harm. (Dkt. 34-5 at 11.) During their meeting, Hill provided a list of institutions in which he demanded to be housed. It was determined at the meeting that Hill would have to remain on suicide watch because of his

behavior cutting on himself with the screws he found in his cell. At one point during the evaluation, Hill became verbally abusive to Hansen. He was later escorted back to his quarters. Hansen recommended Hill continue on suicide watch with daily follow up until released. Hansen also indicated she would follow up with Dr. Claudia Lake regarding discharge from C-3.

Psychology technician Cathey met with Hill on May 12 and 17, 2011, but reported no new information regarding Hill's mental health condition. The May 17, 2011, weekly staffing meeting minutes reflect Hill was still in medical; that Dr. Lake was working on preparing a behavior plan and discharge; and that Hill was not an appropriate candidate for C Block. (Dkt. 34-5 at 28.)

On May 24, 2011, Dr. Lake met with Hill and completed a discharge summary. At the time of discharge, Dr. Lake was of the opinion that Hill had an Axis II diagnosis of "personality disorder with borderline features." (Dkt. 34-5 at 16.) She noted that since Hill's arrival at IMSI, Hill had "continued to use self-harming behavior as a means to cope and deal with his environment, as well as a form of manipulating placement and staff." In relation to his return to IMSI in April of 2011, Dr. Lake noted the following:

> Mr. Hill returned to IMSI in April of 2011. Since this time, he has been placed in the medical unit for suicidal threats and self-harming behavior on three occasions and is currently housed there. Mr. Hill has not been cooperative with the policies and treatment plan on C-3. He remains aggressive with staff and has flooded mental health and custody staff with letters, grievances, and concern forms attempting to force his placement at ISCI BHU. During his stay at IMSI he has not displayed any signs of depression, anxiety, or mental illness. He demands treatment for Borderline Personality Disorder and yet does not provide any attempt at cooperating with any treatment and behavioral options. . . . Discussion with psychiatry and at the 5/17/11 staffing concluded that placement in a secured

> environment with a behavior plan may control his acting out behavior and prepare him for a GP setting, which is the most appropriate placement for an individual without an Axis I disorder.

Dr. Lake determined that Hill's behavior, lack of mental illness, and aggressiveness made placement in C-3 inappropriate.

In Dr. Eliason's opinion, based upon his education, training, and experience, and his personal knowledge of Hill's mental condition, the care and treatment provided to Hill at IMSI in April and May of 2011 was a reasonable and appropriate course of action. Eliason Aff. ¶ 32 (Dkt. 34-3 at 13).

2. Summary Judgment Standard

Summary judgment is appropriate where a party can show that, as to any claim or defense, "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). One of the principal purposes of the summary judgment rule "is to isolate and dispose of factually unsupported claims or defenses." *Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986). It is not "a disfavored procedural shortcut," but is instead the "principal tool[] by which factually insufficient claims or defenses [can] be isolated and prevented from going to trial with the attendant unwarranted consumption of public and private resources." *Id*. at 327. "[T]he mere existence of some alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment . . . ." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986). Rather, there must be no genuine dispute as to any material fact in order for a case to survive summary judgment. Material facts are those "that might affect the outcome of the suit." *Id*. at 248. "Disputes over irrelevant or unnecessary facts

will not preclude a grant of summary judgment." *T.W. Elec. Serv., Inc. v. Pac. Elec. Contractors Ass'n*, 809 F.2d 626, 630 (9th Cir. 1987).

The moving party is entitled to summary judgment if that party shows that each material fact cannot be disputed. To show that the material facts are not in dispute, a party may cite to particular parts of materials in the record, or show that the adverse party is unable to produce admissible evidence to support the fact. Fed. R. Civ. P. 56(c)(1)(A) & (B). The Court must consider "the cited materials," but it may also consider "other materials in the record." Fed. R. Civ. P. 56(c)(3). The Court is "not required to comb through the record to find some reason to deny a motion for summary judgment." *Carmen v. San Francisco Unified Sch. Dist*., 237 F.3d 1026, 1029 (9th Cir. 2001) (internal quotation marks omitted). Instead, the "party opposing summary judgment must direct [the Court's] attention to specific triable facts." *So. Ca. Gas Co. v. City of Santa Ana*, 336 F.3d 885, 889 (9th Cir. 2003).

If the moving party meets this initial burden, then the burden shifts to the opposing party to establish that a genuine dispute as to any material fact actually does exist. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp*., 475 U.S. 574, 586 (1986). The existence of a scintilla of evidence in support of the non-moving party's position is insufficient. Rather, "there must be evidence on which the jury could reasonably find for the [non-moving party]." *Anderson*, 477 U.S. at 252.

Material used to support or dispute a fact must be "presented in a form that would be admissible in evidence." Fed. R. Civ. P. 56(c)(2). Affidavits or declarations submitted in support of or in opposition to a motion "must be made on personal knowledge, set out

facts that would be admissible in evidence, and show that the affiant or declarant is competent to testify on the matters stated." Fed. R. Civ. P. 56(c)(4). If a party "fails to properly support an assertion of fact or fails to properly address another party's assertion of fact," the Court may consider that fact to be undisputed. Fed. R. Civ. P. 56(e)(2). The Court will grant summary judgment for the moving party "if the motion and supporting materials—including the facts considered undisputed—show that the movant is entitled to it." Fed. R. Civ. P. 56(e)(3).

The Court does not determine the credibility of affiants or weigh the evidence set forth by the non-moving party. Although all reasonable inferences that can be drawn from the evidence must be drawn in a light most favorable to the non-moving party, *T.W. Elec. Serv., Inc.*, 809 F.2d at 630-31, the Court is not required to adopt unreasonable inferences from circumstantial evidence, *McLaughlin v. Liu*, 849 F.2d 1205, 1208 (9th Cir. 1988).

3. Section 1983 Standard

Plaintiff brings his claims under 42 U.S.C. § 1983, the civil rights statute. To succeed on a claim under § 1983, a plaintiff must establish a violation of rights protected by the Constitution or created by federal statute proximately caused by the conduct of a person acting under color of state law. *Crumpton v. Gates*, 947 F.2d 1418, 1420 (9th Cir. 1991). Prison officials are generally not liable for damages in their individual capacities under § 1983 unless they personally participated in the alleged constitutional violations. *Taylor v. List*, 880 F.2d 1040, 1045 (9th Cir. 1989); *see also Ashcroft v. Iqbal*, 556 U.S.

662, 677 (2009) ("[E]ach Government official, his or her title notwithstanding, is only liable for his or her own misconduct.").

"A defendant may be held liable as a supervisor under § 1983 'if there exists either (1) his or her personal involvement in the constitutional deprivation, or (2) a sufficient causal connection between the supervisor's wrongful conduct and the constitutional violation.'" *Starr v. Baca*, 652 F.3d 1202, 1207 (9th Cir. 2011) (quoting *Hansen v. Black*, 885 F.2d 642, 646 (9th Cir. 1989)). This causal connection "can be established by setting in motion a series of acts by others, or by knowingly refusing to terminate a series of acts by others, which the supervisor knew or reasonably should have known would cause others to inflict a constitutional injury." *Id*. at 1207-08 (internal quotation marks, citation, and alterations omitted).

4. Standard of Law for Eighth Amendment Claims

The Eighth Amendment to the United States Constitution protects prisoners against cruel and unusual punishment. To state a claim under the Eighth Amendment, a prisoner must show that he is "incarcerated under conditions posing a substantial risk of serious harm," or that he has been deprived of "the minimal civilized measure of life's necessities" as a result of Defendants' actions. *Farmer v. Brennan*, 511 U.S. 825, 834 (1994) (internal quotation marks omitted). An Eighth Amendment claim requires a plaintiff to satisfy "both an objective standard—that the deprivation was serious enough to constitute cruel and unusual punishment—and a subjective standard—deliberate indifference." *Snow v. McDaniel*, 681 F.3d 978, 985 (9th Cir. 2012).

The Eighth Amendment includes the right to adequate medical care in prison, and prison officials or prison medical providers can be held liable if their "acts or omissions [were] sufficiently harmful to evidence deliberate indifference to serious medical needs." *Estelle v. Gamble*, 429 U.S. 97, 106 (1976). The Eighth Amendment right to adequate prison health care includes adequate mental health treatment, and the standards are the same whether the treatment is considered physical or mental. *Doty v. County of Lassen*, 37 F.3d 540, 546 (9th Cir. 1994).

Regarding the objective standard for prisoners' medical care claims, the Supreme Court of the United States has explained that "[b]ecause society does not expect that prisoners will have unqualified access to health care, deliberate indifference to medical needs amounts to an Eighth Amendment violation only if those needs are 'serious.'" *Hudson v. McMillian*, 503 U.S. 1, 9 (1992).

The Ninth Circuit has defined a "serious medical need" in the following ways:

> failure to treat a prisoner's condition [that] could result in further significant injury or the unnecessary and wanton infliction of pain[;] . . . [t]he existence of an injury that a reasonable doctor or patient would find important and worthy of comment or treatment; the presence of a medical condition that significantly affects an individual's daily activities; or the existence of chronic and substantial pain . . . .

McGuckin v. Smith, 974 F.2d 1050, 1059-60 (9th Cir. 1992) (internal citations omitted), overruled on other grounds, *WMX Techs., Inc. v. Miller*, 104 F.3d 1133 (9th Cir. 1997) (en banc).

As to the subjective standard, a prison official or prison medical provider acts with "deliberate indifference . . . only if the [prison official] knows of and disregards an

excessive risk to inmate health and safety." *Gibson v. Cnty. of Washoe, Nev.*, 290 F.3d 1175, 1187 (9th Cir. 2002) (citation and internal quotation marks omitted). "Under this standard, the prison official must not only 'be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists,' but that person 'must also draw the inference.'" *Toguchi v. Chung*, 391 F.3d 1051, 1057 (9th Cir. 2004) (quoting Farmer, 511 U.S. at 837).

"If a [prison official] should have been aware of the risk, but was not, then the [official] has not violated the Eighth Amendment, no matter how severe the risk." *Gibson*, 290 F.3d at 1188 (citation omitted). However, "whether a prison official had the requisite knowledge of a substantial risk is a question of fact subject to demonstration in the usual ways, including inference from circumstantial evidence, . . . and a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious." *Farmer*, 511 U.S. at 842; *see also Lolli v. County of Orange*, 351 F.3d 410, 421 (9th Cir. 2003) (deliberate indifference to medical needs may be shown by circumstantial evidence when the facts are sufficient to demonstrate that defendant actually knew of a risk of harm). Deliberate indifference can be "manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed." *Estelle*, 429 U.S. at 104-05 (footnotes omitted).

Differences in judgment between an inmate and prison medical personnel regarding appropriate medical diagnosis and treatment are not enough to establish deliberate indifference. *Sanchez v. Vild*, 891 F.2d 240, 242 (9th Cir. 1989). "[T]o prevail

on a claim involving choices between alternative courses of treatment, a prisoner must show that the chosen course of treatment 'was medically unacceptable under the circumstances,' and was chosen 'in conscious disregard of an excessive risk' to the prisoner's health." *Toguchi v. Chung*, 391 F.3d 1051, 1058 (9th Cir. 2004) (alteration omitted) (quoting *Jackson v. McIntosh*, 90 F.3d 330, 332 (9th Cir. 1996)).

Mere indifference, medical malpractice, or negligence will not support a cause of action under the Eighth Amendment. *Broughton v. Cutter Labs*., 622 F.2d 458, 460 (9th Cir. 1980) (per curiam). A delay in treatment does not constitute a violation of the Eighth Amendment unless the delay causes further harm. *McGuckin*, 974 F.2d at 1060. Summary judgment is appropriate if medical personnel have been "consistently responsive to [the inmate's] medical needs," and there has been no showing that medical personnel had "subjective knowledge and conscious disregard of a substantial risk of serious injury." *Toguchi*, 391 F.3d at 1061.

5. Standard of Law Applicable to Fourteenth Amendment Claims

Other than claims involving a property interest—which are not at issue here—only claims involving a "liberty interest" are actionable under the Due Process Clause of the Fourteenth Amendment. Because liberty interests are "generally limited to freedom from restraint," a prisoner asserting a due process claim must show that he has suffered an "atypical and significant hardship . . . in relation to the ordinary incidents of prison life." *Sandin v. Conner*, 515 U.S. 472, 484 (1995). In *Sandin*, the Supreme Court held that, in order for a district court to determine whether there is such a liberty interest, it must analyze three factors: (1) whether disciplinary segregation was essentially the same as

discretionary forms of segregation; (2) whether a comparison between the plaintiff's confinement and conditions in the general population showed that the plaintiff suffered no "major disruption in his environment"; and (3) whether the length of the plaintiff's sentence was affected. *Id*. at 486-87.

In *Wilkinson v. Austin*, 545 U.S. 209 (2005), the United States Supreme Court underscored the severity of the conditions required to meet the liberty interest test:

> For an inmate placed in OSP, almost all human contact is prohibited, even to the point that conversation is not permitted from cell to cell; the light, though it may be dimmed, is on for 24 hours; exercise is for 1 hour per day, but only in a small indoor room. Save perhaps for the especially severe limitations on all human contact, these conditions likely would apply to most solitary confinement facilities, but here there are two added components. First is the duration. Unlike the 30-day placement in *Sandin*, placement at OSP is indefinite and, after an initial 30-day review, is reviewed just annually. Second is that placement disqualifies an otherwise eligible inmate for parole consideration. While any of these conditions standing alone might not be sufficient to create a liberty interest, taken together they impose an atypical and significant hardship within the correctional context. It follows that respondents have a liberty interest in avoiding assignment to OSP.

Id. at 223-24 (citations omitted).

"[T]he stigmatizing consequences of a transfer to a mental hospital for involuntary psychiatric treatment, coupled with the subjection of the prisoner to mandatory behavior modification as a treatment for mental illness, constitute the kind of deprivations of liberty that requires procedural protections."). *Vitek v. Jones*, 445 U.S. 480, 494 (1980) "Segregation of a prisoner without a prior hearing may violate due process if the

postponement of procedural protections is not justified by apprehended emergency conditions." *Hughes v. Rowe*, 449 U.S. 5, 11 (1980).

6. Analysis

A. *Defendant Corizon*

To succeed on his claims against Corizon as an entity, Hill must meet the test articulated in *Monell v. Dep't of Social Services*, 436 U.S. 658, 690-94 (1978); *see Tsao v. Desert Palace, Inc.*, 698 F.3d 1128, 1139 (9th Cir. 2012) (applying *Monell* to private entities). Under *Monell*, the requisite elements of a § 1983 claim against a municipality or private entity performing a state function are the following: (1) the plaintiff was deprived of a constitutional right; (2) the municipality or entity had a policy or custom; (3) the policy or custom amounted to deliberate indifference to plaintiff's constitutional right; and (4) the policy or custom was the moving force behind the constitutional violation. *Mabe v. San Bernardino Cnty.*, 237 F.3d 1101, 1110-11 (9th Cir. 2001). An unwritten policy or custom must be so "persistent and widespread" that it constitutes a "permanent and well settled" practice. *Monell*, 436 U.S. at 691 (quoting *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 167-168 (1970)). "Liability for improper custom may not be predicated on isolated or sporadic incidents; it must be founded upon practices of sufficient duration, frequency and consistency that the conduct has become a traditional method of carrying out policy." *Trevino v. Gates*, 99 F.3d 911, 918 (9th Cir. 1996).

Hill has failed to present facts indicating a basis for holding Corizon liable for a violation under the Eighth Amendment and the standard articulated in *Monell*. Hill has not presented evidence of any Corizon custom or policy that caused his alleged injuries.

The undisputed facts indicate the policy for treatment at C-3 was developed by IDOC, not Corizon. And, Corizon does not itself provide medical care. Rather, its contracted physicians and medical care providers dispensed medical care. Finally, Hill admits in his brief that he cannot challenge Corizon's motion for summary judgment. (Dkt. 39 at 2.) Therefore, summary judgment will be granted to Corizon.

B. *IDOC Defendants*[4]

(1) *Conditions of Confinement*

In his complaint, Hill alleged that he received inadequate out-of-cell time, that the suicide watch cells are dirty, ant infested, unsanitary, and cold, and that he was permitted to shower only three times per week. Hill further alleges that the conditions in the suicide watch cells are unconstitutional because prisoners are exposed to bright lighting 24 hours per day, and inmates are stripped nude and given a smock suit or suicide blanket with paper underwear. Hill alleges also that the behavioral modification system, or level system, is unconstitutional.

Hill has not presented evidence that any of the IDOC Defendants knew of and disregarded an excessive risk to Hill's health or safety by knowingly denying him humane conditions of confinement. First, there is no evidence Hill's concerns about his cell conditions were ever voiced. Hill submitted several offender concern forms while in

[4] IDOC Defendants argue that Hill's claims must be dismissed in their entirety under the Prison Litigation Reform Act, 42 U.S.C. § 1997e(e), because Hill has not alleged or shown any physical injury, citing *Oliver v. Keller*, 289 F.3d 623, 627 (9th Cir. 2002). However, *Oliver* does not so hold. Rather, *Oliver* holds that a prisoner may not seek damages for emotional injury unless the prisoner has suffered more than a *de minimus* physical injury. But, Section 1997e(e) does not bar actionable claims for compensatory, nominal or punitive damages premised upon violation of one's constitutional rights, and not on any alleged mental or emotional injuries. *Oliver*, 289 F.3d at 630. Hill seeks compensatory damages for violation of his Eighth and Fourteenth Amendment rights. Therefore, Section 1997e(e) does not bar Hill's claims.

the MHU, none of which complained about the conditions of his confinement. All of his offender concern forms were addressed by IDOC staff members. The absence of any concern forms addressing the alleged unsanitary, dirty, ant infested, cold, or other conditions of which Hill complains equate to a lack of any facts suggesting that any IDOC Defendants were aware Hill was placed in a dirty or unsanitary cell and then acted with deliberate indifference to this condition.

While Hill did claim he was placed in a suicide watch cell on one occasion when the cell was cold and he was provided inadequate clothing, Hill failed to submit any evidence that the IDOC Defendants were personally aware of that condition and were deliberately indifferent to the same. Although Hill reported to Hansen on April 15, 2011, that he was cold, there is no evidence Hansen ignored his concern, or that Hill submitted an offender concern form to address the temperature in his cell. Rather, the evidence in the record does establish that when Hill submitted his concern forms, they were addressed. The lack of any concern forms about the conditions in the MHU Hill experienced indicates a lack of any evidence establishing Hill's Eighth Amendment claims.

Next, Hill has not supported his claim that his lack of out-of-cell-time was detrimental to his mental health condition while in MHU. The records establish that Hill's behavior while in MHU was difficult to manage, and his limited out-of-cell time was for Hill's personal safety and the safety of staff because of his continued suicide threats and self-harming behaviors. An Eighth Amendment violation does not arise when the short-term deprivation of certain basic necessities of life result from an emergency

situation. *See Anderson v. County of Kern*, 45 F.3d 1310, 1315 (9th Cir. 1995) ("[I]n an emergency, prison officials are not culpable when they put an inmate who imminently threatens or attempts suicide temporarily in a place where he cannot hurt himself."). The record indicates Hill had threatened suicide four times in the twenty-one day period before being transferred to the MHU, and that while there, he used objects to harm himself and continued to threaten suicide. Under the circumstances, the temporary deprivation of certain privileges, such as out-of-cell time or more frequent showers, does not constitute deliberate indifference to Hill's conditions of confinement.

In his brief, Hill claims his conditions of confinement were unconstitutional because the IDOC should have a "safe room" for the placement of suicidal inmates. But Hill's argument cannot pass muster. Hill has failed to present evidence that he was subjected to an unreasonable risk of safety while on suicide watch at the MHU, or that the lack of a safe room caused an unreasonable risk of safety.[5] The record indicates Hill was evaluated regularly while housed in the MHU and kept under observation for self-harming behaviors or suicidal ideation.

Hill fails also to present evidence that the level system created an inhumane condition of confinement. Hill argues that, because of his diagnosis of personality disorder, the level system as applied to him was cruel and unusual punishment. But Hill offers nothing more than mere speculation and his own opinion. Further, the medical

[5] Nor does the Court believe Hill would actually want to be placed in a safe room. In *Anderson*, the safe room utilized for suicidal inmates consisted of a padded cell with a pit toilet covered by a grate, no furniture of any kind, and violent suicidal inmates were shackled over the pit toilet. *Anderson*, 45 F.3d at 1313. In that case, the court held the temporary use of a safety cell for placement of prisoners in response to severe safety concerns did not violate the Eighth Amendment.

team either met with Hill or checked in with him on a regular basis to determine his mental health status. There is therefore insufficient evidence to defeat IDOC's summary judgment motion on Hill's Eighth Amendment conditions of confinement claim.

(2) ***Mental Health Care***

Hill contends the IDOC Defendants were deliberately indifferent to his serious medical need because he was subjected to blanket behavioral modification treatment, which was insufficient to treat his borderline personality disorder, and he was not allowed access to programing, counseling, or other related mental health services except for the level system. However, while housed in the MHU, Hill was evaluated thirteen times, by Dr. Claudia Lake (4/14, 5/24), Dr. Scott Eliason (4/19, 5/10), psychology technician Micaela Cathey (4/21, 4/26, 5/6, 5/12, and 5/17), and by Vicki Hansen, M. Ed. (4/14, 4/15, 5/9, 5/11). Each provider performed an individual assessment of Hill's mental health condition as it existed at the time and attempted to engage Hill in his treatment.

These formal evaluations were in addition to the meetings of the members of his treatment team where Hill's behavioral and treatment plan were discussed. The treatment team meetings occurred weekly, on April 19 and 26, and May 3, 10, and 17. Additional evidence establishes that when Hill did not approve of his treatment, he threatened suicide and engaged in self-harm by cutting on himself with objects he found in his cell. He engaged in these behaviors in an apparent attempt to manipulate his cell placement. Thus, the evidence establishes that Hill refused to cooperate in his own mental health treatment, which caused him to be placed on suicide watch while at the MHU as a result of his own behavior choices.

There is also more than sufficient evidence that Dr. Eliason was treating Hill in a sufficient and medically acceptable manner. Dr. Eliason's treatment plan was to wean Hill off medication treating his depression, so the treatment team could better understand Hill's mental health diagnosis, thereby enabling the team to better treat his condition. This is in contrast to Hill's prior treatment plan developed on April 3, 2009, which was designed primarily to address Hill's behavior. *See* Supp. Aff. of Craig (Dkt. 46 at 8.) Hill's disagreement with his treatment plan recommended by his mental health treatment team and with the level system in C-3 was just that—a disagreement, which is not actionable under Section 1983. *See Sanchez*, 891 F.2d at 242. The burden thus shifts to Hill to raise a genuine issue that the level system and the behavioral and treatment plan were "medically unacceptable under the circumstances" or were "chosen in conscious disregard of an excessive risk" to Hill's mental health. *Toguchi*, 391 F.3d at 1058 (internal quotation marks omitted).

Hill has not met this burden. The IDOC Defendants dealt with Hill's behavior as best they could, responding to his threats of suicide and self-harm by placing Hill in the medical unit or on suicide watch. They assessed his status regularly as Hill was tapered off his medications. As a result of the treatment plan, Dr. Eliason ultimately determined Hill would not benefit from anti-depressant medications, and changed his diagnosis from Bipolar disorder to personality disorder. Staff attempted also to help Hill manage his behavioral and mental health issues. Although Hill claims he was subjected to the same treatment plan as all other individuals housed in C-3, the record refutes Hill's contention. Hill was offered an individualized treatment plan, focused on Hill's particular mental

health needs at the time of placement in the MHU. Hill, however, did not wish to follow it, and his own behavior (threats of suicide and self-harm) landed him in the suicide watch cells within the MHU. Hill has not shown that a genuine dispute of material fact exists, and the IDOC Defendants are entitled to summary judgment.

The Court briefly mentions IDOC Defendants Reinke, Evans, Blades, and Blackburn separately. Hill has failed to present evidence that any of these individuals personally participated in his medical care or had knowledge of and were deliberately indifferent to his serious medical needs. Hill's Section 1983 claims will be dismissed.

(3) *Due Process*

Hill alleges that his right to due process was violated by the failure to provide a hearing prior to his transfer to the MHU. He also claims that being forced to participate in the mandatory behavioral modification program and having to take psychotropic drugs on a coerced-compliance basis violates due process.

The segregation of a prisoner without a prior hearing may violate due process if the postponement of procedural protections is not justified by apprehended emergency conditions. *Hughes v. Rowe*, 449 US 5, 11 (1980). Here, Hill's medical care providers were responding to emergency conditions that existed at the time. Hill had been transferred four times between March 20, 2011, and April 11, 2011, to the medical observation cell because of Hill's unstable moods and self-injurious behavior, as well as threats of suicide. Medical staff determined the need to transfer him to the MHU for further evaluation and treatment, both for Hill's safety and staff safety. Hill has not presented any evidence to contradict the facts in the record.

Hill contends the reasoning in *Hughes* is inapplicable under *Vitek v. Jones*, 445 U.S. 480 (1980), because the MHU is a "mental hospital" to which he was transferred. Hill claims this Court must determine whether the MHU is a mental hospital before it can rule on IDOC's summary judgment motion. But Hill's arguments are misplaced.

The holding in *Vitek* does not apply to the facts present here. In *Vitek*, the plaintiff was involuntarily transferred from the prison to a state agency run mental hospital that was not under the auspices of the department of corrections. 445 U.S. at 488. Additionally, the prisoner was transferred because of a mental health diagnosis that the prison could not treat, not because any emergency justified the transfer. *Id.* at 484. Under those circumstances, the United States Supreme Court held that the plaintiff's involuntary transfer to a mental hospital for the purpose of psychiatric treatment implicated a liberty interest protected by the Due Process Clause. *Id.* at 494.

Here, in contrast, Hill was not transferred to a state agency run mental hospital. Rather, the MHU is part of the department of corrections. The MHU is a part of an IDOC prison, IMSI, and over which the IDOC has custody and control. The MHU inmates were treated by medical care providers contracted by IDOC to provide care to IDOC inmates. And Hill was not transferred to the MHU because of a mental health diagnosis IDOC could not treat. Rather, Hill was transferred because his mental health had deteriorated to the point that care providers determined an emergency existed. The purpose of the transfer was clearly expressed, and was for the purpose of conducting diagnostic work to determine the nature of Hill's mental health diagnosis so as to provide better treatment to

him. Under those facts, *Vitek* does not control here, and Hill's due process rights were not violated on account of the transfer.

Next, Hill has not presented contrary facts to suggest that his treatment plan was anything other than specifically tailored to Hill's medical condition and needs at the time. The goals of Hill's treatment plan were to wean Hill from his anti-depressant medications and determine the source of his behavior issues. The behavioral component was designed to address Hill's inappropriate behavior so he could transfer to a less restrictive environment. The plan was therefore tailored to Hill's medical needs, and Hill's due process rights were not violated.

Finally, Hill's contention that he was forced to take psychotropic medications is unfounded. The record establishes Hill's treatment plan indicated discontinuance of his medication to enable medical care providers to accurately diagnose and treat Hill. Therefore, the allegation that Hill's due process rights were violated is without merit.

CONCLUSION

The mental health treatment that Plaintiff received while he was housed in C-3 satisfied the Eighth Amendment. Further, there are no facts to suggest an Eighth Amendment violation based upon the conditions of Hill's confinement in the MHU. And finally, *Vitek* does not apply here, resulting in no due process violation. Therefore, Defendants' motions for summary judgment will be granted.

ORDER

NOW THEREFORE IT IS HEREBY ORDERED:

1. Plaintiff's Motion to Amend Complaint (Dkt. 40) is **DENIED**.

2. Plaintiff's Motion for Judicial Notice (Dkt. 42) is **DENIED**.

3. Plaintiff's Motion for Leave to File Objection to Defendants' Replies (Dkt. 48) is **DENIED as MOOT.**

4. Plaintiff's Motion to Appoint Counsel (Dkt. 50) is **DENIED**.

5. Defendants' Motion to Strike (Dkt. 44) is **DENIED as MOOT**.

6. Defendant Corizon's Motion for Summary Judgment (Dkt. 34) is **GRANTED**.

7. The IDOC Defendants' Motion for Summary Judgment (Dkt. 37) is **GRANTED**.

8. Defendant Lake is hereby **DISMISSED** from this action.

9. The Court hereby certifies, pursuant to 28 U.S.C. § 1915(a)(3), that any appeal from this Order would be frivolous and therefore taken in bad faith. *See Coppedge v. United States*, 369 U.S. 438, 445 (1962). For this reason, Plaintiff's in forma pauperis status is **REVOKED**. Any further request to proceed in forma pauperis on appeal should be directed on motion to the United States Court of Appeals for the Ninth Circuit in accordance with Rule 24 of the Federal Rules of Appellate Procedure.

DATED: December 18, 2014

B. Lynn Winmill
Chief Judge
United States District Court

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

DAVID TYLER HILL, Plaintiff-Appellant, v. BRENT REINKE; SHANE EVANS; JANE DOES, 1-2; RANDY BLADES, Warden; VICKI HANSEN; SHANNON BLACKBURN; RICHARD CRAIG; CLAUDIA LAKE, Defendants-Appellees.	No. 15-35061 DC No. CV 13-38 BLW **O R D E R**

Before: TASHIMA and GRABER, Circuit Judges, and MIHM,* District Judge.

Judge Graber votes to deny the petition for rehearing en banc and Judges Tashima and Mihm so recommend. The full court has been advised of the petition for rehearing en banc and no judge of the court has requested a vote on en banc rehearing. *See* Fed. R. App. P. 35(f). The petition for rehearing en banc is denied.

* The Honorable Michael M. Mihm, United States District Judge for the Central District of Illinois, sitting by designation.

STATUTORY ADDENDUM

Statutes

Regulations

Idaho Code § 66-326

66-326. DETENTION WITHOUT HEARING.

(1) No person shall be taken into custody or detained as an alleged emergency patient for observation, diagnosis, evaluation, care or treatment of mental illness unless and until the court has ordered such apprehension and custody under the provisions outlined in section 66-329, Idaho Code; provided, however, that a person may be taken into custody by a peace officer and placed in a facility, or the person may be detained at a hospital at which the person presented or was brought to receive medical or mental health care, if the peace officer or a physician medical staff member of such hospital or a physician's assistant or advanced practice registered nurse practicing in such hospital has reason to believe that the person is gravely disabled due to mental illness or the person's continued liberty poses an imminent danger to that person or others, as evidenced by a threat of substantial physical harm; provided, under no circumstances shall the proposed patient be detained in a nonmedical unit used for the detention of individuals charged with or convicted of penal offenses. For purposes of this section, the term "peace officer" shall include state probation and parole officers exercising their authority to supervise probationers and parolees. Whenever a person is taken into custody or detained under this section without court order, the evidence supporting the claim of grave disability due to mental illness or imminent danger must be presented to a duly authorized court within twenty-four (24) hours from the time the individual was placed in custody or detained.

(2) If the court finds the individual to be gravely disabled due to mental illness or imminently dangerous under subsection (1) of this section, the court shall issue a temporary custody order requiring the person to be held in a facility, and requiring an examination of the person by a designated examiner within twenty-four (24) hours of the entry of the order of the court. Under no circumstances shall the proposed patient be detained in a nonmedical unit used for the detention of individuals charged with or convicted of penal offenses.

(3) Where an examination is required under subsection (2) of this section, the designated examiner shall make his findings and report to the court within twenty-four (24) hours of the examination.

(4) If the designated examiner finds, in his examination under this section, that the person is mentally ill, and either is likely to injure himself or others or is gravely disabled due to mental illness, the prosecuting attorney shall file, within twenty-four (24) hours of the examination of the person, a petition with the court requesting the patient's detention pending commitment proceedings pursuant to the provisions of section 66-329, Idaho Code. Upon the receipt of such a petition, the court shall order his detention to await hearing which shall be within five (5) days (including Saturdays, Sundays and legal holidays) of the detention order. If no petition is filed within twenty-four (24) hours of the designated examiner's examination of the person, the person shall be released from the facility.

(5) Any person held in custody under the provisions of this section shall have the same protection and rights which are guaranteed to a person already committed to the department director. Upon taking a person into custody, notice shall be given to the person's immediate relatives of the person's physical whereabouts and the reasons for detaining or taking the person into custody.

(6) Nothing in this section shall preclude a hospital from transferring a person who has been detained under this section to another facility that is willing to accept the transferred individual for purposes of observation, diagnosis, evaluation, care or treatment.

§ 66-329. COMMITMENT TO DEPARTMENT DIRECTOR UPON COURT ORDER--JUDICIAL PROCEDURE.

(1) Proceedings for the involuntary care and treatment of mentally ill persons by the department of health and welfare may be commenced by the filing of a written application with a court of competent jurisdiction by a friend, relative, spouse or guardian of the proposed patient, by a licensed physician, by a physician's assistant or advanced practice registered nurse practicing in a hospital, by a prosecuting attorney or other public official of a municipality, county or of the state of Idaho, or by the director of any facility in which such patient may be.

(2) The application shall state the name and last known address of the proposed patient; the name and address of either the spouse, guardian, next of kin or friend of the proposed patient; whether the proposed patient can be cared for privately in the event commitment is not ordered; if the proposed patient is, at the time of the application, a voluntary patient; whether the proposed patient has applied for release pursuant to section 66-320, Idaho Code; and a simple and precise statement of the facts showing that the proposed patient is mentally ill and either likely to injure himself or others or is gravely disabled due to mental illness.

(3) Any such application shall be accompanied by a certificate of a designated examiner stating that he has personally examined the proposed patient within the last fourteen (14) days and is of the opinion that the proposed patient is: (i) mentally ill; (ii) likely to injure himself or others or is gravely disabled due to mental illness; and (iii) lacks capacity to make informed decisions about treatment, or a written statement by the applicant that the proposed patient has refused to submit to examination by a designated examiner.

(4) Upon receipt of an application for commitment, the court shall, within forty-eight (48) hours, appoint another designated examiner to make a personal examination of the proposed patient or if the proposed patient has not been examined, the court shall appoint two (2) designated examiners to make individual personal examinations of the proposed patient and may order the proposed patient to submit to an immediate examination. If neither designated examiner is a physician, the court shall order a physical examination of the

proposed patient. At least one (1) designated examiner shall be a psychiatrist, licensed physician or licensed psychologist. The designated examiners shall report to the court their findings within the following seventy-two (72) hours as to the mental condition of the proposed patient and his need for custody, care, or treatment by a facility. The reports shall be in the form of written certificates which shall be filed with the court. The court may terminate the proceedings and dismiss the application without taking any further action in the event the reports of the designated examiners are to the effect that the proposed patient is not mentally ill or, although mentally ill, is not likely to injure himself or others or is not gravely disabled due to mental illness. If the proceedings are terminated, the proposed patient shall be released immediately.

(5) If the designated examiner's certificate states a belief that the proposed patient is mentally ill and either likely to injure himself or others or is gravely disabled due to mental illness, the judge of such court shall issue an order authorizing any health officer, peace officer, or director of a facility to take the proposed patient to a facility in the community in which the proposed patient is residing or to the nearest facility to await the hearing and for good cause may authorize treatment during such period subject to the provisions of section 66-346(a)(4), Idaho Code. Under no circumstances shall the proposed patient be detained in a nonmedical unit used for the detention of individuals charged with or convicted of penal offenses.

(6) Upon receipt of such application and designated examiners' reports the court shall appoint a time and place for hearing not more than seven (7) days from the receipt of such designated examiners' reports and thereupon give written notice of such time and place of such hearing together with a copy of the application, designated examiner's certificates, and notice of the proposed patient's right to be represented by an attorney, or if indigent, to be represented by a court-appointed attorney, to the applicant, to the proposed patient, to the proposed patient's spouse, guardian, next of kin or friend. With the consent of the proposed patient and his attorney, the hearing may be held immediately. Upon motion of the proposed patient and attorney and for good cause shown, the court may continue the hearing up to an additional fourteen (14) days during which time, for good cause shown, the court may authorize treatment.

(7) An opportunity to be represented by counsel shall be afforded to every proposed patient, and if neither the proposed patient nor others provide counsel, the court

shall appoint counsel in accordance with chapter 8, title 19, Idaho Code, no later than the time the application is received by the court.

(8) If the involuntary detention was commenced under this section, the hearing shall be held at a facility, at the home of the proposed patient, or at any other suitable place not likely to have a harmful effect on the proposed patient's physical or mental health. Venue for the hearing shall be in the county of residence of the proposed patient or in the county where the proposed patient was found immediately prior to commencement of such proceedings.

(9) In all proceedings under this section, any existing provision of the law prohibiting the disclosure of confidential communications between the designated examiner and proposed patient shall not apply and any designated examiner who shall have examined the proposed patient shall be a competent witness to testify as to the proposed patient's condition.

(10) The proposed patient, the applicant, and any other persons to whom notice is required to be given shall be afforded an opportunity to appear at the hearing, to testify, and to present and cross-examine witnesses. The proposed patient shall be required to be present at the hearing unless the court determines that the mental or physical state of the proposed patient is such that his presence at the hearing would be detrimental to the proposed patient's health or would unduly disrupt the proceedings. A record of the proceedings shall be made as for other civil hearings. The hearing shall be conducted in as informal a manner as may be consistent with orderly procedure. The court shall receive all relevant and material evidence consistent with the rules of evidence.

(11) If, upon completion of the hearing and consideration of the record, and after consideration of reasonable alternatives including, but not limited to, holding the proceedings in abeyance for a period of up to thirty (30) days, the court finds by clear and convincing evidence that the proposed patient:

(a) Is mentally ill; and
(b) Is, because of such condition, likely to injure himself or others, or is gravely disabled due to mental illness;

the court shall order the proposed patient committed to the custody of the department director for observation, care and treatment for an indeterminate

period of time not to exceed one (1) year. The department director, through his dispositioner, shall determine within twenty-four (24) hours the least restrictive available facility or outpatient treatment, consistent with the needs of each patient committed under this section for observation, care, and treatment.

(12) The commitment order constitutes a continuing authorization for the department of health and welfare, law enforcement, or director of a facility, upon request of the director of the outpatient facility, the physician, or the department director through his dispositioner, to transport a committed patient to designated outpatient treatment for the purpose of making reasonable efforts to obtain the committed patient's compliance with the terms and conditions of outpatient treatment. If the director of the outpatient facility, the treating physician, or the department director through his dispositioner determines any of the following:

(a) The patient is failing to adhere to the terms and conditions of outpatient treatment or the patient refuses outpatient treatment after reasonable efforts at compliance have been made; or
(b) Outpatient treatment is not effective after reasonable efforts have been made;

the department director through his dispositioner shall cause the committed patient to be transported by the department of health and welfare, law enforcement, or director of a facility to the least restrictive available facility for observation, care and treatment on an inpatient basis. Within forty-eight (48) hours of a committed patient's transfer from outpatient treatment to a facility for inpatient treatment, the department director through his dispositioner shall notify the court that originally ordered the commitment, the committed patient's attorney, and either the committed patient's spouse, guardian, adult next of kin or friend of the change in disposition and provide a detailed affidavit reciting the facts and circumstances supporting the transfer from outpatient treatment to inpatient treatment at a facility. The court shall conduct an ex parte review of the notice and affidavit within forty-eight (48) hours of filing and determine whether the change in disposition from outpatient treatment to inpatient treatment at a facility is supported by probable cause. In no event shall the calculation of forty-eight (48) hours provided for in this subsection include holidays formally recognized and observed by the state of Idaho, nor shall the calculation include weekends. If the court determines that probable cause exists, the department director through his dispositioner shall continue with care and treatment on an

inpatient basis at the least restrictive available facility. Within twenty-four (24) hours of a finding of probable cause, the court shall issue an order to show cause why the patient does not meet the conditions in subsection (12)(a) or (12)(b) of this section. The order shall be served on the committed patient, the committed patient's attorney and either the committed patient's spouse, guardian, adult next of kin or friend. The patient shall have fifteen (15) days to present evidence that the conditions in subsection (12)(a) or (12)(b) of this section have not been met. In no event shall the calculation of twenty-four (24) hours provided for in this subsection include holidays formally recognized and observed by the state of Idaho, nor shall the calculation include weekends. If the court determines that a change in disposition from outpatient treatment to inpatient treatment does not meet the conditions in subsection (12)(a) or (12)(b) of this section, the department director through his dispositioner will continue with outpatient treatment on the same or modified terms and conditions. Nothing provided in this section shall limit the authority of any law enforcement officer to detain a patient pursuant to the emergency authority conferred by section 66-326, Idaho Code.

(13) Nothing in this chapter or in any rule adopted pursuant thereto shall be construed to authorize the detention or involuntary admission to a hospital or other facility of an individual who:

(a) Has epilepsy, a developmental disability, a physical disability, an intellectual disability, is impaired by chronic alcoholism or drug abuse, or aged, unless in addition to such condition, such person is mentally ill;
(b) Is a patient under treatment by spiritual means alone, through prayer, in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof and who asserts to any authority attempting to detain him that he is under such treatment and who gives the name of a practitioner so treating him to such authority; or
(c) Can be properly cared for privately with the help of willing and able family or friends, and provided, that such person may be detained or involuntarily admitted if such person is mentally ill and presents a substantial risk of injury to himself or others if allowed to remain at liberty.

(14) The order of commitment shall state whether the proposed patient lacks capacity to make informed decisions about treatment, the name and address of the patient's attorney and either the patient's spouse, guardian, adult next of kin, or friend.

(15) If the patient has no spouse or guardian and if the patient has property which may not be cared for pursuant to chapter 5, title 66, Idaho Code, or by the patient while confined at a facility, the court shall appoint a guardian ad litem for the purpose of preserving the patient's estate, pending further guardianship or conservatorship proceedings.

(16) The commitment shall continue until the commitment is terminated and shall be unaffected by the patient's conditional release or change in disposition.

Idaho Code § 66-1301

66-1301. PROGRAM ESTABLISHED.

The state board of correction shall establish, operate and maintain a program for persons displaying evidence of mental illness or psychosocial disorders and requiring diagnostic services and treatment in a maximum security setting, and for other criminal commitments as determined by the board of correction or its designee. The program shall be identifiably separate and apart from those functions and other programs maintained by the board for the ordinary prison population.

Idaho Code Ann. § 66-1304

66-1304. SOURCES OF RESIDENTS.

(1) Patients admitted to the program may originate from the following sources:

(a) Commitments by the courts as unfit to proceed pursuant to section 18-212, Idaho Code.

(b) Commitments by the courts of persons acquitted of a crime on the grounds of mental illness or defect pursuant to section 18-214, Idaho Code.

(c) Referrals by the courts for psychosocial diagnosis and recommendations as part of the pretrial or presentence procedure or determination of mental competency to stand trial.

(d) Mentally ill adult prisoners from city, county and state correctional institutions for diagnosis, evaluation or treatment.

(e) Commitments by the courts pursuant to section 66-329, Idaho Code.

(f) Criminal commitments of the Idaho department of correction requiring some form of specialized program not otherwise available.

(2) Residents coming to the program in the circumstances of subsection (1)(a), (b) and (e) of this section must first be found to be both dangerous and mentally ill, as defined in section 66-1305, Idaho Code, in judicial proceedings conducted in accordance with section 66-329, Idaho Code.

Idaho Code Ann. § 66-1317

66-1317. REVIEW OF INVOLUNTARY TREATMENT.

The state board of correction shall adopt procedures ensuring that treatment plans are developed for patients in the program for whom the court has authorized treatment, that the relative risks and benefits of specific modes of treatment contained in such plans are explained, to the extent possible, to each patient; that when treatment is given over the objection of a patient, there is a review of the decision to provide treatment independent of the treating professional and that a statement explaining the reasons for giving treatment over objection of the patient shall be entered in the patient's treatment record over the signature of the program administrator.

Idaho Department of Correction
Involuntary Medication and Treatment
Standard Operating Procedure Control Number 401.06.03.067

BOARD OF CORRECTION IDAPA RULE NUMBER 401

Medical Care

POLICY CONTROL NUMBER 401

Clinical Services and Treatment

DEFINITIONS

Standardized Terms and Definitions List

Chief Psychologist: The Idaho Department of Correction (IDOC) employee who is primarily responsible for overseeing or managing the IDOC's mental health services.

Diagnostic and Statistical Manual of Mental Disorders (DSM): The standard manual of psychiatric diagnoses, as published and amended by the American Psychiatric Association from time to time.

Emergency Involuntary Medication: The administration of medication to an offender without the offender's informed consent but only in situations that warrant emergency intervention and only for a limited duration.

Gravely Disabled: A condition in which a person, as a result of a physical or mental disorder, (a) is in danger of serious physical harm resulting from a failure to provide his essential human needs of health or safety; or (b) manifests severe deterioration in routine functioning as evidenced by repeated and escalating loss of cognitive or volition control over his actions and is not receiving such care as is essential for his health or safety.

Health Authority: The Idaho Department of Correction (IDOC) employee who is primarily responsible for overseeing or managing the IDOC's medical services. (The health authority is commonly referred to as the health services director.)

Idaho Security Medical Program (ISMP): A statutorily-constituted program maintained by the Idaho Board of Correction for persons displaying evidence of mental illness or psychological disorders, requiring diagnosis and treatment in a maximum security setting, and for other criminal commitments.

Involuntary Medication: The administration of medication to an offender without the offender's informed consent. (Under non-emergency involuntary medication situations, the administration of medication will occur only after holding an involuntary medication hearing.)

Involuntary Medication Hearing: A hearing to determine whether an offender in a non- emergency involuntary medication situation should be subject to involuntary medication.

Involuntary Medication Hearing Committee (IMHC): A committee comprised of a deputy warden, non-treating psychologist, and non-treating psychiatrist for the purpose of determining whether an offender should be subjected to involuntary medication. (The non- treating psychiatrist shall serve as chair of the IMHC.)

Involuntary Medication Report: A report, submitted by the treating psychiatrist, requesting the involuntary medication of an offender who will not or cannot give informed consent to treatment.

Likelihood of Serious Harm: A substantial risk that:

- Physical harm will be inflicted by an individual upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on himself; or
- Physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or
- Harm will be inflicted by an individual upon his or other's property as evidenced by behavior which has caused substantial loss or damage to his or other's property.

Medical Director: A physician either employed by the Idaho Department of Correction (IDOC) or contracted through privatized services (i.e., the physician in charge if medical services are privatized).

Mental Disorder: Any organic, mental, or emotional impairment which has a substantial adverse effect on an individual's cognitive functioning or volitional control.

Preponderance of the Evidence: The general standard of proof in most civil cases, which is the degree of proof that will lead a person (e.g., a party, an investigator) to conclude that the existence of the fact is more probable than not.

Regional Health Manager: The individual (a) assigned as the primary manager, and (b) administratively responsible for the delivery of medical services, if health services are privatized.

PURPOSE

The purpose of this standard operating procedure (SOP) is to establish guidelines for the involuntary administration of medications to those offenders suffering from mental disorders, who as a result of those disorders, are considered gravely disabled and/or presents the likelihood of serious harm to self, others, or their property.

SCOPE

This SOP applies to all Idaho Department of Correction (IDOC) employees, offenders, contract medical providers and subcontractors.

More specifically in regards to offenders, this SOP applies to those offenders (a) committed to the custody of the IDOC pursuant to a judgment of conviction, and (b) committed to the Idaho Security Medical Program pursuant to Idaho Code, section 66-1306 et seq.

RESPONSIBILITY

The director of the Education, Treatment, and Reentry Bureau **and** deputy chief of the Prisons Bureau shall be jointly responsible for the implementation of this SOP **and** for designating appropriate personnel to develop and implement procedures in conjunction with this SOP.

GENERAL REQUIREMENTS

1. **Right to Refuse Treatment**

   Pursuant to SOP 401.06.03.071, *Right to Refuse Treatment*, an offender has the right to refuse treatment, including medications. The involuntary medication of an offender may only take place under the circumstances and procedures described herein this SOP.

2. **Informed Consent**

   Prior to any involuntary administration of medication to an offender, an attempt must be made to obtain the offender's informed consent (see SOP 401.06.03.070, *Informed Consent*). If the offender provides informed consent, treatment will be provided and staff shall no longer be required to follow the guidance provided herein this SOP.

3. **Recording the Administration of Involuntary Medication**

   The administration of involuntary medication shall be recorded with a video recorder. A copy of the recording will be retained in the offender's healthcare record.

4. **Use of Force**

   If the administration of involuntary medication is ordered and the use of force is required, only the amount of force necessary to administer the medication shall be used.

5. **Offender's Right to Seek Relief**

   Nothing in this SOP shall be construed as limiting or expanding an offender's rights to seek relief.

Note: The use of force must be preceded by an attempt to use a less restrictive means to administer the medication. When the use of force is required, it shall be in accordance with SOP 307.02.01.001, *Use of Force: Prisons and Community Work Centers (CWCs).*

Note: Offenders shall not use the grievance process described in SOP 316.02.01.001, *Grievance and Informal Resolution Procedure for Offenders*, to seek relief. Instead, offenders may seek relief through the courts.

EMERGENCY INVOLUNTARY MEDICATION FOR OFFENDERS

6. Basis and Procedure for Emergency Involuntary Medication

Generally, an involuntary medication hearing must be held prior to any involuntary administration of medication to an offender. However, a physician or psychiatrist may order the emergency involuntary administration of medication without holding an involuntary medication hearing if, in his professional judgment, the offender:

- Is refusing or is unable to consent to treatment;
- Is suffering from a 'mental disorder';
- As a result of that mental disorder, presents an imminent likelihood of serious harm to self or others, including the failure to care for self if the harm is imminent; and
- Is unlikely to respond to less restrictive medically acceptable alternatives, or such alternatives are not available or have not been successful.

Note: For the purpose of this SOP only, 'mental disorder' includes mental illness or psychological disorders which may provide a basis for commitment to the Idaho Security Medical Program pursuant to Idaho Code, section 66-1306 et seq.

Note: The emergency involuntary administration of medication to the offender shall only occur where there is an existing emergency **and** shall not be ordered in anticipation of a potential or future emergency.

Note: No more than two (2) emergencies for a single offender may be declared within any 30-day period.

Physician and Psychiatrist Responsibilities

Where the emergency involuntary administration of medication is ordered by a physician who is not a psychiatrist, the physician must consult with a psychiatrist within 24 hours of administering the medication to the offender.

- If the psychiatrist concurs with the physician, treatment may be continued for an additional 48 hour period.

- If the psychiatrist does not concur, treatment shall cease immediately.
- Documentation of the psychiatrist's consultation shall be entered in the offender's healthcare record. After the emergency involuntary administration of medication to the offender, the physician or psychiatrist will:

- Ensure monitoring occurs for adverse reactions and side effects;
- Document in the offender's healthcare record the specific justification for the medication, when and how the medication is to be administered, what alternative treatments were attempted (or if no alternative treatments were attempted, document why alternative treatments were not attempted, were unavailable, or were unlikely to succeed); and

• Notify the facility head (or designee) **and** the chief psychologist within 24 hours of initiating treatment and document the notification in the offender's healthcare record.

Duration of Treatment

The emergency involuntary administration of medication to the offender shall have a maximum duration of 72 hours for a single emergency **and** may not continue beyond that time without holding an involuntary medication hearing.

If during the 72-hour period the offender consents to treatment, the 72-hour period will no longer apply. The offender's consent to treatment shall be documented in the offender's healthcare record.

Offender Consent to and then Refuses Treatment

If, after consenting to treatment, the offender again refuses **and** the conditions set forth in this section are applicable, the offender may again be involuntarily administered medication pursuant to the emergency involuntary administration of medication procedures provided in this section. If this occurs, new 24-hour and 72-hour periods begin.

NON-EMERGENCY INVOLUNTARY MEDICATION FOR OFFENDERS

7. Basis for Non-emergency Involuntary Medication

An offender may be subject to non-emergency involuntary medication but only if the Involuntary Medication Hearing Committee (IMHC) holds an involuntary medication hearing, **and** only if the IMHC finds that the offender:

- Suffers from a 'mental disorder' and is gravely disabled; and/or
- Suffers from a mental disorder **and** poses a likelihood of causing serious harm to himself, others, or their property.

  Other safeguards that the IMHC will consider when determining whether or not an offender may be subject to non-emergency involuntary medication are when:

  - A psychiatrist determined that the offender should be medicated;
  - The offender did not consent to the medication after being given the opportunity to do so;
  - All available less restrictive options were exhausted, were shown to be ineffective, or were likely to not be effective;

Note: Also see section 9, subsection titled 'Involuntary Medication Hearing Officer Responsibilities (Post-IMHC Deliberations)'.

Note: For the purpose of this SOP only, 'mental disorder' includes mental illness or psychological disorders which may provide a basis for commitment to the Idaho Security Medical Program pursuant to Idaho Code, section 66-1306 et seq.

Note: Non-emergency involuntary medication shall be administered only at facilities with identified mental health **or** behavioral health units.

- The psychiatrist determined that the potential benefits for the proposed medication outweighed the risks associated with it; and
- A less restrictive means of non-emergency treatment was attempted and exhausted, was not successful, was unlikely to succeed, and if true, specifically what means were attempted or exhausted, and what was the basis for concluding that the treatment did not succeed or was unlikely to succeed.

8. Pre-involuntary Medication Hearing Procedure

The involuntary medication hearing process shall be initiated when the treating psychiatrist submits an Involuntary Medication Report to the facility head, chief

psychologist, medical director, or their designees. The Involuntary Medication Report shall include, but not be limited to:

- The factual basis of the request for non-emergency involuntary medication;
- Observed behaviors and mental status of the offender;
- The factual basis for the offender's tentative diagnosis from the current Diagnostic and Statistical Manual of Mental Disorders (DSM);
- Documentation indicating the offender meets the criteria for non-emergency involuntary medication;
- Methods used to encourage the offender to accept medication voluntarily and the offender's response to those efforts;
- The offender's history of voluntary and involuntary non-emergency treatment;
- Whether less restrictive medically acceptable means of treatment are available, have been attempted, have been effective, and the likelihood of their effectiveness;
- The medication suggested to treat the offender, the offender's expected prognosis with and without the medication, and the risks and benefits associated with it; and
- The likely duration of the medication.

Treating Psychiatrist Responsibilities

Upon submission of the Involuntary Medication Report, the treating psychiatrist shall arrange for:

- Scheduling the involuntary medication hearing;
- Forwarding of a copy of the Involuntary Medication Report (via email or fax) to the IMHC **and** making the offender's healthcare record available to the IMHC no later than 24 hours prior to the hearing; and
- Notifying the facility head (or designee) **and** chief psychologist of the hearing and documenting this notification in the offender's healthcare record.

24 Hours Prior to Involuntary Medication Hearing: Offender's Right to Refuse Treatment

For a period of 24 hours prior to the involuntary medication hearing, the offender shall not be subject to any medication for the 'mental disorder' (see section 7) for which non- emergency involuntary medication is proposed.

Involuntary Medication Hearing Officer Appointment

An involuntary medication hearing shall be facilitated and presided over by an involuntary medication hearing officer.

In consultation with the Deputy Attorneys General (DAGs) who represent the IDOC, the chief of the Operations Division (or designee) shall appoint an involuntary medication hearing officer.

The involuntary medication hearing officer shall not have been involved in the treatment of the offender for whom the involuntary medication hearing is being held for.

Involuntary Medication Hearing Officer Responsibilities (Pre-involuntary Medication Hearing)

The involuntary medication hearing officer's duties shall include, but not be limited to, the following:

- Prior to serving the Notice of Involuntary Medication Hearing on the offender, assigning a staff hearing assistant to assist the offender in the hearing and/or appeal process;
- Arranging for an interpreter or translation service if the offender does not speak English;
- Ensuring that an involuntary medication hearing record is kept (see section 9); and
- Ensuring the involuntary medication hearing record (see section 9) **and** a Notice of the Right to Appeal (see section 10) are delivered together to the offender.

Staff Hearing Assistant Appointment and Responsibilities

In consultation with the DAGs who represent the IDOC, the involuntary medication hearing officer shall appoint a staff hearing assistant.

The staff hearing assistant must be an IDOC physician's assistant, nurse practitioner, or registered nurse who has not been directly involved in the offender's treatment or diagnosis.

The staff hearing assistant shall be responsible for assisting the offender with understanding the medical and psychiatric issues involved in the involuntary medication hearing process, and obtaining witness statements, other documents, or evidence.

If the offender is excluded from the involuntary medication hearing process, chooses not to participate, or is unable to participate due to the severity of his 'mental disorder' (see section 7), the staff hearing assistant shall attend the hearing for the offender (having the same rights as the offender) and represent the offender's wishes as best as possible.

Note: An offender receiving emergency involuntary medication shall have the right to refuse medication during the same 24-hour period.

Prior to the involuntary medication hearing, the staff hearing assistant shall meet with the offender and explain to him the following:

- The contents of the Notice of Involuntary Medication Hearing;
- The stated reason for the hearing;
- The medication being recommended, its expected result, and the likely outcome without benefit of the medication;
- The reason the offender is being offered staff assistance;
- The hearing process and the offender's right to attend the hearing;
- The offender's right to challenge the recommended medications;
- The offender's rights to speak at the hearing, to present witnesses and documentary evidence, and to cross-examine witnesses;
- The offender's right to an interpreter or translation service, if one is required; and
- The offender's right to appeal the IMHC's decision to the facility head.

Prior to the involuntary medication hearing, the staff hearing assistant shall determine whether the offender requires an interpreter or translation service. If so, the staff hearing assistant shall immediately inform the involuntary medication hearing officer. If translation services are required but unavailable, the hearing should be delayed until such services are available.

Notice of Involuntary Medication Hearing

No later than 24 hours prior to the scheduled involuntary medication hearing, the offender shall be served with a Notice of Involuntary Medication Hearing. As designated by the involuntary medication hearing officer, service may be performed by the staff hearing assistant, a facility security staff member, or a clinician. The person performing service shall execute a Return of Service and deliver it to the involuntary medication hearing officer prior to the hearing.

The Notice of Involuntary Medication Hearing shall include:

- The date and time of the hearing;
- The reason for the hearing;
- The factual basis for the offender's tentative diagnosis (from the current DSM) and the data that supports it; and
- The evidence (see section 9) to be presented at the hearing that will be used to establish whether the offender meets the criteria for non-emergency involuntary medication. (The IDOC's evidence will include why staff believes non-emergency involuntary medication is necessary. The reasons why shall also be stated in the Notice of Involuntary Medication Hearing.)

Involuntary Medication Hearing Committee (IMHC) Responsibilities

The IMHC shall determine whether non-emergency involuntary medication is appropriate based on the evidence presented at the involuntary medication hearing.

Prior to the involuntary medication hearing, the IMHC shall review the Involuntary Medication Report **and** the offender's healthcare record.

Offender's Non-participation or Exclusion From the Involuntary Medication Hearing Process

The offender may elect to not participate **or** may be unable to participate in the involuntary medication hearing process due to the severity of his 'mental disorder' (see section 7). In such cases, the chair of the IMHC may request to the involuntary medication hearing officer that (a) the staff hearing assistant act for the offender during the hearing, and (b) the reasons why the offender is unable to participate be noted in the involuntary medication hearing record (see section 9).

An offender may be excluded or removed from the involuntary medication hearing for (a) safety or security reasons, or (b) if his behavior is so disruptive it is not possible to otherwise proceed with the hearing. The involuntary medication hearing officer will state for the involuntary medication hearing record (see section 9) the reasons why the offender has been excluded or removed. If the offender is excluded or removed from the involuntary medication hearing, (a) the hearing may proceed with the staff hearing assistant representing the offender's wishes, **or** (b) the involuntary medication hearing officer may continue the hearing for no more than three (3) days.

9. Involuntary Medication Hearing Procedure

Involuntary Medication Hearing Officer Responsibilities (Pre-IMHC Deliberations)

The involuntary medication hearing officer shall:

- Convene and preside over the involuntary medication hearing;
- Determine whether translation services are necessary and available;
- Verify that the offender, staff hearing assistant, interpreter (if necessary), all IMHC members, a DAG who represents the IDOC, and a person to create the involuntary medication hearing record are present;
- Identify all personnel who are authorized to remain present for procedural, security, clinical, legal, or training purposes;
- Inform those present of the rules and procedures that must be adhered to during the hearing, and exclude all non-essential personnel;
- Verify that the offender received a Notice of Involuntary Medication Hearing at least 24 hours prior to the hearing;
- Verify that the staff hearing assistant had the opportunity to consult with the offender prior to the hearing, and the offender understands his rights and (a) can adequately understand the proceedings, or (b) the staff hearing assistant can adequately represent the offender's wishes at the hearing;

  Note: No IMHC member shall at the time of the hearing be directly involved in the offender's treatment or diagnosis for the disorder for which non-emergency involuntary medication is proposed.

• Verify that the IMHC members have reviewed the Involuntary Medication Report, the tentative diagnosis, and the offender's healthcare record and/or mental health record.

Presentation of Evidence

During the presentation of evidence, IMHC members may question any witness **or** the offender.

The IDOC

The IDOC may present evidence through testimony, witnesses, or by records or documents. Evidence of the need for non-emergency involuntary treatment, the treatment proposed, the likelihood of the proposed treatment's success, its benefits and risks, and why less restrictive alternatives did not **or** will not work shall be presented by the treating psychiatrist. The offender may examine the evidence and cross-examine the IDOC's witnesses.

The Offender

The offender may present evidence, through testimony, witnesses, or by records or documents. The offender shall have the opportunity to state his preference as to non- emergency involuntary treatment options. The IDOC may examine the evidence and cross examine the offender's witnesses.

In the event the offender is not present, has been removed or excluded, or is unable to understand the hearing proceedings due to the severity of his 'mental disorder' (see section 7), the staff hearing assistant may present and examine evidence, testify, and cross-examine IDOC witnesses for the offender.

Inclusion or Exclusion of Evidence

Testimony from remote locations, including telephonic or videoconference testimony, may be allowed at the discretion of the involuntary medication hearing officer. Written witness statements provided by the offender may be considered upon a showing of good cause why the witness could not personally appear.

The involuntary medication hearing officer may allow, limit, or exclude evidence and the cross-examination of witnesses. Reasons for limiting or excluding evidence include, but are not limited to: relevance and/or security considerations.

When the involuntary medication hearing officer limits or excludes evidence or the cross- examination of witnesses, the reasons for doing so shall be reflected in the involuntary medication hearing record.

The involuntary medication hearing officer shall ensure that the involuntary medication hearing record reflects all witnesses giving testimony **and** all exhibits are entered into the record.

IMHC Deliberation

When the presentation of evidence is complete, the involuntary medication hearing officer will allow the IMHC to deliberate on whether the offender meets the criteria for being administered non-emergency involuntary medication.

IMHC Responsibilities

The IMHC shall be responsible for rendering a decision based on the following:

- The Involuntary Medication Report;
- All evidence presented at the involuntary medication hearing;
- The offender's healthcare record and/or and mental health record; and
- The offender's stated preference for non-emergency involuntary treatment.

Involuntary Medication Hearing Officer Responsibilities (Post-IMHC Deliberations)

When the IMHC has concluded its deliberations and recorded its decision, it shall inform the involuntary medication hearing officer **and** the offender shall be allowed to return to the hearing proceedings.

The involuntary medication hearing officer shall inquire of the chair of the IMHC as to the evidence relied upon to reach their decision.

Following inquiry as to the evidence considered, the involuntary medication hearing officer shall inquire of the chair of the IMHC as to whether their decision was unanimous.

If their decision was unanimous, the chair of the IMHC shall speak to the decision made and that decision and the reason for the decision reflected in the involuntary medication hearing record.

If the decision was not unanimous, the involuntary medication hearing officer shall poll each IMHC member as to their individual findings so that their findings can be reflected in the involuntary medication hearing record.

Based on whether the decision was unanimous or not, the involuntary medication hearing officer shall inquire to the chair of the IMHC **or** each IMHC member as to whether they believe the evidence established that:

- The offender suffers from a 'mental disorder' (see section 7) and is gravely disabled; and/or
- The offender suffers from a mental disorder **and** poses a likelihood of causing serious harm to himself, others, or their property.

Note: During deliberation, all personnel present (except for the IMHC members **and** the DAG who represents the IDOC) must leave the room, no additional evidence may be presented, and the facility head-designated staff member shall not take written minutes **or** a transcription (if the hearing is being electronically recorded). However, the IMHC will be allowed to consult with the DAG who represents the IDOC.

Note: The chair of the IMHC shall preside over their deliberations and summarize the IMHC's findings **and** evidence relied upon to reach a decision.

Note: The involuntary medication hearing officer shall also inquire to the chair of the IMHC whether or not the safeguards noted in section 7 were considered.

The chair of the IMHC must be in the majority of members who were polled to be in favor of allowing the IDOC to administer non-emergency involuntary medication to the offender.

The involuntary medication hearing officer shall ensure that the IMHC's findings are reflected in the involuntary medication hearing record.

If the IMHC's findings support non-emergency involuntary treatment, the involuntary medication hearing officer shall inform the offender of his right to an appeal (see section 10).

The involuntary medication hearing officer shall ensure that the involuntary medication hearing record be finalized and as soon as possible be transmitted (via

email or fax) to the facility head, chief psychologist, medical director, and also provide the offender a hard copy of the record.

The involuntary medication hearing officer may consult with a DAG who represents the IDOC at any time during the non-emergency involuntary medication hearing.

Involuntary Medication Hearing Record

The facility head (or designee) shall designate a facility staff member to (a) be present at the non-emergency involuntary medication hearing **and** (b) take written minutes **or** a transcription (if the hearing was electronically recorded).

At the conclusion of the non-emergency involuntary medication hearing, the facility head-designated staff member shall finalize the written minutes **or** transcription.

The involuntary medication hearing record shall include, but not be limited to, the following:

- Instructions by the involuntary medication hearing officer to those present;
- The involuntary medication hearing officer's verification that the offender received a Notice of Involuntary Medication Hearing, was advised of involuntary medication hearing procedure **and** of his rights, had access to a staff hearing assistant, and whether or not an interpreter was required;
- Whether or not the offender refused to participate, was unable to participate in the non-emergency involuntary medication hearing due to the severity of his 'mental disorder' (see section 7), or was excluded or removed from the hearing, and if the latter, the grounds for excluding or removing the offender from the hearing;
- Whether or not all evidence and witnesses, cross-examination, and evidentiary rulings were allowed;
- The IMHC's findings;
- Whether or not the IMHC found in favor of allowing the IDOC to administer non- emergency involuntary medication to the offender; and

Note: During deliberation, the facility head-designated staff member shall not take written minutes **or** a transcription (if the hearing is being electronically recorded).

• Whether or not the offender was informed of his the right to appeal the IMHC's decision to the facility head.

The involuntary medication hearing record shall not reflect any consultation the involuntary medication hearing officer **and/or** an IMHC member had with a DAG who represents the IDOC.

Facility Head-Designated Staff Member's Responsibilities

The facility head-designated staff member who is responsible for finalizing the involuntary medication hearing record shall forward the record (via email or fax) to the involuntary medication hearing officer within 24 hours of the conclusion of the non- emergency involuntary medication hearing. Upon the involuntary medication hearing officer's approval, the staff member shall, as soon as possible, transmit the record (via email or fax) to the facility head, chief psychologist, medical director, and also provide the offender a hard copy of the record.

10. Appeal and Automatic Review of IMHC's Decision

An offender shall have the option to appeal the IMHC's decision to the facility head within 24 hours of receiving a hard copy of the involuntary medication hearing record.

In addition to the offender's option to appeal the IMHC's decision, and regardless of whether the offender exercises that option, the facility head shall automatically review the decision.

In conducting the automatic review, the facility head must consider the involuntary medication hearing record **and** if the offender appealed, all reasons set forth by the offender as the basis for the appeal.

Except on the grounds that the IMHC's decision was based on inaccurate or erroneous factual evidence, the facility head shall not override the IMHC's decision. The facility head does not and shall not have the authority to override an IMHC decision based on medical grounds.

If the facility head overrides the IMHC's decision based on inaccurate or erroneous factual evidence, the facility head's decision shall be in writing and specific reasons documented for overriding the IMHC's decision.

- In cases where the offender exercises his option to file an appeal, the facility head shall render a decision within one business day of receiving the appeal.
- In cases where the offender did not exercise his option to file an appeal, the facility head shall render a decision within one business day of receiving a copy of the involuntary medication hearing report.
- In all cases, the facility head should consult with a DAG who represents the IDOC when determining an offender's appeal **or** an automatic review.
- In all cases, the facility head shall forward (via email or fax, as soon as possible) his decision to all IMHC members, the DAG, the chief psychologist, the medical director, and also provide the offender a hard copy of the decision.

Note: The offender must be informed of the facility head's decision prior to the IDOC being allowed to administer non-emergency involuntary medication to the offender.

In cases where the facility head overrides the IMHC's decision, the facility head's decision shall constitute a remand, and the case shall be returned to the IMHC. In the case of a remand, the IMHC shall reconvene, and may:

- Accept the facility head's decision and issue a new decision to not allow the IDOC to administer non-emergency involuntary medication to the offender; or
- Set the matter for another involuntary medication hearing as soon as possible, with instructions to the IDOC to address the specific items set forth in the facility head's decision.

11. Periodic Review of the Administration of Non-emergency Involuntary Medication

After an involuntary medication hearing decision, the administration of non-emergency involuntary medication may continue for up to 180 days, and only upon periodic review, as set forth in this section.

After the first seven days of administering non-emergency involuntary medication, the treating psychiatrist shall prepare an Involuntary Medication Report regarding the offender's progress to the IMHC. The IMHC shall review the offender's case, consult, and either re- approve non-emergency involuntary medication or discontinue it. The IMHC's consultation of

members may be in person or via electronic media (e.g., telephone, email, and teleconferencing). The IMHC's decision shall be transmitted (via email or fax) by the chair of the IMHC to the treating psychiatrist.

If the IMHC re-approves non-emergency involuntary medication, the treating psychiatrist shall, for every 14 days thereafter while the non-emergency involuntary medication continues, prepare an Involuntary Medication Report regarding the offender's progress to the health authority.

At the end of each 180 day period, another IMHC shall be convened and new findings must be made to continue the non-emergency involuntary medication. If non-emergency involuntary medication is again approved, the offender may appeal and the automatic review (see section 10) and periodic review (see this section) processes shall again take place.

NON-EMERGENCY INVOLUNTARY MEDICATION FOR OFFENDERS DEEMED UNFIT FOR CRIMINAL TRIAL

12. Idaho Security Medical Program (ISMP)

Pursuant to Idaho Code, section 18-212 **and** 66-1304(a), an offender may be committed to the Idaho Security Medical Program (ISMP) upon a finding that the offender is unfit to proceed in his criminal case. In such cases, non-emergency involuntary medication shall not be administered solely for purposes of rendering an offender competent to stand trial, except where the court which has jurisdiction over the criminal case and which has ordered the offender's commitment to the ISMP has made findings that:

- Important governmental interests are at stake in bringing the offender to trial;
- Non-emergency involuntary medication will significantly further those interests;

Note: If the IMHC conducts another involuntary medication hearing, the IMHC's decision shall again be subject to the appeal and automatic review process described in this section.

- Non-emergency involuntary medication is necessary to further those interests;
- Non-emergency involuntary medication is medically appropriate; and

- The IDOC is therefore authorized to administer non-emergency involuntary medication for purposes of rendering the offender competent to stand trial.

  The administration of non-emergency involuntary medication under this section may take place only upon the chief psychologist's expressed authorization, based on a review of the applicable court order **and** consultation with the facility head, a DAG who represents the IDOC, and the director of the IDOC.

  Pursuant to Idaho Code, section 66-1306, the director of the IDOC retains discretion to discharge an offender from the ISMP at any time.

REFERENCES

Balla v. Idaho State Board of Correction, 869 F.2d 461 (9th Cir. 1989)

Idaho Code, Title 18, Chapter 2, *Section 18-212, Determination of Fitness of Defendant to Proceed – Suspension of Proceeding and Commitment of Defendant – Postcommitment Hearing*

Idaho Code, Title 66, Chapter 13, *Idaho Security Medical Program*

Idaho Code, Title 66, Chapter 13, Section 66-1304, *Sources of Residents*

Idaho Code, Title 66, Chapter 13, Section 66-1306, *Final Decision*

Idaho Code, Title 66, Chapter 13, Section 66-1307, *Return of Patient*

Idaho Code, Title 66, Chapter 13, Section 66-1308, *Transport of Patients*

Idaho Code, Title 66, Chapter 13, Section 66-1309, *Costs and Charges*

Idaho Code, Title 66, Chapter 13, Section 66-1310, *Civil Rights of Residents*

Idaho Code, Title 66, Chapter 13, Section 66-1311, *Right to Humane Care and Treatment*

Idaho Code, Title 66, Chapter 13, Section 66-1312, *Standards for Treatment*

Idaho Code, Title 66, Chapter 13, Section 66-1313, *Mechanical Restraints*

Idaho Code, Title 66, Chapter 13, Section 66-1314, *Interstate Contracts*

Idaho Code, Title 66, Chapter 13, Section 66-1315, *Short Title*

Idaho Code, Title 66, Chapter 13, Section 66-1316, *Patients from Other Institutions*

Idaho Code, Title 66, Chapter 13, Section 66-1317, *Review of Involuntary Treatment*

Idaho Code, Title 66, Chapter 13, Section 66-1318, *Transfer of Noncorrectional Facilities*

National Commission on Correctional Health Care (NCCHC), *Standards for Health Services in Prisons,* Standard P-I-02, Emergency Psychotropic Medication

National Commission on Correctional Health Care (NCCHC), *Standards for Health Services in Prisons,* Standard P-I-05, Informed Consent and Right to Refuse

Riggins v. Nevada, 504 U.S. 127 (1992) *Sell v. United States*, 539 U.S. 166 (2003)

Standard Operating Procedure 307.02.01.001, *Use of Force: Prisons and Community Work Centers (CWCs)*

Standard Operating Procedure 316.02.01.001, *Grievance and Informal Resolution Procedure for Offenders*

Standard Operating Procedure 401.06.03.070, *Informed Consent*
Standard Operating Procedure 401.06.03.071, *Right to Refuse Treatment Standards for Adult Correctional Institutions*, Third Edition, Standard 3-4342; *Vitek v. Jones*, 445 U.S. 480 (1980); *Washington v. Harper*, 494 U.S. 210 (1990)